第七十九期 issue 79
Sep-Oct, 2012

聖保祿醫院
St. Paul's Hospital

NEWS 院訊 Letter

Direct Immunofluorescence Study in Dermatopathology

CME Presentation Recap:

- Psychiatry & ADHD
- Vascular

Dr. William Ho
Medical Superintendent

MESSAGE

From The Medical Superintendent

Private hospital business in Hong Kong for the last 20 years had seen a lot of ups and downs. In the old days, those who could not afford private care had to put up with long queues, poor environment and suboptimal care in the public hospitals. Service improvements by the Hospital Authority (HA) since 1991, coupled with heavy injection of resources from the Government changed all that. The private hospitals felt major impact. In less than 10 years, however, the HA was facing budget deficits, staff discontent and then SARS. Experienced staff started leaving again, and the private sector revived. On top of that, a historical twist resulted in unexpected business. Obstetric services for Mainland mothers really took off around 2005. Then as everybody knows, this is going to end by 2013. So what's the outlook?

A government document presented to the Legislative Council last year revealed the following: The 12 private hospitals provided 11% beds in Hong Kong and served 21% of total Inpatients in 2010, up from 19% in 2006. From 2006 to 2010, they registered 26.4% growth in beds and 36.5% growth of patients. In 2011, Mainland obstetric patients constituted around 8.7% of total patients in private hospitals. More interestingly, the Government projected that additional 500-600 beds would be opened in private hospitals from 2011 to 2015 (up 12-14%). This is not even counting the 4 new private hospitals that the Government originally planned, which have a total capacity of 2,000 beds (another 49%). We also noticed that bidders for first round of the new private hospital sites were all overseas capital - new and powerful competitors. Now with the world economy looking anything but good, are we looking at possible over-capacity in the horizon and harder times ahead?

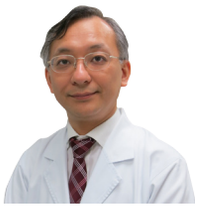
Nobody can be sure. But the LegCo paper also hints on the inevitable. There is increasing call for price transparency, package pricing, tighter control on quality, and revamp of the outdated *Hospitals, Nursing Homes and Maternity Homes Registration Ordinance*. It is therefore most likely that local private hospitals will face a tighter grip from regulators and politicians, greater competition, and cut off from one fast-expanding and lucrative business of Mainland mothers.

So much on the business side – after all, 10 of the 12 private hospitals are registered as non-profit organizations. Of course, even non-profits have to survive and status quo is not an option. Why? New drugs and technology are emerging fast, and patients may be even more updated in demanding the latest. Hospitals have no choice but to invest. More importantly, both public and private hospitals are competing for the same limited pool of healthcare professionals through pay and benefits. But apart from resources, there is a lot more in the quality dimension.

When people relate to quality, many refer to hospital accreditation. It certainly helps, but is just one of the many aspects. To us old timers, the word Professionalism looms large. A silent revolution has been occurring among private hospitals, in the sense that clinical governance is now much more structured than before. Credentialing requirements in granting admission and procedure privileges are often tighter than stipulations of the specialty Colleges on who can do what. Peer reviews and quality assurance activities are increasing. Patient safety and risk management assume top priority. Medical advisory committees (there are 12 in St. Paul's Hospital by specialty/subspecialty) have teeth in influencing clinical behavior. Admittedly, patients and the community at large, including politicians, may not be able to appreciate the significance of such work. Yet we as healthcare professionals know that patient care is more than market relations of supply and demand, or business transactions. We want to practice responsible and good medicine. That may also include avoiding over-investigation and over-treatment.

Gone are the days when private hospitals satisfy themselves in merely collecting fees for use of facilities by patients and visiting doctors. Hospital management increasingly sees the vital importance of forging partnership with visiting and in-house professionals to deliver high quality clinical services and continually improving standards. This opens up a whole new agenda on shared goals, teamwork, and skill mix among the people. In the team building workshop of St. Paul's Hospital early this year, there was a loud and clear message from the participants – clear directions. Admittedly, only in-house staff was involved. In the days ahead, we look forward to engage more the visiting doctors who account for 75% of inpatient admissions in shaping the future service development. We aspire to patients choosing our hospital because of the reliability and quality, and professionals choosing to work here because they enjoy the collegial environment and atmosphere of continuous improvement. If package pricing and DRG help, so be it. But we know, and patients know, that most important is excellent clinicians practicing excellent medicine.

