第七十八期 issue 78
Jul-Aug, 2012

聖保祿醫院
St. Paul's Hospital

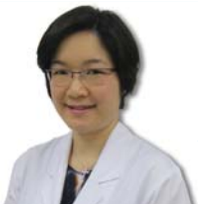
NEWS 院訊 Letter

What's new about Attention Deficit Hyperactivity Disorder

CME Presentation Recap:

- Neuropathic Pain
- Report on Management of Lung Cancer

MEDICAL ARTICLE



Dr. Sylvia Doo
Specialist in Paediatrics
Child Development and Assessment Centre
St Paul's Hospital

What's new about Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is the most commonly diagnosed neurobehavioral disorder that typically begins in childhood and often persists into adulthood. ADHD is characterized by developmentally inappropriate levels of inattention and hyperactivity resulting in functional impairment in academic, family, and social settings. There are increasing trends in prevalence during the past decade and increases in ADHD medication use. The worldwide-pooled (for all age) prevalence was 5.29% [1]. The American Psychiatric Association stated that 3%-7% of school-aged children have ADHD [2]. The prevalence of ADHD in Hong Kong is 6.1% in Primary 1 schoolboys and 3.9% in early adolescence [3, 4]. In this article, I would like to highlight some latest update on this topic.

AAP Clinical Practice Guideline on ADHD 2011

The American Academy of Pediatrics had published the latest clinical practice guideline in 2011 [5]. Attention should be paid to the few key action statements:

1. With emerging evidence, evaluation for ADHD can be initiated for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.

2. To make a diagnosis of ADHD, the DSM-IV criteria should be met, including documentation of impairment in more than 1 major setting. Information should be obtained primarily from reports from parents or guardians, teachers, and other personnel involved in the child's care. Any alternative cause should also rule out.

3. Assessment for other conditions that might coexist with ADHD should be included. These include emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders), developmental (e.g., learning and language disorders or other neurodevelopmental disorders), and physical (e.g., tics, sleep apnea) problems.

4. ADHD should be recognized as a chronic condition and, therefore, consider children and adolescents with ADHD with special health care needs.

5. Recommendations for treatment of children and youth with ADHD vary depending on the patient's age:

a. For preschool-aged children (4-5 years of age), evidence-based parent- and/or teacher-administered behavior therapy is the first line of treatment. Approved medication may be added if there is no significant improvement with moderate-to severe continuing disturbance in the child's function. This special recommendation based on study finding that that many young children experience improvements in symptoms with behavior therapy alone, and the overall evidence is strong. Depending on severity, many young ADHD children might still require medication to achieve maximum improvement, and medication is NOT contraindicated for this age.

b. For elementary school-aged children to adolescents (6-18 years of age), approved medications for ADHD is the first line treatment with/without evidence-based behavior therapy, preferably both. Evidence is particularly strong for stimulant medications; and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine.

6. Doses of medication for ADHD should be titrated to achieve maximum benefit with minimum adverse effects. Because stimulants might produce positive but suboptimal effects at a lower dose, titration strictly on a milligram-per-kilogram basis is not recommended. Education of parents is an important component to ensure their cooperation in appropriate titration.

Diagnostic and Statistical Manual of Mental Disorders – 5th edition (DSM-V) 2013

As mentioned above, we are now using the DSM-IV diagnostic criteria for diagnosing ADHD. A new revision of DSM-V will be issued in May 2013 (Table 1) [6]. The major changes are:
1. Increase the limit for age of onset from 7 to 12 years. A substantial literature overwhelmingly indicated that the age of onset by age 7 was invalid by all criteria: not able to be reliably assessed, no clinical differences between children identified as onset by 7 versus later in terms of course,

severity, outcome, or treatment response. While other data in the literature indicate that 96% of lifetime cases of ADHD are captured by age 12-14, suggesting that an age 12 cutoff is superior to most alternatives. With renewed concern about appropriate criteria for adults, issues of retrospective recall also were clinically relevant. Population survey data indicated that in adults with ADHD, only half recalled onset by age 7 but 95% recalled onset by age 12.

