"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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聖保祿醫院
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NEWSLETTER 院訊

Christmas & New Year Message
from
Hospital Managing Director

"Stay Hungry, Stay Foolish." It is the farewell message of the Whole Earth Catalog, placed on the back cover of its 1974 edition and is popularized by Apple co-founder Steve Jobs during his 2005 Standford University commencement speech. Steve's brilliance, passion and energy were the source of countless innovations that enrich our lives. The driving force behind his audacity and success was his great wish to remain hungry and foolish. Steve Jobs was a determined man, a visionary who stayed true to himself, thus allowing himself to stay open to new ideas and breakthroughs. "Do not deceive yourselves. If any of you think you are wise by the standards of this age, you should become 'fools' so that you may become wise." (1 Corinthians 3:18) We should never assume that we're clever enough, because it is all too easy to become complacent and we will stop seeking new knowledge and insights.

What are you hungry for? What is it that drives your life, that motivates you for living? What are you living for? Is it the material or is it the spiritual? We all need to discover our purpose in life, to find what we love and hunger for. When we find that great passion, we'll find ourselves hungry for more. The journey may be tumultuous, but such is life. If we stay open, life can become a fantastic adventure. It is better to live for something rather than nothing at all, only to regret it when it is too late.

In the Gospel of St Matthew, we find the Sermon on the Mount, which reveals to us the teachings of Christ, the Beatitudes. They are essential to all who seek the path of holiness and the kingdom of God. "Blessed are they that hunger and thirst after justice: for they shall have their fill." (Matthew 5:6) Our hearts ought to hunger for goodness and justice. We may not always find them here on earth, but we must always hope, always believe, always persevere. At the same time, we have to pray for God's enlightenment to upkeep our quality service with love and justice.

Long ago a gift was given, and it is and will always be the greatest gift to the world. "For unto us a child is born, unto us a son is given: and the government shall be upon his shoulder: and his name shall be called Wonderful, Counsellor, The mighty God, The everlasting Father, The Prince of Peace." (Isaiah 9:6) The birth of Christ our King, our Savior, brought hope, joy, and the gift of eternal life. Our Lord came to this world to ignite our hunger for wisdom, knowledge, righteousness, love, and kindness. May we never cease to desire that "God's Will be done on earth".

May God bless you abundantly with peace, joy, and love. Merry Christmas to all!

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Message from the Hospital Management

First of all, on behalf of the management team, I would like to wish you all a very merry Christmas and an enjoyable holiday with your family.

As 2011 is coming to the end, it is a good time for reflection and outlook. Over the past year, St. Paul's Hospital has undergone lots of major changes and restructuring; being appointed as one of the deputy medical superintendents early this year was probably one of the major changes and challenges in my career path.

Among the many challenges and changes ahead, the Quality and Risk Management is proved to be most surmountable.

Introducing quality and risk management into a hospital involves changes in culture, habits, and behaviour, and it disrupts the sociological hierarchy. Unfortunately, the hospital environment is not favourable for such changes. We are brought up in "mentor-mentee" training, as a result of which we do not usually challenge authority. The hierarchical authority however has only limited impact on quality assurance and improvement, not to mention risk management.

Risk management consists of two major components. These include 1) Identification and reduction of risk and 2) Cut loss or damage control. This process requires a systematic approach to identification and critical analyze of environment, structures, procedures and practices that may pose significant risk to patients, staffs and hospital itself. It is necessary to develop strategies to eliminate, avoid and minimize the risks. The ultimate aim of risk management is to handle risk involved systematically and effectively, and then deploy the subsequent measures to improve the quality of services provided to patient.

In order to make the Quality and Risk Management function effectively and efficiently. The hospital needs to devise plans that aim to:

- Develop regular statistical that reflect services standards, clinical outcomes and adverse events.
- Establish mechanisms to maintain and develop structures and process for a cohesive approach to the management of clinical and non-clinical risk.
- Conduct operational reviews of departments to identify deficiencies and potential areas for improvement.

