



聖保祿醫院
St. Paul's Hospital

NEWSLETTER 院訊

"I made myself all things to all men" (1 Cor. 9:22)
“我為一切人成為一切” (格前 9:22)

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Message from the Hospital Management

It is my honour to be appointed together with Dr. Lee Siu Wing and Dr. Arthur Lee as Deputy Medical Superintendents of St. Paul's Hospital. I see it as a chance for me to contribute more to the Hospital apart from my clinical service. I have been working as a Pathologist throughout most of my career life and I must say that it is a real challenge for me to assume my new role in the management team of SPH. Having worked in the past 6 months under the leadership of our Medical Superintendent Dr. Lau Kam Ying, I truly appreciate the complexity and the amount of the work involved and my deficiencies. Working closely with the corporate governance, the MS team strives to strengthen the clinical governance and raise the standard of medical care of the hospital.

I have been entrusted to the Chairmanships of the Infection Control Team and the new Drug and Therapeutics Committee, in which I learn a lot myself. The Hospital has reformed the infection control team and instituted some new infection control policies since 2010. As the Infection Control Officer, I would like to elaborate more on the infection control in St. Paul's Hospital. Infection control is the prevention of spread of infection within the hospital. It is our responsibility to maintain a high standard of infection control within our hospital to protect the public, our patients and our staff. An efficient infection control needs cooperation and understanding of all our hospital staffs and the visiting doctors. Their advice, support and compliance are keys to our success. As for the recent outbreak of gastroenteritis in the Nursery ward, the dedication and cooperation of all the frontline staffs of the Nursery and Maternity wards, and our paediatric specialists are most crucial in controlling the spread of the infection. Together with the front line staffs, we work as a vigilant team with high efficiency. I hope this serves as a good exercise for all of us and raises the need on continuous education, surveillance and monitoring. To protect our patients, our staffs and the public, we should always stay alert and keep tab to the emergence and pattern of infection occurring within the hospital. I am really fortunate to work with a team of dedicated people, especially the two infection control nurses. In addition, the professional advice from Dr. Vincent Cheng is invaluable.

Nowadays, patient safety is an important key issue in every hospital. Medication incident is high on the list of patient safety incidents in the healthcare system of most developed countries. One of the main aims of the new Drug and Therapeutics Committee is to ensure the best possible drug safety through monitoring, evaluating and thereby preventing, as far as possible, adverse drug reactions and medication errors. The Committee is in its infancy and it will require the help of all our frontline staffs to achieve its goal.

I sincerely hope that we can all work together to make St. Paul's Hospital a safe environment in every aspects for our patients, our staffs and the public. There have been a lot of changes in the Hospital and the outside health care environment; and I am sure more challenges are to come. We shall adapt and adjust to all these changes and together we shall move forward to make St. Paul's Hospital a modern Hospital in the years to come.

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Medical Information 醫療資訊

The Role of Capsule Endoscopy in Obscure Gastrointestinal Bleeding

Obscure gastrointestinal bleeding (OGIB) is defined as bleeding from gastrointestinal (GI) tract that persists or recurs without an obvious source found in the initial upper and lower endoscopies [1]. It can be sub-classified as either **obscure-occult**, detected only by positive fecal occult blood tests and/or iron deficiency anemia, or **obscure-overt** with recurrent or persistent visible episodes of bleeding.

Approximately 5% of all GI bleeding are of obscure in origin [2]. The source of bleeding in about 75% of OGIB is from the small bowel [3]. The remainder of cases are due to missed lesion in either the upper or lower GI tract. Lesions within reach of a standard upper or lower endoscopy may be missed for a variety of reasons; thus a repeat examination may be justified. Commonly missed upper GI lesions include Cameron's ulcers in a hiatus hernia, vascular ectasias, Dieulafoy lesions and hemobilia [4].

