"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)

Issue 76 | January - April 2012
第七十六期 | 二零一二年一月至四月

聖保祿醫院
St. Paul's Hospital

NEWSLETTER 院訊

Message from the Hospital Management

St. Paul's Hospital is pleased to announce the appointment of Dr. William Ho Shiu Wei as Medical Superintendent from 1 February 2012. I trust that most of you are familiar with Dr Ho and are aware of his numerous contributions to Hong Kong public healthcare sector in the past years as he was the former Chief Executive of the Hospital Authority.

Our hospital is undergoing major redevelopment project which aims at providing high quality services to patients. The new Block B is expected to be completed by 2014. With Dr. Ho's extensive experience, we are confident that under his strong leadership, our new medical governance team will set a clear vision in the future development of our hospital and continue to drive for clinical excellence in the years ahead.

Dr. Ho is taking over his role from Dr. Lau Kam Ying who has tendered his resignation. I would like to take this opportunity to express my deepest gratitude and appreciation to Dr. Lau for his invaluable contribution in the past two years. Dr. Lau demonstrated leadership in hospital planning and redevelopment project, Trent Accreditation, crisis management, and setting up of new advisory committees.

As the Chief of Service of Diagnostic and Interventional Radiology Department, Dr. Lau led the team in launching the public-private interface project – the electronic transfer of digital images between all Hospital Authority hospitals and our hospital in January 2011. Dr. Lau's contribution has laid a strong foundation for our hospital's future development. We wish him every success in his future endeavours.

With God's blessings, and the teamwork of all hospital departments and colleagues, I strongly believe that St. Paul's Hospital can rise to the challenges ahead to serve our patients and the community.

Sr. Nancy Cheung
Managing Director

St.Paul's Hospital
2, Eastern Hospital Road,
Causeway Bay, Hong Kong
Tel: 2890 6008
Fax: 2576 4558
Website:www.stpaul.org.hk

聖保祿醫院
香港銅鑼灣東院道2號
電話：2890 6008
傳真：2576 4558
網址：www.stpaul.org.hk

2011 was a challenging year for St. Paul's Hospital. We had to deal with many pressing issues, including strengthening quality and risk management to ensure patient safety, improvement of the Hospital's physical facilities and crucial electricity supply, the Trent Accreditation re-visit and the ongoing implementation of the Hospital Information System. In addition, we have had to collaborate with the Department of Health in implementing its policies, including their hotly debated new policy in relation to obstetric services.

The Hospital redevelopment project presented other challenges, including limited bed spaces, elevators and parking spaces. In spite of our best efforts, these problems will not be fully resolved until the new Block B is completed in 2014. The reconstruction has caused inconvenience to patients and their relatives, visiting doctors and our staff. Furthermore, the implementation of the Hospital Information System (the St. Paul's Hospital Information Project or SHIP Project), was not without difficulties and required improvement and fine tuning. We applaud the integrated team effort in endeavoring to rectify the challenges posed by the SHIP project.

Looking back, I must admit that our path has not been an easy one. However, the hospital is still doing well. We established a smooth integration of the public private interface - the electronic transfer of all digital images between all Hospital Authority hospitals and our hospital. On behalf of the Hospital, I would also like to take this opportunity to thank all patients and their relatives for their patience and support of our hospital.

To further improve our services and to equip us for facing future challenges ahead, the hospital has established several new advisory committees: the Drug and Therapeutic Committee, the Minimally Invasive Gynaecology Advisory Committee, the Radiology Advisory Committee and the Public Relation & Education Advisory Committee. The Quality & Risk Management Department was also restructured this year and is now under the Medical Superintendent's team. To provide a platform for information gathering and communication among colleagues, we have once again begun to hold evening seminars in which invited speakers provided updates on various specialties.

I would like to thank the chairpersons and members of all advisory committees for their contribution and invaluable input, the unfailing support of the management team for their contribution and leadership in hospital development, all staff and their families, all visiting doctors and volunteers for their support throughout the years. Last but not least, I would also like to extend my gratitude to our former Medical Superintendent Dr. David Fang for his shared experience in medical governance of Hospital.

I was deeply impressed by one of the speeches in the high school graduation dinner of my elder son in 2005, where the speaker reminded everyone that "whenever there is a beginning, there is an end". I would like to thank Mother Jacqueline Ho, the Board of Directors, Sister Nancy Cheung and all sisters of the St. Paul de Chartres for providing me the opportunity to serve the hospital as the Medical Superintendent and the Chief of Service of the Diagnostic & Interventional Radiology Department. I have learned a lot during my two years here. Let us team up with Dr. William Ho, the new Medical Superintendent and together work for the benefit of the Hospital. I do hope that we can bring God's love and care not only to our community but also to communities beyond us.