MEDICAL ARTICLE



Dr. Dr Lee King Chung
Consultant Pathologist,
St. Paul's Hospital

Direct Immunofluorescence Study in Dermatopathology

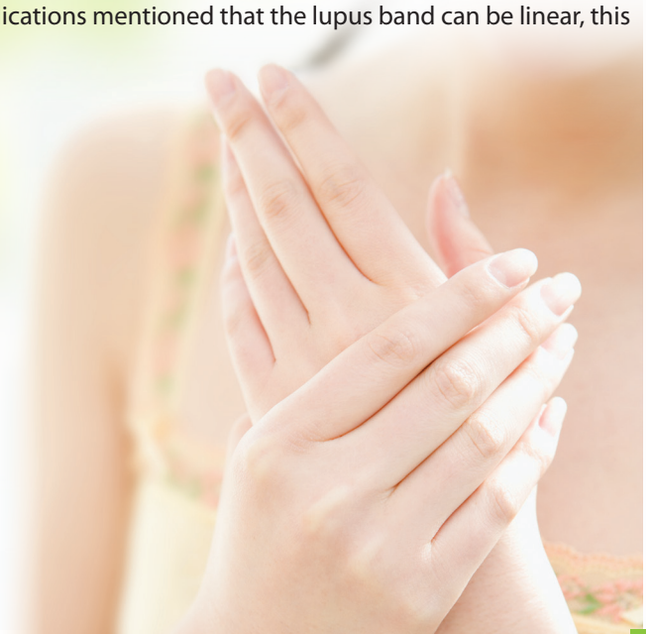
Direct Immunofluorescence Study is the standard method for demonstration of immunoglobulin deposit in skin biopsies. It is also used to demonstrate lost of structural antigens in some specialized centers abroad. It uses a fluorescent dye (usually fluorescein isothiocyanate) conjugated antibody from animal (like rabbit, mouse, goat etc) raise against different human immunoglobulin classes, incubate it with the biopsy section and visualize under a fluorescent microscope. The pattern and location of the fluorescence provide information on type of immunoglobulin deposit. In general, a linear deposit corresponds to immunoglobulin reacting against structural antigen and a granular deposit suggests immune complex deposition. The classical indications are in the study of bullous disease, vasculitis and study of lupus erythematosus.

Special handling

Direct immunofluorescence study only works on fresh frozen tissue. Therefore, the biopsy needs to be sent to the Laboratory immediately for handling. If there is inevitable delay, the specimen can be placed into Michel's solution in room temperature which can preserve immunoglobulin for up to 10 days(1). However, the tissue will not be suitable for routine histological examination after placed into Michel's solution meaning that Dermatologist doing the biopsy needs to put a portion of the biopsy in Michel's and another portion in formalin. When dealing with bullous disease, we need to assess for deposit in non-blister, peri-lesional skin. Therefore, it is important not to cut through the blister as this can sometimes cause complete separation of the epidermis from the underlying dermis and making assessment for any deposit along the dermal epidermal junction not possible. For practical purposes, cutting out one of the tips in an incisional ellipse is good enough. If a punch biopsy is taken for assessment of vasculitis, one can submit a third of the specimen for direct immunofluorescence study. However, do not bisect a punch biopsy if it is targeted for a small lesion because the lesion can be entirely lost on the initial trimming of the tissue block to get a flat surface.

Lupus erythematosus

One of the classical uses of direct immunofluorescence study is in the diagnosis of lupus erythematosus and its differentiation between cutaneous and systemic form. The presence of IgG, IgA, IgM together with deposit of C3 constitute the time honored lupus band. Its presence in non-lesional, sun protected skin is considered sensitive and specific evidence of systemic lupus erythematosus. Although its usefulness is still emphasized in the recent editions of standard Dermatopathology textbooks and publications, I have some reservation as this is not included as a diagnostic criteria for lupus erythematosus on the one hand and serology, being simpler, less invasive and quantitative, is correlated with a positive lupus band(2). The reported high sensitivity and specificity of this test on non-lesional and non-sun exposed skin is complicated by lack of uniform definition of what constitute a positive lupus band(3). The presence of granular C3 with or without IgM deposit is not uncommon in cases without suggestion of lupus erythematosus in my experience and if this is included as a positive lupus band, the sensitivity will be high. While I agree that presence of more than one immunoglobulin, including IgG, is very specific for lupus erythematosus, the few cases that I have encountered already have other features of lupus erythematosus. Interpretation of the quality of deposit is even more important. Despite some publications mentioned that the lupus band can be linear, this



is more likely than not to represent pemphigoid rather than lupus erythematosus. Being immune complex deposit rather than antibody against structural antigen, the deposit should be granular rather than linear. Having said that, a fine granular deposit is sometimes difficult to distinguish from a linear deposit on casual glance. However, by paying attention to the tangentially sectioned region, it is usually possible to tell the difference. In addition, in cases where the basement membrane is thickened, a homogenous staining pattern can be seen and this should not be taken as a linear deposit.