2. Removal of Pervasive Developmental Disorder (Autistic Spectrum Disorder in DSM V) from the exclusion criteria. There is a growing literature suggesting that ADHD and Autism Spectrum Disorder might co-exist.

3. Change the three subtypes to four current presentations. The change was based on that 'subtype' denote a stable difference, whereas 'presentation' denote a current status that is less reifying.

4. More stringent requirement that information must be obtained from two or more different informants.

5. Change the examples in the items, without changing the exact wording of the DSM-IV items, to accommodate a lifespan relevance of each symptom and to improve clarity.

Table 1 DSM V- Diagnostic criteria for Attention Deficit Hyperactivity Disorder [6].

ADHD consists of a pattern of behavior that is present in multiple settings where it gives rise to social, educational or work performance difficulties.

A. Either (A1) and/or (A2) :
Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that impact directly on social and academic/occupational activities.

A1.

a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or reading lengthy writings).
c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily side tracked; fails to finish schoolwork, household chores, or tasks in the workplace).
e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized, work; poor time management; tends to fail to meet deadlines).
f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing re ports, completing forms, or reviewing lengthy papers).
g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, or mobile telephones).
h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
i. Is often forgetful in daily activities (e.g., chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

A2.

a. Often fidgets with or taps hands or feet or squirms in seat.
b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, office or other workplace, or in oth er situations that require remaining seated).
c. Often runs about or climbs in situations where it is inappropriate. (In adoles cents or adults, may be limited to feeling restless).
d. Often unable to play or engage in leisure activities quietly.
e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable or uncom fortable being still for an extended time, as in restaurants, meetings, etc; may be experienced by others as being restless and difficult to keep up with).
f. Often talks excessively.
g. Often blurts out an answer before a question has been completed (e.g., com pletes people's sentences and "jumps the gun" in conversations, cannot wait for next turn in conversation).
h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission, adolescents or adults may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12.

C. Criteria for the disorder are met in two or more settings (e.g., at home, school or work, with friends or relatives, or in other activities).

D. There must be clear evidence that the symptoms interfere with or reduce the quality of social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).

Specify Based on Current Presentation:
Combined Presentation: If both Criterion A1 (Inattention) and Criterion A2 (Hyperactivity-Impulsivity) are met for the past 6 months.
Predominantly Inattentive Presentation: If Criterion A1 (Inattention) is met but Criterion A2 (Hyperactivity-Impulsivity) is not met and 3 or more symptoms from Criterion A2 have been present for the past 6 months.
Predominantly Hyperactive/Impulsive Presentation: If Criterion A2 (Hyperactivity-Impulsivity) is met and Criterion A1 (Inattention) is not met for the past 6 months.
Inattentive Presentation (Restrictive): If Criterion A1 (Inattention) is met but no more than 2 symptoms from Criterion A2 (Hyperactivity-Impulsivity) have been present for the past 6 months.

Coding note: For individuals (especially adolescents and adults) who currently have symptoms with impairment that no longer meet full criteria, "In Partial Remission" should be specified.

Reference:

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2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR. Washington: American Psychiatric Association, 2000.
3. Leung PW, Luk SL, Ho TP, Taylor E, Mak FL, Bacon-Shone J. The diagnosis and prevalence of hyperactivity in Chinese schoolboys. Br J Psychiatry 1996;168:486-96.
4. Leung PW, Hung SF, Ho TP, et al. Prevalence of DSMIV disorders in Chinese adolescents and the effects of an impairment criteria: a pilot community study in Hong Kong. Eur Child Adolesc Psychiatry 2008;17:452-61.
5. Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. Pediatrics 2011;128;1007
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PRESENTATION
RECAP AT CME

Neuropathic Pain

17th April 2012

Orthopaedic Clinical Experiences in Neuropathic Pain

Dr. Ko Put Shui, Peter
Specialist in Orthopaedics & Traumatology

According to the International Association for the Study of Pain (IASP), pain can be classified according to duration of pain as acute and chronic, or classified by patho-physiology as nociceptive and neuropathic. For neuropathic pain, it is initiated or caused by a primary lesion or dysfunction in the nerve system without nociceptive stimulation and it is quite often disproportionate to the stimulation of receptors. It is commonly described as shooting, electric shock-like burning and commonly associated with tingling or numbness. Painful region may not necessarily be the same as the site of injury and can occur in the neurological territory of the affected structure. This kind of neuropathic pain responds poorly to conventional analgesics.