May God's love always be with the hospital, and may His grace and blessings be with you and your family always.

Dr. Lau Kam Ying
Departing Medical Superintendent

I have joined St. Paul's Hospital for over a month. It is a very pleasant working environment with many friendly staff members. I am impressed by the huge amount of new development and improvement measures that the hospital is embarking on. The myriads of meetings I have to attend every day offer me a condensed exposure to many aspects of the hospital's work, human relations, and major challenges that the hospital is facing. The Team Building Workshop of department heads held earlier also gave me great opportunities to know the key people and how they thought about the hospital.

There are a number of priorities in my mind. Top on the list are patient safety and clinical service quality. In particular, the core business of a Medical Superintendent is to manage medical services and doctors. I am therefore taking an active role in co-chairing the various Advisory Committees of different specialty areas, which are excellent mechanisms for clinical governance. These take the form of proper credentialing of doctors for admission and procedure privileges, advice on new technology and equipment, and directions of clinical service development. Secondly, I am helping to further strengthen the complaints handling mechanism and medico-legal support. We are in the process of recruiting a full time Quality and Safety Manager to revitalize this important area, particularly in incident reporting, root cause analyses and process improvements. Thirdly, I am also devoting time into understanding and fine tuning the Block B plans, which will offer the hospital great opportunities of service upgrade and operational improvements in the decades to come. My next target for the coming month is to understand the computer system, particularly the clinical applications.

In this era of transparency and rising public expectations, a proactive approach is needed to address patient and community concerns. I certainly did not expect to hold a press conference just two weeks in my new job. But that was considered necessary in view of the misunderstanding on our hospital policy regarding obstetric services, which was rapidly amplified through the Internet among citizens. Likewise, we were quick to spot false web pages that used our hospital name to target Mainland mothers. Timely clarification and reporting to the Police may help deter such fraud.

I consider myself very fortunate to receive great trust from the sisters of St. Paul de Chartres, and generous help from top management colleagues. The "Site Office" workplace, nicely termed "Block E" with a very "cozy" meeting room and roaring during heavy rain, is a never-ending hustle and bustle of activities from dawn to dusk. Throughout the hospital, I see diligence, professionalism, and commitment towards continuous improvement. Such organizational culture must have been the result of painstaking nurturing by the sisters of St. Paul de Chartres and others throughout the years. I wish to pay special tribute to the great contributions of my predecessors Dr. David Fang and Dr. Lau Kam Ying, as well as their advice to me. I certainly look forward to work closely with all colleagues and visiting doctors in the pursuit of excellence to serve our patients and the community.

Dr. William Ho
Medical Superintendent

Medical Information 醫療資訊

A Brief Update on the Management of Childhood Upper Respiratory Infection

As a paediatrician on the front line of patient care, I am exposed throughout the day to patients who present with upper respiratory infection (URI). URI is associated with significant societal costs for children in terms of lost school days and accounts for numerous health care visits, including unnecessary antibiotic prescriptions. Viral URI also commonly is associated with acute otitis media (AOM) in children, which is the most frequent diagnosis leading to antibiotic prescriptions for young children. In this short review, I try to summarize the meta-analyses on childhood URI hoping it can assist the management of children with these commonly encountered childhood infections in office setting.

Acute Otitis Media

Acute otitis media (AOM) is extremely common in children, particularly those aged 3 months to 3 years. Currently published guidelines support a "watchful waiting" approach for the treatment of children with AOM. This means delaying the administration of antibiotics for at least 72 hours, especially for children 6 months old or older [1]. This recommendation is based on the observation that spontaneous remission can occur in a substantial number of children, presumably those suffering from viral infections. Indeed, six different meta-analyses confirm that antibiotics provide only a modest benefit to children with AOM [2-7].

Antibiotic therapy is important in children under 2 years of age with bilateral AOM [3], in children with AOM and otorrhoea [3], and in children at higher risk for mastoiditis [4]. When a decision to prescribe antibiotics is made, 5- day- therapy is usually adequate for most cases of uncomplicated AOM [8, 9]. Long prophylactic courses of antibiotics (>6 months) can be used to reduce the probability of recurrent AOM in children who had three or more episodes of AOM within the last 6 months or four episodes within the last year [10].

Neither decongestants nor antihistamines offer any additional benefit to the treatment of children with AOM [11]. Moreover, although otic preparations with analgesic agents (excluding antibiotics) are frequently prescribed in children with AOM, their use is not supported by solid scientific evidence [12].