Vasculitis

In the Ankara 2008 European League Against Rheumatism/ Paediatric Rheumatology International Trials Organization/ European Rheumatology European Society (EULAR/PRINTO/ PRES) criteria for diagnosis of Henoch-Schonlein purpura (HSP), a paediatric patient with lower limb predominant purpura or petechiae and biopsy showing typical leukocytoclastic vasculitis with predominant IgA deposit is considered diagnostic of HSP(4). Even we put aside the fact that using skin biopsy to establish such a diagnosis in the paediatric group is not the usual practice, blindly applying the criteria to the non-paediactric group is not without risk. This is because IgA predominant leukocytoclastic vasculitis is present in up to 17% of non-HSP leukocytocalstic vasculitis cases (5) and it has been found in cases with internal malignancy, cryoglobulinaemia, Wegener's granulomatosis and inflammatory bowel disease (5,6). It is also my experience that perivascular IgA deposit can be seen in situations outside the context of vasculitis. If one really wants to request for direct immunofluorescence study for suspected cases of vasculitis, one needs to biopsy a freshly developed lesion not more than 48 hours old. In addition, if the lesion is in the form of tiny petechiae, inclusion of 2 or more lesions in the biopsy is advisable to guarantee that the more important H&E sections contain some lesional areas.

Bullous dermatosis

The most practical use of direct immunofluorescence study is in the biopsy investigation of bullous disease. It helps to differentiate immunobullous disease from other causes of bullous dermatoses on the one hand and classify the various forms of immunobullous dermatoses according to the predominant immunoglobulin type involved and location of the deposit. The two positive patterns are dermo-epidermal junction staining and intraepidermal intercellular staining. The most common immunobullous disease being diagnosed is bullous pemphigoid (PB) and it typically shows linear IgG and C3 staining along the dermal epidermal junction. Invariably, the C3 is stronger than IgG and not uncommonly, linear C3 is the only deposit without accompanying IgG staining. This has been shown to be due to limited reactivity of commercial antihuman IgG conjugates to the IgG4 subclass which is the predominant immunoglobulin in at least some cases(7). Attention has to be paid to look at the level of split of the subepidermal blister because epidermolysis bullosa acquisita (EBA) also has this pattern on direct immunofluorescence study. A simple method is to determine the location of basement membrane by PAS stain. If the PAS positive portion of basement membrane is on the roof of the blister, it is a case of EBA, otherwise, it is BP. However, this method may fail in rare cases as the PAS positive layer of basement membrane may be poorly visualized. A common question is can we exclude a diagnosis of BP or other immunobullous diseases based on a negative direct immunofluorescence study result. The answer is "no" as presence of immunoglobulin below the detection threshold and other causes for a false negative immunofluorescence result cannot be excluded. The presence of IgA deposit along the dermo-epidermal junction is defining for the group of IgA related bullous dermatosis: namely dermatitis herpetiformis and linear IgA bullous dermatosis. Presence of intercellular deposit of immunoglobulin indicated various forms of pemphigus.

In summary, direct immunofluorescence study is an indispensible tool for work up of possible immunobullous disease. It is also traditionally considered useful in cases of vasculitis and connective tissue disease in particular lupus erythematosus but this is not without pitfall and controversy.

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Psychiatry & ADHD

19th June 2012

Common Psychopathologies: Descriptive and Psychodynamic

Dr. Tsang Fan Kwong
Specialist in Psychiatry

Psychic activities include our consciousness, perception, thought and thinking, affect and emotion, volition, attention, concentration and memory, etc. The brain is responsible for all psychic activities. Problems in one or more of the psychic activities might bring about impairment in normal functions and torture to the individuals or others.

Psychopathologies or abnormal psychic features can be divided into two big categories, descriptive and psychodynamic. Descriptive psychopathology is just a phenomenological description of the symptom and sign, e.g., persecutory delusion, elated mood, impaired short term memories, etc. Early identification of such symptoms and signs needs good understanding of the symptoms and skills to qualify the features concerned.

For example, a patient expressed that her neighbours were talking about her and she would be driven away from home. Based on this statement, we could not conclude if the patient had auditory hallucination, delusion of reference, delusion of persecution or just a bit suspicious or having overvalued ideas. Suspiciousness might be character in nature or the patient was in a state of extreme anxiety and became over-sensitive. If auditory hallucination in the third person, reference or persecutory delusion could be qualified, a diagnosis of psychosis or schizophrenia is highly likely.

Psychodynamic psychopathologies originates from psychodynamic concepts. and include the following;

1. Theories of the mind which include topographic model (conscious, subconscious and unconscious), structural model(Id, Ego and Superego), object-relation theory, attachment theory and mentallization theory.

