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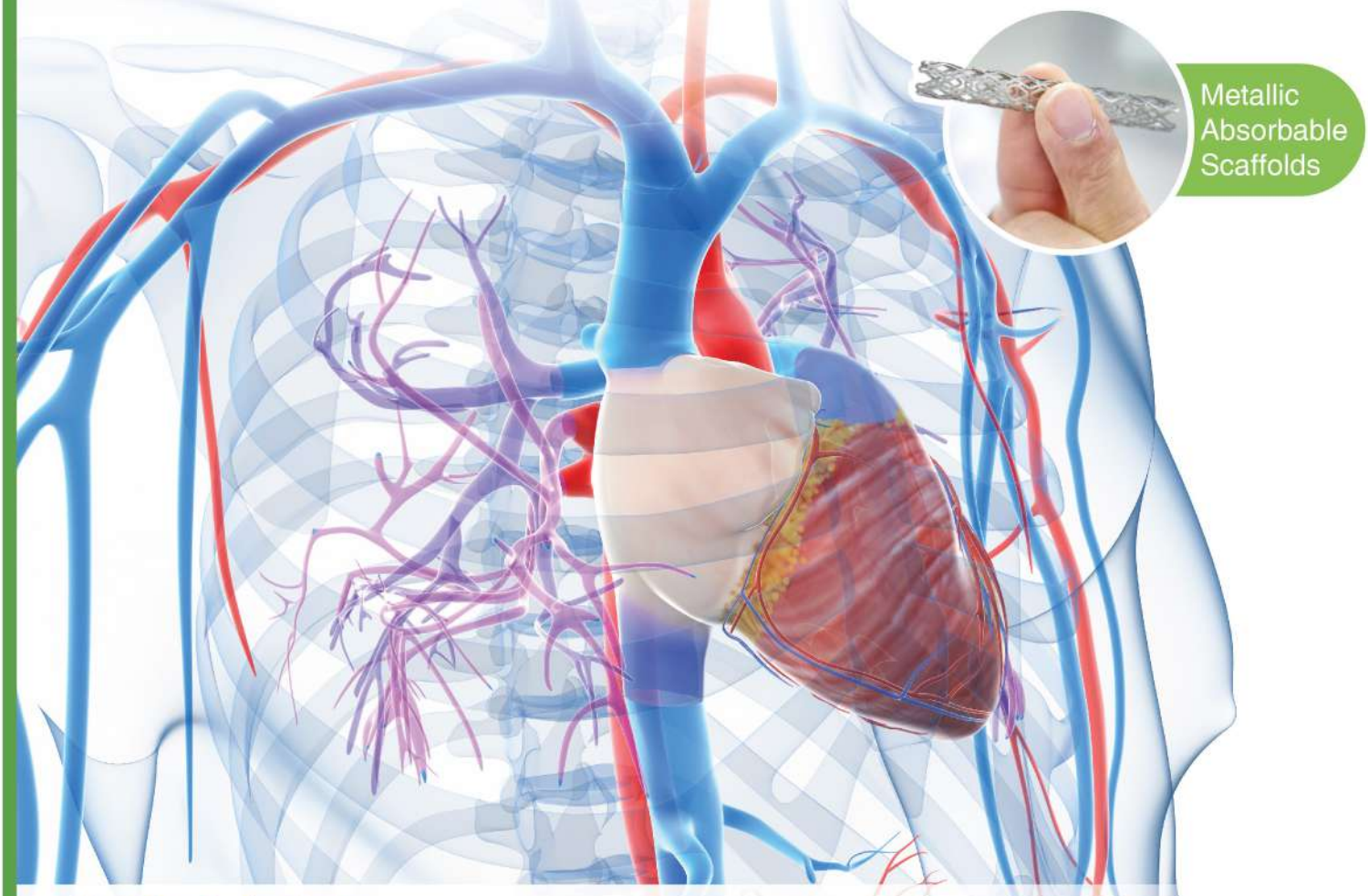
聖保祿醫院
St. Paul's Hospital

NewsLetter
院訊



Medical Article:

- From "No stent" to "No stent"
  - Development of percutaneous coronary intervention and latest advances

Hospital Activities:

- New Block B Open House
- International Nurses Day 2017
- OSH Wellness Day
- New Block B Blessing Ceremony

MESSAGE
FROM THE MEDICAL SUPERINTENDENT

Dr. William Ho
Medical Superintendent

15 April 2017 marked an important milestone for St. Paul's Hospital as services formally commenced in our new Block B. As you can see from this issue, much had happened in the lead up to this day. On March 18, Rev. Joseph Yim, Vice President of Caritas Hong Kong and ten other Fathers from the Catholic Diocese of Hong Kong graced us with a Blessing Ceremony for the new block. Provincial Superior Sr. Joanna Marie and other Sisters of St. Paul de Chartres accompanied the Fathers to bless all floors and all rooms, no small feat given the vast area, multiple floors, and hundreds of rooms and corridors. On March 29, we also organized an Open House event where visiting doctors and other guests were given a preview of the wards, Endoscopy Centre and Operating Theatres. All were impressed by the spaciousness, superb design and splendid views from the wards, as well as brand new equipment. Most favorable comments were received particularly on the grand Main Lobby with a fascinating LED display, and efficient escalators that serve the busiest floors of Out Patient Department, Admission Office, Pharmacy, Cashier, Radiology Department and Rehabilitation Centre. The sheer number of 17 lifts in total is certainly a quantum leap from what we were used to, and the use of intelligent lifts a first among hospitals in Hong Kong. In addition, a new Boxveyor system serves to afford speedy vertical transport of materials across all floors.

01 Rev. Joseph Yim, Vice President of Caritas Hong Kong and ten other Fathers from the Catholic Diocese of Hong Kong graced us with a Blessing Ceremony for the new block.
02 Overview of St. Paul's Hospital.
03 Open House event where visiting doctors and other guests were given a preview of the wards, Endoscopy Centre and Operating Theatres.
04 Spacious ward environment with natural light.

I must take this opportunity to thank the Sisters of St. Paul de Chartres for not only the generous investment that made this project possible, but more importantly for their most painstaking considerations in ensuring that the building and facilities really provide a healing environment. Praise from users and visitors that we often hear include such adjectives as elegant, calm, peaceful, bright, spacious, and of course, beautiful. Everything is uncluttered and orderly.

I would also like to thank our dedicated and excellent staff. Many of us have personal experience of moving house and know what a hassle that could be, let alone moving the activities of almost the whole hospital into a new block. With months of prior preparation and drills, such complicated task was immaculately accomplished, with no adverse comments from patients. While not every situation can be fully anticipated, problem solving on the spot under immense time pressure required ingenuity and flexibility. All staff members deserve a big applause for the silky smooth transition, and that includes our team of volunteers as well. There were also great effort from external parties – project architects, contractors, consultants and field staff, whose responsiveness and help were crucial in tackling unanticipated situations.

While new facilities will always require getting used to and perhaps new workflow procedures, all of us are quickly learning and problem-solving to ensure that our internal and external customers are satisfied. We hope to achieve even better teamwork and mutual support in the process. We welcome constructive comments from service users, doctors and staff so as to continually improve. Meanwhile, pressure is certainly on in terms of increased admissions, and our Human Resources Department is working real hard to ensure adequate manpower supply to cope with the volume of work.

Approaching the centenary of St. Paul's Hospital next year, we are very fortunate to have such a massive upgrade of hardware on our precious location at the heart of city. The other half of the equation is even more important – how do we harness our collective wisdom and spirit to serve our patients and the community in even better ways to match what we are endowed with, in accordance with the teaching of St. Paul and the love of God. What we do should truly come from the heart, and we shall always hold dear our hospital motto:

We Serve and We Care.

05 Moving into the new Block - happy moments of our dedicated and excellent staff.

06 New Block B Lobby.

Dr. Cheung Chi Yeung
Specialist in Cardiology
St. Paul's Hospital

From "No stent" to "No stent"
- Development of percutaneous coronary intervention and latest advances

Percutaneous coronary intervention (PCI) is a crucial treatment for coronary artery disease nowadays. This innovative technique develops dramatically in last four decades and has become one of the great advances in medicine. It prevented the patient from major operation, coronary artery bypass graft (CABG), which carries significant morbidity to the patient at that time.