Tonsillitis and Croup

Laryngotracheitis or croup is a virally induced infection of the trachea below the level of the vocal cords that affects almost exclusively children under 6 years of age. Two of the most widely used agents against this disease are epinephrine and corticosteroids. Although no meta-analysis has been published regarding the effects of epinephrine against croup, two recent [13, 14] and one older [15] meta-analyses confirm that corticosteroids are effective in relieving the symptoms and reducing the length of hospital stay for children with croup. Although treatment with humidified air has also been widely used against croup, recent reports shed doubts over the value of this practice [16].

Tonsillitis, an infection of the tonsils and pharynx, is a common infection in children of all ages. Although most cases are of viral origin, a substantial number of cases (5%–20%) are due to group A beta-hemolytic streptococci (GABS).

Although penicillin has for decades been considered as the treatment of choice for GABS tonsillitis, several reports of treatment failure associated with its use have been published over the years. Cephalosporins represent an alternative antibiotic in this setting because of their good overall antimicrobial spectrum and excellent safety profile. Four meta-analyses concluded that in comparison to penicillin, cephalosporins are indeed associated with better treatment outcomes (clinical and especially bacteriologic cure rates) in children with GABS tonsillitis [17-20]. Moreover, all available cephalosporin formulations seem to work equally well, with no major efficacy differences among agents of different generations [19].

Regarding penicillin, one previous meta-analysis compared twice-a-day versus four-times-a-day dosing and concluded that the former regimen was superior [21]. Ten days of penicillin are a reasonable

treatment option for GABS tonsillitis, since shorter treatment courses are associated with inferior bacteriologic outcomes (i.e. lower GABS eradication rates) [22]. Although some clinicians advocate the use of antibiotics to prevent post-tonsillectomy complications (i.e. post-operative bacterial infections of the tonsillar fossa and the associated pain), this practice is not supported by sufficient data [23].

One meta-analysis evaluated the practice of administering antibiotics for sore throat and found some evidence to support their use as a means of preventing serious complications, albeit this is only applicable to developing countries, where rheumatic fever continues to be common [24].