2. Psychic defenses: unconscious mechanisms to protect our ego when being threatened. Without the knowing by the consciousness, psychic defense, in various ways can avoid the ego from being traumatized. Primitive psychic defenses like splitting, denial, projection and distortion might give rise to schizophrenia, delusional disorder, manic-depressive disorder and borderline personality disorder. Neurotic psychic defenses might give rise to phobia, obsessive compulsive disorder or conversion disorder, etc.

3. Illness model according to psychodynamic theories: Intrapsychic conflicts might give rise to various forms of neurotic conditions like anxiety, obsession, phobia and conversion, etc., and interpersonal conflict might give rise to anxiety and depression

4. Symptoms appeared during psychotherapy like therapeutic alliance, regression, boundary issue, transference, counter-transference, acting out, etc., These symptoms are valuable feature for us to know the treatment progress.

Psychodynamic psychopathologies enable us to have a thorough understanding of our patients in particular when we found repeated maladaptive behavioural patterns and gaps or areas that cannot be explained by physical pathologies.

Having adequate understanding of psychopathologies and skills to verify them will help to make early identification of psychological problems and hence early treatment could be provided to avoid further deterioration.

Advance Learning in ADHD

Dr. Ting Sik Chuen
Specialist in Psychiatry

Attention Deficit Hyperactivity Disorder (ADHD) is one of the common mental illnesses in children. It affected 3 to 10% children worldwide (Biederman and Faraone, 2004; Shastri et al., 2010). The three major symptoms of ADHD are i) inattention, ii) impulsivity & iii) hyperactivity. Affected children would become bored with a task after a few minutes unless doing something enjoyable such as playing electronic console, having difficulty focusing attention on organizing and completing a task, be easily distracted, miss details & forget things. They are very impatient, could not sit still in their seats, difficulty waiting for things they want. They are easy to get conflict with people and trouble with authority. The symptoms are conspicuous to recognize but parents are reluctant to accept.

The core symptom of ADHD is extensively examined recently. "Executive Function Deficit" is widely accepted after a meta-analysis by Willcut in 2005. Executive function is defined by a group of high cerebral processes including inhibition, working memory, the ability to plan and problem solving skills (Gioia et al. 2000). It in turn influences more basic cognitive abilities such as attention, language and perception.

The cause of ADHD is mainly hereditary. The siblings have twice the risk being affected. About 10 to 20% of their

parents are also suffering from ADHD. The interesting findings in evolution showed that the ADHD males are attractive to females. As a result, it promotes ADHD in our human gene pool (William J., 2006). The association of certain artificial colours and ADHD confirmed by scientists in Southampton University and the European Commission ruled that any food products containing the "Southampton Six" (The contentious colourings are: sunset yellow FCF (E110), quinoline yellow (E104), carmoisine (E122), allura red (E129), tartrazine (E102) and ponceau 4R (E124)) must display warning labels on their packaging by 2010. The other causes of ADHD includes birth trauma, perinatal infection, prematurity, smoking in pregnancy etc.

Treatments of ADHD are drug treatment and others such as classroom management, social skill training, behavioural modification and parent training & education. Drug treatment is mainly stimulant. Methylphenidate is the only available stimulant in Hong Kong for treatment of ADHD. Methylphenidates have different preparations in terms of duration of action. Poor appetite is the major side-effect which would be minimized by using slow-released, long acting preparation. Exacerbation of motor tics could be embarrassing. Some patients may require alternative medications if methylphenidate fails such as Atomoxetine, Clonidine, Bupropion etc.

Vascular

17th July 2012

Minimally Invasive Therapy of Varicose Veins: Options Besides Stripping

Dr. Tse Cheuk Wa, Chad
Specialist in General Surgery,
Vascular Surgeon

Chronic Venous Disorder (CVD) has very diverse clinical presentations, ranging from simple spider veins, unsightly varicose veins to debilitating venous ulcers. The CEAP classification helps to provide guidance in choosing the appropriate treatment for such patients. The six CVD categories are defined in Table 1.

Currently, there are a number of well established minimally invasive options in the treatment of varicose veins, besides the traditionally Tredelenberg's operation and stripping procedure. Most of these procedures are Ultrasound guided.

Duplex Scan Ultrasound

Duplex ultrasound has evolved to become the most important imaging study for patients with varicose veins, both for diagnostic and therapeutic purpose. It is essential in planning for treatment and to identify the specific points of reflux so that treatment is appropriate and reduces the chance of recurrence.

Foam Sclerotherapy

The use of foam for sclerotherapy has greatly improved the efficacy and safety of the procedure. Sclerosants (Sodium Tetradecyl Sulfate or polidocanol) are mixed with air or CO_2 to form microbubbles. Foam acts by completely displace blood away from the vein wall, and hence increase the contact area of scleroants with the endothelium. Current use is mainly for closing the spiders and reticular veins, and tributaries of varicose veins.