Before the development of capsule endoscopy (CE) in 2001, the examination of small intestine for OGIB can only be achieved by push enteroscopy, arteriography, scintigraphy and barium radiology. These studies were deficient because the small bowel could not be examined reliably in its whole nor permitting a direct visualization of small intestinal mucosa [5]. Capsule endoscopy is a disposable 26mm x 11mm plastic capsule (Figure 1), consisting of an optical dome, 4 light-emitting electrodes, a sensor, 2 batteries and a micro-transmitter. It acquires and transmits images 2 frames per second (until the battery expires after 7h +/- 1h) to a sensor array attached to the patient. Image features include a 140-degree field of view, 1:8 magnifications, 1 to 30mm depth of field and a minimum size for detection of about 0.1mm [6]. It is passively propelled by peristalsis and it captures images of the entire length of the small intestine. Therefore, CE approaches the concept of physiological endoscopy and images the mucosa in a collapsed state without disturbance of normal peristalsis and blood flow to small vessels. According to 2005 ICCE Consensus [7], the indications of CE for small bowel imaging include:

- (1) Obscure gastrointestinal bleeding
- (2) Investigation of suspected Crohn's disease
- (3) Surveillance of hereditary polyposis syndrome
- (4) Investigation of suspected small bowel tumor
- (5) Complicated celiac disease

The main limitations are the lack of air insufflations, the unavailability of rinsing, obtaining biopsy or therapeutic intervention [5]. In addition, the capsule does not reach the cecum within the recording time in up to 16% of cases, probably due to slow gastric transit. Major contraindications for CE include strictures in

GI tract, dysphagia, pregnancy, electromedical implants and planned magnetic resonance imaging. The incidence of capsule retention rate is less than 1% [5] and is generally related to the presence of endoluminal narrowing. For patient with high suspicion of bowel strictures (history of NSAID's intake, Crohn's disease, occlusive symptoms or ischemic bowel disease), they should undergo other investigations such as CT scan, small bowel series or M2A patency capsule before CE. In general, surgical intervention to remove the capsule should also address the underlying cause of the retention.

The overall yield of CE for OGIB has been reported to be in the range of 45% - 70%. The diagnostic yield can be up to 93%, especially for those cases with obscure-overt bleeding [7]. The most commonly detected lesions in the small bowel include fresh blood (Figure 2), vascular ectasia, polypoid or tumoral lesions, varices, ulceration and strictures (Figure 3). The ability to exclude bleeding lesions is between 82.6% and 100% [5]. When compared with push enteroscopy, CE revealed additional findings in 25 - 55% of cases [1]. A meta-analysis of 14 observational studies estimated that the overall yield of CE (63%) was significantly higher than for push enteroscopy (26%) and barium studies (8%) [8]. Repeat capsule endoscopy has been proposed for patients whose initial capsule endoscopy studies are negative. In a retrospective study of 676 patients, 82(12%) had repeat capsule studies. Overall, the diagnostic yield was 55% and successful management was achieved in 39% [9]. The yield was highest in patient with a prior positive study (77%) and was lowest in patients with ongoing symptoms and a prior negative study (32%). The high yield for repeat capsule endoscopy in this study was not surprising since capsule endoscopy does not visualize the entire small bowel mucosa on a single pass. This occurs because the video capsule does not pursue an axial path; rather, it is known to tumble quite frequently [10] and is unable to see behind folds of the small intestine.

In conclusion, capsule endoscopy plays an important role in the effective investigation of OGIB nowadays. Repeat CE in appropriate clinical situation could be useful even when the first CE examination is negative. Suggested algorithm for OGIB by International Consensus on Capsule Endoscopy is shown in Figure 4.