Dr. Chan Chun Wing, Desmond
Specialist in Paediatrics

References

1. *American Academy of Pediatrics Subcommittee on Management of Acute Otitis Media: Diagnosis and management of acute otitis media. Pediatrics 113.1451-1465. 2004.*
2. *Koopman L., Hoes A.W., Glasziou P.P., et al: Antibiotic therapy to prevent the development of asymptomatic middle ear effusion in children with acute otitis media: a meta-analysis of individual patient data. Arch Otolaryngol Head Neck Surg 134. 128-132. 2008.*
3. *Rovers M.M., Glasziou P., Appelman C.L., et al: Antibiotics for acute otitis media: a meta-analysis with individual patient data. Lancet 368. 1429-1435. 2006.*
4. *Glasziou P.P., Del Mar C.B., Sanders S.L., et al: Antibiotics for acute otitis media in children. Cochrane Database Syst Rev. 2004; CD000219.*
5. *Damoiseaux R.A., van Balen F.A., Hoes A.W., et al: Antibiotic treatment of acute otitis media in children under two years of age: evidence based? Br J Gen Pract 48. 1861-1864.1998.*
6. *Rosenfeld R.M., Vertrees J.E., Carr J., et al: Clinical efficacy of antimicrobial drugs for acute otitis media: metaanalysis of 5400 children from thirty-three randomized trials. J Pediatr 124. 355-367. 1994.*
7. *Del Mar C., Glasziou P., Hayem M.: Are antibiotics indicated as initial treatment for children with acute otitis media? A meta-analysis. BMJ 314. 1526-1529. 1997.*
8. *Kozyrskyj A.L., Hildes-Ripstein G.E., Longstaffe S.E., et al: Short course antibiotics for acute otitis media. Cochrane Database Syst Rev. 2000; CD001095.*
9. *Kozyrskyj A.L., Hildes-Ripstein G.E., Longstaffe S.E., et al: Treatment of acute otitis media with a shortened course of antibiotics: a meta-analysis. JAMA 279. 1736-1742. 1998.*
10. *Leach A.J., Morris P.S.: Antibiotics for the prevention of acute and chronic suppurative otitis media in children. Cochrane Database Syst Rev. 2006; CD004401.*
11. *Coleman C., Moore M.: Decongestants and antihistamines for acute otitis media in children. Cochrane Database Syst Rev. 2008; CD001727.*
12. *Foxlee R., Johansson A., Wejfalk J., et al: Topical analgesia for acute otitis media. Cochrane Database Syst Rev 2006; 3: CD005657.*
13. *Russell K., Wiebe N., Saenz A., et al: Glucocorticoids for croup. Cochrane Database Syst Rev. 2004; CD001955.*
14. *Ausejo M., Saenz A., Pham B., et al: The effectiveness of glucocorticoids in treating croup: meta-analysis. BMJ 319. 595-600. 1999.*
15. *Kairys S.W., Olmstead E.M., O'Connor G.T.: Steroid treatment of laryngotracheitis: a meta-analysis of the evidence from randomized trials. Pediatrics 83. 683-693. 1989.*
16. *Moore M., Little P.: Humidified air inhalation for treating croup. Cochrane Database Syst Rev. 2006; 3: CD002870.*
17. *Brook I.: A pooled comparison of cefdinir and penicillin in the treatment of group A beta-hemolytic streptococcal pharyngotonsillitis. Clin Ther 27. 1266-1273. 2005.*
18. *Deeter R.G., Kalman D.L., Rogan M.P., et al: Therapy for pharyngitis and tonsillitis caused by group A beta-hemolytic streptococci: a meta-analysis comparing the efficacy and safety of cefadroxil monohydrate versus oral penicillin V. Clin Ther 14. 740-754.1992.*
19. *Pichichero M.E., Margolis P.A.: A comparison of cephalosporins and penicillins in the treatment of group A beta-hemolytic streptococcal pharyngitis: a meta-analysis supporting the concept of microbial copathogenicity. Pediatr Infect Dis J 10. 275-281.1991.*
20. *Casey J.R., Pichichero M.E.: Meta-analysis of cephalosporin versus penicillin treatment of group A streptococcal tonsillopharyngitis in children. Pediatrics 113. 866-882.2004.*
21. *Lan A.J., Colford J.M., Colford , Jr., Jr. J. M.: The impact of dosing frequency on the efficacy of 10-day penicillin or amoxicillin therapy for streptococcal tonsillopharyngitis: a meta-analysis. Pediatrics 105. e19. 2000.*
22. *Falagas M.E., Vouloumanou E.K., Matthaiou D.K., et al: Effectiveness and safety of short-course vs long-course antibiotic therapy for group A beta hemolytic streptococcal tonsillopharyngitis: a meta-analysis of randomized trials. Mayo Clin Proc 83. 880-889. 2008.*
23. *Dhiwakar M., Clement W.A., Supriya M., et al: Antibiotics to reduce post-tonsillectomy morbidity. Cochrane Database Syst Rev. 2008; CD005607.*
24. *Del Mar C.B., Glasziou P.P., Spinks A.B.: Antibiotics for sore throat. Cochrane Database Syst Rev. 2004; CD000023.*

Presentation at a CME/CPD/CNE Meeting
持續醫學進修講座

Different Modalities in Managing Urinary Tract Stones

St. Paul's Hospital, 15th November 2011

ESWL – What we can achieve in St. Paul's Hospital?

Dr. Lo Hak Keung, Alex
Specialists in Urology
St. Paul's Hospital

Abstract:

Key Words:
Urinary tract stones, Extra-corporeal Shock Wave Lithotripsy (ESWL), Outcomes.

Topic:
Clinical Audit of the New Extra-corporeal Shock Wave Lithotripsy (ESWL) machine (Storz Modulith SLX-F2) in St. Paul's Hospital.

Objective:
To evaluate the effectiveness and safety of the newly installed ESWL machine (Storz Modulith SLX-F2) in the treatment of urinary tract stones.

Methodology:
All patients who had been treated with urinary tract stone (larger than 5 mm in size) by the newly installed ESWL machine in 2009 to 2010 were included. Patients' demographic data, target stone characteristics, patients' discomfort and treatment outcomes were prospectively collected. Treatment was considered a success if the patient was stone free or had asymptomatic, unobstructed stone fragments less than 4 mm.

Results:
329 patients were analysed. M:F= 3:1. Age ranged from 24 to 81. 135 patients had renal stone and 194 patients had ureteric stone. Their stone size ranged from 5 – 36 mm, mean 8.7 mm. 92.7 % of the target stone were radio-opaque and 56.7% of the stones had obstructive effect. 76.3% of them had their procedures performed under sedoanalgesia. 95.4% of the target stones were localized by X-ray. The no. of shocks given per treatment ranged from 1000 to 4000 shocks. The overall single session success rate was 88.1% (Complete stone clearance: 64.4%; CIRF: 23.7%). The single session success rate / complete stone clearance rate for renal and ureteric stone was 84.4% / 40% and 93.3% / 81.4% respectively. Stone size was the only pre-treatment factor associated with the treatment outcome (p=0.010). 79.9% and 2% of the patients complained minor symptoms on D1 and D14 respectively.