Endovenous Radiofrequency Ablation (RFA)

RFA is mainly for treatment of Great or Small Saphenous vein reflux. RF waves from the tip of the catheter destroys the saphenous endothelium and denatures the vein wall collagen in a bloodless field, resulting in the formation of fibrous cord with obliteration of the vein. The RF catheter is introduced through a sheath along the Saphenous Vein, up to the Saphenofemoral or Saphenopopliteal junction. The procedure can be done under local anaesthesia in the clinic setting.

Endovenous Laser Therapy (EVLT)

EVLT works very similar to RFA procedure, but is using Laser energy to ablate the vein. It initiates a non-thrombotic occlusion by direct and indirect thermal injury to the vein wall, causing endothelial denudation, collagen contraction and later fibrosis.

Recent studies showed RFA and EVLT have similar efficacy and safety. However RFA is associated with less pain and bruising in early post-operative period.

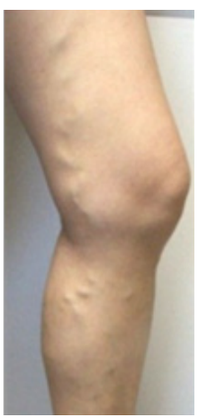


Figure 1: Varicose vein of great saphenous vein.

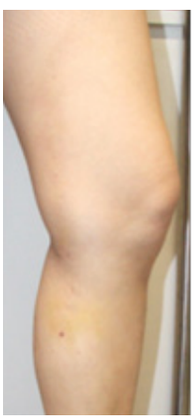


Figure 2: After treatment of RFA.

Conclusion

None of these therapies are perfect.

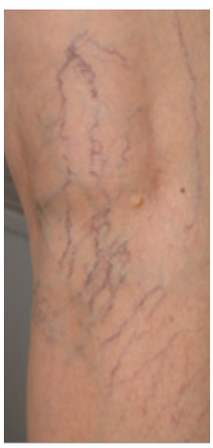
Each therapy has their own limitation, risk, and failure rate. Treatment has to be tailored to individual patients based on their clinical status and symptoms.

There are newer therapies coming up like glue, steam therapy etc, but evidence is not enough to prove their role yet.

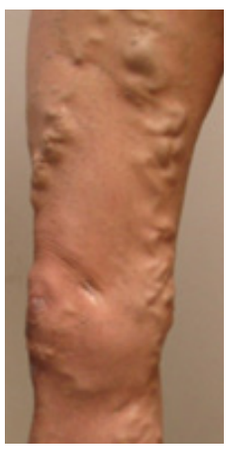
Table 1. CEAP Classification - Clinical, Etiologic, Anatomic, Pathophysiologic

C-Clinical Class	Characteristics*		
0	No clinical findings or symptoms	E-Etiology**	
1	Telangiectasia or reticular veins	C	Congenital
2	Varicose veins	S	Secondary
3	Edema, only due to a venous etiology	P	Primary
4	(a) Pigmentation and/or eczema	A-Anatomy**	
	(b) Lipodermatosclerosis, atrophie blanché	S	Superficial (Great and short saphenous systems as well as any branch varices)
5	Prior ulceration, dermatitis	P	Perforator (Veins that communicate between the superficial and deep systems)
6	Active ulceration	D	Deep (Calf veins and sinuses, popliteal, femoral, iliac veins and vena cava)
A, S	Subscript: Asymptomatic, Symptomatic	P-Pathophysiology**	
Date	Date of investigation	R	Reflux
Level	Level of investigation (I, II, III)	O	Obstruction
		R-O	Both
		N**	No evident disease**

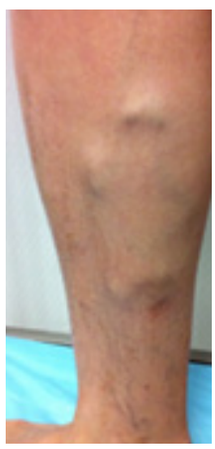
**Complaints are expected to be related to venous insufficiency and are not classified if another etiology is present (i.e. edema secondary to heart failure).*
***The N subscript indicates no evidence of disease. It is applicable to E, A, and/or P of CEAP.*



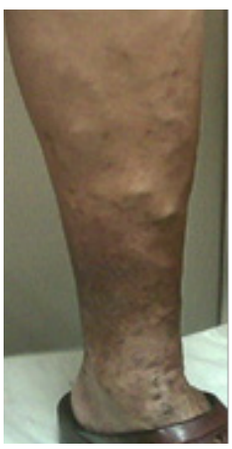
Class 1:
Telangiectasia.



