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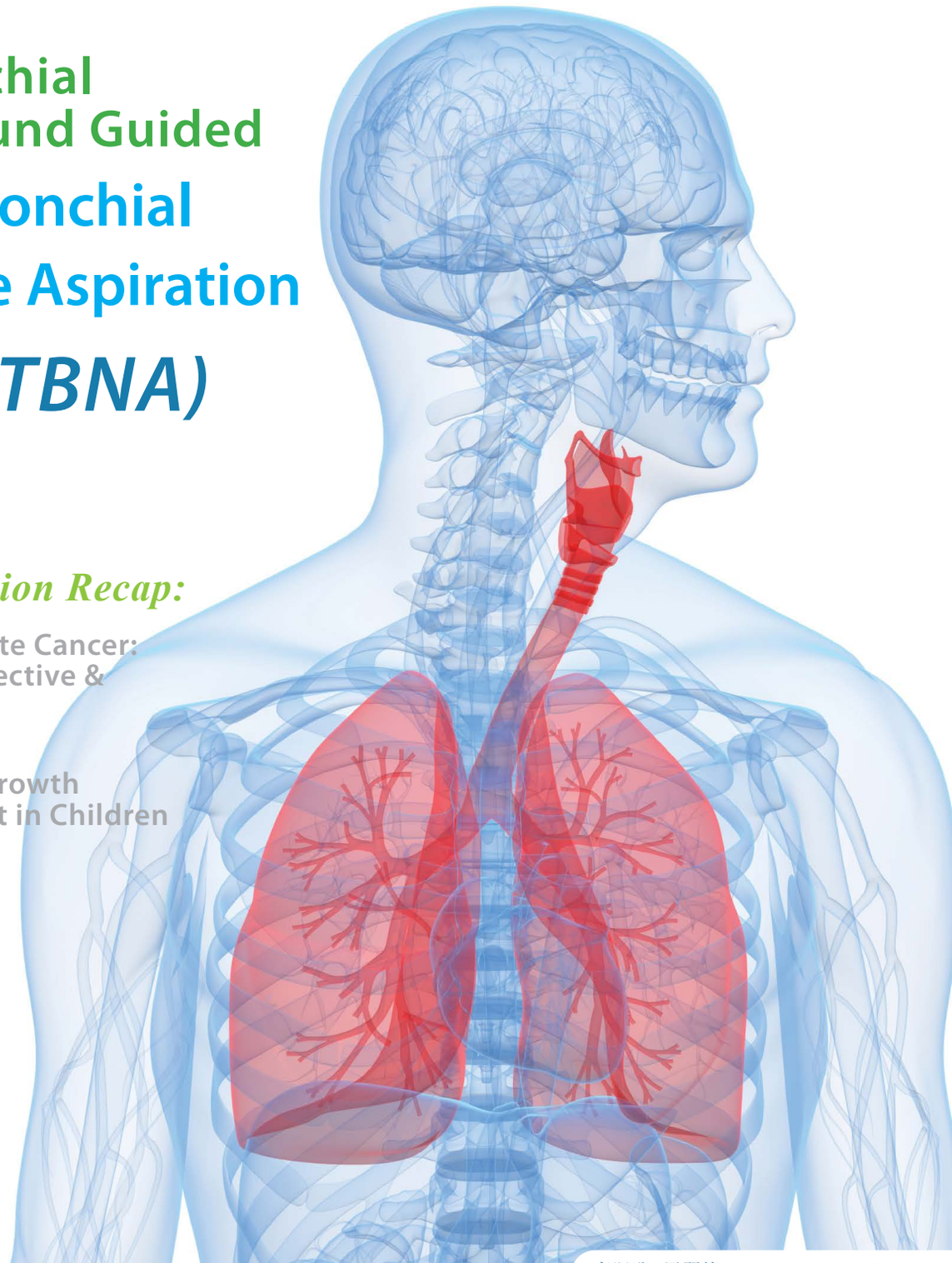
聖保祿醫院
St. Paul's Hospital

NewsLetter 院訊

Endobronchial Ultrasound Guided Transbronchial Needle Aspiration (EBUS-TBNA)



CME Presentation Recap:

- Debate on Prostate Cancer: Urologist's Perspective & GP's Perspective
- Understanding Growth and Development in Children

Message from

Managing Director

The beginning of a year is an excellent time for a fresh new start. Taking this opportunity, I'd like to share with you a story of faith, which proves how everyone can live his/ her life to the fullest even when hardship and difficulties seem to have paved your way from the very beginning.