Dr Lok Ka Ho

Specialist in Gastroenterology
and Hepatology



Figure 1: Small bowel PillCam



Figure 2: Fresh blood in small bowel



Figure 3: An ulcerated small bowel stricture due to NSAID

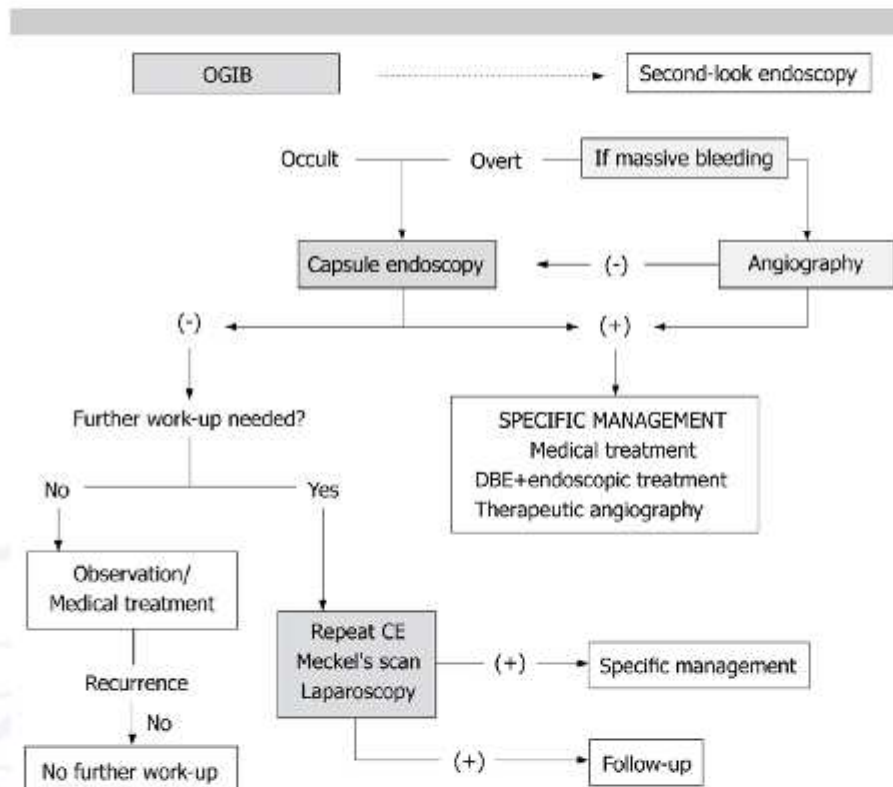


Figure 4: Suggested algorithm for obscure GI bleeding by ICCE

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Presentation at a CME/CPD/CNE Meeting

持續醫學進修講座

Advanced Endoscopy in 2011

St. Paul's Hospital, 21st June 2011

“Right Upper Quadrant Pain” – the Echo-Endoscopist Approach

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Patients presented with right upper quadrant (RUQ) pain may suffer from various disorders including gastric, biliary and pancreatic diseases, in which investigation by conventional methods could be challenging. Endoscopic ultrasonography (EUS) combines both luminal (endoscopic) and extraluminal (sonographic) examinations into one. The high frequency ultrasound (US) probe that is located at the tip of the endoscope could be directed to the disease area of interest and detail examination is feasible. Also through real time EUS-guided fine needle aspiration and trucut biopsy, the Echo-Endoscopist (who uses echoendoscope for examination and treatment) could obtain cytology and histology to confirm tumour diagnosis. After 30 years of development, EUS has become an integral part in the management of gastric, pancreatic, biliary and pulmonary diseases.

In patients presented with RUQ pain and suspected to have biliary disease, EUS is shown to have higher sensitivity and accuracy in the detection of choledocholithiasis as compared with transabdominal US and CT examination.(1) When compared with MRI examination, both are showing high accuracy close to 95%. However, the accuracy of EUS would not be affected by the bile duct size and the diameter of the stone.(2) When the stone diameter is less than 5mm, MRI sensitivity could drop down to 62%.(3) Also limited by the resolution, MRI could not detect biliary sludge disease.(4) Using EUS as a triage tool, unnecessary ERCP examination could be avoided and its related complication prevented.(5)

Pancreatic cancer (PC) disease should be excluded in patients presented with RUQ pain especially in those who have risk factors such as male gender, old age, smoking habit, family history, diabetes especially recent onset one, presence of chronic pancreatitis and pancreatic cystic diseases. In two meta-analyses, the sensitivity and specificity in the detection of PC were 91% and 85% for CT and 94% and 90% for PET.(6,7) However, in small PC disease, the sensitivities would decrease significantly. Giving the high resolution of EUS, it would be less affected by the size of the tumour. In a head to head comparison, the sensitivities for EUS, PET and CT were 93%, 87% and 53% in detecting PC.(8) EUS is highly sensitive in detecting pancreatic neuroendocrine tumour especially insulinoma.(9) Since EUS has high negative predictive value, it could be used to exclude PC confidently.(10)

