第九十二期 issue 92
May - Nov, 2015

聖保祿醫院
St. Paul's Hospital

NewsLetter 院訊

Congratulations on the Golden Jubilee of our Sister Hospital in Taiwan

Hospital Updates:

- MALDI-TOF in Clinical Microbiology
- St Paul's Hospital Antibiogram 2014
- Serotonin Syndrome

Dr. William Ho
Medical Superintendent

The New Normal of Private Hospital Care

These days we hear a lot about the New Normal in China, referring to its slowed economy that should now be taken as the norm in years to come. It certainly seems to be the case also across much of the world including Hong Kong. Inevitably, it will affect our private sector.

Indeed, there had been much discussion concerning changing times and operating environment in recent meetings of the Hong Kong Private Hospitals Association. A number of big changes are coming besides the economy.

In terms of capacity, there will be huge expansion of private hospital bed numbers within these few years, in the form of expansion projects including our own, and two new big players. The latter are also likely to influence the rules of the game by virtue of their agreements with government on such things as package pricing. Understandably, agreed pricing (and associated with it the standardization of fees and consumables) is easier achieved with in-house Resident doctors or contracted doctor groups. To what extent this development may affect solo visiting doctors is yet to see.

Then there will be tightening in the regulatory environment, both mandatory and voluntary. The government has completed its consultation and is about to announce new measures to regulate private healthcare facilities. As for voluntary accreditation, all of us who underwent ACHS surveys also know about the vast amount of controls that have to be put in place, not always to the liking of the doctors.

One aspect that is going to attract public attention is that of price transparency that the government is planning to enforce. Mandatory price estimates, transparency on actual bill sizes, and package pricing will likely become part of the New Normal.

Government's plan to launch the Voluntary Health Insurance Scheme is bringing a new dimension to the ecological change that will impact insurers, provider organizations, and practitioners. Besides possible impact of linking reimbursement to package pricing, hospital admissions for endoscopy and other investigations may be significantly reduced if insurance schemes favor lower cost providers in the community setting.

The government draws extensive references to Singapore in its consultation documents. I visited some hospitals in Singapore last month and witnessed how they have surpassed us in many respects, compared with a decade ago. While private hospitals and doctors are facing intensified competition within Hong Kong, the whole of our society may be facing even tougher challenges in our international competitiveness. Now is the time for a strategic rethink on the mode of operation in our private hospitals, so as to continue add value to our clients as well as for the long term development of our health care system.

Dr. Lo Chi Hung
Specialist in Neurology
St. Paul's Hospital

2 Unusual Cases of Myelitis

Case 1

A 52 year-old woman presented with 6-month history of intermittent bilateral upper limb numbness with exacerbation of symptoms for a few days prior to consultation. She denied any neck pain / neck injury. There was no associated sphincter disturbance. She got married and denied any history of sexually transmitted disease (STD). Physical examination was unremarkable. There was no nuchal rigidity. Tendon jerks were normal. No sign of cervical myelopathy was noted clinically. Gait was normal and was not spastic. Romberg test was negative.

She underwent neuoimaging studies with MRI Cervical Spine performed, which showed increased T2 signal noted at the C6/7 to C7/T1 level of spinal cord, more over the left side. Contrast enhancement was noted (Fig. 1 & 2). Lumbar puncture (LP) was performed and revealed cerebrospinal fluid (CSF) pleocytosis (Red blood cells 273/uL, total leukocytes 25/uL, 93% mononuclear cells). Serum rapid plasma regain (RPR) turned out to be REACTIVE (1:16). Confirmatory test with serum Treponema pallidum (EIA) turned out to be POSITIVE. Subsequent CSF VDRL came back to be reactive (1:2). Serum HIV antigen / antibody test was negative.

The diagnosis of neurosyphilis with myelitis was confirmed. Patient was referred to public hospital for continuity of care upon her request.