Born just before Christmas in 2002 with a missing front leg and the other deformed, a 3-week old female puppy, Faith was found smothering by her own mother knowing too well how her puppy would not be able to battle the others for a place to feed with such birth defect. But Jude Stringfellow ,who later became the owner of this little puppy, took mercy on her, rescued her and took round-the-clock care of her when the vet suggested euthanasia. The Stringfellows never gave up on Faith when everyone else did. They trained little Faith to use her hind legs with patience and love after her deformed front leg was amputated, and miraculously, Faith managed to sit up, hop, and then one day, after months of trials and training, she walked, with two legs, just like humans!

Faith's story touches many people's heart. She now accompanies the Stringfellows on motivational talks. From the handicapped in veteran's hospitals to returned veterans of Iraq, Faith has brought hope, joy and inspirations to hundreds of thousands by her own story of turning a hopeless and loveless life to a miracle with faith, courage and perseverance.

2012 was a fruitful yet challenging year for all of us at St. Paul's Hospital (SPH). With the great effort and support from both internal and external members, I am delighted to have seen major progress on various fronts including better quality of patient care, improved standard of service and safety, and we are all excited with the progress made to the construction of Block B, all of which reflect our commitment to provide loving and dedicated service to the sick and the poor, through which we make present the love of God for all men.

Chinese New Year is the most important festive season when we celebrate with our family and loved ones. I am inspired by the story of Faith, as much as the skill and unwavering commitment and support that our doctors, nurses and staff bring to SPH each day. Your dedication and hard work lay the foundation upon which we build our promises of excellence, and continue to expand our services to better serve the public. As we reflect on 2012 and enter another year, let's take hope and faith with God's blessings in the progress we have made for now and the years to come. I wish you all a happy New Year full of faith and love!

Sr. Nancy Cheung

MESSAGE

FROM THE MEDICAL SUPERINTENDENT

Dr. William Ho
Medical Superintendent

Firstly I would like to wish everybody a

Happy and Prosperous New Year!

The past year had seen major progress in hospital and clinical governance in SPH. Through the good work of external experts and in-house staff in the various Clinical Advisory Committees by specialty, we have been able to promote good practice to enhance the quality of care, and tighten credentialing criteria for clinical rights to better protect the interests of patients. Much effort had been put to compile Fact Sheets for a wide range of operations and procedures, for the purpose of informed consent, patient education, and protection of the doctor and hospital. New rules on medication safety and use had been laid down to minimize risks. Guidelines on infection control and patient screening had been implemented, aimed at reducing nosocomial infections. A task force on fall prevention was set up to specifically address this area of risk. More notably, a new scoring system (MEWS) had been introduced to assess change of patient condition, coupled with a revised call system for in-house and visiting doctors to ensure all patients get timely medical attention where necessary.

I would like to thank all internal and external members whose great effort, contribution and commitment to quality patient care made all these possible. In the process, we may have imposed restrictions and inconveniences. We wish to seek your understanding on the purpose behind these changes, and will continue to listen to everybody's views on the actual implementation.

On the service side, a new Child Assessment Centre was opened. Activities in Pathology, Radiology, Endoscopy Centre and Urology Centre saw a steady increase. Certain infrastructure problems in the Cardiac Centre and Eye Centre had been solved with improvements, with services fully resumed and back on track. We are also seeing an increase in the number of Staff Specialists, and the Out Patient Department will be expanded. A new floor in Block A had been recently opened to accommodate more patients, while Operating Theatre sessions had been expanded on Sundays to cater for the demand.