Patients with nonspecific RUQ pain may undergo multiple non-diagnostic investigations such as OGD, US, CT and more. Giving the high accuracy of EUS, studies had shown that it could be used as the first investigational tool to rule out both luminal and extraluminal pathologies at the same time to avoid diagnostic dilemma.(11) Therefore in Endo-Endoscopist point of view, EUS should be considered for patients presented with RUQ pain either as the first examination, or when other investigations fail to reveal the cause and the symptom persists after treatment.

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Obscure Gastrointestinal Bleeding – No Man Land in the Past

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Constituting 5% of all gastrointestinal bleeding cases, obscure gastrointestinal bleeding (OGIB) carries a significant burden to both the patients and health care system. Despite multiple investigations and admissions, the time from first presentation to definitive treatment could still be ranging from months to years in the past. Thanks to the advancement of technology, we are now capable of examining the entire small bowel by capsule endoscopy (CE) and double-balloon enteroscopy (DBE), which was used to be the no-man-land.

Capsule Endoscopy

With the miniature video camera, light-emitting diode, battery and signal transmitter all encapsulated in a tiny plastic capsule, CE provides a non-invasive method to obtain the intraluminal view of entire small intestine. It is well tolerated by patients with low complication risk (capsule retention risk less than 1%). [1]

When compared with conventional investigations, CE is persistently better than push enteroscopy and barium studies for its diagnostic yield (CE: 63%; push enteroscopy: 26%; barium study 8%) as shown in meta-analysis. [2] CE is also a reliable risk stratification tool. Negative CE can often predict lower rebleeding rate, and these patients could be managed conservatively. [3, 4] Therefore it is now recommended as the first-line investigation for OGIB patients. [5]

Double Balloon Enteroscopy

The DBE system contains a video endoscope (2 metres in length), an polyurethane overtube, a balloon-dilating device, and two soft latex balloons attached at the tips of both endoscope and overtube. Through its working channel, DBE enables us to take biopsy and perform endoscopic interventions. By sequential inflation and deflation of the two balloons and passage of the overtube, it plaits the small bowel mucosa over the shaft of endoscope, and hence allows examination of the whole length.

The diagnostic yield of DBE is ranging from 50% to 80%, [6 – 10] and it will be highest when performing in patients with overt-ongoing bleeding. [6] Major complication rate is around 1%, which includes perforation, pancreatitis (possibly due to traction injury on mesentery), bleeding and paralytic ileus. Altered anatomy from prior surgeries also increases the risk of bowel perforations from DBE. [7, 11, 12] Given its potential risk and complexity of operation, DBE is generally recommended for the definite treatment, obtaining histological proof, or marking the site for subsequent laparoscopic surgery, as guided by the initial finding of CE.

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Orthopaedic Foot Problems

St. Paul's Hospital, 19th July 2011



Hallux Valgus Managements

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Hallux valgus is one of the most common orthopaedic conditions. Sixty percent of the disease is familial. It is becoming more common with the westernization of life style i.e. wearing high heel pointed shoes. Other intrinsic factors include congenital spray foot, systemic rheumatoid diseases and congenital ligament laxity.

The presentations of this disease in youth and elderly are quite different. Young patients usually present with primary symptoms like bunion pain, deformity. Elderly patients usually present with secondary symptoms like callosity, hard corn, overriding 2nd toe and big toe pronation.

Conservative managements consist of avoiding the high heel pointed shoes, wearing shoes with wide toe box, wearing night hallux valgus splint and toe web spacer. Besides oral analgesics, Physiotherapy, Podiatrist treatments can also be considered.