Researchers suggest that the key elements that contribute to high-performance hospitals and an effective, efficient quality and risk management include:

1. Develop the right culture for quality to flourish.

- Establish of a clear quality-related mission, and performance measurement and targets consistent with the mission.
- Strong leadership and support from Board and management.
- Department heads with expectations that they will work with physicians in their departments to change practice patterns and ensure the certain practices are followed.
- Supportive organizational structure such as standing and ad-hoc quality-related committees.
- **Clear communication and rules that encourage staffs to report errors.** This requires ensuring that those who report errors may remain anonymous and not be penalized.

2. Attract and retain the right people to promote quality. (It is something we have to work harder.)

- Selective hiring, credentialing, and retention of physicians and nurses, even in an era of shortages.
- Ability to attract and employ an adequate number of high-quality nurses through generous staffing levels that ensure a reasonable caseload, competitive salaries.
- Establish multi-disciplinary teams to manage and coordinate patient care and to conduct quality analysis and projects with IT support.

3. Devise and update the right in-house processes for quality improvement.

- Develop a multi-disciplinary team that include representative of all clinical or administrative areas that play a role in the problems being examined.
- Enable the team to question and explore possible factors contributing to sub-optimal performance.
- Develop and implement an action plan.

4. Give staff the right tools to do the job.

- A willingness to invest in IT. (It is quite obvious that St. Paul's Hospital management are most willing to do!)
- Work with physicians and others to customize an information system to meet specific needs and culture of the institutions
- Device IT systems that provide real-time feedback to providers as they are caring for patient.
- Reduce time lags in getting lab and imaging results can reduce length of stay and may reduce iatrogenic disease.
- Make user-friendly guidelines and recommendations readily accessible to physicians, based on the latest medical research on specific conditions, procedures, medications, etc.

The challenge is clear, imminent and huge, tremendous efforts are needed. Despite its commitment, the management nor the medical superintendent team will be able to achieve a good quality and risk services without your understanding, dedication, concerted effort and team work.

Dr. Lee Siu Wing
Deputy Medical Superintendent

Medical Information
醫療資訊

Peer Review and Proctorship

"No doctor knowingly would like to practice poor medicine" provided that clinicians know what's poor medicine, and knowing whether they are performing at an acceptable level of standards as viewed by their peers….

We are now living in a time and society that it is no longer acceptable to just do one's best in medical care. The public and patient and especially the media require the medical fields whether it is the doctors, nurses or alliance health care professionals to be trusted and reassured that the level of care provided are up to standards. Being a professional body, apart from regulatory autonomy that was delegated by law, we are also held accountable for our performance. It is therefore important to measure and ensure the performance of doctors and healthcare personnel. The recent focus on qualification, appraisal system, credentialing ,continuous medical education, continuous professional development witness to the interest in how to assess the ability of clinicians in order to maintain, sustain their competence and improve the quality of care provided.

Despite the enthusiasm of various colleges and the Academy itself in provision and monitoring of doctors' CME and active CME periodically, continue medical education in terms of self study, attending conferences, workshops, have not been shown to improve the standards of performance of clinicians nor improve the quality of care. Other means to improve the performance of professionals are needed, these includes peer review and proctorships or perceptorship.

Peer review literally means evaluation by colleagues. It is used to describe for an instance, the assessment of manuscripts for scientific journal or the assessment of research proposal. It is also used as an approach by health care professionals to maintain, assess individuals' performance and standards of care and subsequent improving the quality of care provided. In this process the physicians analyze critically the medical services performed by their colleagues for the purpose of decreasing instances of medical malpractice. It is meant to be a learning process where problems and shortcomings are identified, the physicians involved can then be educated and measures to be taken to promote and enhance the quality of care that is to be delivered to the patients in the future.

Peer review in small groups or teams of care providers seems to provide an effective and feasible method for evaluation and improving performance of the professionals. The process of peer review matches the profile of effective behavior change in health care professionals as found in the literature. Elements of this profile include:

- Care providers are subjects to powerful and potentially determinating influence from opinion leaders and influential respected peers in their professional networks and their local setting. These influences can and should be used in bringing about change.

- Peer audit and feedback as well as mutual support are crucial in inducing change.