Neuropathic pain can be due to ectopic discharges in peripheral nerve with hyperactivity due to changes in the ion channel function. It can also be caused by loss of inhibitory controls with loss of descending modulation causing exaggerated pain due to an imbalance between ascending and descending signals. After nerve injury, there can also increased input to the dorsal horn which can induce central sensitization.

Positive sensory symptoms of neuropathic pain includes dysesthesias, paresthesias, spontaneous pain and evoked pain. Negative sensory symptoms include loss / impairment of sensory quality, numbness and reduced sensation. Most commonly encountered neuropathic pain by orthopaedic surgeons includes radiculopathy (cervical or lumbar), spinal cord lesions, peripheral nerve entrapment e.g. carpal tunnel syndrome.

For the pharmacological treatment for neuropathic pain, EFNS guideline (European Federation of Neurological Societies) recommends use of different medications. First line therapy includes use of pregabalin / gabapentin or tricyclic anti-depressants. Second line therapy includes opioids and iamotrigine. The use of conventional NSAID's and COX2's are effective for inflammatory pain but they are known not effective for treatment of neuropathic pain. They can be used in combination with pregabalin and gabapentin as well as opioids. Pregabalin is more potent than gabapentin with superior pharmacokinetics as well. It also has superior oral bio-availability and faster action to reach effective dose. However, after adequate period of conservative treatment and if the treatment response is still suboptimal, further intervention may be required like carpal tunnel release for carpal tunnel syndrome, decompression and transposition of ulnar nerve in carpal tunnel syndrome and also decompression +/- spinal fusion for cervical or lumbar radiculopathy.

In considering pharmacological treatment of neuropathic pain, polypharmacy is the rule rather than exception.

Basic Science and Literature Review

Dr. Law Yee Cheong, Wally
Specialist in Orthopaedics & Traumatology

Scientific studies on the mechanism of neuropathic pain come with certain basic hurdles that make it difficult to conduct extensive researches. First and foremost is the non-existence of human model. Anecdotal cases offer sporadic examples but one cannot deliberately sever any human nerve to study its response. Therefore animal models provide most of the basic science evidence base.

Another obstacle involves outcome measurement. Animal cannot gauge their perception of pain. The most commonly reproducible measurement is the sensory evoked potential. Yet behavioral response to pain constitutes a major clinical concern, which cannot be measured in animal model. Some researchers consider self-mutilation of limb (Autotomy) in response to severing a peripheral nerve as a behavioral response. But autotomy is also regarded as non-humanitarian and therefore not suitable as a study perimeter.

Neuropathic pain involves allodynia and hyperalgesia, which arise after nerve injury through central or peripheral phenomenon. There are not mutually exclusive and in many cases more than one occurs at a singe injury to produce the symptoms.

Peripheral Changes after nerve injury

1. Ectopic Discharge.
a. Dorsal root ganglion resting potential rises closer to firing threshold after injury
b. Percentage of A fiber oscillates in resting potential rises from 10% to 23% after injury
2. Ephaptic Conduction
a. Injured type A fiber cross-excitating un-injured fiber and amplifying the
3. Alteration in ion channel expression
a. sodium channel composition is altered after injury. Neuroma contains more Tetradotoxin sensitive Type III channel.
4. Collateral spouting of primary afferent neurons
a. Neuropathic growth factor is fount to be produced from injured keratinocytes, which starts sprouting of new neurons

10 days after nerve injury.

5. Sprouting of sympathetic neurons in the DRG
a. Sympathetic activity leads to pain sensation, through chemical coupling or ephaptic coupling at the dorsal root ganglion. This is believed to be the mechanism of regional pain syndrome
6. Nociceptor sensitization
a. Bradykinin binding sites increase at the DRG after injury.