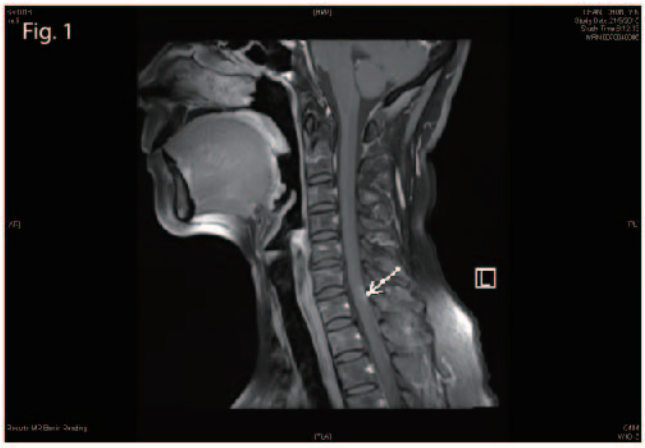


Fig. 1

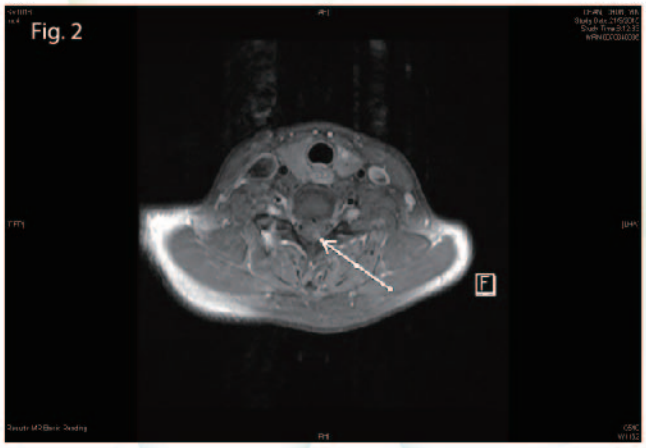


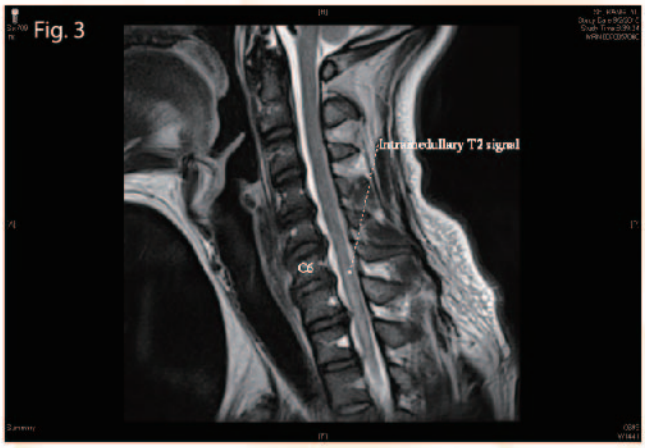
Fig. 2

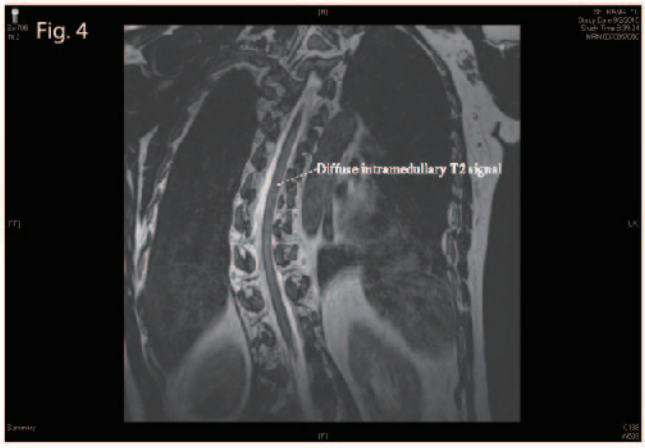
Case 2

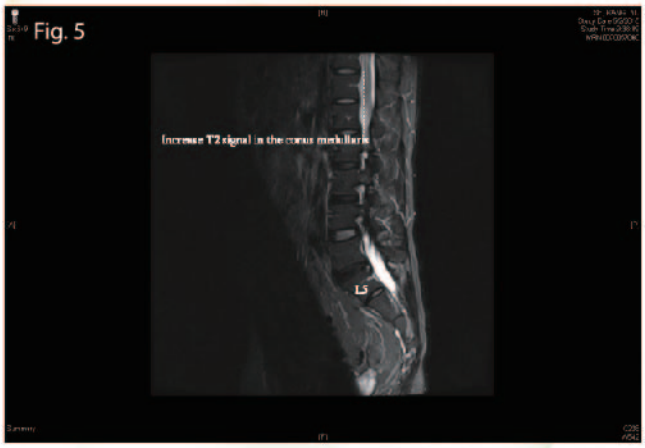
A 38 year-old man with history of presumed idiopathic thoracic scoliosis was admitted for acute retention of urine after taking cough mixture for upper respiratory tract infection. A urinary catheter was inserted on admission. He had low-grade fever (38.1 °C) on admission. Complete blood count (CBC) revealed total white cell count (WBC) of 7.0 K/uL. Urine WBC was negative.