The pioneer of interventional cardiology was Andreas Roland Gruentzig. He had undergone the first coronary angioplasty on 16th September 1977. The patient had follow up angiogram done 23 years later and showed still patent vessel[1].

However, despite the continuous advancement of technique and equipment of angioplasty, it still facing two major challenges: 1) acute occlusion during the procedure leading to emergency CABG, which in most cases was accompanied by a large infarction and 2) the problem of restenosis. Coronary stenting provided the solution to these major problems.

The first stent was implanted by Puel on 28th March 1986. It was a self-expandable Wallstent with suboptimal result due to subacute stent thrombosis. It was necessary to wait nearly 10 years to eliminate the risk of subacute stent thrombosis by dual antiplatelet therapy (Aspirin and Ticlopidine ¶).

¶ Ticlopidine is not recommend anymore as part of DAPT because of its rare but serious side effects of neutropenia and thrombotic thrombocytopenic purpura.

Safety and Efficacy

More researches were done for better development of coronary stent. The primary goal of stent implantation is to achieve an optimal luminal area without damaging the artery, ensure rapid endothelialization, and prevent chronic inflammation.

Continuous improvements in stent technology provide safety and efficacy to angioplasty procedures as well as easier and safer stent implantation.

"Safety" refers to the potential risk of stent thrombosis, whereas "efficacy" refers to the restenosis rate and suppression of neointimal hyperplasia.

Stent thrombosis vs In-stent restenosis

When a stent is implanted to the vessel, it is exposed in the blood steam as a foreign body. Platelets and other thrombotic factors would attach to the stent surface and eventually thrombus will be formed and cause stent thrombosis. Before the stent is completely covered by endothelium (re-endothelialized), this thrombus formation process is dangerous. It is effectively prevented by Aspirin and another P2Y12 inhibitor (Clopidogrel, Prasugrel or Ticagrelor). The duration of dual anti-platelet therapy (DAPT) depends on different stents used.

Stent implantation would inevitably injure the vessel wall. The inflammatory reaction and the proliferation of smooth muscle cells could eventually lead to in-stent restenosis. The antimitotic drug on drug-eluting stent can effectively prevent the cell proliferation. On the other hands, endothelialization is also inhibited and takes longer time to complete. That is the reason for the need of longer DAPT use in drug-eulting stent.

Bare Metal Stents (BMS)

Although BMS reduces the need for repeat revascularization compared to balloon angioplasty, their use is limited in the drug-eluting stent era.

After BMS implantation, patient should be put on at least 4 weeks of DAPT to prevent stent thrombosis. After 4 weeks, the BMS was supposed to be endothelialized and risk of stent thrombosis is minimal.

Practically, BMS is still used for patients who have planned for early non-cardiac surgery after PCI or who have high risk of bleeding when put on long term DAPT. Or it can be used for simple lesions in big vessels in low-risk patients, or in vein grafts. BMS should also be used in pregnant lady to avoid the teratogenic effect of DES.

Bio-engineering stent

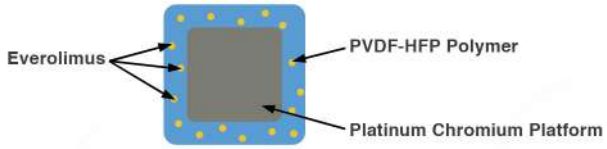
Genous™ Stent is a bio-engineered coronary stent coated with immobilized anti-CD34 monoclonal antibodies. It can effectively capture endothelial progenitor cell (EPC) circulating in the blood, which promotes the accelerated natural healing of the vessel wall and form an endothelial layer that provides protection against thrombosis and modulates restenosis[2].

The accelerated endothelialization makes it safe to further shorten the DAPT to around 2 weeks. It is beneficial for patients who required a very early surgery after PCI, says, resection of malignant tumour, or for patients who have extremely high bleeding risk due to DAPT.

