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聖保祿醫院
St. Paul's Hospital

NewsLetter 院訊

An Overview of *Nephrogenic Systemic Fibrosis*

CME Presentation Recap:

- New Paradigm of Atrial Fibrillation Management
- Minimally Invasive Surgery - Gynaecological Operations

MESSAGE
FROM THE MEDICAL SUPERINTENDENT

Dr. William Ho
Medical Superintendent

The Doctor's Responsibility

In line with many public and private hospitals in Hong Kong, St. Paul's Hospital is undergoing the hospital accreditation exercise by ACHS (Australian Council on Healthcare Standards), with the purpose to assure quality and safety to patients. During the consultancy survey earlier this year, there were substantial observations and Priority Action Items. Many touch on the responsibilities of doctors, particularly concerning Consent, Medication Safety and Medical Record documentation.

The hospital has done a lot in improving the consent process and we are very grateful to the cooperation of visiting and staff doctors. Detailed Fact sheets are now available for patients' information, to ensure there is really "informed consent". Systems are in place such that proper consent has been signed prior to procedures. A further recommendation from ACHS is to have separate consent form for blood transfusion, which is now in place.

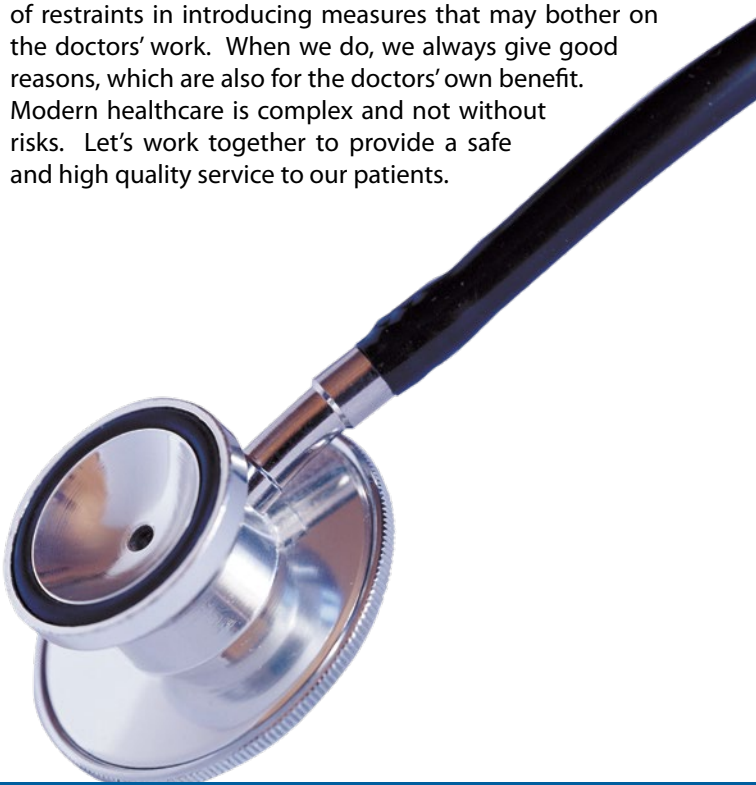
Medication safety involves the contribution of many members of the healthcare team. In our analysis, Prescribing Errors by doctors out-number errors arising from other processes such as transcription, dispensing, and drug administration. The ACHS particularly emphasizes on no transcribing by nurses. The hospital has recently introduced a Prescription Form for doctors to directly enter prescriptions in standard formats, which would hopefully eliminate some omissions and improve clarity.

Poor legibility of doctors' handwriting is definitely associated with medication errors. In this issue of the Newsletter, we show our readers some samples, where one is almost assured of problems. We certainly hope everyone will carefully consider poor legibility against the possible risks to patients, and whether a bit more conscientious handwriting can save many regrets.

Another deliberation concerns patient's own medication. It is understandable that a doctor who admits a patient for a simple procedure may find it troublesome to trace the multiple drugs that the patient is taking. Our nurses could assist in some regard, and doctors may take reference from their notes. But it remains the ultimate clinical responsibility of doctors to ascertain the patient's drug profile, aas I regret to say that incidents do occur. It is therefore inadequate for the doctor to tell the patient "Just continue to take whatever you've been taking". From a liability point of view, we are also not immune to problems of the brought-in medication, because the patient is under our care when things happen.

Quality of doctors' documentation in medical record is a frequent issue. When it comes to medico-legal disputes however, it is often the adequacy or otherwise of what is there in the medical record that makes or breaks your case. Our hospital has started a medical record audit on a sample of 300 cases, and results are available soon. Suffice it to say that poor documentation is quite prevalent. And "busy doctor" is not an excuse. We have seen very detailed and conscientious documentation from some of the busiest and prominent doctors here. Some even routinely type their records. It's all a matter of sense of duty.