Central Changes after nerve injury

1. Spinal re-organisation
a. A fiber changes their destination laminae at the DRG after injury, producing allodynia
2. Central sensitization
a. Cortical response is accentuated through lowered thresholds.
3. Cortical re-organization, through collateral sprouting and ephpatic coupling
4. Inhibitory pathways
a. Opioid receptors are reduced after wallerian degeneration.

Pharmacological Management of Neuropathic Pain

Dr Wong Lai Yee, Belinda
Specialist Anaesthesiologist

Recently published international guidelines on the pharmacological management of neuropathic pain were discussed.

The International Association for the Study of Pain (IASP) Neuropathic Pain Special Interest Group (NeuPSIG) guidelines for the pharmacological treatment of neuropathic pain

The first-line treatments are calcium channel $\alpha 2$-δligands (ie, pregabalin and gabapentin), tricyclic antidepressants (TCAs), selective serotonin norepinephrine reuptake inhibitors (SSNRI) and topical lidocaine.

Second-line options are opioids and tramadol.

Third-line treatments include other antiepileptic and antidepressant agents, mexiletine, N-methyl-D-aspartate receptor antagonists, and topical capsaicin. The guidelines advocate a stepwise management strategy. In addition, combination pharmacotherapy may be of benefit.

European Federation of Neurological Societies (EFNS) guidelines on pharmacological treatment of various common neuropathic pain conditions

Diabetes painful polyneuropathy: the recommended first-line treatments are pregabalin and gabapentin, TCAs, duloxetine and venlafaxine. Tramadol is recommended as a second-line treatment, except in patients with exacerbations of pain or in those with predominant nociceptive pain component for whom it can be used first-line. Strong opioids are reserved for third-line treatment because of concerns of addition. There may be some benefit with TCA-gabapentin and gabapentin-opioid combinations.

Postherpetic neuralgia: Pregabalin, gabapentin or TCA are first-line treatments. Topical lidocaine is considered first-line for elderly, if there are concerns about CNS side effects of oral medications. Second-line are strong opioids and topical capsaicin.

Classical trigeminal neuralgia: The first-line treatments are carbamazepine and oxcarbazepine. For those with intolerable side effects, lamotrigine may be prescribed. Surgical intervention may also be considered.

Central neuropathic pain (due to stroke,spinal cord injury or multiple sclerosis): the first-line medications are pregabalin, gabapentin and amitriptyline. Tramadol may be considered as second-line. Strong opioids are recommended for second- or third-line treatment. Lamotrigine and cannabinoids may also be considered.

Reference
1. Dworkin RH, et al. Mayo Clin Proc 2010;85(Suppl):S3-S14.
2. Attal N, et al. Eur J Neurol 2010;17:1113-1123.

Report on Management of Lung Cancer

15th May 2012

Minimally Invasive Video-Assisted Thoracoscopic Resection of Non-Small Cell Lung Cancer

Dr. Chui Wing Hung
Specialist in Cardiothoracic Surgery
Honorary Clinical Associate Professor,
The University of Hong Kong

Early-stage non-small cell lung cancer (NSCLC) is primarily treated through surgical resection. The variety of procedures that can be performed using minimally invasive surgical approaches is expanding with the advancement and refinement in instrumentation. In the 1990s, surgeons began using video-assisted thoracoscopic surgery (VATS) to perform lobectomies. As experience grew, VATS lobectomy began to be used to treat patients with early-stage (i.e. stage I and II) NSCLC. Proponents of the VATS approach have touted several potential advantages compared with a thoracotomy: less morbidity, shorter chest tube duration, shorter convalescence and superior survival rates. Critics of the VATS approach have argued that it may not be an equivalent oncological operation when compared to the open thoracotomy approach.