Conclusion:
Storz Modulith SLX-F2 lithotripter is effective and safe in the treatment of urinary tract stones.

PCNL – Prone or Supine?

Dr. Fu Kam Fung, Kenneth
Specialist in Urology and Associate Consultant Urologist
Queen Mary Hospital

Introduction:
Percutaneous nephrolithotomy (PCNL) is the most suitable treatment for large renal stones and stones refractory to extracoporeal shock wave lithotripsy (ESWL) and ureteroscopic lithotripsy. In the mid-1970s, Fernström & Johansson reported their first case of stone extraction through a nephrostomy tract. The tradition of PCNL in prone position was established until 1987, Valdivia-Uria introduced the technique of supine approach.

However, the uncertain outcomes and complications rates, and steep learning curve retarded the development of supine PCNL in the last 20 years. The literature echoed this interest with several international comparative studies and review articles.

Traditional PCNL in Hong Kong:
An audit of traditional prone PCNL in 2000 in Queen Elizabeth Hospital concluded that 30–40% staghorn stones and 80–100% complicated renal and upper ureteric stones were rendered stone free after a single session of PCNL. The role of PCNL for the remaining staghorn stones (60–70%) was debulking prior to ESWL. A similar local study in 2005 by the same group of urologists was conducted. The outcomes of prone PCNL were

improved in overall single session & final stone free rates (25% & 12% respectively), reduced re-treatment rate (18%), and raised efficiency quotient (21.5), while overall complication rate remained low (13.9%) when compared to those in 2000 after the use of ultrasonic lithotripter, flexible nephroscopy and multiple PCNL tracts, as well as maturation of operative technique.

When do we turn to supine position?

In Hong Kong, the supine PCNL was described in 2004. The primary stone clearance rate was 76%, and the mean number of sessions of PCNL was 1.3. There was no procedure-related major complication. There are several advantages to the supine position for the patient and the urologist, with greater flexibility of stone manipulation along the whole upper urinary tract. PCNL with the patient in the supine position is a sound alternative to the conventional prone position. An Italian study in 2008 compared the modified supine versus prone position in single tract PCNL. The outcomes of two groups are comparable. However, these results can only be reproduced in a carefully selected patient population with uncomplicated renal stones. This selected stone must be treatable with single percutaneous access, larger than 2.5 cm, BMI less than 30. Stones more than one calyx, complete staghorn stones and co-existing renal anomalies are excluded. Obviously, it is more favorable to supine approach. The table summarized the advantages of supine and prone PCNL.

Supine	Prone
Patient selection	
a.accommodate patients who cannot assume prone position: ▪limb contracture ▪significant kyphosis b.better position for obese patients: ▪cardiopulmonary compromise secondary to prone position is more pronounced in obese patients	
Anaesthetic concern	
a.less cardiopulmonary compromise b.less venous thromboembolic event c. easy airway access in case of conversion to general anaesthesia	
Theatre staffing	
a.less labour-demanding in patient mobilisation b.entire procedure done in one draped position	
Surgeons' concern	
a.comfortable sitting position b.less radiation exposure c.time-saving in patient positioning	a.traditional and familiar standing position
Nephrostomy tract formation	
a.facilitate simultaneous ureteroscope to access upper pole calyces b.less colonic injury ▪colon floats away instead of being pushed against the kidneys	a.easy access to upper pole calyces b.flexible working space allowing angulation of instruments & multiple access channels c.less caudal displacement of kidneys during respiration d.less anteromedial movement of kidneys during tract dilatation
Stone manipulation	
a.low pressure filling of collecting system minimising urosepsis b.tract position encourages spontaneous stone evacuation	a.good filling of collecting system to enhance nephroscopic vision and enlarge working space b.better position for staghorn stones ▪shorter operative time ▪slightly better stone free rates

Table 1: Advantages of prone and supine position

Learning Supine PCNL:

There are so many advantages of supine over prone position. Should we shift all PCNL to "new" supine approach?

Besides the limitation to the carefully selected stone, another hurdle to the popularization of supine PCNL is the steep learning curve.

The initial experience of percutaneous renal access in supine position conferred the safety and effectiveness for both kidney drainage and removing renal stone in selected patients. Proper positioning and experience in using ultrasonography is crucial for the success of such technique.

Data of patients receiving supine (modified Valdivia position) PCNL as compared to the standard prone technique in a local tertiary hospital were studied.

For complete staghorn stone, it is performed in prone position. It is expected that staghorn stone required more nephroscopic manipulation or sometimes more than one tracts. This may not be feasible in supine position.