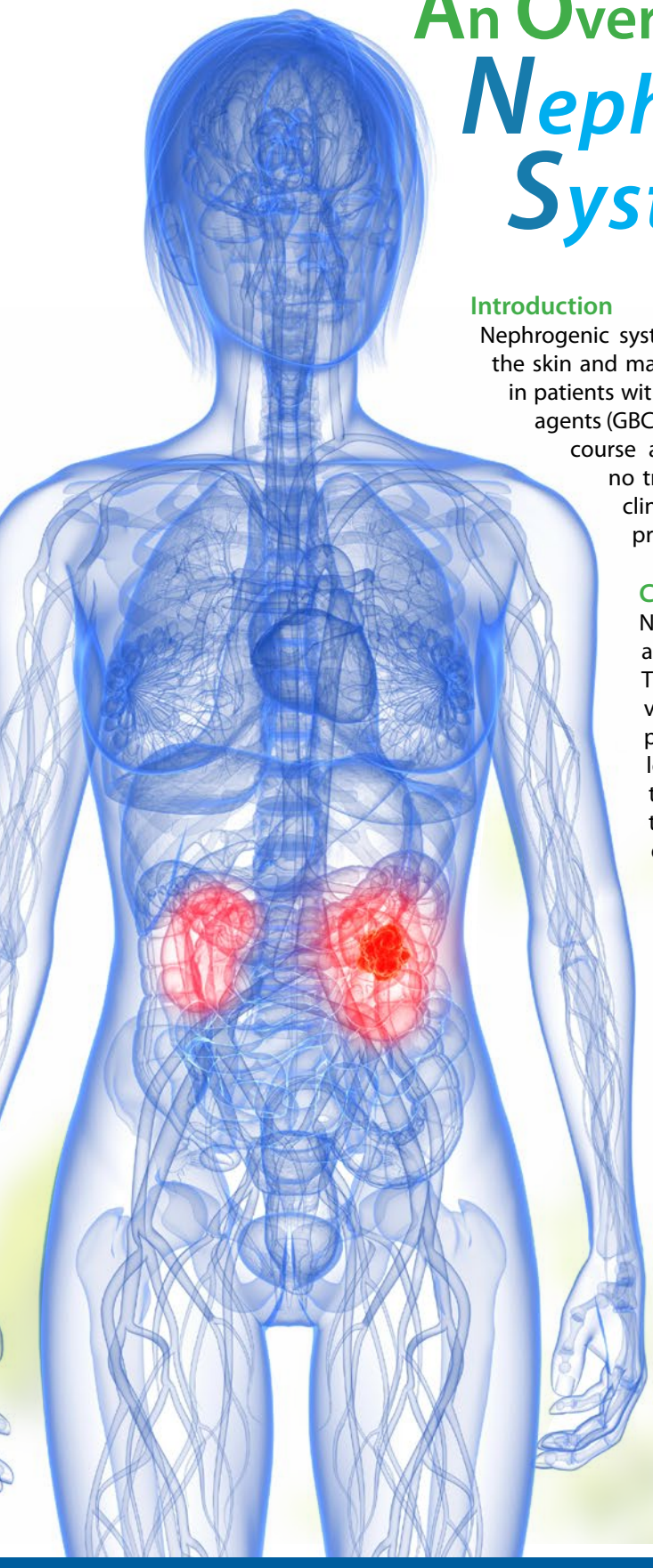
We treasure all visiting and staff doctors as part of the team and are thankful for their contribution. We do exercise a lot of restraints in introducing measures that may bother on the doctors' work. When we do, we always give good reasons, which are also for the doctors' own benefit. Modern healthcare is complex and not without risks. Let's work together to provide a safe and high quality service to our patients.



MEDICAL ARTICLE

Dr. Lee, Jeriel
Staff Specialist in Radiology,
St. Paul's Hospital

An Overview of *Nephrogenic Systemic Fibrosis*



Introduction

Nephrogenic systemic fibrosis (NSF) is a rare fibrosing disorder primarily affecting the skin and may affect visceral organs. This disorder appears to occur exclusively in patients with renal impairment who has been given gadolinium-based contrast agents (GBCA) used in MRI examinations. The disease has a relentless progressive course and will result in significant morbidity and even mortality; and no treatment has been shown to be effective. It is important for both clinicians and radiologists to recognize this disease entity in order to prevent its occurrence.

Clinical features[1,2]

NSF primarily affects cutaneous and subcutaneous tissues but may also involve organs such as liver, lung, heart and skeletal muscles. The onset of symptoms occurs within days to 2 to 3 months in the vast majority of patients. Initial clinical manifestation includes pain, pruritus, swelling and erythema of the skin, which usually begins in the legs. Patients may experience burning, itching or severe sharp pains in the affected areas. There will be thickening of skin and subcutaneous tissues producing a 'woody' texture and brawny plaques. As the disease progresses, joint contractures ensue and patients become bedridden. Visceral fibrosis may lead to cardiomyopathy, pulmonary hypertension and skeletal muscle weakness. About 5% or less of the cases have a rapid and fulminant disease course[3].