Drug-Eluting Stents (DES)

DES consists of a platform (stent scaffold), the drug (antimitotic drug), and a carrier for drug attached to the stent (polymer). DES have dramatically reduced the rate of in-stent restenosis (5% vs 20% in BMS) and the need for subsequent target vessel revascularization compared to BMS. However, because of the presence of polymer and the antimitotic drug, there is a delayed vascular healing and complete re-endothelialization of DES, that increases the risk of stent thrombosis. As a result, prolonged (up to 6 months to 1 year) of DAPT is required to prevent stent thrombosis[3,4], and the annual incident rate is around 0.6% only.

Stent Strut Cross-Section:



"No Stent" again – But not back to square one

As the polymer is one of the main components leads to chronic inflammation and delay re-endothelialization, new generation of DES with bioresorbable polymer or polymer-free platform have been developed. As a result, the beneficial effect of BMS with shorter DAPT will probably be replaced by a new generation DES, BioFreedom™ (by Biosensors International Ltd), which is a polymer free stent that supposed to be safe with only 1 month of DAPT[5]. Compared to BMS, it provides additional protection from restenosis without the need of prolonged DAPT.

Bioresorbable vascular scaffold (BVS)

The principle benefit of stenting is to reduce the risk of restenosis after balloon angioplasty; however, restenosis is uncommonly seen 9 to 12 months after the procedure. As a result, the clinical need for stent scaffolding after this period is likely limited. And this is the concept of invention of the bioresorbable scaffold.

Bioresorbable vascular scaffold. ABSORB-type BVS platform structure. BVS: bioresorbable vascular scaffold.

BVS (by Abbott Vascular Corporation) is a DES made of a bioresorbable polymer (poly-L-lactic acid, PLLA), which will dissolve into water and CO_2 within few months. After delivering the drug, the stent strut will be fully metabolized and naturally absorbed without leaving any permanent metallic implant. It is theoretically beneficial as the stented segment can respond to ischemia as its vasomotor and endothelial function is regained and returns to normal. And potentially there is no risk of late stent thrombosis. In case of bypass surgery is required in the future, there will be no metallic stent at the desired anastomotic site (**Table 1**).

Table 1| Advantage of resorbale coronary scaffold

No permanent scaffolding
Fully metabolized
Fully absorbed
No chronic inflammation
Decreased risk of stent thrombosis
Easier reintervention
No metal a site of possible future CABG anastomosis
No image interference with CT and MRI (noninvasive follow-up)

Despite of the excellent concepts of BVS in the initial trial, the latest ABSORB III trial showed an increased risk of major adverse cardiac events for the BVS based on review of two-year data[6].

And according to a 2016 meta-analysis that included six randomized trials and six observational studies that directly compared BVS with metallic DES found a higher risk of stent thrombosis with the BVS implantation (OR 2.17, 95% CI 1.25-3.77)[7].

Metallic Absorbable Scaffolds

The latest advance of stent development is the absorbable scaffolds with metal alloys. Magmaris™ from Biotronik is a DES made of both resorbable Magnesium scaffold and PLLA polymer. Around 95% of Magnesium is resorbed at 12 months and with more rapid endothelial coverage compared to previous BVS. The landmark BIOSOLVE-II study showed favorable 0% scaffold thrombosis rate at 12 months and 80% of the patient showed stable vasomotion at 6 and 12 months[8]. Latest trial further confirms the promising outcomes up to 24 months[9]. Although longer term result is still pending, but this could definitely lead to a new era of stent use in PCI.

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Sodium-Glucose Cotransporter 2 Inhibitors for Type 2 Diabetes Mellitus Management:

Type 2 diabetes mellitus (T2DM) could lead to long-term complications including stroke, cardiovascular diseases, diabetic retinopathy, neuropathy and nephropathy. In Hong Kong, the prevalence of diabetes mellitus has raised from 4.5% in 1990's to around 10% in recent years. The disease burden brought to the society must not be overlooked.