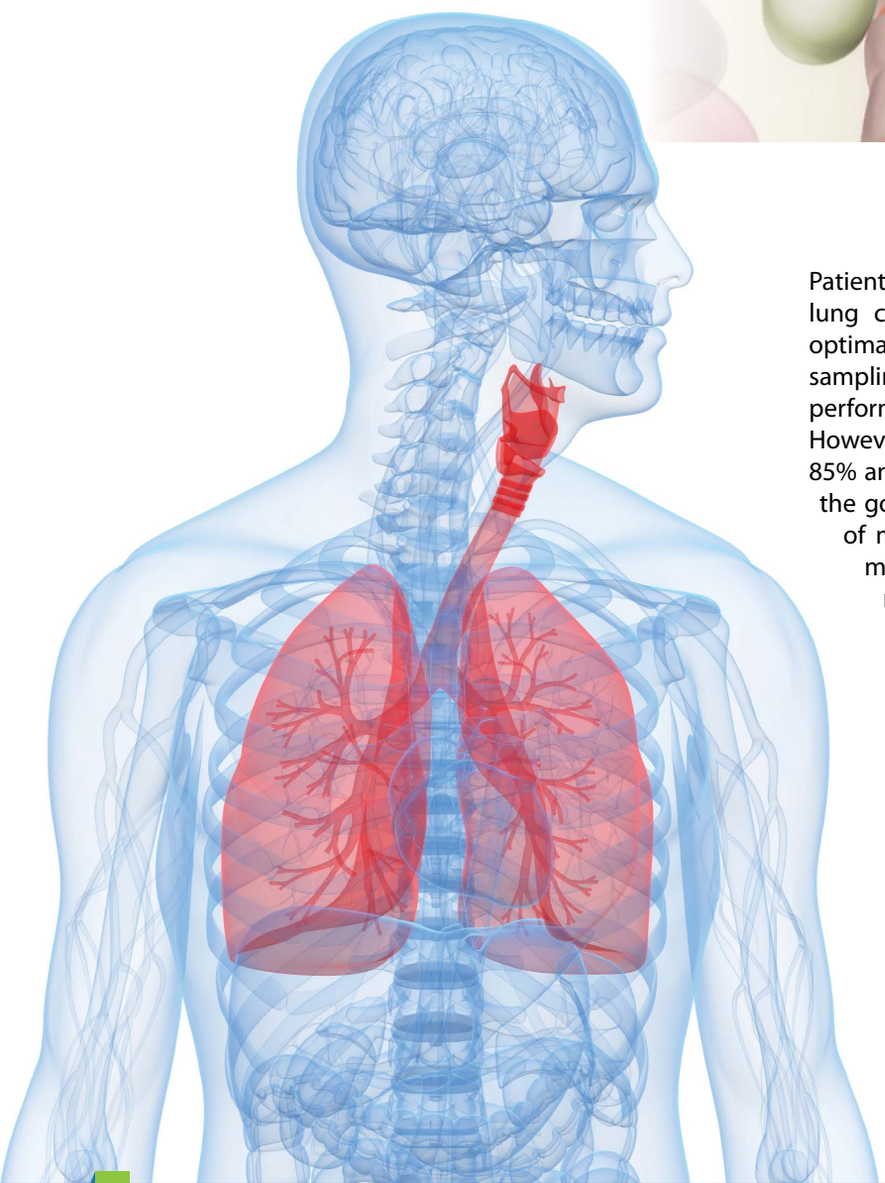
Over to the construction site, we will soon be seeing the superstructure rising up behind all the hoarding for the new Block B, now that everything underground had been largely completed. The hospital has devoted great energy in the planning and equipment for this building which will be the main inpatient block for the future. We will be delighted to see bigger wards, more spacious Operating Theatres, many more lifts and car park spaces (!) not to say a brand new Oncology Department.

Meanwhile however, we are faced with a challenging year. With the "zero quota" policy on Mainland mothers, it can be envisaged that competition among private hospitals will increase. The public is also demanding greater transparency and accountability. The hospital will go through a strategic re-look into fundamental issues of efficiency and quality, and how they can be significantly improved. Status quo is not an option. At the same time, we are embarking on ACHS accreditation in line with other hospitals. Rather than merely another piece of work, we are seeing the exercise as presenting great opportunities to help us focus and improve our internal processes and elevate our performance. We need the dedication and commitment from everybody, and we need to hear from all of you on how we can do better!