Pathogenesis[4]

The postulated pathogenesis is based on the deposition of gadolinium compound in tissues producing a fibrotic reaction. Gadolinium is the essential component of virtually all contrast agents used in MRI examination. In patients with normal renal function, gadolinium based contrast agent is excreted by kidneys rapidly. In patients with significantly impaired renal function, due to the prolonged clearance time of gadolinium based contrast agents, gadolinium may dissociate from its chelates and binds with an anion such as phosphate resulting in the formation of an insoluble precipitate. When the precipitate deposited into tissues, fibrotic reactions ensue.

Gadolinium-chelates molecules configured in cyclic form bind more tightly than linear chelates. Hence, it has been theorized that GBCA configured in linear form may be more pathogenic than the ones in cyclic configuration[5].

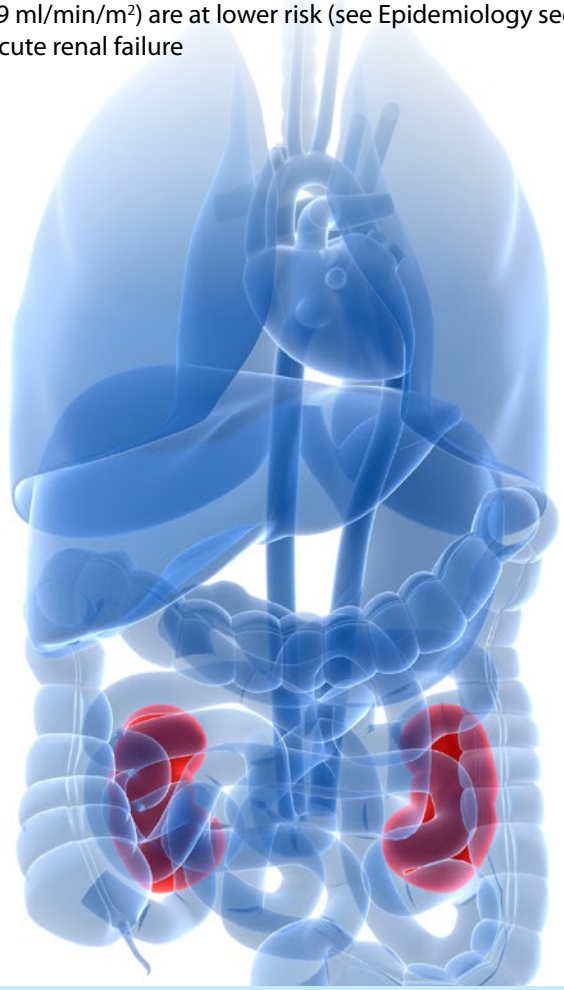
Epidemiology

To date, the NSF registry has collected over 380 cases worldwide[3]. The prevalence of NSF after exposure to gadolinium based contrast agent in patients with reduced renal function has been reported to be between 3-7%[6]. In a cohort study, the prevalence of NSF after single exposure to gadolinium in chronic kidney disease (CKD) stage 5 patients has been reported to be up to 12%[6]. There is only one case of NSF reported in a patient with estimated glomerular filtration rate (GFR) values above 30 ml/min/m^2 [4]. No cases of NSF have been reported in patients with GFR greater than 60 ml/min/m^2 [4]. Between 12% and 20% of confirmed cases of NSF have occurred in patients with acute or acute on chronic kidney disease[4].

Identifying Patients at Risk[4]

Based on current of evidence, the following patients are at risk of developing NSF:

- Patients on any form of dialysis
- Patients with CKD stage 4 and stage 5 (GFR <30 ml/min/m^2) are at higher risk while patients with CKD stage 3 (GFR 30–59 ml/min/m^2) are at lower risk (see Epidemiology section).
- Acute renal failure



Previously, FDA has warned against the use of gadolinium based contrast agents in acute renal insufficency of any severity due to hepatorenal syndrome or in the perioperative liver transplantation period. In a recent retrospective review, it has however been shown that hepatic disease alone, without acute renal injury or severe CKD, is not an independent risk factor for NSF.

Other proposed risk factors such as metabolic acidosis, elevated iron, calcium and phosphate levels, high-dose erythropoietin therapy, immunosuppression and infection have not been consistently confirmed as a true risk factor.

Recommendations to prevent NSF[4]

In principle, any patients with risk factors for NSF as outlined above should consider alternate diagnostic examination not requiring GBCA.

In patients with end-stage renal disease on chronic dialysis, iodinated contrast-enhanced CT can be considered. If contrast-enhanced MR examination must be performed, the lowest possible dose of GBCA should be used. The MR examination should be scheduled as closely before hemodialysis as possible although there is no evidence that immediate hemodialysis protects against NSF. Multiple dialysis sessions should also be considered after administration of GBCA.

In patients with CKD stages 4 and 5 (GFR<30 ml/min/m^2) not receiving chronic dialysis treatment, the lowest possible dose of contrast required to obtain the needed diagnostic information should be used. Re-administration of GBCA after several days to a week should be avoided.

In patients with CKD stage 3 (GFR 30-59ml/min/m^2), the risk of development of NSF is exceedingly rare. The American College of Radiology recommends that caution should be exercised for patients with borderline GFR of 30-40 ml/min/m^2 as estimated GFR calculations may fluctuate from day to day. Borderline CKD3 should follow the CKD stages 4 and 5 recommendations.