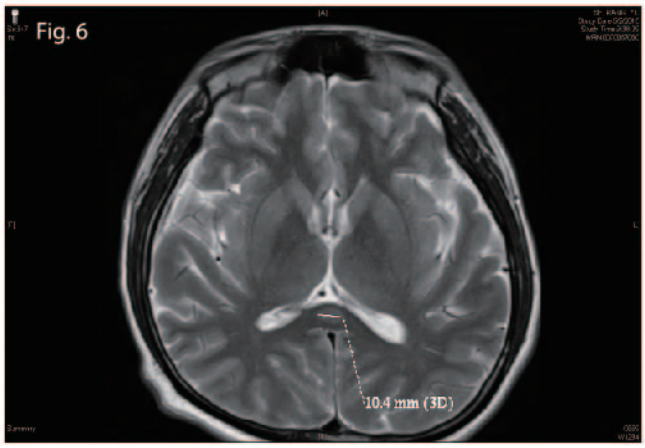
He developed bilateral lower limb weakness on the next day after admission. Clinically he had acute flaccid paraparesis with bilateral up-going plantar response. Sensory level was detected at T11 level. There was no associated relative afferent papillary defect (RAPD), sustained nystagmus or cerebellar sign detected. No meningismus was noted clinically.

Neuroimaging with MRI Brain and whole spine confirmed a T2 hyperintense intra-axial lesion about 10.4mm at the splenium of corpus callosum. There was complete longitudinally extensive intramedullary T2 hyperintense signal from C6 level down to conus medullaris without significant contrast enhancement and can involve more than 50% of the cross-sectional area of the spinal cord (Fig. 3 – 6).









LP was performed and obtained slightly turbid CSF. Opening pressure was measured to be 16 cm H2O (normal). CSF leukocytosis was noted with WBC 180 /uL (99% mononuclear cells). CSF Protein was raised up to 1,019mg/L. Microbiological investigations of CSF were all negative. CSF oligoclonal band was NEGATIVE. Extensive immunological, microbiological and metabolic investigations (including serum NMO-IgG, anti-SSA / anti-SSB antibodies and HIV screening) were all negative. The diagnosis of longitudinally extensive transverse myelitis (LETM), either due to seronegative neuromyelitis optica (NMO) or acute disseminated encephalomyelitis (ADEM) was made.

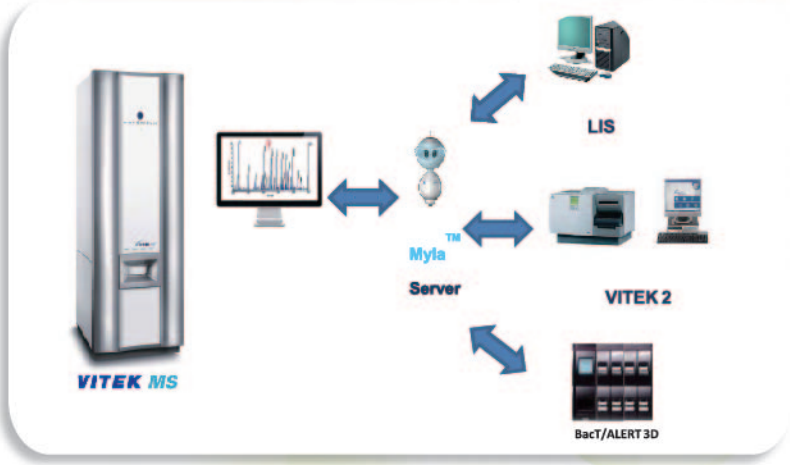
Pulse steroid therapy was started right after LP. Unfortunately the disease progressed and patient developed complete paraplegia despite the use of pulse steroid. Plasma exchange (PLEX) as 2nd line therapy for acute transverse myelitis was commenced. The response to PLEX was dramatic and patient was able to move his toes right after 1st session of PLEX. Mobility improved gradually with treatment. Follow-up LP in 1 month after onset of symptoms showed normalization of CSF WBC and protein level. Patient was able to walk unaided by about 3 months after symptom onset. Follow-up contrast MRI Brain + whole spine showed complete resolution of cord and brain lesions.