- The methods of quality improvement preferred by many care providers are small scale activities which are related to their own work that include personal contact with colleagues, and do not take too much time and do not interfere unduly with daily routines. These act ivies should include reflection on performance and learning new skills and they should reduce uncertainty in daily work.

Unfortunately, doctors are reluctant to have their work evaluated, it is probably closely linked to the fact that most doctors are also unwillingly to comment on, or to complain the behavior and performance of their colleagues. This attitude of "live and let live" is in our blood as it is stipulated in our small red book, **Code of Practice 19.3 – "It is unethical for a doctor to make unjustifiable comments which, whether directly or by implication, undermine trust in the professional competence or integrity of another doctor."** In order to encourage an effective peer review, it is therefore important that efforts should be made to ensure that peer review activities whether it is mortality and morbidity meeting or audit meeting, these are constructed and conducted with an aim to improve performance and the desire for self-improvement. The process of peer review must not be part of disciplinary instrument in order to ensure honest, candid, valid and opened discussion and frank exchange of opinions of what had happened and level of care provided by individual healthcare professionals and it is a tool for learning by feedback and knowingly the mistake one made.

Managed well, peer review can become a lifelong learning process for clinicians, departments and hospital can also utilize the peer review to maintain, review the quality of care provided by individual healthcare professionals and to reassure public that appropriate level of care can be delivered to patients when admitted to the hospitals.

Peer review is consistent with the reflection of Goethe, some 200 years ago that "the most fruitful lesson is the conquest of one's own error. Whoever refuses to admit error may be a great scholar, but he is not a great learner."

Proctoring is defined as an objective evaluation of a physician clinical competence by a proctor who represents, and is responsible to, professional bodies, hospitals or departments. The proctor should be impartial and have documented training, experience, demonstrated abilities and current competence in the service or procedure that is the subject of proctoring. Occasionally, a proctorship can be an educational program in which proctoree acquires new skill or perfection of existing skill from the proctor. As exemplified by the recent proctorship program organized by the Hong Kong College of Surgeons.

Proctorship in contrary to peer review is a one-to-one or one-to-several relationship between proctoree and proctors relationship. In this process, proctors exercise either an observer, monitor role or in some instance act as a "mentor" which is better described as perceptorship. Very often however, the terms proctorship and perceptorship are very often used interchangeably. Proctorship does not restricted to interventional procedures; it can extend to the patient management protocol and guidelines. In some hospitals in the States, proctorship is employed as a mean to ensure standards, credentialing, quality of care provided by associated doctors.

Proctoring as mean to monitor, maintain standard and improve quality of patient care has not been widely advocated in Hong Kong. However, we are all well aware that necessary credential, qualification does not equivalent to clinical competence, esp. in intervention treatment. Proctorship provides an instrument for close monitoring of clinicians' standard as well as an educational opportunity.

Dr. Lee Siu Wing
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Presentation at a CME/CPD/CNE Meeting 持續醫學進修講座

Updates on Breast Cancer Surgery

St. Paul's Hospital, 20th September 2011

Endoscopic Breast Surgery

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There have been significant advances in the surgical management of breast cancer since William Halstead first proposed the radical mastectomy in 1891 [1]. By 1948, Patey and Dyson reported a less radical approach, preserving the pectoralis muscle and overlying skin [2]. Another significant milestone was the introduction of breast-conservation surgery (BCS). Two clinical trials in 1980s [4] [5] have confirmed that BCS combined with radiotherapy was as effective as mastectomy. In 1991 Toth and Lappert introduced skin-sparing subcutaneous mastectomy, for maximal skin preservation to facilitate breast reconstruction without compromising oncological safety [3].

The quest for a less invasive approach

Asian women have small breasts and BCS can result in obvious breast deformity or inadequate resection margins, therefore, reconstruction using endoscopic approach has become increasingly popular even in early stage disease. The main indications for endoscopic mastectomy (ESM) include:

1) Extensive or multifocal ductal carcinoma in-situ (DCIS)
2) Early invasive disease (T1/2) not suitable for BCS
3) Risk-reducing mastectomy in patients with BRCA1/BRCA2 mutation

Operative Techniques

Patient in supine position with surgery-side arm placed at 90°. Skin incision is made in the axilla for point of access, and also for sentinel lymph node biopsy, if indicated. Additional circumareolar incision is usually made to facilitate dissection.