MEDICAL ARTICLE

Dr. Wan Chi Kin, Raymond
Specialist in Respiratory Medicine,
St. Paul's Hospital

Endobronchial Ultrasound Guided Transbronchial Needle Aspiration (EBUS-TBNA)



Patients with mediastinal lymphadenopathy or suspected lung cancer required accurate diagnosis to determine optimal treatment. For these patients, mediastinal nodal sampling is often necessary and has traditionally been performed by mediastinoscopy or anterior mediastinotomy. However, mediastinoscopy, with a sensitivity of 80% to 85% and a specificity of nearly 100%, which is considered the gold standard for diagnosis with tissue confirmation of mediastinal lymphadenophy and lung cancer with mediastinal or hilar lymph nodes involved, does not allow access to all lymph node stations and is associated with 2% risk of morbidity and 0.08% mortality. Mediastinoscopy can only sample nodal stations 1-4, 7, access to hilar nodal stations could be difficult and may require thoracoscopy and on occasion a thoracotomy. Moreover, it cannot be repeatedly operated on the same patient. This situation has led to the promotion in recent years of minimally invasive techniques for mediastinal lymph node evaluation.

Real-time endobronchial ultrasound guided transbronchial needle aspiration (EBUS-TBNA) is a new technique that combines endoscopic visualization with high frequency ultrasound imaging, which is used to obtain cytological and histological samples of lesions adjacent to the tracheobronchial tree. This makes it easier to locate the lymph nodes to be sampled. As Yasufuku and colleagues reported, EBUS-TBNA had a sensitivity of 94.6%, specificity of 100% and diagnostic accuracy rate of 96.3%, which seemed to be superior to those of mediastinoscopy. EBUS-TBNA, when combined with EUS, can sample all the key nodal stations and also can be performed repeatedly.

Theoretical adverse events as hoarse voice, sore throat, cough, coughing up a small amount of blood, fever, significant bleeding, pneumothorax, pneumomediastinum, medastinitis and respiratory failure. But no severe adverse events were reported from all previous studies.

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PRESENTATION
RECAP AT CME

Debate on Prostate Cancer: Urologist's Perspective & GP's Perspective

9th October 2012

Debate on Prostate Cancer: Urologist's Perspective

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

The worldwide burden of suffering from prostate cancer is significant. In 2009, approximately 192,000 and 2.6 million men were diagnosed with prostate cancer in United States and Europe respectively. Although the incidence of prostate cancer in South East Asia remains low when compared to Western countries, it is the most rapidly escalating male cancer in Hong Kong. Its incidence was increased from 597 cases in 1999 to 1484 cases in 2009. It constitutes about 10.8% of all male cancers, and accounts for 4.0 % of all cancer deaths among men in Hong Kong.

Although the blood test of prostate-specific antigen (PSA) has changed the landscape of prostate cancer in the past 20 years - creating a dramatic rise in the incidence and shifting the stage of disease at the time of diagnosis to a much earlier and potentially more curable stage, there remain significant uncertainties regarding the overall value of detecting prostate cancer early. The two highest-quality and largest trials of screening - the European Randomized Study of Screening for Prostate Cancer (ERSPC) and the US Prostate, Lung, Colorectal, and Ovarian (PLCO) cancer screening trial - appeared to report conflicting results, despite their confidence intervals of the estimates overlapped. The ERSPC demonstrated a 20% reduction in prostate cancer-specific mortality in men randomized to screening compared with controls, whereas the PLCO did not demonstrate a reduction in mortality. The United States Preventive Task Force (USPTF) recent recommendation against PSA-based prostate cancer screening in October, 2011 had taken the PSA controversy to new heights.

Emerging evidence that periodic testing with PSA may reduce the likelihood of dying from prostate cancer must be weighed against the serious risks incurred by subsequent invasive investigation namely TRUS + prostate biopsy, over-diagnosis and hence over-treatment. There is no debate that surgery and radiation therapy, the most commonly used therapies for localized prostate cancer, are associated with important harms including perioperative death, cardiovascular complications, urinary incontinence, and erectile dysfunction, etc.