Discussion

Pathologically myelitis refers to inflammation of spinal cord. The diagnosis and management of myelitis is always challenging due to diversity of etiologies. A prompt diagnosis with meticulous search for the underlying cause through extensive investigations within a short period of time is almost always inevitable, especially when the patient's condition deteriorates rapidly. For presumed idiopathic transverse myelitis (TM) or TM due to autoimmune causes, pulse steroid is the mainstay of treatment. Second line therapy with PLEX should be considered early in the course of disease if patient failed to response to pulse steroid. For patients with significant deficits, waiting until glucocorticoid treatments to be completed before commencement of PLEX is not necessary. Clinical judgment must be used and some patients may benefit from earlier intervention with PLEX.

MALDI-TOF in Clinical Microbiology

MALDI-TOF (Matrix-Assisted Laser Desorption Ionization Time of Flight) Mass Spectrometry was developed in 1980's by a group of scientists from Germany and Japan. This technology is recently applied to bacterial identification in microbiology laboratories. The benefit of the technology is evidenced by the fact that the microbiology community is eagerly placing MALDI-TOF instruments in their laboratories.



VITEK MS™ plus instrument is the only FDA-approved mass spectrometer for both Gram-positive and Gram-negative bacteria identification in the market(1). The underlying principle is that each bacterial strain has its unique protein fingerprint. This is used to match the acquired protein profile in the VITEK MS™ database which has more than 1400 species including yeasts and molds(3). Compared to the conventional bacterial identification methodology e.g. biochemical methods, the VITEK MS™ is reliable and accurate for routine microbial identification(2). The bacterial ID can be given within a day once the bacterial colony was grown. Only one single pure isolated bacterial colony is good enough for identification.

The Department of Pathology of St. Paul's Hospital has its first VITEK MS™ plus (MALDI-TOF Mass Spectrometer offered by bioMérieux Inc.) installed in February 2015. There is a significant improvement in reducing our turnaround time especially for those organisms know to be difficult to classify. The identification is down to species level and this greatly improves clinical patient care with timely antibiotic therapy(4).

New report	Enterococcus faecalis (etc)	Streptococcus anginous Streptococcus constellatus Streptococcus intermedius Streptococcus anginosus	Finegoldia magna Parvimonas micra Peptoniphilus species
Previous report	Enterococcuus species	Streptococcus milleri group	Anaerobic Gram-positive cocci

Our current microbiology reports give full identification name of the bacteria instead of just reporting the bacterial group or species previously. This hopefully can help our doctors to choose the most appropriate antibiotics to treat the infection.

We will keep our database of the VITEK MS system up to date and continue to improve on our microbiology services.

References:

1. Adam Bonislaesi. BioMerieux's Vitek MS wins FDA Clearance as Firm Battles Bruker in US Clinical Microbiology Market. Available on: https://www.genomeweb.com/proteomics/biomerieuxs-vitek-ms-wins-fda-clearance-firm-battles-bruker-us-clinical-microbio
2. Damien Dubois. Marion Grare, Marie-Francoise Prere . Performances of the Vitek MS Matrix-Assisted Laser Desorption ionization-Time of flight mass spectrometry system for Rapid Identification of bacteria in routine clinical microbiology. Available on website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3421507/
3. Mahe P. Arsac M. Chatellier S. Monnin V. Automatic identificationof mixed bacterial species fingerprints in a MALDI-TOF mass-spectrum. Available on website: http://www.ncbi.nlm.nih.gov/pubmed/24443381
4. Anderson Fernandes Santos. Rodrigo Gayo, Lygia Schandert, Ana Vristina Gales. Evaluation of Maldi-Tof MS in the microviology laboratory

St Paul's Hospital Antibiogram

Organisms (no. of isolates)	St Paul's Hospital (Pathology Department) Antibiotics Resistance Pattern of Bacteria Isolated in 2014[a] % nonsusceptible[b]																						
	Ampicillin	Amoxycilin/ Clavulanate	Cloxacilin	Piperacillin/ Tazobactam	Cefuroxime	Ceftazidime	Ceftriaxone	Cefepime	Amikacin	Gentamicin	Netilmicin	Ciprofloxacin	Levofloxacin	Ertapenem	Imipenem	Meropenem	Azithromycin	Clarithromycin	Clindamycin	Co-trimoxazole	Nitrofurantoin	Linezoid	Vancomycin
Enterococcus spp. (174)	5									29[c]		32										0	0
Escherichia coli (917)	73	44			31		29	28	2	30			34	0		0				44	2		
Haemophilus influenzae (82)	60	29			32			10					1				5			45			
Klebsiella pneumoniae (230)	100	33			30		27	27	0.4	14			21	0		0				27	43		
Proteus mirabilis (64)	38	16			3		0	0	3	14			16	0		0				41	98		
Pseudomonas aeruginosa (131)				2		5		12		14		13	26		19								
Staphylococcus aureus (358)		29	29		29						0						37	37	31	0		0	0
Stenotrophomonas maltophilia (24)													38							4			
Salmonella spp. (96)	40						4					41								7			