Working planes are achieved by CO2 insufflation, dissecting balloons or tissue elevation. 5 or 10mm, 0° endoscopes are usually preferred. Subcutaneous and sub-mammary dissections by using blunt (tunnelling method) or sharp dissection under direct vision (electrocautery, bipolar scissors or harmonic scalpel).

Systemic review on the oncological and cosmetic efficacy of ESM

In a systematic review conducted in 2010 [6], 14 studies, with a total number of 1389 patients having undergone ESM or endoscopic BCS for early breast cancers, were investigated. Most of the studies limit the tumour size to below 3cm. Patients with confirmed nipple-areolar or skin involvement, axillary nodal or distant metastasis are excluded. 8 studies reported nil local recurrence (LR) (average FU 24 months). However, rates of positive margin involvement are at best highly variable (3-24%). 5 studies reported rates of distant metastasis from 4.5% to 10% over a mean FU period of 38 months, which is correlated to a positive nodal involvement at the outset. The overall survival (OS) in two of the non-randomized studies suggested that OS following ESM and open surgery is comparable (mean FU 19 months). Infection and haematoma are rare complications in ESM, more common ones are skin burn associated with the use of electrocautery. Majority of patients are satisfied with post-op cosmesis. However, there is no statistically significant difference in patient's self-reporting cosmetic outcome at 6 months or more following ESM. None of the studies compare the cost effectiveness of ESM versus open procedure. However, there is definitely higher cost in terms of longer operating time (ESM 192 +/- 38 mins vs Open 154+/- 19 mins) and the initial cost of the instruments.

Conclusion

Initial results are encouraging and suggest that ESM is technically feasible and approaching equivalent oncological results to open surgery.

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Updates on Sentinel Node Biopsy

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Axillary lymph node status remains the single most important prognostic variable for breast cancer overall survival and disease-free survival. It also guides the decision on subsequent adjuvant treatment. Sentinel node biopsy (SNB) harvests the sentinel lymph node(s) (SLN) which is the first regional lymph node(s) receiving lymphatic drainage from the breast. The benefit of SNB, as compared with axillary dissection (AD), related to range of motion, edema, pain and sensory deficits were evident in several studies.

Can sentinel node biopsy replace axillary dissection?

There are five randomized controlled trials currently comparing SNB with conventional AD in clinically node-negative patients. But the NSABP B-32 trial is the biggest. The trial randomly assigned 5611 patients to either SNB plus AD or to SNB alone (with AD only if SLNs were positive). In a mean follow-up of 95.6 months, there was no statistically significant difference in overall survival, disease-free survival and regional control between groups when SLN is negative.

Is axillary dissection necessary for positive sentinel node?

ACSOG Z0011 trial randomly assigned 891 patients with SLN metastases to undergo AD or no further-axillary treatment. All patients underwent lumpectomy and tangential whole-breast irradiation. Systemic therapy was at the discretion of the treating physician. Overall survival and disease-free survival were not inferior in patients with SLN metastases who did not undergo AD. These results do not apply for patients undergoing mastectomy, lumpectomy without radiotherapy, partial breast irradiation and neoadjuvant therapy.

How about isolated tumor cells and micrometastases in sentinel node?

Isolated tumor cells (ITC) is defined as a tumor deposit ≤ 0.2mm and micrometastases as between 0.2mm to 2mm. Many studies have evaluated the significance of these occult metastases in SLN, but resulted in conflicting conclusions. At the St Gallen Consensus 2011, completion AD after ITC in SLN was not suggested.

Conclusion

New results from clinical trials supported the safety of omitting axillary dissection not only in patients with a negative SNB, but also in patients with clinically node negative but pathological positive SLN in the context of breast-conserving surgery, tangential field irradiation and systemic therapy. In selected group of patients, doing less surgery is not harmful but reduces morbidity.