No special precautions are required in patients with GFR > 40ml/min/m^2.

The general recommendations for pediatric group follow the recommendations for adults. Although no cases have been reported in children under 6 years of age, it still seems reasonable to take precaution in infants and neonates because of their immature renal function.

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PRESENTATION
RECAP AT CME

New Paradigm of Atrial Fibrillation Management

18th June 2013

Novel Oral Anticoagulant for Atrial Fibrillation

Dr. Li Shu Kin
Specialist in Cardiology

Atrial fibrillation (AF) is one of the commonest arrhythmia especially in older patients. Stroke is the most devastating complication of AF with much disability and long term mortality. It had long been demonstrated that anti-thrombotic treatment could prevent stroke. In a meta-analysis for aspirin trials, it could offer 19% relative risk reduction over placebo with wide range of confidence intervals. On the other hand, warfarin had showed to be a more powerful agent to prevent stroke with relative risk reduction around 65%. Ironically, despite higher efficacy in stroke prevention, use of warfarin is not as popular as aspirin in reality. Interactions with food, frequent blood tests are some of the obstacles deterring patients to choose warfarin.

In recent years, a number of novel oral anticoagulants (NOAC) have been developed. Dabigatran, rivaroxaban and apixaban had obtained FDA approval and available in the market. They are either direct anti-thrombins or anti-factor Xa agents. Typically, their anticoagulation efficacy is highly predictable on fixed dose saving the need of blood test monitoring. They have no interaction with food and only few with drugs.
They all demonstrated similar or even higher efficacy than warfarin, depends of the dose, while the bleeding complication rate appeared also favorable.

There has been a belief that Asian patients have higher bleeding rates while on warfarin and the concerns extend to the use of NOAC naturally. The data from the analysis of Asian recruits of one of the phase III trial, namely the RELY-Asia trial, could perhaps reassure us that the efficacy and safety of NOAC in Asian subjects were as good as the main trial.

Though much fewer than warfarin, NOAC could still have some interactions with certain group of drugs. Competitors for P-glycoprotein transport or inhibitors for enzymes CYP3A4 would potentiate the anticoagulation effect. Conversely, inducers of P-gp or CYP3A4 would reduce their efficacy. Management of the bleeding complications is less straight-forward as there is no direct antidote. Also, the peri-operative care for elective surgery in patients receiving NOAC will vary according to the complexity of surgery and the renal function of the patients. In general, NOAC needs to be stopped earlier for operations with higher bleeding risk or impairment of renal function. Typically, NOAC could be resumed 48-72 hours after surgery. Anticoagulation effect will be apparent 2 hours after resumption of these drugs, which is again an advantage over warfarin.

Today, the role of NOAC in stroke prevention is clearly established and endorsed in various clinical practice guidelines in the management of atrial fibrillation. Their use is increasingly popular. Clinicians of different streams will encounter such patients in their practice. To have some basic knowledge of this class of drugs is vital for the optimal care of AF patients.

Interventional Treatment for AF -Including Radiofrequency Ablation and LAA Occluder

Dr. Chan Yat Sun, Joseph
Specialist in Cardiology

The main treatment strategies for atrial fibrillation (AF) management include rate control and rhythm control. Randomized studies showed rate control is non-inferior to rhythm control in both elderly and heart failure population. The likely explanations to this findings are the poor efficacy and side effects of rate controlling agents namely class I and III anti-arrhythmic agents, in fact in subgroup analysis of AFFIRM study patients successfully maintained in sinus rhythm under rhythm control strategy had favourable outcome compared with rate control strategy. Catheter ablation of AF has been shown to be more efficient than anti-arrhythmic agent in rhythm control in symptomatic patients not well controlled with at least one anti-arrhythmic agent and has been recommended to be standard of care by international guidelines. There are many different techniques for AF ablation but nearly all of the techniques include isolation of pulmonary vein which is considered to be the cornerstone of AF ablation. However, AF ablation also has it drawback, namely recurrence rate up to 30% which continues to occur even after one year. Refinement of the technique including ablation targeting for rotors and drivers of AF and autonomic modulation are included as part of the ablation lesion sets in an attempt to improve the recurrence rate with some success. There are also significant improvement in technology to shorten the procedure time, reduce radiation exposure and improve catheter contact by remote navigation and control system, multipolar catheter ,use of different energy source and hybrid catheter and mini-thoractomy procedure. There is also an on-going large randomized study (CARBNA) looking at the efficacy of AF ablation as first line therapy versus anti-arrhythmic with mortality as the primary outcome.

The next important issue in AF management is prevention of thromboembolic events, apart from pharmacological approach, catheter based left atrial appendage occlusion (LAAO) has been shown in randomized trial (PROTECT-AF) to be non-inferior to warfarin in thromboembolic events prevention. There are currently two devices available in the market: the WATCHMAN and the Amplatzer Cardiac Plug with different design. From the initial studies there is a learning curve effect with much less peri-procedural complications (3%) including cardiac tamponade and device embolization after operators have passed the initial learning curve. There is no direct comparison study of LAAO with the novel oral anticoagulants, but the likely role for LAAO is for patients with high thromboembolic risk (CHADSs or CHADS2-VASc score) and high bleeding risk (HAS-BLEED score).