a Interpreted acording to CLSI 2014 (Clinical & Laboratory Standards Institute)
b Nonsusceptible include both intermediate and resistant
c High level aminoglycosides was used
indicated 10% or more increase in resistant rate compared to 2013 figures
indicated 10% or more reduction in resistant rate compared to 2013 figures

Serotonin Syndrome

SPH Pharmacy Department

A case that should not be too soon forgotten:[1]

Libby Zion was an 18-year-old freshman at Bennington College in Vermont. Libby was recently prescribed phenelzine, a monoamine oxidase inhibitor, for depression. During this time she had also received other prescriptions, including imipramine, flurazepam, diazepam, tetracycline and doxycycline. In late February, she had a dental extraction and Percodan (aspirin+oxycodone) was added to her growing list of medications.

On Thursday, March 1st, 1984, she began to suffer from what she believed to be a cold. She visited her pediatrician and was prescribed erythromycin and chlorpheniramine. On Friday, Libby left work early because she suffered from worsening "flu-like" symptoms. On Sunday her temperature was at 102°F; the pediatrician was consulted by phone and he advised continuing the course of antibiotics. At approximately 10pm that night, Libby's condition had taken a turn for the worse. She was found to have flushed skin, dilated pupils and roving eye movements so her family rushed her to the emergency department.

Libby arrived at the New York Hospital emergency department at 11:30pm on March 4th. On her initial assessment she was noted to be writhing and agitated but able to convey her history. She was noted to be febrile at 103.5°F and also to have a right hyperemic tympanic membrane, a soft murmur and petechiae on her right thigh. The chest film was normal and her hematology panel was notable for an elevated white blood cell count of 18,000/mm^3. The resident in the emergency room administered intravenous fluids and obtained blood cultures. Libby was given acetaminophen and admitted to the hospital's medical service at 2:00 am. She was then examined separately by both an intern and a resident, who made a

provisional diagnosis of "viral syndrome with hysterical symptoms". Additional cultures were ordered, antibiotics and phenelzine were withheld. At 3:30am, Libby received an intramuscular injection of 25mg of pethidine for agitation and shivering. Between 3:30am and 4:30am, her agitation increased, she was noted to be confused and she began to thrash around in bed. Physical restraints, in addition to 1mg of haloperidol, were administered and finally she began to settle. Unfortunately, her agitation returned shortly thereafter and her temperature began to climb even higher. It was last recorded at 107°F. Despite cooling measures, she deteriorated, finally suffering a respiratory and cardiac arrest at 6:30am from which she could not be revived.

– Obtained from http://epmonthly.com/article/serotonin-syndrome-and-the-libby-zion-affair/

This infamous case was probably more remembered for its legislative regulation on hospital residents' work hours than as a hallmark case for illustrating the lethality of serotonin syndrome, which was not as well-known at that time. The term serotonin syndrome (SS) is often said to be a misnomer as it is not idiosyncratic like neuroleptic malignant syndrome (NMS), but rather is a predictable toxic state that is correlated with excessive serotonergic activity in the central nervous system.[2,3] SS is attributed to the hyper-stimulation of serotonergic receptors usually involving a dose increase of a serotonergic drug or, more commonly, involving combination with more than one serotonergic agents.[1-4,6]

The diagnosis of SS can be difficult as there are no specific laboratory findings but relies solely on clinical assessment (physical and neurological) and a thorough medication history evaluation.[1-4] To make the diagnosis even more challenging, there are various differential diagnosis for SS: NMS, sepsis, dystonia, encephalitis, tetanus, anticholinergic toxicity, thyroid storm, and withdrawal of antidepressant agents.[2-4,6] The presentation of SS usually involves a triad of altered mental status, autonomic hyperactivity, and neuromuscular effects (see Table 1 for common clinical features).[1-5] Although the presentation can vary greatly and the condition can progress rapidly, the most distinguishing clinical features for SS are hyperreflexia and symmetrical clonus.[3]