The most important indicator for hallux valgus must be pain. Other relative indicators are failed conservative management, rapid progression of the hallux angle or strong cosmetic reason. The pathology of hallux valgus includes changes in bone, soft tissue and the first metatarsal phalangeal joint. Hence the comprehensive operative management must be able to address all these three aspects. The goal of the

operation is to correct all deformities of foot in the same operation. There are more than one hundred different procedures described for hallux valgus. However, no single one can deal with all different types of hallux valgus. Common classic surgeries like Chevron osteotomy, Mitchell osteotomy and basal osteotomy perform the osteotomy with single screw fixation at the cancellous bone of 1st metatarsal bone. The drawbacks are unstable fixation, less predictable correction and surgical wound adhesion. Frequently, Post-operative non-weight bearing and casting are required.

With more predictable result, Scarf's osteotomy is getting popularity in Europe and Japan. This osteotomy with distal soft tissue release is a relative new procedure that is suitable for most of the hallux valgus cases. The "Z" osteotomy is performed over the diaphyseal bone, fixation with two headless Titanium screws. It is versatile in lengthening, shortening, lowering, elevating, transverse plane rotating and axial plane rotating the first metatarsal bone. According to Weil's institute, good result was found in more than 90 percent of his 2500 patients between 1984 to 2000. Similar result is also achieved in centres performing this procedure in Hong Kong.

Salvage procedures like first metatarsal phalangeal joint fusion are used for severe degenerative painful joints.



Lesser Toe Deformity

Dr. Law Yee Cheong, Wally

Specialist in Orthopaedics & Traumatology

Deformity in the lesser toes can cause major troubles to the patient. The need of footwear cause pressure and frictions on the deformity toes, and cause pain, callosity and ulcers. Here are a few commonly seen deformity in the lesser toes:

Claw toes:

Distal interphalangeal joint and the proximal Interphalangeal joint fixed in flexion.



The deformity is caused by tightness at the toe flexors. It may be combined with contracture at the Metacarpophalangeal joint (MCPJ).

Surgery at the PIPJ involves transfer of the flexor to extensor surface, serving both to reduce the flexion deforming force and to increase the extension force of the proximal phalanx. Surgical treatment at the MCPJ involves release of the dorsal capsule together with tenotomy at extensor to allow flexion of the joint.

Hammer toes deformity also has flexion at the PIPJ. Yet the DIPJ is in extension. It is caused by tightness of the flexor with resultant flexion at the PIPJ, which secondarily produce tightness at the MCPJ in prolonged situation.



Surgical treatment at the PIPJ involves release of the tight flexor, possibly involve excision or fusion of the PIPJ. At the MCPJ release of the tight dorsal capsule and extensor sometimes are combined with excisional arthroplasty in severe case.

Mallet toes involves flexion deformity at the DIPJ. If the joint is still supple release of the tight flexor can reduce the deformity. In severe cases partial amputation is needed.



Pincer nail is a fairly common yet often ignored deformity. It causes pain, ulcers and sometimes infection in the nail bed and eponychium. More often than not it is mistaken to be ingrowing toe nail.

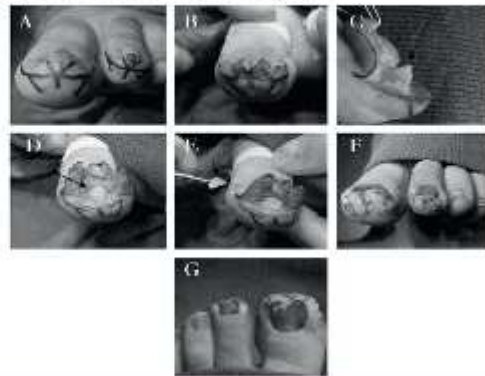


The end on view of the big toe demonstrates the main feature of a pincer nail. The nail plate curves in the coronal plane as it approaches the pulp. The germinal matrix and lunula are usually normal.

The root cause of this deformity is an osteophytes underneath the nail bed, which deforms the nail plate and produces an exaggerate nail arc. The sides of the nail plate are therefore cutting into the nail bed, producing ulcers, infections, and granulations.

Nail avulsion is a quick and simple method of temporary relief, allowing the infection and ulceration to heal. Definitive treatment requires excision of the osteophytes, and reconstruction of the narrow nail bed.