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Practical Skills in Laparoscopic Surgery

St. Paul's Hospital, 18th October 2011

Approaches to Dissection of the Uterine artery and Ureter in Laparoscopic Hysterectomy

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Dissection of the uterine artery and ureter in laparoscopic hysterectomy is necessary in cases with distorted anatomy, like endometriosis or chronic pelvic infection. As the ureter and uterine artery are very close to each other, dissection of the UA almost always involves dissection of the ureter. Ureteric injury can occur during securing of UA by **direct Injury** like cutting, crushing or direct burning, or **indirect Injury** like lateral heat spread by electrocautery.

A good understanding of the anatomy of the UA relative to the hypogastric artery (internal iliac artery) is mandatory. The UA is the first visceral branch of anterior division of Internal Iliac artery. It arises from the anterior surface of internal iliac artery. It runs a straight course just **lateral, adjacent, and parallel** to the ureter, and becomes tortuous immediately at or after it crosses over the ureter. The internal iliac artery continues as the obliterated hypogastric artery towards and under the round ligament, and terminates as medial umbilical ligament.

The lecture demonstrated **5 Approaches to dissection of the UA with** ample video clips illustrating also the use of various vessel sealing devices including the Ligasure, Plasmakinetic forceps, the Enseal, Haemolock clips and suture tie.

1. The **Conventional Approach** is the easiest one: One pushes up the vaginal delineator so as to displace the ureter **laterally** and **below** the cup. The favourite uterine elevator and vaginal delineator I use is the **Biswas Cup**. After making an anterior and posterior colpotomy, the UA will stand out at the lateral edge of the uterus at the level of the Internal os: The UA is then dessicated. One must remember

to dessicate always **at or above** the cup's edge, and never below.

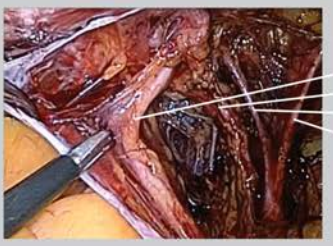
2. The **Superior Approach** is my favourite choice. It starts from the pelvic brim. One should always start from the area of normal anatomy to abnormal anatomy, i.e. from the easier part with normal surgical landmarks. The ureter is then identified through peritoneum leaf. The peritoneum between the ureter and the IP Ligament is then incised to enter the retroperitoneal space. Further dissection is facilitated by the pneumoperitoneum. The peritoneal leaf is pulled medially, hence also the ureter. The ureter is then traced caudally. The UA will be found lying just lateral to the ureter.

3. The **Medial approach** is similar to the superior one, but one starts opening the broad ligament from the medial leaf of the broad ligament. The peritoneum just above the ureter is entered, and then dissection is performed as in the superior approach.

4. **Lateral Approach:** A triangle is formed by round ligament, external iliac artery, and the fallopian Tube. The uterus is pushed to the contralateral side. The round ligament is cut and the anterior leaf of broad ligament is opened cranially along the lateral border of the tube. The ureter will be found deep on the medial leaf and the UA lies just laterally.

5. **Anterior Approach:** The round ligament is cut open, the uterus is pushed up with the uterine elevator, and the bladder peritoneum is incised. The bladder is then pushed down. With dissection inside the peritoneal loose tissue, the UA will be found at the level of Internal Os. This approach is especially good for uterus with big posterior fibroid or with obliterated POD.

In summary, one must know the anatomy well, try to restore and identify the pelvic anatomy whenever possible so that important surgical landmarks are recognised, know the various approaches to UA dissection and apply the particular technique where appropriate, and try to practice the techniques on easier cases first.