Although overly under-reported, the incidence and reporting rates of SS are on the raise. This trend may partly be due to the greater awareness for SS and it may also be due to the increased number and usage of serotonergic agents on the market.[2,3,6] Of the various serotonergic agents, selective serotonin reuptake inhibitors (SSRIs) are the most notorious for causing SS, yet many practitioners are not aware of other problematic drug groups associated this condition (see Table 2 for examples).[1-6] The chance and severity of SS are amplified with combinations of agents possessing different mechanisms of action in enhancing serotonin levels.[2-4] There have been local reports of serotonin toxicity with the use of tramadol, dextromethorphan, and metoclopramide.[7] Other commonly described cases in the literature often involve patients on antidepressants who are then given tramadol or other opioids for incidental or post-surgical pain management and patients switching antidepressant agents without an adequate washout period.

Table 1 Clinical features of SS [3]

Clinical features of serotonin syndrome	
Cognitive	Confusion, agitation, hypomania, hyperactivity, restlessness
Autonomic	Hyperthermia, sweating, tachycardia, hypertension, mydriasis, flushing, shivering
Neuromuscular	Clonus (spontaneous/inducible /ocular), hyperreflexia, hypertonia, ataxia, tremor

Hypertonia and clonus are always symmetrical and are often much more dramatic in the lower limbs

Table 2: Examples of medications that can increase serotonin levels [1-6]

Mechanism	Drug Group and examples
Serotonin precursor	L-Tryptophan
Inhibit serotonin reuptake	SSRIs (paroxetine, fluvoxamine, sertraline, citalopram) SNRIs (venlafaxine, desvenlafaxine, duloxetine) TCAs (amitriptyline, nortrptyline, doxepin) Serotonin modulators (trazodone) 5-HT3 receptor antagonists (ondansetron, granisetron, palonosetron) Tramadol Dextromethorphan
Serotonin agonist	Opioids (pethidine, fentanyl, buprenorphine, oxycodone) Triptans (sumatriptan, rizatriptan, zolmitriptans) Buspirone Levodopa Lysergic acid diethylamide (LSD)
Inhibit serotonin metabolism	MAO inhibitors (isocarboxazid, phenelzine, moclobemide, selegiline) Linezolid
Others	St. John's Wort Lithium Amphetamines (dextromethorphan) Cocaine Chlorpheniramine

So what?

Generally, SS is a self-limiting condition and most mild to moderate cases will improve in 2 to 3 days after cessation of the precipitating agents.[2-4] However, in severe cases, the patient may develop hyperthermia, rhabdomyolysis, acute renal failure, disseminated intravascular coagulation, respiratory distress syndrome, or seizure and require intensive care monitoring.[2,3,6] Like in Libby's case, it is believed that awareness and earlier recognition of SS would have allowed for better medical support and avoided the drug-drug interaction between phenelzine and pethidine.[1,6,8]

The utmost important steps in treating SS and improving mortality are quick recognition of this possible condition and prompt cessation of offending drugs. Supportive care is the mainstay in managing the condition while in moderate to severe cases, the use of serotonin antagonists is considered.[2,3,6] Of the serotonin antagonists, cyproheptadine probably carries the most supporting data in treating SS.[3,6] Other drugs that have been tried include chlorpromazine, methysergide, and propranolol, but these agents may have more adverse effects and contraindications.[2,3,6] To reiterate, pharmacotherapy vigilance and prevention are key. Healthcare professionals should keep watch for SS and adhere to the recommendations regarding the washout periods of certain serotonergic agents and be up-to-date about possible drug-drug interactions.

References:

1. Serotonin Syndrome and the Libby Zion Affair. (No date). 2015 August 11 Retrieved from Emergency Physicians Monthly: http://epmonthly.com/article/serotonin-syndrome-and-the-libby-zion-affair/
2. Boyer, E. (2014, November 17). Serotonin syndrome. 2015 August 12 Retrieved from Uptodate: http://www.uptodate.com/contents/serotonin-syndrome?source=search_result&search=serotonin+syndrome&selectedTitle=1%7E150
3. Hall, M., Buckley, N. (2003, June 1). Serotonin syndrome. 2015 August 11 Retrieved from Australian Prescriber : http://www.australianprescriber.com/magazine/26/3/62/3
4. Heitmiller, D. (June). Serotonin Syndrome: A Concise Review of a Toxic State. Rhodes Island Medical Journal, pg 33-35.
5. FDA Drug Safety Communication: Serious CNS reactions possible when linezolid (Zyvox) is given to patients taking certain psychiatric medications. (2011, July 26). 2015 August 15 Retrieved from US Food and Drug Administration : http://www.fda.gov/Drugs/DrugSafety/ucm265305.htm#table
6. Boyer, E., Shannon, M. (2005). Serotonin Syndrome. N Engl J Med, 352(11), 1112-1120 Retrieved from http://toxicology.ucsd.edu/art%203%20serotonin%20syndrome.pdf
7. Kung, SW., Ng, MH. (2007). Serotonin syndrome with tramadol and dextromethorphan. Hong Kong J. Emerg. Med, 14(1), 48-52. Retrieved from http://www.hkcem.com/publications/Journal/2007-1/2007_1_p48-52.pdf
8. Lexi-Comp Online Interaction Monograph.

CME ANNOUNCEMENT

聖保祿醫院
St. Paul's Hospital

CME/CPD/CNE Programme 2016

Prevention of HPV associated Cancers and Genital Warts by HPV Vaccination

Speakers: **Dr. Karen Kar Loen CHAN**
Clinical Associate Professor, The Department of Obstetrics and Gynaecology, The University of Hong Kong

Chairman: **To be confirm**

Date: **19 January 2016 (Tuesday)**

Time:

7:00 pm – 7:30 pm	Reception (light refreshment provided)
7:30 pm – 8:50 pm	"Prevention of HPV associated Cancers and Genital Warts by HPV Vaccination" by Dr. Karen Kar Loen CHAN
8:50 pm – 9:00 pm	Q & A Session

Venue: **Conference Room, 2/F, St. Paul's Convent**
(Entrance via St. Paul's Hospital, No.2, Eastern Hospital Road, Causeway Bay)

Registration & Enquiry:
(First-come-first-serve)

Contact Person: Ms. Merrillin Leung
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E-mail: sph.sdd@mail.stpaul.org.hk

CME / CPD/ CNE Accreditation for all Colleges (Pending approval)

MSD
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HOSPITAL ACTIVITIES

大嶼山聖母神樂院一日遊(朝聖)

「咦！香港有隱修院？」、「隱修士的生活是怎麼樣呢？」.....看到活動海報後，你曾否有這樣的反應？我們很高興是次活動得到同事們的踴躍支持，活動迅速額滿。

四月十九日，我們一行四十六人一起去探索熙篤會隱修士生活的地方。在沿路上，小朋友和修女們一邊走路，一邊玩氣球，不消一會便到達聖堂。在彌撒開始前，隱修士們帶領我們參與簡短的「時辰祈禱(即在指定的時間到聖堂祈禱)，包括唱拉丁文短誦和誦唸聖詠。

李達修神父和我們分享，熙篤會隱修士在1950年代從內地河北遷移本港後，便在大嶼山這個地方建立會院。隱修士們每日聚集祈禱七次，平日彌撒的時間是由上午三時半開始，因此他們在晚上八時左右便會休息。日間活動主要是打掃地方、煮飯、清理樹葉、製作曲奇餅等等。隱修士過的雖是隱世祈禱的生活，但仍會透過報章關注世界各地發生的大事，並以本地和世界的人和事作為祈禱的意向。分享過後，李神父帶我們參觀聖母亭。門上的匾額一邊以拉丁文寫著「進入此門的人得到和平」，另一邊為「走出此門的人得到安全」。

我們飽嚐了隱修士預備的美味午餐和參觀過後，便沿著山路通往愉景灣。雖然大家都汗流浹背，但聊聊天、散散步，很快就步入歸程。感謝上主賜予我們清風送爽的天氣，感恩所有參加者都健康平安地渡過了一天。

願教友和同事們經過今次朝聖後，可更肯定修道人為教會服務的無私奉獻精神，並特別為聖召祈禱，這也是今年教宗方濟各定為「獻身生活年的焦點之一。

天主保佑！
牧靈部

▲阮修女帶著一位小孩進出聖母亭的門，盼望上主給予她特別祝福

▲聖母亭門上的匾額

▼於聖堂後方合照，當中「TM」代表 Trappist Monastery

秋季燒烤聯歡會

由聖保祿醫院舉辦，員工諮詢委員會籌備的「秋季燒烤聯歡會」已於十月三十日圓滿結束。由於報名反應熱列，同事及親屬的參加人數多達二百五十人，燒烤聯歡會特地分為上下兩節，讓更多同事能參與其中。