One way to widen the nail bed is longitudinal slitting after excision of the osteophytes and the fibrotic nail bed. M. Mutaf (2007) described a method of a triple transpositional flap in the pulp, to widen the distal pulp and to produce a flat surface for the new nail plate to grow.



Reference: Mutaf M, Sunay M, Isik D. A new surgical technique for the correction of pincer nail deformity. *Ann Plast Surg.* 2007; 58:496-500



Plantar Fasciitis

Dr. Chan Tun Kut, Roger

Specialist in Orthopaedics & Traumatology

The **plantar fascia** is a fibrous sheath which extends from the base of the toes to the medial calcaneal tuberosity. **Plantar fasciitis** is an inflammation of the plantar fascial tissue, often adjacent to its insertion into the heel.

Plantar fasciitis commonly causes stabbing pain that usually occurs with very first steps in the morning. Once the foot warms up, the pain of plantar fasciitis normally decreases, but it may return after long periods of standing or after getting up from a seated position.

Plantar fasciitis is particularly common in runners. It affects 10% of runners. It also affects numerous other athletes such as players of soccer, basketball, tennis, gymnastics. In addition, people who are overweight, women who are pregnant and those who wear shoes with inadequate support are at risk of plantar fasciitis.

Causes

Under normal circumstances, plantar fascia acts like a shock-absorbing bowstring, supporting the arch in the foot. If tension on that bowstring becomes too great, it can create small tears in the fascia. Repetitive stretching and tearing can cause the fascia to become irritated, inflamed and degeneration of fascia which is more similar to tendonitis than tendinitis.

Factors that may increase the risk of developing plantar fasciitis include extrinsic factors like training errors, improper footwear, unyielding running surfaces, increased levels of activity, increased body weight and intrinsic factors like pes planus, pes cavus, tight heel cords and weak intrinsic foot muscles.

Treatment

About 90 percent of the people who have plantar fasciitis recover with conservative treatments in a few months. Medications to control symptoms may include **Nonsteroidal anti-inflammatory drugs (NSAIDs)** and Corticosteroids. NSAIDs, such as ibuprofen or COX II like celebrex and arcoxia, may reduce pain and inflammation, although they will not treat the underlying problem. **Corticosteroids** may be delivered through injection. Multiple injections are not recommended because they can weaken plantar fascia and possibly cause it to rupture, as well as shrink the fat pad covering heel bone. **Stretching and strengthening exercises** may provide symptom relief. Doctor may prescribe off-the-shelf or custom-fitted arch supports (**orthotics**) to help distribute pressure to the feet more evenly. Doctor may recommend wearing a **night splint** that stretches the calf and the arch of the foot while patient sleep. This holds the plantar fascia and Achilles tendon in a lengthened position overnight and facilitates stretching.

When more-conservative measures are not useful, doctor might recommend **Extracorporeal Shock Wave Therapy (ESWT)**. In this procedure, sound waves are directed at the area of heel pain to stimulate healing. It is usually used for chronic plantar fasciitis that has not responded to more-conservative treatments. Few people need **surgery** to detach the plantar fascia from the heel bone. It is generally an option only when the pain is severe and all other treatment fails. Side effects include a weakening of the arch in the foot.

Advanced Endoscopy in 2011, 21st June 2011



Dr. Lee Yuk Tong shared his experience in treating right upper quadrant pain.



Dr. Lai Hin gave a talk on obscure gastrointestinal bleeding.



Around 60 professionals attended the seminar.

Orthopaedic Foot Problems, 19th July 2011



Dr. Ngai Yiu Hing, William shared his experience in hallux valgus managements.



Dr. Law Yee Cheong, Wally presented on the topic of lesser toe deformity.



Dr. Chan Tun Kut, Roger further elaborated on plantar fasciitis in the Q & A Session.