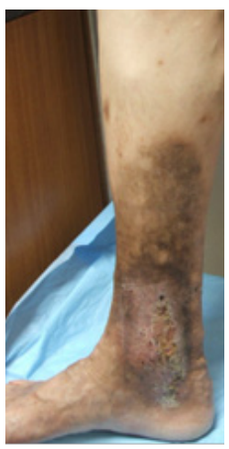
Class 2:
Varicose vein.



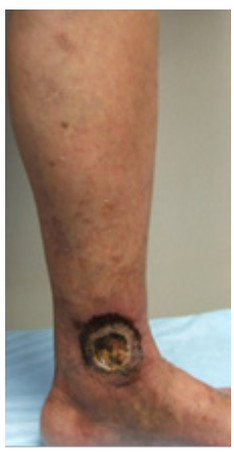
Class 3:
Edema.



Class 4:
Pigmentation /
Eczema.



Class 5:
Healed Ulcer.



Class 6:
Venous Ulcer.

Novel Treatment of Venous Thromboembolism (VTE) Other Than Warfarin

Dr. Ma Shing Yan, Lawrence
Specialist in Haematology & Haematological Oncology,
St. Paul's Hospital

VTE is the third most common CV disease after coronary heart disease and stroke. VTE can present as deep vein thrombosis (DVT), pulmonary embolism (PE) or both. Up to 50% of patients with proven DVT have evidence of silent PE and up to 70% of patients with proven PE have DVT. VTE patients with permanent risk factors remain at high risk of developing another VTE for many years. DVT is often asymptomatic, sometimes revealed only after diagnostic tests. Serious long-term complications of VTE include recurrent VTE, post-thrombotic syndrome (incidence of PTS is 23% after 2 years), chronic thromboembolic pulmonary hypertension (CTPH), venous ulcers, and right heart failure.

The mainstay of therapy of VTE is anticoagulation. The goals of acute VTE treatment are to prevent clot propagation, embolism, clot prevention, recurrent thrombosis and complication. Appropriate anticoagulant therapy provides a three-fold reduction of recurrent VTE. Long-term treatment is necessary for patients at continuous risk for recurrence.

General guideline of treating acute events includes 5 days of heparin/LMWH followed by 3 months of warfarin as the risk of recurrence can be reduced to 5% at 3 months. Duration of treatment is dependent on underlying disease and risk factors. Warfarin has several limitations that make it difficult to use in practice:
a) unpredictable response,
b) narrow therapeutic window (INR range 2-3) ,
c) routine coagulation monitoring,
d) slow onset/offset of action,
e) frequent dose adjustments,
f) numerous food-drug and drug-drug interactions

New oral anticoagulants should have the advantages over warfarin with predictable pharmacology, few interactions with food or concomitant drugs, target a single coagulation

factor, wide therapeutic window, no requirement for routine coagulation monitoring, used at fixed doses and improved benefit–risk profiles.

There are two novel oral anticoagulants in the market: Rivaroxaban (Factor Xa inhibitor) and Dabigatran (Factor IIa inhibitor). Figure 1 shows the mechanism of action of these two anticoagulants.

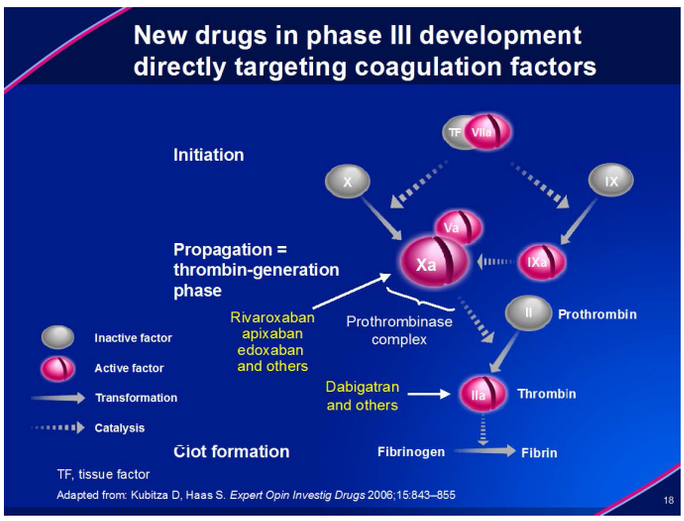


Figure1: The mechanism of actions of dabigatran and rivaroxaban

Rivaroxaban

The landmark study EINSTEIN DVT and PE demonstrates that oral rivaroxaban, 15 mg bid for 3 weeks followed by 20 mg od, could provide clinicians and patients with a simple, single-drug approach for the acute treatment of DVT. In patients who had acute symptomatic proximal DVT, without symptomatic PE, rivaroxaban showed non-inferiority to LMWH/warfarin for efficacy (HR=0.68; 95% CI 0.44–1.04; p<0.001), similar findings for principal safety outcome (HR=0.97; 95% CI 0.76–1.22; p=0.77), consistent efficacy and safety results irrespective of age, body weight, gender, creatinine clearance and cancer.