燒烤聯歡會由下午三時半正式開始，同事們與親屬陸續結伴而來，一起享受燒烤樂趣。難忘的除了有香味撲鼻的食物外，還有大會安排的扭氣球環節。導師按各人的喜好扭出不同造型的卡通公仔氣球，無論成年人還是小朋友都被逗得開懷大笑。大會更悉心準備了糖果禮品送給每位小朋友，各人都表現得十分雀躍和興奮。趁著這個難得聚首的機會，參加者都盡情拍照，留住歡樂的時光和笑臉。

燒烤聯歡會於晚上八時正結束，所有人都盡興而歸。我們期待來年能為員工及家屬舉辦更多的聯歡活動，藉以調劑緊張的生活，並增進同事彼此間的互動和友誼。

2015夏季旅行 —「廈門鼓浪嶼休閒之旅」

本院一年一度的夏季旅行已於五、六月期間順利舉行。是次「廈門鼓浪嶼休閒之旅」為我們帶來很多難忘的回憶，各人都非常盡興。這次旅程讓我們能暫時放下忙碌的工作，輕輕鬆鬆地享受旅遊的樂趣。欣喜的是在旅程中大家能夠結識到不同部門、不同職位的同事，在工作以外有更深入的相處和溝通，從而增進彼此之間的友誼。

在這三天旅程中，我們分別參觀了有「海上花園」之稱的鼓浪嶼、華安土樓的典型代表「二宜樓」、廈門現存最完善的原生態漁村「曾厝垵」、文化氣息濃厚的「集美學村」等等，除了讓我們認識當地的歷史和閩南風俗文化外，更可沿途欣賞不同的歷史建築，特別是鼓浪嶼，島上完好地保留了許多具有中外建築風格的建築物；海島景觀也格外宜人，遠離煩囂，確是都市人休閒的勝地。另外，我們亦品嘗了當地的特色美食，如：廈門傳統風味餐、二誼土樓家宴及閩南菜，大飽口福，沿途我們更購買了不少當地手信呢!

這三天的行程雖然編排緊湊，但內容十分充實，我們有充裕的時間遊覽各景點，享受大自然的美好風光及品嘗地道美食，住宿也舒適滿意。在此，我們多謝參加者之踴躍支持，也感謝院方之悉心安排，我們期待來年夏季之旅的舉行！

台灣聖保祿醫院50周年金慶典禮

二零一五年十一月上旬為台灣桃園聖保祿醫院創立五十周年，本院受邀出席其周年慶祝活動，與有榮焉。

桃園聖保祿醫院為慶祝周年紀念展開了一系列精彩豐富的慶祝活動，其中不得不提便是五十公里「超級馬拉松活動。桃園聖保祿醫院上下均積極參與這項勇跑活動，不僅參與的健兒卯足起勁，沿途觀眾更為他們加油打氣，場面歡樂融洽。

翌日，本院隨台方參觀醫院歷史文物展及印象保祿攝影展，其間展出多項見證醫院歷年變遷的文物及照片。其後出席醫院五十周年金慶典禮暨醫院重建啟動禮及感恩彌撒，感謝天主對醫院五十年來的祝福，期望未來繼續台灣為民眾提供健康照護。接著，由陳志忠副院長為本院作簡報介紹，並走訪醫院各部門，以深入了解醫院的運作。

當晚，醫院舉行了院慶晚會，節目精彩不斷，除了動聽的歌唱表演外，醫生的家屬更帶來精湛的魔術表演，令人目不暇及。最令人印象深刻的便要數當地原住民帶來的民族舞，台上的人翩翩起舞，台下的人拍案叫絕。

此外，本院更獲林口長庚紀念醫院邀請參觀其質子中心的開幕典禮，並隨長庚醫院人員參訪各個部門。長庚醫院為台灣第一個設立美食街的醫院，這次更有幸親嚐台灣特色美食。

在此，祝願桃園聖保祿醫院同仁健康愉快，繼續為台灣民眾提供醫療服務。

▲與院長沈雅蓮修女及醫院管理團隊合照

◀香港團合影

原住民於院慶晚會表演民族舞

參觀桃園聖保祿醫院及林口長庚紀念醫院

台灣聖保祿醫院
50周年金慶典禮及聖祭會場

▲為長跑健兒打氣

▲迎接50公里長跑健兒完成壯舉