ME/CPD/CNE Programme

持續醫學進修概覽

Program Announcement

Date:	15 th November, 2011	13 th December, 2011
Topic:	Different Modalities in Managing Urinary Tract Stones <ol style="list-style-type: none"> 1. ESWL - What We can Achieve in St. Paul's Hospital? 2. PCNL - Prone or Supine? 3. URSL - Rigid or Flexible? 	Audit Review on Surgery and Urology <ol style="list-style-type: none"> 1. Audit Results of Appendicectomy, Haemorrhoidectomy, Cholecystectomy and Herniorrhaphy 2. Audit Results of ESWL and TRUS of Prostatic Biopsy
Speakers:	<ol style="list-style-type: none"> 1. Dr. Lo Hak Keung, Alex Specialist in Urology, St. Paul's Hospital 2. Dr. Fu Kam Fung, Kenneth Associate Consultant Urologist, Queen Mary Hospital 3. Dr. Wong Bok Wai, Byron Specialist in Urology 	<ol style="list-style-type: none"> 1. Dr. Lee Siu Wing Specialist in of General Surgery, St. Paul's Hospital 2. Dr. Lo Hak Keung, Alex Specialist in Urology, St. Paul's Hospital
Chairman:	Dr. Wong Tak Hing, Bill Honorary Consultant Urologist, St. Paul's Hospital	Dr. David Fang Specialist in Orthopaedics & Traumatology
Time:	7:30pm – 9:00pm (Light refreshment provided at 7:00pm)	
Venue:	Conference Room, 2/F, St. Paul's Convent	
Registration:	Ms Sally Pun, Tel: 2830 3905, Fax: 2837 5271, E-mail: sph.sdd@mail.stpaul.org.hk	

CME / CPD Accreditation for all Colleges (Pending approval). CNE Point: 1 Point

In-house Program for Doctors - Airway Management Workshop

In September 2011, Staff Development Department of the St. Paul's Hospital launched an in-house program "Airway Management Workshop" for all staff specialists. It was our pleasure to have invited four experienced anesthetists - Dr. Chan Chi Keung; Dr. Low Matthew, John; Dr. Law Ngai Leung, Alan and Dr. Sun Chi Hong, Nicholas as the guest speakers to share their valuable knowledge and experience in airway management and special technique of laryngoscopy in the workshops.

The workshops provided a hands-on instruction on face mask ventilation, insertion of oropharyngeal airway and laryngeal mask airway and endotracheal tube intubation. The speakers also gave valuable advice in treating difficult ventilation cases. This learning and experience sharing opportunity has enhanced overall risk management of our clinical service, and continuously improved the quality of care to our patients.

1st September: Speaker - Dr. Sun Chi Hong, Nicholas



8th September: Speaker - Dr. Law Ngai Leung, Alan



15th September: Speaker - Dr. Chan Chi Keung



22nd September: Speaker - Dr. Low Matthew, John





Outreach Activities

外展活動

天水圍外展活動 - 免費健康檢查日

聖保祿醫院服務市民大眾不遺餘力，熱心參與基層護理，彰顯愛心。本院之牧靈中心義工隊伍，於二零一一年十月九日與天水圍婦聯聯合辦外展活動。是次活動於天水圍伯裘書院舉行，當日，本院一共有四十五人出席此活動，包括醫生、修女、十多名義工、醫護人員、及二十二名公開大學護理系學生，為約四百多名天水圍居民及長者進行免費身體檢查，及進行多種超聲波檢查，包括頸動脈超聲波掃描檢查及婦女盆腔超聲波掃描檢查等等。



本院義工團隊參與天水圍外展活動之大合照



義工們熱心參與社會服務，不遺餘力



沙爾德聖保祿女修會何美蘭省會長獲頒發感謝紀念品，以表揚樂善好施精神



為天水圍居民進行身體檢查

世界心臟日2011 - 「環球健步行」

為響應一年一度的世界心臟日，聖保祿醫院逾三十名熱心人士(包括修女、醫生、員工及親友)於二零一一年十月二日，參與由香港心臟專科學院舉辦的「環球健步行」活動。參加者環繞跑馬地馬場步行一周，以行動支持社會大眾關注心臟健康。此活動鼓勵不同年齡人士，以步行鍛鍊體魄，增強心肺功能，促進身心健康。此外，本院心臟中心與聖保祿學校中學部合辦攤位遊戲 - 夾「喜」廚房，吸引在場之男女老幼參加，大家十分開心。