Unfortunately, prospective multi-institutional randomized trials have not been performed. The evidence in the literature to guide surgical management of early-stage NSCLC is limited to single institution case series and small observational studies. A large scale meta-analysis using a systematic review of the literature in order to enable a more objective assessment of the available published evidence was performed. (1) This permitted a more accurate comparison of VATS versus thoracotomy lobectomy for early-stage NSCLC in terms of short-term morbidity and long-term survival rates. This was intended to help resolve uncertainty and efficacy between the two approaches. In this meta-analysis, the authors concluded that comparing VATS lobectomy with open lobectomy, patients who undergo VATS lobectomy have (1) a lower overall complication rate, (2) a shorter duration of chest tube drainage, (3) a shorter length of stay and (4) a superior overall survival rate at 4 years after resection. This analysis lends data to support the expanded use of the VATS lobectomy for anatomically appropriate early-stage NSCLC lesions.

To disseminate the practice, appropriate training should be encouraged and expanded. A note of caution should be made because there can be a learning curve associated with performing adequate VATS mediastinal lymph node dissection. In general, approximately 90% of lobectomies can be performed by VATS. Elderly or high-risk patients can tolerate VATS resection better than a thoracotomy. Tumours of sufficient size such that ribs need to be spread, potentially unfavourable conditions for unsafe dissection and extrapulmonary invasion or spread are the major contraindications to attempted VATS resection.

Reference
(1) Whitson BA, Groth SS, Duval SJ, et al. Surgery for early-stage non-small cell lung cancer: a systematic review of the video-assisted thoracoscopic surgery versus thoracotomy approaches to lobectomy. Ann Thorac Surg 2008;86:2008-18.

Recent Advances in Lung Cancer: Diagnosis & Beyond

Dr. Wong King Yan, Matthew
Specialist in Respiratory Medicine
The University of Hong Kong, Queen Mary Hospital

Abstract
Lung cancer is the leading cause of cancer death in the world. The poor prognosis of the disease mainly due to its biologically aggressive nature and most cases are detected only at an advanced stage which precluded curative surgery. Lung cancer can affect all parts of the thorax, from inner part of the airway to the outer part of pleural cavity.

Endobronchial ultrasound (EBUS) is a recent promising modality developed for assessment of processes in the airway wall and outside the airways. EBUS guided transbronchial needle aspiration (EBUS-TBNA) enables the bronchoscopist to perform real-time biopsy of mediastinal lymph node/ tumour and prevents inadvertent puncture of the adjacent blood vessels. Indications for EBUS-TBNA are: mediastinal lymph node staging in lung cancer; diagnosis of mediastinal tumours including extrathoracic metastases; and other benign condition affecting the mediastinum such as tuberculosis, sarcoidosis and fungal infection. The sensitivity is more than 90% and there is minimal serious complication reported.

Peripheral pulmonary lesions are commonly detected with the widespread use of CT scan of thorax. However, conventional bronchoscopy with transbronchial lung biopsy has reported wide range of diagnostic yield and is lower especially for smaller and peripheral lesions. Recently

developed endobronchial ultrasound guided sheath biopsy (EBUS-GS) has advantageous of the absence of irradiation, less expensive and allows repeated accurate biopsy of the lesion.

Medical thoracoscopy (pleuroscopy) can be performed by physicians for the evaluation of the pleural space and can be carried out in a bronchoscopy suite under local anaesthesia. The intervention performed by physician targets at the diagnosis of pleural effusion and pleural metastasis, chest tube placement under visual guidance and talc pleurodesis (poudrage) for malignant effusion.

The treatment of lung cancer is rapidly evolving due to the introduction of targeted therapy. Recent development has been the identification of genetic profiling of tumour cells to predict which patients are likely to benefit from a particular treatment. The recent advances of the above diagnostic procedures might therefore allow adequate tissue specimens for histological examination and formulate personalized therapy.

Role of Radiotherapy, Chemotherapy & Targeted Agents for Non-Small Cell Lung Cancer (NSCLC)

Dr Ying Chi Ho Anthony
Specialist in Clinical Oncology

Surgery, radiotherapy and chemotherapy are the three main modalities commonly used to treat patients with NSCLC. They can be used either alone or in combination depending on the disease extent.