Minimally Invasive Surgery - Gynaecological Operations

16th July 2013

The Development of SILS and My Hidden Scar Surgery

Dr. Wong Wu Shun, Felix
Specialist in Obstetrics & Gynaecology

Laparoscopic surgery has rapidly developed as the method of choice for many gynaecological surgeries. In his lecture, Dr. Felix Wong presented the development of Single-incision laparoscopic surgery (SILS) which works towards further reduction of the number of scars from standard laparoscopy and towards scarless surgery. This surgical approach (SILS) is the latest innovation and advancement of endoscopy. It aims to replace the multiple incisions by a single 2-3 cm incision at the umbilicus, through which the entire surgical procedure can be completed. It would minimize the potential port related complications, and provide a safe, scarless and aesthetic superior surgery. Patients often enjoy the speedy postoperative recovery and the impressive technique.

Various umbilical single port devices have been invented and developed by the endoscopic surgical industry. There are many

different models available in the market. Dr. Wong reviewed all these models in his talk. All devices enabled the gynaecologists to achieve and complete their single incision surgery. Yet, these devices add additional cost for the procedures. Even though modified laparoscopic instruments and camera are being developed to facilitate the performance, additional operative costs and new techniques are required to make the SILS feasible. In the literatures, many small studies and reports are being published to illustrate SILS applications in hysterectomy, myomectomy, adnexal surgery as well as early cancer surgery. Despite the changes and rising trends of SILS, there remain many limitations and challenges in this surgical approach e.g. clashing and crossover of instruments, more demand for advanced skill leading to steep and long learning curve, unsuitable for surgery requiring manipulations from various quadrant of abdomen and the loss of angulation for manipulation such as suturing, separation of tissues and haemostasis.

Two years ago, Dr. Wong started to look at a modification of this approach into a modified 3 ports but hidden scars surgery. His approach hopefully would produce nonvisible scars similar to SILS, but minimize the technical difficulties and the need of new modified instruments. Only two 5 mm ports are used at the umbilicus for the manipulation of a laparoscope and an operative instrument, and an additional port is placed either at the suprapubic area below the pubic hairline. If the insertion of a trocar above the hairline is necessary, a 3 mm miniport trocar and cannula or a maximal 5 mm trocar and cannula will be used at the left lower quadrant of the abdomen.

The surgical steps of the modified 3 ports "hidden scars" laparoscopic surgery (HSLS) was described at the lecture. HSLS appears to offer an advantage to surgeons to operate with its familiar view of operating field and the standard instruments similar to those used in conventional laparoscopy. Its demand of technical skill currently stands between standard laparoscopy and SILS in the armamentarium of minimal access surgery. The speaker had performed more than 50 hidden scars surgery at St. Paul's Hospital with successful outcome and no complications. The hidden scars laparoscopic surgery remains an evolving surgical technique used successfully by the speaker, but it still has a significant way to go before it can become a mainstream surgical approach.

Minimal Invasive Surgery: From Robotic to Endoscopic

Prof. Chiu Wai Yan, Philip
Director, CUHK Jockey Club Minimally Invasive Surgical Skills Center and
Professor, Department of Surgery, The Chinese University of Hong Kong

Over the past two decades, the development of minimal invasive surgery (MIS) had significantly improved the patients' outcomes and postoperative recovery. While majority of the surgical procedures can now be performed under MIS approach, there were difficulties in performing some of the ultramajor procedures using MIS approach. The instruments for performance of MIS are designed as rigid with limited degree of freedom, which made performance of complex surgical tasks very difficult in a confined area. The development of Robotic surgical system enhanced the performance of these complex tasks like suturing within the confined area with more degree of freedom. Our group introduced the performance of Robotic Esophagectomy since 2009 and we had performed 20 cases of Robotic esophagectomy for treatment of squamous esophageal cancers. The perioperative outcomes showed a mean operative tie of 494 minutes and blood loss of 390 mls.

All the patients had clear resection margins and the mean number of lymph node resected as 18.1. The oncological principles of cancer therapy were recently applied to treatment of early GI cancers through endoscopic resection. The development of endoscopic submucosal dissection (ESD) can achieve en-bloc resection for early GI cancers with wide margins. Our team has performed more than 300 cases of ESD for treatment of early GI cancers since 2004. Compared to gastrectomy, ESD for treatment of early gastric cancers resulted in lower complication rate, shorter operative time and hospital stay. Moreover, the function of the stomach can be preserved in these patients. Hence the postoperative outcomes are much improved. However, ESD is difficult to perform as the dissection only relied on single instrument. In a preclinical animal study, our group demonstrated that the first time performance of ESD can result in a 60% perforation. The development of a novel Master and Slave Transluminal Endoscopic Robot (MASTER) endoscopy enhanced the performance of ESD through two robotic arms attaching to the ordinary endoscope. In a multicenter prospective study in collaboration with National University of Singapore, Nanyang Technological University and Chinese University of Hong Kong, our team performed world first series of endoscopic robotic ESD for treatment of early gastric cancer in 5 patients in Hong Kong and India. The results of this study showed that ESD can be greatly enhanced by the robotic technology. Our team will continue the result in enhancing development of endoscopic surgery through advance technologies.