超過三十名本院員工及其親友參與環球健步行



本院心臟中心主管謝德新醫生率領眾人起步



心臟中心同事及同學們上下一心，團結一致，將攤位辦得有聲有色



攤位遊戲大受歡迎

Hospital Activities 醫院活動

「零」針刺意外 由我做起

醫護人員經常要提醒十二分精神使用針和刀片等利器，一不留神，便有機會被針刺和利器所傷。為加強員工的警覺性，及減少意外，聖保祿醫院感染控制組及職業安全健康組策劃一連串之推廣活動，分別於今年九月至明年四月舉行。打響頭炮的是一連四集的「預防針刺意外及利器傷害」推廣短片，希望提升員工的安全警覺，創造一個「零」針刺意外的工作環境。四集短片的預告片和第一集短片已率先於九月十六日首播，為連串的預防針刺意外宣傳活動揭開序幕。

根據統計，約有百分之八十的意外事故是人為因素引起，要對症下藥，必須從人為疏失及安全作業方法著手。四集短片的故事背景均是醫護人員熟悉的工作環境，包括為病人縫合傷口和打點滴、手術期間遞儀器、及手術後清洗儀器。內容描述醫護人員在分心、貪方便、缺乏良好溝通、警覺性不足的情況下，不慎被針刺或利器所傷。並且強調只要妥善處理個人壓力、集中專注工作、按照既定指引小心謹慎地執行每一個步驟，再加上同事間互相提點關照，便可締造一個安全的工作環境。



本院管理層參與「預防針刺意外及利器傷害」宣傳活動起動禮。



各部門主管以身作則，簽署承諾締造一個安全的工作環境。



前線同事主動參與，通力合作，定能大大減低意外風險。

Siemens Youth Program 2011 – 參觀聖保祿醫院

聖保祿醫院獲邀參與西門子有限公司二零一一年度青少年計劃(Siemens Youth Program 2011)，接待十一名青少年參觀醫院，實地考察醫療資訊系統的優勢。

參觀活動於二零一一年八月二日舉行，分別參觀本院之門診部和診斷及介入放射部，親身體會醫療資訊系統及放射科信息系統的作業流程，觀摩各式各樣尖端的放射科儀器，了解醫療影像數碼化如何更有效率地為客人提供更高質素的服務。



青少年對尖端放射科儀器大感興趣



了解放射科信息系統運作



參觀門診部以考察醫療資訊系統作業流程

Introduction of new faces 員工動態



Dr. Chan Chun Wing, Desmond
Specialist in Paediatrics

I am Dr Chan Chun Wing, Desmond and have recently joined the family of St. Paul's Hospital as a Staff Specialist in Paediatrics. I graduated in the University of Hong Kong and worked as an Associate Consultant in the Department of Paediatrics and Adolescent Medicine of United Christian Hospital. I am particularly interested in Paediatric Infectious Diseases and Nosocomial Infections. I was a member of Hospital Infection Control Committee in previous hospital and is a council member of Paediatric Immunology and Infectious Diseases Society. It is my honor and pleasure to work here and hope my expertise and experience would serve patients in St. Paul's Hospital.

Hi, my name is Wings Lee, I joined St Paul's Hospital in April 2011 as a Senior Manager of Material Management Department. Before joining the hospital, I have been working as a SAP consultant focusing on logistic module for client such as Epson, Fujitsu, CLP; hence the SPH's Material Management System is also implemented by me when I was a consultant.

From being an external consultant to an internal staff, I must have surprised many people, including myself. I am very grateful that I am offered the opportunity to open this new chapter of my life as a member of St Paul's family.

Working in St Paul's Hospital is a completely new experience to me and I look forward to all the challenges ahead to improve the service of material supplies, procurement function for every staff and to be able to make a long lasting contribution to the success of the hospital.



Mr. Lee Wing Kong, Wings
Senior Manager, Material Management Department

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