In the EINSTEIN Extension study, patients who had completed 6 or 12 months of anticoagulation, rivaroxaban showed 82% RRR in the recurrence of VTE (HR=0.18; p<0.001), absolute risk reduction 5.8%; low incidence of major bleeding, efficacy and safety results were consistent irrespective of body weight and creatinine clearance, modest increase in non-major clinically relevant bleeding (5.4% versus 1.2%; p<0.01) and no signal for liver toxicity. Rivaroxaban should be taken with food and contraindicated in patients taking azoles and HIV protease inhibitor. No doses adjustment is required in elderly patients, obese, and patients with mild renal and liver impairment.

Dabigatran

RECOVER A phase III, randomised, double blind study of the efficacy and safety of oral dabigatran150mg bd (Pradaxa) compared to warfarin (INR 2.0–3.0) for 6 month treatment of acute symptomatic venous thromboembolism, following initial treatment (5–10 days) of LMWH/heparin showed similar efficacy but reduction in major or clinically relevant bleeding. Side effects of Pradaxa are minimal and usually mild. Around 10% of patients have dyspepsia, which can usually be relieved with PPI, H pylori eradication and taken with food.

Testing of Dabigartran/Rivaroxaban Anticoagulation Effect

Testing is routinely not required except in patients with moderate to severe renal impairment, perioperative setting and in the event of bleeding. Tests that can measure the anticoagulation effect of dabigartran/rivaroxaban exist but not yet well understood. INR will only raise to 2 at supra-therapeutic concentration. The recommended tests for dabigatran is 1) APTT with moderate sensitivity but reduced responsiveness at higher doses and 2) thrombin time (TT) with sensitivity in linear relationship. The recommended testing of rivaroxaban is prothrombin time (PT). Such tests cannot provide information on drug level, but are best regarded as a qualitative indicator of drug presences. The timing of last doses of these two anticoagulants should be indicated to the laboratory for proper result interpretation.

Management of Bleeding with Dabigatran/ Rivaroxaban

- Initiate stardard resuscitation measures
- Check aPTT, TT/PT, CBC, RFT, Ca
- There is no specific reversal agents
- Vit K and plasma infusion not useful.
- Local haemostatic measure.
- Transamine 15mg/kg four times per day

In Moderate to severe bleeding:

- Consult haematology service
- Mechanical compression or surgical intervention
- Fluid replacement
- Consider platelet transfusion if less than 100 or on anti-platelet agent
- Transamine
- Oral charcoal if taken <2 hours
- Consider Activate Prothrombin Concentrate Complex
- Life Threatening BleedingRecombinant factor VIIa (NoveSeven)
- Haemodialysis if renal failure present (not for Rivaroxaban as high protein bound)

Perioperative Management of Dabigatran/ Rivaroxaban before Surgery

- No need to stop for minor procedure.
- Assess the risk of bleeding against risk of thrombosis when considering stopping anticoagulation.
- Timing of discontinuation is dependent on the renal function.
- If there is a risk of thrombosis, consider heparin as bridging
- Wait till TT/PT and aPTT is normal.
- If urgent life-saving surgery, prepare NovoSeven and consult Haematologist.
- For normal creatinine: stop 24 hr for standard bleeding risk and 48 hrs for high risk.

聖保祿醫院榮獲第十一屆香港職業安全健康大獎
宣傳推廣大獎 - 優異獎

聖保祿醫院積極維護病人及員工安全的工作獲得大眾認同。本院首次參與今年由職業安全健康局主辦的「第十一屆香港職業安全健康大獎」，以「推廣人為因素及安全作業全面預防針刺意外」為題參賽，很榮幸地獲得「宣傳推廣大獎 - 優異獎」，為日後的持續推廣工作注入強心針。頒獎禮於二零一二年九月七日舉行，本院執行董事張柱見修女及醫務總監何兆煒醫生到場鼎力支持，以彰顯管理層對保障病人及員工安全的決心。

報章亦有報道本院獲獎消息。

本院榮幸首次獲得第十一屆香港職業安全健康大獎「宣傳推廣大獎-優異獎」。

持續保持警覺性

醫院本 「以人為本」的核心價值，透過推廣人為因素「十二禍因」及安全作業「做好準備、加強意識及小心注意」，在醫護程序前、中及後期滲入安全元素，並配合引進安全利器，進一步避免意外發生。推廣活動推出短短半年，針刺及利器的工傷數字減少了44%，超過一千人次參與推廣活動及訓練，員工給予非常正面的評價，成績令人鼓舞。