ACCREDITATION UPDATES

聖保祿醫院於2013年5月13至16日順利完成醫院認證顧問調查後，日前正式收到ACHS澳洲醫療服務標準委員會的顧問報告，內裡提出不少切實可行的寶貴建議，院方會逐一研究，配合醫院的實際情況，如何循序漸進地落實報告內的建議。正式的醫院認證機構評審 (Organization Wide Survey)將安排於2014年5月12至15日舉行，距今只有數月時間，要順利達標，必須得到訪院醫生、駐院醫生、護士、專職醫療、行政及支援服務等全院上下同事的衷誠投入、合作及參與，方能逐步推行改善計畫。

報告針對「臨床」、「支援」及「機構」三方面均有著墨，以下簡介臨床方面的優先處理項目：

準則	優先處理項目
1.1.1	建立評估入院病人生命表徵的標準時間；制定兒科病人評估表格；檢討評估病人的過程
1.1.2	制定兒科病人臨床及護理計劃；評估臨床及護理過程，包括臨床情況之變化
1.1.3	- 就手術同意書進行審計； - 與私家醫院聯會協商簽署同意書的最佳方式及醫生的責任； - 制定獨立的、符合國際標準的輸血同意書； - 在手術同意書上不要使用簡寫去標示手術位置； - 其他情況下只許使用已獲認可的簡寫，並將認可簡寫盡可能減至最少
1.1.5	評估交更、轉送病人及病人出院的過程，如就出院清單進行評估
1.1.6	評估病人持續護理系統，並使用評估結果制定改善計劃
1.1.7	- 為末期疾病及將要離世的病人提供全面的護理計劃，及就有關服務進行評估； - 為有關員工提供照顧末期及離世病人的培訓
1.1.8	- 改善住院病歷的設計，以確保病歷順序排列； - 更改限制醫生閱覽其他病人病歷的政策，由單次住院病歷整合為完整病歷； - 成立醫療記錄委員會；成立表格委員會或小組委員會，以確保多專科參與表格設計； - 定期進行醫療記錄審計，並跟進審計結果； - 確保有關臨床及醫療記錄標準的新政策能有效傳播，並進行審計評估依從情況； - 評估現行同時採用手寫及電子病歷的系統，制定策略確保不會影響病人護理的完整性； 評估員工處理手寫及電子病歷的培訓需求
1.3.1	制定相關政策及指引，以協助員工評估服務的合適程度； 利用適當指標去評估服務的合適程度；落實一套系統去整體評估服務的合適程度
1.5.1	- 制定程序確保護士毋須抄寫藥物處方，包括化療處方； - 評估貯存疫苗政策，評估將疫苗存放於冷藏庫下層的風險； - 參考國際指引，評估現行貯存及處理高風險藥物、危險藥物、 及外觀或藥名相似藥物的政策和程序，包括藥物冷藏庫的標籤系統； - 為預備化療藥物的隔離器進行風險評估，以確保藥物質素、病人及員工安全；參考國際指引， 引入隔離器的恆常硬件及環境監測； - 評估將有關轉換藥物供應商、藥物成份變更等消息通報予醫生及護士的系統； - 評估在病房稀釋濃縮電解液的政策，進行風險評估，並引入預先開稀的電解液； - 確保有毒或危險藥物在運送過程中上鎖； - 評估記錄及處理藥物過敏或不良反應的政策，確保所有藥物處方均適當標示過敏警告，包括藥名； - 加強由藥劑師向護士提供藥物教育，尤其是新藥； 為新入職的有關專業職系員工提供必修的藥物安全培訓
1.5.2	- 評估手術前替病人清理毛髮的做法； - 確保病人曾使用的手術儀器及內窺鏡等資料適當地記錄在手寫或電子病歷； - 確保使用滅菌程序處理膀胱鏡，而非高程度消毒； - 停止在開放的環境中使用戊二醛作高程度消毒，如經直腸超聲波探頭； - 制定意外錯誤餵哺母乳的處理政策； - 確保所有利器箱穩固地裝置於工具車、牆上或檯上，並加入環境審計項目中； - 評估眼科及腦外科手術病人患克雅二氏症的風險； - 引入用完即棄的手術前手部清潔刷子； - 停止使用含高濃度酒精的溶液清潔金屬表面