Stage I-II NSCLC

Patients with stage I-II disease are generally treated with curative intent if performance status is good (0-1) and pulmonary reserve is adequate. Treatment options include:

- Surgery alone (if excision is complete)
- Surgery followed by adjuvant radiotherapy for microscopic residual disease after surgery or N2 disease : addition of post-operative radiotherapy can improve local control but has little or no effect on survival.
- Surgery followed by adjuvant chemotherapy using four cycles of cisplatin combination chemotherapy for fit patients with resected stage IB & II disease : meta-analysis showed a 5% overall survival benefit with post-operative cisplatin based combination chemotherapy.
- Radical radiotherapy (for patients who are unfit for surgery or refuse surgery)

Stage III NSCLC

Patients with stage III disease comprise a complex and heterogeneous group with varied treatment outcome. The result of surgery alone is poor.

The current standard of care is concurrent chemoradiotherapy if performance status is good. Studies have shown that concurrent chemoradiotherapy is more effective than sequential chemotherapy followed by radiotherapy.

In young fit patients with stage III disease due to involvement of adjacent structures, concurrent chemoradiotherapy can be used to downstage the tumour and aim for surgical resection.

Stage IV NSCLC

A significant number of patients with advanced and metastatic disease may need radiotherapy to palliate symptoms such as bone pain due to bone metastases, symptoms arising from brain metastases and symptoms due to superior vena cava obstruction.

For patients presenting with metastatic disease, they should be referred for Epidermal Growth Factor Receptor (EGFR) mutation test if adequate biopsy material is available. Among Asian patients, adenocarcinoma represents up to 80% of NSCLC, and about half of them have an EGFR mutation.

For patients with EGFR mutations, they may benefit from single-agent EGFR tyrosine kinase inhibitor. Randomized controlled trials in chemotherapy naïve NSCLC with EGFR mutations have shown that EGFR inhibitors improved progression-free survival and have favourable toxicity profiles versus combination chemotherapy.

For patients who are EGFR mutation-negative and with good performance status, systemic chemotherapy is the treatment of choice. Cisplatin-based doublet chemotherapy improves survival by 6-12 weeks over best supportive care and palliates disease-related symptoms. For patients with adenocarcinoma histology, treatment using cisplatin / pemetrexed resulted in superior overall survival compared with cisplaltin / gemcitabine. Randomized study showed that a combination of bevacizumab (anti-angiogenic agent) with chemotherapy improves survival by 2 months in patients with untreated advanced non-squamous cell lung cancer.

Patients with disease progression after first-line treatment may benefit from second-line treatment provided their performance status remain good. Single-agent docetaxel, pemetrexed and erlotinib are well known second-line drugs for advanced NSCLC.

HOSPITAL ACTIVITIES

聖保祿醫院主保瞻禮日2012
(29/6/2012)

聖保祿宗徒為本院之主保，每年本院均以他的瞻禮日作為本院之院慶。為慶祝這個特別日子，沙爾德聖保祿女修會聯同聖保祿醫院於二零一二年六月二十九日下午五時，於基督君王小堂舉行感恩彌撒，由林銘副主教主祭及多位聖瑪加利大堂神父及執事共祭。

當日亦同時舉行沙爾德聖保祿女修會修女之進會週年感恩禮，慶祝高慧儀修女及林桂屏修女進會鑽禧。隨後更舉行聖保祿之友收錄禮。

感恩聖祭多達數以百人出席，基督君王小堂坐無虛席。一眾嘉賓、修女及聖保祿醫院各部門同事，在林銘副主教帶領下一同誠心祈禱。禮儀後，眾人與兩位進會鑽禧的修女一同切蛋糕慶祝和拍照留念，場面溫馨愉快。大家聚首一堂，享用自助美食，感謝上主的恩典。當日，院方更安排免費午餐及自助晚餐，與全院同事一起分享瞻禮日歡樂的氣氛。


林銘副主教、共祭神父及執事


一眾修女出席感恩聖祭

祭典後眾修女、神父及聖保祿之友合照

切蛋糕慶祝高慧儀修女及林桂屏修女進會鑽禧


眾人享用自助美食

沙士/禽流感病案演習 (7/8/2012)