計畫的成功除有賴管理層支持，駐院及訪院醫生、護士及專職醫療人員的衷誠合作實在不可或缺。希望大家在未來的日子，能夠持之以恆，處理針刺及利器時刻保持高度警覺，以策安全，實行「預防針刺意外，由我做起」！

醫院管理層出席頒獎禮鼎力支持，對針刺預防計畫的成果給予肯定。

本院安全健康經理及感染控制護士在頒獎禮上分享針刺預防計畫的成效。

公私營醫院安全經驗交流會

聖保祿醫院在預防針刺意外方面逐漸建立了一定程度的認受性。為促進本院與同業之間的合作交流，醫院管理局九龍東醫院聯網的職安健、感染控制及其他相關臨床部門之管理人員，於二零一二年十月十八日到訪本院，以進行「公私營醫院安全經驗交流會」。會上大家分享公私營醫療體系在預防針刺意外上遇到的不同挑戰，互相交流心得，雙方獲益良多，不單增進彼此了解，亦為日後的公私營交流機會奠下基礎。

九龍東醫院聯網到訪本院交流針刺意外預防心得。

職安健及員工健康日2012 (14/8/2012)

員工是聖保祿醫院最重要的資產，本院時刻關懷每位員工。為促進員工對日常工作環境中對職業安全危害的認知，及加強員工對個人健康的了解，職安健委員會於二零一二年八月十四日首次舉辦「職安健及員工健康日」。活動由本院管理層及復康中心物理治療師示範運動橡筋操作為起動禮，帶起全場熱鬧氣氛。全日的活動設有十二個遊戲及健康測試攤位。有賴復康中心、物業管理部及工程部、診斷及介入放射部、客戶服務部、感染控制部、健康中心、職員發展部的全力合作，活動深受全院上下歡迎，接近三百名員工積極參與，寓遊戲於學習，希望大家能夠將職安健的訊息帶進每一個工作單位，提升員工的整體安全文化。

電力中斷演習 (6/9/2012)

保障病人安全是聖保祿醫院堅守的承諾。為確保一旦出現醫院電力中斷時，對病人的影響減至最低，本院於二零一二年九月六日舉辦電力中斷演習，模擬產科部及育嬰室突然停電，以測試有關部門的應變反應。演習的結果理想，參與的臨床醫護人員及設施管理部人員均能在事發時，按照既定機制執行應變措施。演習共有三十名來自不同部門的前線員工及管理層參與或在場觀察，演習隨後進行分享會，以檢討成效。


電力中斷時後備電燈馬上啟動。


三十名前線及管理人員參與演習。


演習模擬產科部電力中斷。


工作人員迅速接駁後備電燈。

二零一二年聖保祿醫院
秋季旅行 (14-20/9/2012)

本院於九月十四日至二十日期間在棕櫚島舉行秋季大旅行，活動已完滿結束，多謝各同事踴躍參加，反應非常熱烈，更有多達二百名同事參加。島上設有各項康樂及設施，悠閒活動，讓各位同事遠離煩囂，感覺悠然自得，樂而忘返。
在此感謝沙爾德聖保祿女修會對活動給予全力支持，令同事藉著愉快的假期為身心注滿正能量，在工作崗位上繼續努力，為醫院提供優質服務。

世界心臟日2012 - 「環球健步行」

(7/10/2012)

聖保祿醫院參與社區健康推動活動不遺餘力。為響應每年一度的世界心臟日，本院心臟中心、其他部門的員工、家屬、聖保祿學校的老師及同學們，一同參與由香港心臟專科學院舉辦的世界心臟日「環球健步行」及「心臟健康嘉年華」。活動於二零一二年十月七日於跑馬地香港賽馬會舉行，參加者環繞跑馬地馬場步行一周，不少員工帶同親友參加，以行動響應大會主題「全球護心，家家齊心」。此外，本院心臟中心於「心臟健康嘉年華」設有遊戲攤位「為食加油站」，藉此遊戲灌輸飲食健康，遊戲設計別出心裁，吸引不少觀眾駐足，與眾同樂。

修女們及同事熱心參與社會服務，與眾同樂。

心臟中心的遊戲攤位吸引不少男女老幼參加。

本院醫生及同事帶同家人參加，將健康訊息宣揚至家家戶戶。

CME ANNOUNCEMENT

TOPIC	CHAIRMAN	SPEAKERS
27/11/2012 ***Understanding Growth and Development in Children*** 1. Child Development – Normal or Abnormal? 2. Short Stature in Children: To Treat or Not To Treat?	*Dr. Chan Chun Wing* Specialist in Paediatrics, St. Paul's Hospital	1. *Dr. Sylvia Doo* *Specialist in Paediatrics, St. Paul's Hospital* 2. *Dr. Yu Chak Man, Aaron* Specialist in Paediatrics

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

Our new website was launched on 15 Oct 2012.

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