General consensus suggest no solid evidence to recommend population-based mass screening for prostate cancer, but men who had at least 10 year life expectancy should have the opportunity to make an informed decision about the possibility of early cancer detection. The criterion standard of using screening trials to assess cancer-specific mortality may make sense in establishing public health policy but not for the individual patient. More information should be provided to the population through patient's education. An individual who is informed about the probability of benefit and harm may choose to be screened because he places a higher value on the possibility of benefit than the known harms that accompany screening and subsequent treatment, particularly harms related to over-diagnosis and over-treatment.

Debate on Prostate Cancer: GP's Perspective

Dr Lee Wang Yat, Paco
Specialist in Family Medicine

As a family physician, I always get a question from my patients that Prostate-specific antigen (PSA) is still routinely recommended for prostate cancer screening since its introduction in late 1980s. This is highly controversial and it is a very individual decision for the patient.

Prostate cancer screening is an attempt to identify individuals with prostate cancer in a general population in their asymptomatic stage. An intelligent screening selects appropriate candidates who will benefit from high-quality, effective treatment to prevent suffering and death. Prostate cancer, on one hand, can progress into a fatal disease, but

it can also grow very slowly without causing any problems in the life. It is difficult for a general practitioner to predict the final outcome just based on the screening test result as PSA is not cancer-specific. A diagnosis of prostate cancer can provoke anxiety and confusion. Concern that the cancer may not be life-threatening can make decision making complicated.

The debate over the effectiveness of PSA screening has quickly filtered into the offices of general practitioners and urologists. Compelling evidence comes from international studies for prostate cancer screening. The European Randomized Study of Screening for Prostate Cancer (ERSPC) reported that men who were assigned to be screened had a 20% lower death rate from prostate cancer than men not assigned to be screened. However, screening carried a high risk for over-diagnosis, and a large number of men would have to be screened and treated to save one life. Another trial from the United States (Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial [PLCO]) reported that screening with a PSA cutoff of 4 ng/ml and prostate examination did not decrease the death rate from prostate cancer. The American Cancer Society (ACS) has updated its guidelines making clear that it does not recommend routine prostate cancer screening for "all" men. Moreover the United States Preventive Services Task Force (USPSTF) recommended against PSA screening in healthy men concluding that "prostate-specific antigen–based screening results in small or no reduction in prostate cancer–specific mortality and is associated with harms related to subsequent evaluation and treatments, some of which may be unnecessary."

Despite all these recommendations, most men with elevated PSA levels will certainly opt for further investigations-transurethral ultrasound and prostate biopsy. It not only imposes possible physical side effects such as incontinence and impotence, but also gives emotional and psychological toll on the millions of men who are being overdiagnosed and overtreated.

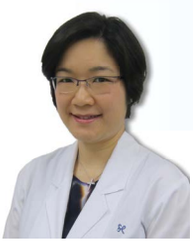
Another important issue is the annual expenses for screening. There would be a huge amounts of money to spend for a population-based screening programme for prostate cancer in Hong Kong. According to the census at mid 2000, there were 916900 male population at age group 45- 65 and over. The estimated annual cost for the test and subsequent assumed investigations would be more than $ 600 million a year.

Some pitfalls of PSA screening should be highlighted. Screening only increases the chance of finding a cancer but not reduces patient's risk of having it. A normal PSA value does not guarantee cancer free. A false positive PSA level occurs in other non-cancerous disease and treatment would cause possible urinary and sexual side effects. Therefore it recommends that the risks and benefits of screening need to be weighed, and discussions should start early for those in high risk groups. Every doctor should discuss the pros and cons of prostate cancer screening with your patients before having a PSA blood test prescribed.

Understanding Growth and Development in Children

27th November 2012

Child Development - Normal or Abnormal?