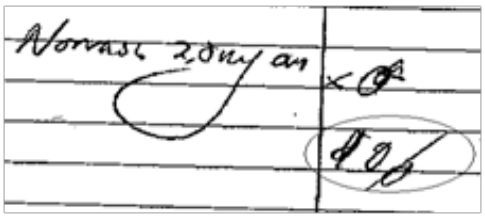
準則	優先處理項目
1.5.3	- 為新員工及現職員工提供有系統的預防及處理壓瘡培訓； - 引入多專科模式囊括醫生、專職醫療及手術室員工參與處理及預防壓瘡； - 檢討壓瘡的護理及評估方法； - 系統化地收集及分析壓瘡數據，包括在特定時間進行壓瘡普查
1.5.4	- 為新員工及現職員工提供系統化的預防及處理跌倒培訓
1.5.6	- 評估全院每個部門遺留物件在病人體內的風險，確保適當記錄物件的數目，審計病人的醫療記錄、評估事故及險失事件； - 停止使用紗布架去計算手術使用的紗布； - 根據世衛標準保存 'time out'（術前暫停步驟)的完整記錄，並定期進行審計；確保全院所有有關部門均適當地進行 'time out'
1.5.7	- 在特定一天進行病人營養失調普查；利用普查結果制定相關政策和行動計劃

HOSPITAL UPDATES

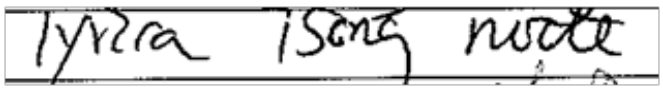
Let's Talk About Penmanship

Handwriting is a person's unique style of expression. In graphology, it suggests that specific stroke structures relate to personality traits and the analysis is often performed in relation to psychology. For all of us who have worked long enough with our fellow co-workers, we can usually identify the writer based on our prior interactions with the individual, as the handwriting has evolved to become one's signature. However, when it comes to the interpretation of medical orders, this unique trait could sometimes be problematic. Below are a few examples to illustrate the challenges our colleagues face when reading the orders.

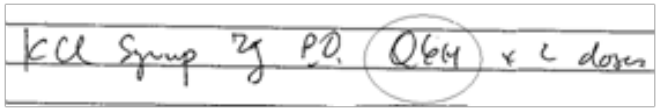
1. What is the duration of treatment indicated in the circle?



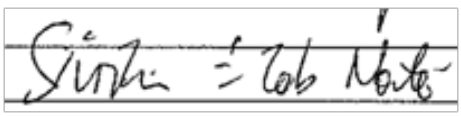
2. What is the strength written?



3. What is the frequency of use, Q4H or Q6H?



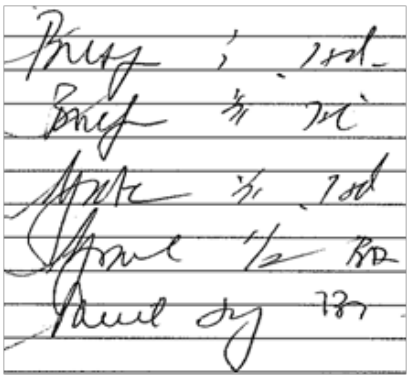
4. What is the name of the medication?



There are a lot of understandable and forgiving reasons behind scrawls, such as: having to write a lot, being under time-constraints, writing in a way so that orders cannot be forged, just to name a few. On a more serious note, there are near-misses and medical incidents causing patient harm due to poor penmanship. For example, a doctor's "q.d" on the clinical summary was incorrectly transcribed by a nurse to "qid", which would have resulted in the patient receiving four times the indicated dose! Another commonly seen issue is trying to differentiate if the order calls for "PO", "PRN", or "PR". In another case, an infant was accidentally given theophylline 10ml instead of 1.0ml as the decimal landed on the pre-printed line of the prescription sheet. This latter example is a classic case supporting the safe medication practice of avoidance of trailing zeros.

There is a suggestion that scrawl writers tend to be independent thinkers, highly creative, or exceptional individuals, like Picasso, Beethoven, or Napoleon, who were all notorious for poor penmanship. All these are important traits which make us outstanding in our field, but instead of picking the brains and straining the eyes of our colleagues, let's all ask ourselves "do you see what I see"?

Ready for more challenges? Here we go!



5. Please interpret the orders on the left

Answers ▶

New Drugs available at St. Paul's Hospital
The following new drugs have been approved by DTC since 2013:

Feburic® (febuxostat) tablet - This is a new class of drug for uric-acid lowering treatment. Feburic® is a selective inhibitor of xanthine oxidase and indicated for treatment of chronic hyperuricaemia. The usual dosage is 80mg orally once daily. Feburic® should not be started until an acute attack of gout has subsided. During the initiation of Feburic® treatment, gout flare prophylaxis with NSAID or colchicines is recommended for at least 6 months. If a gout flare occurs during Feburic® treatment, Feburic® should not be discontinued. There is no dosage adjustment required in elderly and in patients with mild to moderate renal impairment. Common side effects of Feburic® include headache, diarrhea, nausea and rash.

Firmagon® (degarelix) injection - This is a pure GnRH antagonist which suppresses testosterone for the treatment of advanced hormone dependent prostate cancer. It is given as a subcutaneous injection with the initial dose of 120mg followed by 80mg every month. Firmagon® is available as a second line treatment in prostate cancer in SPH (GnRH agonist Enantone® remains as first line treatment) and pharmacy will order Firmagon® only on doctor's request.