模擬有懷疑感染禽流感患者求診

本院於二零一二年八月七日舉行沙士／禽流感病案演習。這個一年一度的大型演習活動由感染控制組統籌及職員發展部協辦，並得到醫院管理層全力支持及在場觀察。參與的部門及員工態度專業認真，包括當值醫生、當值護士主任、門診部、客戶服務部、入院登記部、工程部及中央運輸組。演習過程模擬有懷疑感染禽流感的個案到本院求診，以測試醫院整體應變措施及前線醫護人員的應變反應。是次演習邀請了各病房主管及有關同事前來觀察，以加強同事對處理沙士／禽流感個案的警覺性。


以紅外線監察病人及訪客的體溫


量度訪客體溫

為發燒求診者進行分流

前線人員嚴陣以待

醫護人員穿著保護裝備

OUTREACH ACTIVITIES

外展服務 - 屯門區 (20/5/2012)

聖保祿醫院之病人資源中心於二零一二年五月二十日與屯門區婦女會合辦外展活動。當日，本院一共有三十六位義工出席此活動，包括修女、醫生及護理人員，為四百多名屯門區街坊免費進行身體檢查。當日，本院更有醫生為市民舉行鼻鼾及睡眠窒息醫學講座及負責各項檢查，包括眼科檢驗、肝膽及婦女盤腔超聲波掃描等。另外，本院之物理治療師教授市民做橡根操，以強化四肢肌肉及減少關節痛症，參加之市民十分踴躍。

物理治療師教授橡根操

主禮嘉賓及全體義工合照

醫生及護士為市民進行乙型肝炎抗原測試

聖保祿醫院執行董事
張柱見修女接受
屯門區婦女會名譽顧問
譚耀宗先生送贈感謝禮品


醫生講解睡眠窒息講座


修女及護士為市民解答健康問題


修女及義工為市民量度骨質密度

澳門外展健康檢查日

(15/7/2012)

除熱心服務本港居民外，本中心的外展活動更遍及澳門。於七月十五日，本中心與澳門社會服務中心合辦健康檢查服務，多達五十名本院熱心醫護人員、修女、醫生及義工參與。沙爾德聖保祿女修會何美蘭省會長、聖保祿醫院執行董事張柱見修女及聖保祿醫院醫務總監何兆煒醫生亦前往澳門出席及全力支持此活動。義工們除替三百六十名澳門市民量度血壓及進行尿液測試等檢查外，亦替百多名市民提供眼科檢查及血液測試，包括乙型肝炎抗原、膽固醇及血糖。當日更有超過一百名市民進行超聲波檢查，包括肝膽腎超聲波掃描、頸動脈及盤腔超聲波檢查。

舉辦單位大合照


醫生及義工們為參與體檢的澳門居民進行血液及尿液測試

本院管理層與病人資資源中心接受澳門社會服務中心頒發感謝狀

本院放射科醫生、放射師、醫護人員及眼科醫生接受感謝狀

HOSPITAL
Updates

Rapid PCR Tests

A PCR method is available; providing rapid diagnosis of 4 infectious diseases, Group B Streptococcus, TB, MRSA, Influenza virus A&B.

To promote this new service,
a ***35% discount*** is offered to the above tests
until 31 Decemeber 2012.

For enquiries, please contact ***Pathology Department at 2830 8885***

INTRODUCTION
Of New Faces

Ms. Linda Ho
Senior Manager - Quality & Safety
Quality & Risk Management Department

I am Ho Suk Hang, Linda, Senior Manager of Quality and Safety in Quality and Risk Management Department, Just joined the family of St. Paul's Hospital in May 2012. I am a Fellow of the Hong Kong College of Nursing and Health Care Management and I obtained my Degree of Master of Business Administration – Health Care Management in 2007.

Since 1996, I was being the Senior Nursing Officer in Central Nursing Division of Caritas medical Centre (CMC) of Hospital Authority (HA), I retired in February 2012. My major responsibilities were concentrated on training and development (Corporate, Cluster and Local hospital); quality and safety management and nursing administration. I have gone through the ACHS accreditation journey in CMC. I keen in training and I am the faculty of Basic Life Support training in Caritas Medical Centre Resuscitation Centre (CMCRTC) of American Heart Association (AHA). It is a great challenge for me to join a private sector – St. Paul's Hospital. I enjoy the atmosphere here and work with all teams.