Dr Sylvia Doo
Specialist in Paediatrics,
St. Paul's Hospital

As important systems are still differentiating and growing, children are different from adults for having unique physiology and critical time windows for susceptibilities. Neurodevelopment begins in the early prenatal stage with a complex processes that begins with proliferation of neurons. These continue to develop in the postnatal years and are not complete until almost 3 years of age. Migration of neurons occurs from the 2nd to the 6th month of gestation, and again within the cerebellum postnatally. Synapse formation occurs essentially in the last trimester and first 2 years of life, is critical to ongoing functioning and development. Myelination begins in the second half of gestation and goes on to adolescence. Cortex maturation occurs from ages 5 to 20 years with "synaptic pruning" of unused neural connections. Abnormalities in any of the above processes may underlie neurodevelopmental disorders.

Understanding the normal course of different developmental aspects permits early detection of delay and deviance. Neurodevelopmental disorder has traditionally included physical as well as functional abnormalities. They are very common, as high as 15% of children are described as having language delay, developmental delay, intellectual disability, learning disabilities, attention deficit hyperactivity disorder (ADHD), autistic spectrum disorders (ASD), visual impairment, hearing impairment or cerebral palsy. The commonest functional conditions identified are ADHD and ASD, each consist of various subgroups depending on an individual's predominant symptomatology. It is widely recognized that although some children with neurodevelopmental disorders, especially ADHD, "grow out" of their condition, many remain affected and frequently develop co-morbidities i.e. oppositional defiant disorder, depression/anxiety, substance

abuse, conduct disorder. This may lead to school failure and incarceration.

Many important factors interact to determine the outcome of the neurodevelopmental process in an individual child. Socio-cultural factors may include nutrition, prenatal care, education, access to healthcare, maternal IQ, gender, culture, support networks, quality of childrearing. Genetic factors may include chromosomal abnormalities, e.g. trisomy 21. Specific gene location (chromosomes 6, 15) is linked with reading disability. Children with Fragile X syndrome may have specific language deficits or autistic features. Medical factors may include hypoxic ischemic encephalopathy, very low birth weight, severe intrauterine growth retardation, prenatal exposure to alcohol, tobacco and drugs, brain injury from head trauma and intraventricular hemorrhage. Conductive hearing loss (from otitis media with effusion) may lead to language problems. Environmental factors may lead to infections in early life e.g. AIDS, meningitis, septicemia may result in neurodevelopmental disorders. Concern is growing regarding high volume industrial neurotoxic emissions into the environment.

Short Stature in Children: to Treat or not to treat?

Dr Yu Chak Man, Aaron
Specialist in Paediatrics

Physical growth is routinely monitored in normal child health visit. Statistically a child is defined as short when his physical height is below 3% of his population standard, and referral to specialist is warranted. The purpose of paediatric assessment is to identify possible causes for the short stature (chronic medical illnesses, endocrine disturbance, skeletal dysplasia, genetics or syndromal disorders, familial shortness, constitutional delay in growth and puberty, etc), and to determine whether treatment is available and beneficial. If no cause can be identify, the patient would be labeled as idiopathic short stature (ISS).

The production of Growth Hormone (HGH) by recombination DNA technology since 1985 had revolutionized the approach to short children. While there is no room for debate in classical growth hormone deficiency, expansion of use of HGH to other pathological conditions leading to short stature should be carefully examined, the effectiveness should be evaluated against the cost as well as side effects from the treatment. In Hong Kong, HGH was approved for treatment of growth hormone deficiency from 1989, further expanded to children with Turner Syndrome and Chronic Renal Insufficiency in 1998, and to Prader Willie Syndrome and SHOX deficiency in 2012. However, in other countries, short children due to intrauterine growth retardation, or even idiopathic short stature (ISS) are accepted indications for HGH.

SHOX gene was firstly discovered in 1997, which is located at the short arm of sex chromosome. While phenotype of SHOX gene deficiency can be highly variable and may not be observed until later in life, short stature is usually evident in early childhood. Treatment with HGH is effective and the final height gain is similar to that of treatment of Turner Syndrome.