UA in relation to the Internal Iliac artery

1. Ureter
2. Uterine artery
3. Superior vesical artery
4. Hypogastric artery

Laparoscopic Myomectomy Suturing Technique - Wing Knot

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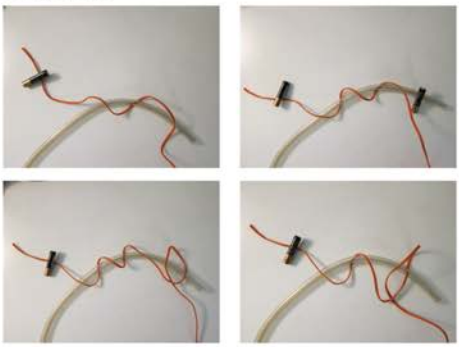
Laparoscopic myomectomy suturing technique follows the same methodology as in open surgery myomectomy. It entails the usage of the least number of uterine incisions to deliver the maximaum number of fibroids through each incision, using the least quantity of suturing material to occlude all the dead spaces in the myomectomy wounds. Myomectomy in general has not been an enthusiatic choice of management in institutional and government practice, in Hong Kong and likewise abroad. As a consequence the laparoscopic route in myomectomy has somewhat been shelved. This directly leads to the learner surgeon in this operation, an intuitional need to go worldwide to pick up their knowledge, as well as learning from their own mistakes, and finally thoughts on a solution to overcome their mistakes.

To me, laparoscopic myomectomy is a challenging operation, difficulty level often predicted by the location, size and number of the fibroids. A laparoscopic hysterectomy takes less than 2 hours, plus lymphadenectomy takes another 45 minutes, but laparoscopic myomectomy takes 2-5 hours. Yet, ironically, some insurance company often reimburst patients as having had an intermediate operation, heaven knows why.

Myomectomy wounds are often wounds under tension, and tensile force tends to pull the sutures apart. This holds true when one uses the granny knot or square knot. After tying the first knot, the tensile force can be overcome by putting artery clamp on the knot from an assistant, not ideal but this was the way to go. The Roeder knot and Western knot can provide less chance of the suture being open by the wound after tying, without the help of an assistant. The mechanics of the nonslippage is the result of that part of the suture wishing

to slip, is held down by another loop in the knot. This is the basic concept of the knot used by me for more than 10 years, and was given a name the "Wing Knot" by Dr. Eric Lee, a well known Laparoscopic Gynaecologist in Hong Kong.



Basically it is a knot using standard knot tying technique, but, one needs to create a complete loop on one side of the suture, prior to the standard knot tying technique.

I have used this knot on all open surgery myomectomy, during closure of subcutaneous fat layer of abdominal wound that was under tension, lifting, using sutures, organs to the abdominal wall, such as bowel loops, uterus, round ligament, peritoneal edges, and of course laparoscopic myomectomies, or during the process of tying bigger vessels, such as the infundibulopelvic ligament or the uterine artery.

I used vasopressin 20 units per ml. diluted 1 to 30 ml, as the haemostatic agent, introduced through the abdominal wall in the midline using a spinal needle, and injecting around the fibroid.

For suturing, I used vicryl 1 - 9251 - CTX round bodied 48 mm. 4 sutures, wetted, introduced through the LLQ - 5mm port, length 28cm medial to the ASIS. The introduced sutures are then pulled back to allow the needle being seen hanging down from the port. If the endometrial cavity is opened, it closed by a continuous layer of viryl 1 suture. The myometrium, I would closed for haemostasis, using the interupted Wing knots suture at places where wound tension is an issue, and granny or square knot for the other areas. I seldom use the bipolar machine and requirement for transfusion is rare. A second continuous layer stitching is done for the wound's superficial cosmetic layer using the needles hanging from the wound edge from the interupted Wing knot or the granny or square knot and after suturing secure them to any nearby suture ends available. Intercoat or interceed are used to prevent adhesions particularly true for all myomectyomies with infertility in mind. I would allow pregnancy as early as 3 months if infertility or maternal age becomes an issue, a controversial decision. However, after more than 300 cases in a period of 16 years, I have yet to see an uterine scar rupture, for more than 50 pregnancies after myomectomy. I would define elegibility for laparoscopic myomectomy as myomata total diameters are less than 10 cm. However bigger fibroids are subjected to abdominal gasless laparoscopic techniques, and time will tell whether this is the way to go.

Personally I feel the Wing knot has a great future for the present as well as future generation of surgeons, medical students and nursing staff and students. Please carry on the duty of spreading the know how of this knot on my behalf.