Ms. Ruby Lee
Senior Human Resources Manager

I am Ruby Lee. I joined St. Paul's Hospital in January 2012 as Senior Human Resources Manager. Possessing previous exposure in both public and private sectors, I felt excited with my joining the health care business as it will bring me into a new page of my career. This is definitely a challenging role since people management is crucial in this industry which requires their staff possessing the professional attributes and ethics, perseverance and customer-oriented mindset.

I have completed my tertiary education, major in Personnel Management in Hong Kong and MBA in the UK. I have worked with sizeable organizations including the Airport Authority and listed property developer, Hang Lung Properties Ltd. In these organizations, I have been involved in various re-engineering projects and organizational development programs. I have also established new HR Offices for Hang Lung's PRC subsidiaries. Prior to joining St. Paul's Hospital, I worked with Vitasoy International Holdings Ltd. as Human Resources Manager, overseeing the HR operation of their local plant.

I look forward to working and partnering with you in the years to come.

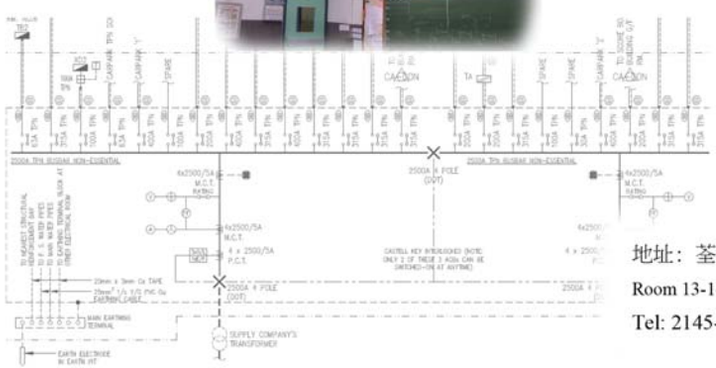
CME
Announcement

Topic	Chairman	Speakers
18/9/2012 ***Management of Stroke: Current Update*** 1. From Coil to Flow Diversion - a Revolution in Treatment of Stroke 2. Stroke Management: Medical Perspective	*Dr Fong Chung Yan* Specialist in Neurology	1. *Dr Kwok Ching Kwong* Specialist in Neurosurgery 2. *Dr Tsang Kin Lun* Specialist in Neurology
9/10/2012 ***Debate on Prostate Cancer: to Screen or Not to Screen*** Details will be provided later	*Dr Wong Tak Hing, Bill* Specialist in Urology	1. *Dr Lo Hak Keung, Alex* Specialist in Urology 2. *Dr Lee Wang Yat, Paco* Specialist in Family Medicine

Time: 7:30pm - 9:00pm (Light Refreshment Provided)
Venue: Conference Room, 2/F, St. Paul's Convernt
Registration: Ms. Merrillin Leung, Tel: 2830 3905, Fax: 2837 5271, Email: sph.sdd@mail.stpaul.org.hk
CME/ CPD Accreditation for all colleges (Pending approval). CNE Point: 1 Point

興業（香港）機電工程有限公司
Hing Yip (HK)Engineering Contracting Co. Ltd.

ISO 9001 : 2008 Certificate No.: CC 5018 ISO 9001 : 2008 Certificate No.: CC 5018



專責承接電氣工程，為客戶提供全面的電氣工程服務，其中包括不同類型樓宇的電氣保養，固定電氣裝置加改/維修工程。過往承接的電氣工程項目包括不同的政府部門、政府大樓、中/小學、醫院、商場及停車場之工程等。

地址：荃灣德士古道168號德豐工業中心1座12樓13-14室
Room 13-14, 12/F, Block 1, Tak Fung Industrial Centre, 168 Texaco Road, Tsuen Wan, N.T.
Tel: 2145-4611 Fax: 2145-4612 E-mail: hyeccl@yahoo.com.hk

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