ISS is the most common diagnosis for children referred for paediatric assessment of short physical height. In 2004, Leschek EW reported that short children who were subjected to a randomized control trial of treatment with HGH for a mean duration of treatment for 3.8 year, the final adult height would be increased by 0.52 SDS or 3.8 cm.1 In 2011, Deodati A reviewed all the relevant studies on use of HGH in ISS, and concluded that on average, an increase of 0.65 SDS (or 4 cm) would be expected, and dose-response relationship was also observed.2 The average dose of HGH is higher than that of classical growth hormone deficiency or Turner Syndrome.

Common side effects of HGH include slipped femoral epiphyses, benign intracranial hypertension, worsening of scoliosis, prepubertal gynaecomastia, oedema, arthralgia, myalgia and local reaction at the injection site. Impaired glucose tolerance is also possible to warrant regular monitoring, but diabetes mellitus is uncommon. However, safety of growth hormone is always a major concern. There is no conclusive evidence to support a role of HGH in cancer pathogenesis, despite a previous retrospective review from United Kingdom indicating a possible increase in risk of colonic cancer. Recently a French retrospective study of patients ever treated with growth hormone demonstrated a slight increase in overall mortality from all causes in treated subjects. 3 The report led to FDA black box warning on HGH for a brief period, and which was withdrawn due to insufficient data support. Healthcare professionals and patients were recommended to continue to prescribe and use HGH according to the labeled recommendations until further study data is available.

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二零一二年
聖保祿醫院聖誕聯歡晚宴

(12-13/12/2012)

二零一二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，共延開八十多席，近千名來賓出席，包括神父、修女、管理層、醫生、本院合作伙伴及同事。晚宴開始前，牧靈部及多名來自不同部門的同事高唱聖詩及帶出聖誕真意義，象徵主耶穌的愛降臨人間。晚宴主題為「那些年」，不少同事以衷心的懷舊扮相，更參與「那些年衣著 Fun Fun Show」，帶領大家時光倒流。互動遊戲「時光歡樂卡」與大家回顧醫院過去百年的歷史建築面貌；另一遊戲「同心協力起大樓」則象徵同事們熱切期待新B座大樓的落成。

祝酒儀式為聯歡晚宴揭開序幕。


醫生們濟濟一堂共享晚宴。


同事們興高采烈參與晚宴。


愛心大使向嘉賓及同事派發糖果。

多個部門同事合唱聖誕歌。

沙爾德聖保祿女修會何美蘭省會長及執行董事張柱見修女頒發十年、二十年及三十年長期服務獎。

晚宴的高潮在於醫務總監何兆煒醫生以神秘嘉賓的形式出現，與同事們載歌載舞，演繹風靡全球的南韓名曲「江南Style」，舞步專業一致，充份體現全院上下的團隊合作精神，令全場賞心悅目。晚宴亦頒發長期服務獎予服務了十年、二十年及三十年的同事，以表揚他們多年的貢獻。此外，首日晚宴亦頒發了職安健通訊命名比賽獎項。大抽獎環節掀起全場另一高潮，獎品豐富，不少同事都滿載而歸。

職安健通訊命名比賽大獎得獎者的命名作品為「拉闊職安健」，而最熱烈參與部門獎則由內鏡中心獲得。

醫務總監何兆煒醫生擔任神秘嘉賓與同事們載歌載舞，掀起晚宴高潮。

「那些年衣著 Fun Fun Show」獲同事們熱烈支持參與，同事們都以別出心裁的懷舊服飾務求脫穎而出。

互動遊戲「同心協力起大樓」象徵醫院B座快將落成。

「時光歡樂卡」則懷緬醫院過百年的建築面貌。

大抽獎的禮品豐富，不少同事都滿載而歸。

農曆年謝主感恩聖祭 (29/01/2013)

醫院於1月29日(星期四)在基督君王小堂舉行了2012年度的謝主感恩聖祭，為感謝天主在過去一年的保守，並為新的一年向上主祈求福佑，期盼仰賴天主的恩寵，使我們生活在天主的聖意之內，獲享平安。感恩聖祭由談雷濤神父主禮，參加人數約有百多人。