The Abdominal Lifting Laparoscopy – An Alternative Approach to Conventional Laparoscopy

Professor Wong Wu Shun, Felix
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Professor Felix Wong introduced to Hong Kong a new laparoscopic approach to surgery known as 'abdominal lifting laparoscopy'. Formerly, it was known as 'Gasless Laparoscopy'. Various devices have been designed to lift up the abdominal wall so as to create operative space for surgery. A well known device known as 'Laparolift' had been devised previously and that requires a portal wound of 10 mm to achieve lifting up of the abdominal wall. Not only that it is undesirable in achieving enough operative space, it also causes more postoperative pain. Although Gasless laparoscopy is still performed in some European centres, it has gradually lost its popularity over the years. On the other hand, conventional CO_2 laparoscopy has been employed in performing most laparoscopic surgery. After an initial enthusiasm in doing gasless laparoscopy, it started to fall in popularity and lacked in further development. Professor Keiichi Isaka from Tokyo University, however, did not give up his pursuit in this approach. In 1993, he developed the present 'abdominal lifting approach' using a strong steel needle, hanged by a chain to an overlying supporting metal bar which in turn is fixed by the side of the operating table. This subcutaneous approach obviates the use of a large portal wound, but instead creates only two tiny needle holes (Figure

1). The abdominal lifting approach is effective as it can create 'adequate' space for various procedures as demonstrated by the videos at the presentation. Professor Felix Wong also highlighted the advantages of this abdominal lifting approach as compared with the conventional laparoscopy.

Figure 1: The set up of the Abdominal Lifting Laparoscopy

For example:

1. Laparoscopic myomectomy – using this approach, conventional open abdominal instruments can be used in performing myomectomy. These instruments include:

   i. A pair of Littlewood clamps to lift the myoma out of its bed. Traditional needle holder is used to stitch the myomectomy wound and that can provide effective and secure wound closure. It also enables the surgeon to close the wound faster and without bleeding.

   ii. Morcellation for removal of myoma can be performed via a 1.5 – 2 cm portal wound without the use of a manual or electric morcellator.

   iii. Suction of blood clots or removal of myoma debris can be performed quickly and easily without resulting in the loss of vision from collapse of surgical space.

   iv. Multiple myomas can easily be removed quickly and deep seated myomas can be detected by finger palpation through a portal wound.

2. Laparoscopic ovarian cystectomy – for any benign ovarian cyst, irrespective of its size, ovarian cystectomy can be performed outside the body after the cyst is decompressed by sucking out of its content and the ovary displaced through the abdominal wound (Figure 2).

Figure 2 Ovarian cystectomy performed outside the abdomen in abdominal lifting laparoscopy

   i. This enables the removal of the cyst wall from the ovarian stroma while outside the abdominal cavity as in a case of open surgery.

   ii. The ovarian cyst can be delivered outside the wound and haemostatically sutured, thus minimizing the damage to ovarian tissue as a result of diathermy for haemostasis.

   iii. Peritoneal lavage can be performed faster, without any concern for collapse of peritoneal space due to quick suction of gas.

3. Laparoscopic hysterectomy – similar to that of conventional laparoscopic hysterectomy (LAVH/LH), except that conventional instruments as used in open surgery can be used and operated in the same manner. LAVH and LH performed with the abdominal lifting approach are similar to conventional LH and LAVH with respect to the steps involved. In the case of laparoscopic subtotal hysterectomy, removal of the uterine body can also be done easier by using cold knife morcellation at a portal wound. The risks associated with the use of electric morcellator can be avoided using this new approach.

Other advantages of this new approach are,

1. Instruments can go in and out of the wound without the problem of leaking of gas. Often more than one instrument can go through the same port.

2. There is less shoulder pain and rib pain after the operation as compared with conventional laparoscopy.

3. There are no similar complications from pneumoperitoneum, for example, emphysema, gas embolism, CO_2 acidosis, cardiovascular problem.

4. The cost of using these instruments and abdominal lifting device is much reduced as they are reusable, apart from the initial cost of purchase.

5. This laparoscopic approach is associated with a short learning curve for the majority of experienced surgeons or gynaecologists.

This abdominal lifting laparoscopy received much interest from the floor and stimulated much discussion after the presentation. Professor Wong further emphasized that this laparoscopic approach will enable general gynaecologists to perform laparoscopic surgery with their open abdominal surgical skill. He also announced that a summit meeting of gasless laparoscopy will be held in Hong Kong in March 2012. Hopefully this will further enhance the development of gasless laparoscopy and benefit those who have not been able to attend this CME meeting.