For those patients who underwent supine PCNL, a modified supine position combining the Lloyd Davis position is adopted to facilitate the access to the ureter and bladder. For large obstructed upper ureteric stone, the simultaneous PCNL & URSL was performed with this position. The supine PCNL was performed with on-table real time USG guided renal puncture and C-arm fluoroscopy. The results showed that both groups are comparable. In supine group, the stone free rate is 61% and prone is 46 %. The haemoglobin drop in supine group is 1.52 and prone group is 0.93. The hospital stay is 4 days in both groups. The re-treatment rate in both groups is ~20%. The complication rate is < 1% in both groups, without case of bowel injury. The

operative time is usually longer in prone PCNL as it required re-positioning the patient. The stone pattern affected the choice of approach. Branched stone or staghorn stone is less favourable to supine. The modified supine combined with Lloyd Davis position or named modified Valdivia position allowed simultaneous PCNL and URSL. In selected patients contraindicated for prone positioning, supine PCNL can be offered with comparable outcomes and safety measures. After all, should we do supine or prone PCNL?

I personally adopt the supine PCNL if (1) the stone is not branched and non-staghorn stone, and (2) relatively contraindicated conditions in prone position. It frankly takes some time to adjust from prone to supine.

URSL – Rigid or Flexible?

Dr. Wong Bok Wai, Byron
Specialists in Urology

Introduction

Urolithiasis is a common condition affecting 120-140/100,000 people each year. Stone formation is often multifactorial and complex. While small renal stones are often asymptomatic, the larger ones and those that dropped down to the ureter can often give rise to severe pain (renal / ureteric colic), hematuria, and / or obstructive uropathy. Endourologic treatments of such stones include extracorporeal shock wave lithotripsy (ESWL) or ureterorenoscopic laser lithotripsy (URSL), both having its own merits and disadvantages. This article will aim to give a brief overview of utilizing URSL in the treatment of ureteric and kidney stones.

Limitations of ESWL

There is no doubt that of the two aforementioned endourologic modalities, ESWL often offers a simpler and less invasive solution. However, when the stone is large (> 1cm), tightly impacted, or at a site where localization may be difficult (e.g. the mid ureter), EWSL may not be as effective. Moreover, there are some stone compositions that are not amenable to shock wave lithotripsy (e.g. cystine stone). The stone fragmentation by ESWL is also not as reliable as laser lithotripsy, and in certain situations where there is an urgent need to disimpact a stone to relieve obstructive uropathy, ESWL may not be as suitable.

Advances in URSL

URSL involves the passage of a specialized endoscopic instrument (the ureteroscope) in a retrograde fashion, via the urethra, bladder, and through the ureteric orifice into the ureter and up to the level of the stone. This is usually performed under fluoroscopic guidance. Once the stone is visualized, lithotripsy can be carried out using one of many intracorporeal lithotripters.

The high success rates of URSL nowadays can largely be credited to the advances in instrumentation, especially the small-caliber semi-rigid and flexible ureteroscopes; the Holmium laser, which can fragment all stones regardless of composition; and the availability of various specialized guidwires and stone manipulation devices (e.g. baskets, prongs, etc). Both the semi-rigid and flexible ureteroscopes allow easy and atraumatic access into the upper ureter and pelvicalyceal system, while effective and safe intracorporeal lithotripsy can be carried out using the Holmium laser. In fact most stones anywhere along the ureter or even in the kidney can be treated by URSL. Impacted stones can usually be cleared and the obstruction reliably relieved by URSL. Another advantage is that if there are multiple stones along the same ureter or if there are concomitant ureteric and kidney stones in the same system, these can be treated in one single session. Patients can generally be discharged on the same day or the next day following surgery.

Complications of URSL

The most significant complication of URSL is ureteric perforation and avulsion of the ureter. Fortunately, in the hands of experienced endourologic surgeons and in most large reported series, the rate of this serious complication should be less than 1%. Other known complications include post-op bleeding, fever & urosepsis, minor mucosal injury and ureteric stricture.

URSL vs ESWL: Stone free rates

In terms of management of ureteric stones, both ESWL & URSL are effective treatment modalities. However, the reported stone free rates after single primary treatment is generally higher for URSL irrespective of stone size or location in the ureter, except for proximal ureteric stone of less than 1cm in size, where ESWL gives a slightly better result. For kidney stones, ESWL is still the treatment of choice. However, for lower pole stones, URSL using the flexible scope and repositioning of the stone with flexible forceps / baskets prior to laser lithotripsy will give superior results to ESWL.