談神父在講道中，鼓勵我們聽從上主的旨意，在好的和壞的事情上，都有上主的旨意在其中，讓我們去領略；另一方面，談神父也勸勉我們要多感恩，世上比我們聰明的人有很多，但不是全部人都有喜樂和平安的工作和生活，我們應該珍惜及感謝天主的恩典，因為這份平安和喜樂不是憑人的能力掌握得住。

在感恩聖祭中，談神父祝福了祭台前的紅封包，也隆重降福了參加者，紅封包在感恩聖祭之後派發，參加者也為未能出席的同事及親友代取。

謝主感恩聖祭在一片感恩的心情中順利進行，在此誠心感謝天主的恩典，也感謝醫院內各部門的支持，更要感謝各位禮儀人員抽空服務，在此向各位拜個早年，祝大家身體健康，萬事勝意，龍馬精神，主佑各位！

主內平安！

牧靈部

醫院認證啟動禮

(11/01/2013)

聖保祿醫院將於今年參與澳洲醫療服務標準委員會(ACHS)醫院認證計劃，本院於二零一三年一月十一日舉行簡單而隆重的醫院認證啟動禮，象徵醫院正式踏上ACHS認證的旅程。醫院認證是全球普遍發展的趨勢，許多地區都用以提升醫療機構的質素及保障病人安全。ACHS將會根據臨床醫療(Clinical)、支援服務(Support)及機構管理(Corporate)三方面，共四十七項準則作出評核。亮燈儀式特別按照臨床、支援、機構、及管治四大支柱來設計，以四把鑰匙作為比喻，邀請董事局代表尤穎怡修女、執行董事張柱見修女、醫務總監何兆煒醫生及總經理張文景先生以鑰匙啟動亮燈儀式，象徵管理層的全力支持。四名管理層隨後在巨型承諾書上簽署，以彰顯對醫院認證的決心和信心，帶領全醫院上下員工，透過認證提升醫院服務質素及病人安全。

啟動禮上播放了一齣特別拍攝的短片，由部份來自不同臨床及後勤部門的同事表達對醫院認證的心聲，以團隊精神互相鼓勵。啟動禮共有約六十名部門主管及醫院認證統籌人員出席，大家都在巨型承諾書上簽署，承諾在不同的工作崗位上自我鞭策，不斷求進。

St. Paul's Doctors Association Golf Competition 2013

(30/01/2013)

St. Paul's Doctors Association Golf Competition was held at Phoenix Hill Golf Club, Dongguan on 30 Jan 2013 with a total of 27 participants. Dr. Henry Tang won the Championship while Dr. Godwin Leung won the Best Gross Score prize.

INTRODUCTION
Of New Faces

Dr. Lau Yip Kwong, Francis
Specialist in
Orthopaedics & Traumatology

Hello my new colleagues.

I am Dr Francis Lau Yip Kwong, the new Orthopedics and Traumatology resident specialists here at the St Paul's Hospital. It is my pleasure to work with all of you in this friendly hospital.

I studied at the London University but have returned and worked in Hong Kong since 1996. All along I have worked at the Queen Elizabeth Hospital in the O+T department. Being involved and participated in various sports myself e.g. Tae Kwon Do, snowboarding, mountain biking etc, I am interested in sports injuries and have sub-specialized in arthroscopic surgeries since 2005, mainly on shoulders and knees initially, and later extended to hips and ankles.

It has only been weeks since I started and I am still trying to adjust myself to this new environment, especially the OPD, the lifts, and the car park. Do forgive me if somewhere somehow I have caused any of you any trouble or extra work. It is a big change and challenge for me working in the private sector after being in the government service for 16 years.

CME
Announcement

Topic	Chairman	Speakers
19/3/2013 (TUE)	*To Be Confirmed*	1. *Dr. Lee Siu Wing* Specialist in General Surgery, St. Paul's Hospital
Audit Review		2. *Dr. Ngai Yiu Hing, William* Specialist in Orthopaedics & Traumatology, St. Paul's Hospital
1. Audit on Colorectal Cancer Screening		
2. Audit on Scarf's Osteotomy for Hallux Valgus		

Time: 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, Email: sph.sdd@mail.stpaul.org.hk
CME/ CPD Accreditation for all colleges (Pending approval). CNE Point: 1 Point