Hospital Activities 醫院活動

大中華電子健康及醫療信息化論壇

大中華電子健康及醫療信息化論壇(Greater China eHealth Forum 2011)於二零一一年十月七日及八日於九龍灣國際展貿中心舉行，聖保祿醫院參與論壇前活動，招待二十多名與會者於十月六日參觀本院，以觀摩本院近年積極發展先進醫療資訊系統的成果。

二十多名參觀者均是來自大中華多個地區的醫護界及醫療信息界專業人士。他們參觀本院之門診部、私家病房、心臟中心、診斷及介入放射部及藥劑部，親身體會電子醫療資訊系統及床邊終端機於醫療資訊的應用，並由本院醫護人員示範各個系統的臨床運作情況。

此外，本院總經理張文景先生更擔任論壇的演講嘉賓，向一眾與會人士分享本院近年醫療資訊系統發展的成果，及私家醫院營運模式轉變的經驗。

參觀私家病房考察電子病歷的優勢。

逾二十名專業人士參觀本院，了解資訊科技運作情況。

床邊終端機可臨床顯示電子病歷及為病人提供上網服務及娛樂資訊。

參觀心臟中心體會醫療影像數碼化的便捷。

本院總經理張文景先生擔任論壇的演講嘉賓，分享醫療資訊系統發展經驗。

本院總經理張文景先生獲主辦單位頒發感謝狀。

Hospital Update 醫院動態

全新健康中心開幕

聖保祿醫院之全新健康中心於二零一一年十一月十一日舉行開幕及祝聖典禮。本院很榮幸邀請到陳永超神父蒞臨為中心主持祝聖儀式。健康中心由A座十八樓搬遷到地庫二樓，佔地約三千平方呎，設有六間會客室。中心環境設施採用流線形設計，有別於傳統診症室，比以前更寬敞、更舒適。

新中心的設備更為完善，服務範圍比以前更廣、更多元化。除了提供個人身體檢查之外，中心內更設有超聲波儀器，提供一站式女士健康服務，並設有尿速流動量檢查室，使男士檢查時更為方便。此外，為全面照顧兒童成長發展所需，中心特設兒童評估室，專門提供兒童發展及評估門診服務。完善的設備配合健康中心醫護人員的熱誠及專業服務，定能為顧客提供盡善盡美、體貼入微、度身訂造的個人化健康檢查及會診服務。

陳永超神父與沙爾德聖保祿女修會何美蘭省會長及本院管理層切燒豬慶祝全新健康中心開幕。

陳永超神父為健康中心主持祝聖儀式。

健康中心全體醫護人員團結一心，為顧客提供高質素及專業的醫療服務。

健康中心設有橢圓形的演講室，以舉辦健康教育活動。

會客室內設有超聲波儀器為客人提供一站式女士檢查及診斷服務。

兒童評估室設有直播錄影裝置，方便鄰房的醫生即時評估兒童的身心發展。

全新面貌 煥然一新: 新客戶服務中心及住院登記

為持續提升客戶服務質素，本院A座地下大堂增設全新客戶服務中心，為顧客提供醫院資訊及專業諮詢服務。顧客可致電2830 8888查詢；至於電話轉線服務，則可致電本院總機2890 6008。

此外，本院之住院登記團隊已換上全新設計的制服，感覺煥然一新。

全新客戶服務中心為客人提供親切的專業服務。

本院執行董事張柱見修女與客戶服務中心及住院登記團隊合照。

Outreach Activities 外展活動

澳門健康講座

繆建文醫生(左三)和劉子榮醫生(左二)與主辦單位合照。

聖保祿醫院推動市民健康教育不遺餘力。本院兩名專科醫生－心臟科專科繆建文醫生及耳鼻喉科專科劉子榮醫生，於二零一一年十月二十九日到澳門參與健康講座，主講題目為「高血壓和心臟衰竭及睡眠窒息症你知多少？」是次健康教育活動由澳門社會服務中心及澳博娛樂場員工俱樂部主辦，當日共吸引約二百五十名澳門市民出席講座，場面熱鬧，台上台下互動參與，獲益不少。