Conclusion & recommendations

The choice of treatment modalities in the management of ureteric & renal stones depends on a number of factors: stone size, location, composition & degree of impaction; availability of specialized instruments and technical expertise;

and certainly patient's preference. However, under most circumstances, I would recommend URSL in the following situations: stone in the mid or lower ureter, or larger stone (>1cm) in the proximal ureter, tightly impacted stone with evidence of obstructive uropathy, and in cases of multiple stones within the same ureter / pelvicalyceal system.

Further reading & Reference

C. Turk (Chairman), T. Knoll (Vice-chairman), A. Petrik, K. Sarica, M. Straub, C. Seitz. European Association of Urology Guidelines on Urolithiasis. Uroweb 2011.
Available at: http://www.uroweb.org/gls/pdf/18_Urolithiasis.pdf

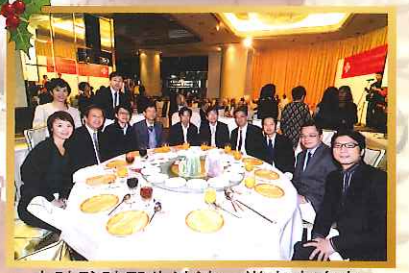
Hospital Activities 醫院活動

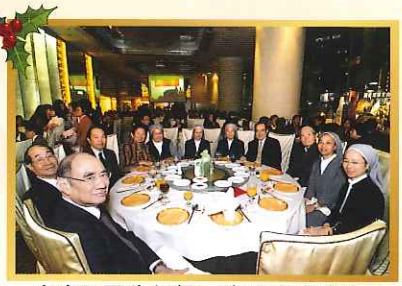
二零一一年聖保祿醫院聖誕聯歡晚宴

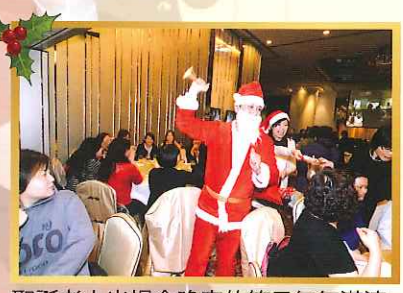
二零一一年聖保祿醫院聖誕聯歡晚宴一連兩晚在銅鑼灣富豪酒店舉行，兩晚共多達一千名賓客出席，包括神父、修女、醫生、本院合作伙伴、管理層及同事。今年除了一如以往頒發長期服務獎予為本院效力了十年、二十年、及三十年的同事之外，更首次舉辦「才藝大賽Fun Fun Show」。來自十個部門的五組參賽者施展渾身解數，為大家表演唱歌、跳舞、話劇及樂器。最後由復康中心及診斷及介入放射部組成的「R & D」組合奪得大獎。他們的表演充滿創意與熱誠，充分發揮了團隊合作精神，將晚宴的氣氛推上頂峰。此外，兩晚均舉行幸運大抽獎環節，共有超過五百份禮品，總值逾二十五萬元，大家都滿載而歸。

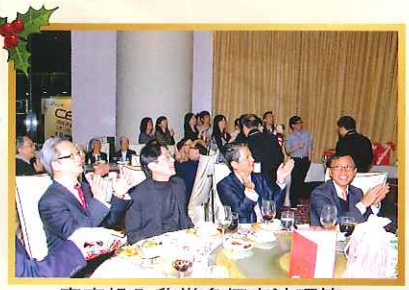
聯歡晚宴亦頒發了「預防針刺意外標語創作比賽大獎」，得獎者為A14病房同事蘇海慧，得獎標語為「針咀丟進收集箱，工作安全零受傷」。此外，「最熱烈參與部門獎」則由A9病房同事奪得。