Prolia® (denosumab) injection - Human monoclonal antibody indicated for the treatment of postmenopausal osteoporosis. It reduces the incidence of vertebral, nonvertebral and hip fractures. Prolia® is given as 60mg subcutaneous injection every 6 months. It is suitable for patients with renal impairment (no dosage adjustment required), or those at high risk of fracture but have difficulties or intolerant of taking bisphosphoponates. Common adverse reactions include back pain, pain in extremity, musculoskeletal pain, hypercholesterolaemia and cystitis. Please also note denosumab is available as a 120mg subcutaneous injection, Xgeva®, (currently not available at SPH) which is given every 4 weeks for prevention of skeletal related events in adults with bone metastases from solid tumours. These two preparations are not inter-changeable.

Answers:

1. 10 Days 2. 75mg 3. Q6H 4. Simvastatin
5. Buscopan 1 TDS; Biofermin 2 TDS; Gastrocaine 2 TDS; Gravol 1/2 BD; Pariet 20mg BD

HOSPITAL ACTIVITIES

世界心臟日2013 - 「環球健步行」
(29/9/2013)

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」。活動於二零一三年九月二十九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，不少員工參加，以行動響應大會主題「共創強心路，你我齊起步」。此外，本院心臟中心於「心臟健康嘉年華」設有遊戲攤位「全民起動為心臟」，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。


心臟中心的遊戲攤位吸引不少男女老幼參加。


修女們、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。

本院同事、聖保祿學校的老師及同學們熱心參與社會服務，與眾同樂。

職安健及員工健康日2013

(6/9/2013)

為了提升員工對職業安全及健康的認識，本院職安健委員會於9月6日舉辦了“職安健及員工健康日2013”。同事反應熱烈，當天有超過220名本院員工參加，並給予非常正面的評價。

活動分為兩大主題: 1) 健康特區 及 2) 安全地帶，共設有10個遊戲及健康檢查攤位，同事可透過互動的方式，加深對工作安全及個人健康的了解，活動更可加強同事之間的凝聚力及對醫院的歸屬感。

熱身遊戲：決戰一分鐘

本院總經理梁兆鏘先生致感謝狀給協辦部門

本院執行董事張柱見修女致歡迎辭

藥物安全攤位

體適能測試

同事寓遊戲於學習

職業安全健康大獎 - 安全改善項目: 銅獎

本院一向致力提倡持續改善文化，不斷優化工作流程，提升員工及病人安全。在第十二屆香港職業安全健康大獎中，同事藉著跨部門之安全改善項目“小工程大改善 - 人體工程改善計劃”，在安全改善項目組別中獲得銅獎。

「小工程大改善」項目著重軟件及硬件的配合，透過由下而上的推動方式，鼓勵同事主動提出意見、自發改善於工作崗位上所遇到的人體工學問題。例如工程部技術員設計的“鬼馬工具車”以解決替換損壞光管時所遇到的職安健問題。復康中心的同事為了減低傳統設計懸吊系統為員工及病人所帶來的風險，設計了一套新懸吊系統。病房同事把日常工序如處理污衣，更換窗簾，搬運醫療儀器等加以分析其風險，並發揮團隊精神制定改善策略。

這些來自前線員工的「小智慧」不是大製作，亦不涉及昂貴資源，卻能有效地減少因人體工學危害而產生的工傷意外，長遠達致醫院和員工雙贏局面。

OUTREACH
ACTIVITIES

沙田區外展服務 (8/9/2013)

聖保祿醫院於二零一三年九月八日與沙田婦女會及沙田扶輪社合辦外展活動。本院一共有五十名熱心醫護人員、修女、醫生、義工參與以全力支持此活動。義工們除替超過二百名沙田區街坊及長者量度血壓及骨質密度測試外，亦替百多名市民提供血液檢驗，包括膽固醇、血糖及乙型肝炎抗原測試。當日更有數十名市民進行眼科檢驗及超聲波檢查，包括肝膽腎超聲波掃描、頸動脈及婦女盤腔超聲波檢查。

主禮嘉賓及全體義工合照


修女及護士為市民解答健康問題

主禮嘉賓為健康日揭開序幕


醫生為市民進行眼科檢驗


修女及義工為市民量度血壓、骨質密度及血液測試

CME
ANNOUNCEMENT

Topic	Chairman	Speakers
26/11/2013 ***Illustrative Cases of Reconstructive Surgery*** 1. Perineum & Lower Limb 2. Breast & Trunk 3. Head/Neck & Face	*Dr. Lam Lai Kun* Specialist in Plastic Surgery	1. *Dr. Cheung Wing Yung* *Specialist in Plastic Surgery* 2. *Dr. Ho Chiu Ming* Specialist in Plastic Surgery 3. *Dr. Lam Lai Kun* Specialist in Plastic Surgery

Time: 7:30pm - 9:00pm (Light Refreshment Provided at 7:00pm)
Venue: Conference Room, 2/F, St. Paul's Convent
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