祝酒儀式為聯歡晚宴揭開序幕。

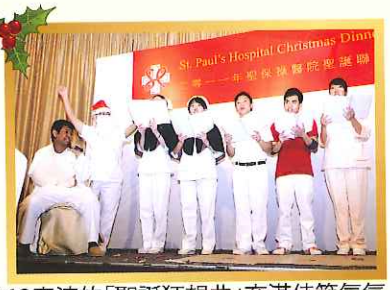

本院駐院醫生濟濟一堂出席晚宴。


來賓及醫生們撥冗光臨出席晚宴。

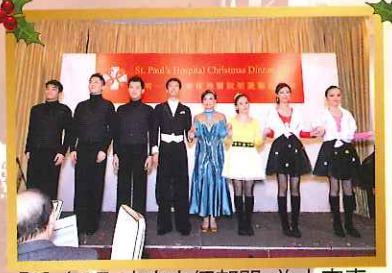

聖誕老人出場令晚宴的節日氣氛滿溢。


賓客投入欣賞多個表演環節。

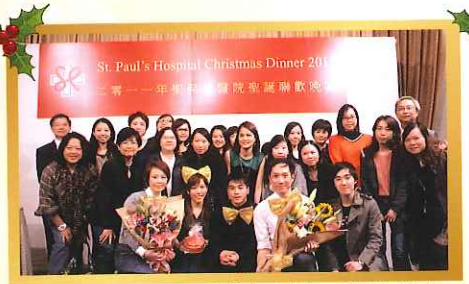
「IQ同盟」演出「St. Paul 無間道之針刺預防篇」。



A13表演的「聖誕狂想曲」充滿佳節氣氛。

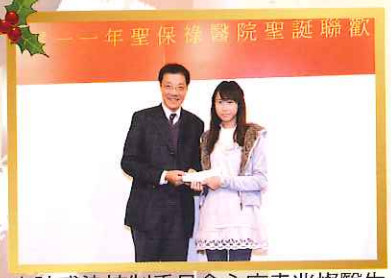


「愛. 舞吧」來自六個部門, 為大家表演「歡慶聖誕舞出愛」。



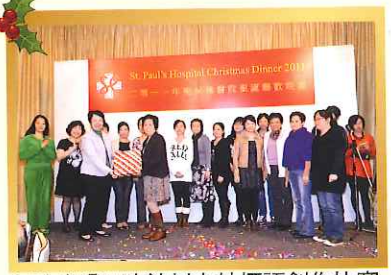
「R & D」憑著動人歌聲與創意MV製作獲得大獎。

A12病房同事及門診部同事以歌舞及樂器演繹一曲「挪亞方舟」。



本院感染控制委員會主席袁兆燦醫生頒獎予「預防針刺意外標語創作比賽大獎」得主。

沙爾德聖保祿女修會何美蘭省會長頒發大獎予幸運兒。



A9奪得「預防針刺意外標語創作比賽大獎」的「最熱烈參與部門獎」。

Hospital Retreat

A full-day Hospital Retreat, one of our management and development series on leadership training, was successfully completed on 31 January and 2 February 2012 with a total participation of 79 managerial personnel. The objective of this workshop was to promote team-building among the staff. Through various team building games and sharing sessions as led by the professional trainer, the beliefs and skills for creating a trustworthy and harmonious working environment to effectively support each other was delivered. This workshop was recognized positively by the participants. Their valuable comments and enthusiasms fueled our continuation of leadership development for our staff in the near future.


Island
No Talk
ISLAND
No SEE

ME/CPD/CNE Programme
持續醫學進修概覽

Program Announcement

Topic	Chairman	Speakers
Date: 17th April, 2012		
Neuropathic Pain *1. Orthopaedic Surgeon's Perspective in Neuropathic Pain* *2. Basic Science and Literature Review* *3. Anaesthetic Pain Management*	Dr Ngai Yiu Hing, William *Specialist in Orthopaedics & Traumatology,* *St. Paul's Hospital*	1. Dr. Ko Put Shui, Peter *Specialist in Orthopaedics & Traumatology* 2. Dr. Law Yee Cheong, Wally *Specialist in Orthopaedics & Traumatology* 3. Dr. Wong Lai Yee, Belinda *Specialist in Anaesthesiology*
Date: 15th May, 2012		
Report on Manangment of Lung Cancer *1. Minimally Invasive Video-Assisted Thoracoscopic Resection of Non-Small Cell Lung Cancer* *2. Recent Advances in Lung Cancer: Diagnosis & Beyond* *3. Role of Radiotherapy, Chemotherapy & Targeted Agents for Lung Cancer* *4. Can We Have Cheaper Target Therapy for Lung Cancer?*	1. Dr Cheng Lik Cheung *Specialist in Cardiothoracic Surgery* 2. Dr Leung Siu Man, John *Specialist in Cardiothoracic Surgery*	1. Dr Chui Wing Hung *Specialist in Cardiothoracic Surgery* 2. Dr. Wong King Yan, Matthew *Specialist in Respiratory Medicine* 3. Dr. Ying Chi Ho, Anthony *Specialist in Clinical Oncology* 4. Dr. Leung Siu Man, John *Specialist in Cardiothoracic Surgery*
Date: 19th June, 2012		
Psychiatry & ADHD *1. Common Psycho-Pathological Phenomena* *2. Loss of Executive Function - New Perspectives of ADHD*	Dr Lau Ying Kit, David *Specialist in Psychiatry*	1. Dr. Tsang Fan Kwong *Specialist in Psychiatry* 2. Dr. Ting Sik Chuen *Specialist in Psychiatry*

Time: 7:00pm / 7:30pm - 9:00pm (Light refreshment provided)
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