*The classic hypoglycaemic agents target to increase insulin secretion, reduce insulin resistance, limit glucagon release, slow carbohydrate digestion and/or supply exogenous insulin. Despite the efficacy to lower glucose level, these medications are associated with adverse effects such as weight gain and hypoglycemia. The emergence of sodium-glucose cotransporter 2 (SGLT2) inhibitors, a novel class of anti-diabetic drug which acts by increasing glucose excretion by the kidneys, allows a new option in management of T2DM. There are three SGLT2 inhibitors currently available in Hong Kong, namely dapagliflozin (Forxiga®), canagliflozin (Invokana®) and empagliflozin (Jardiance®) (**Table 1**). In this article, their characteristics, clinical benefits and precautions will be discussed.*

SGLT2 Inhibition

In a healthy adult, approximately 180 gram of glucose is filtered from the glomerulus per day, with 90% of them reabsorbed into the circulation by SGLT2 in the proximal tubule and the remaining 10% by SGLT1. Up-regulation of SGLT2 is observed in T2DM patients. The increased glucose reabsorption leads to circulating glucose level greater than the physiological need, resulting in prolonged hyperglycemia.

By inhibiting SGLT2, reabsorption of glucose is reduced and glycosuria results (**Figure 1**). Reduction in circulating glucose could confer to net calorie loss and thereby, weight loss. Moreover, the increased renal glucose excretion is accompanied by sodium excretion. Thus, systolic blood pressure can be lowered to a certain extent.

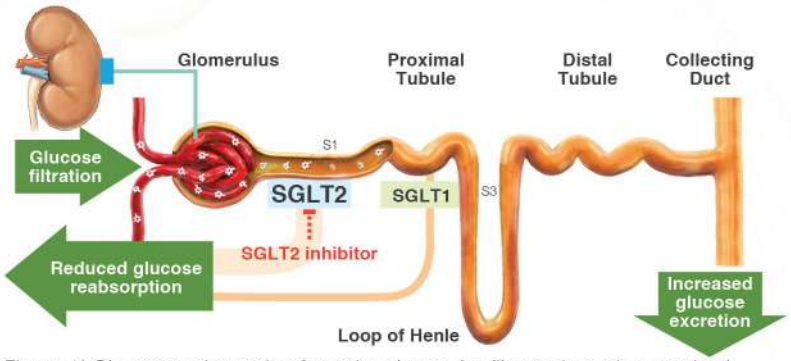

Figure 1| Glucose reabsorption from the glomerular filtrate through a proximal tubule epithelial cell into the blood (Adapted from US FDA).

Drug Name and Available Strengths at SPH	Dapagliflozin 10mg	Canagliflozin 100mg, 300mg	Empagliflozin 10mg, 25mg
Indication	Treatment of type 2 diabetes mellitus (non-insulin dependent, NIDDM) as an adjunct to diet and exercise to improve glycaemic control		
Dose	Initial dose: 10mg daily	Initial dose: 100mg daily, up to 300mg daily	Initial dose: 10mg daily, up to 25mg daily Note: Jardiance should not be initiated in patients with eGFR <60 ml/min.
Renal Impairment	• eGFR <60ml/min: Not recommended by manufacturer	• eGFR 45-59 ml/min: ≤100mg daily • eGFR <45ml/min: Not recommended by manufacturer	• eGFR <45ml/min: Not recommended by manufacturer
Hepatic Impairment	• Severe hepatic impairment: Start with 5mg daily	• Severe hepatic impairment: Not recommended by manufacturer	• Severe hepatic impairment: Not recommended by manufacturer
Administration	Can be taken any time of the day, with or without food	Taken orally before the first meal of the day	Taken in the morning , with or without food
Hypoglycemia Risk	Monotherapy: <4% Use with a SU: 2%-6% Use with insulin: 40%	Monotherapy: 3%-4% Use with metformin and a SU: 27-30% Use with insulin: 48-49%	Use with metformin and a SU: 12%-16% Use with insulin: 28%
Adverse Effects (frequency)	Fungal vaginosis (7%-8%) Nasopharyngitis (7%) Urinary tract infection (6%)	Hyperkalemia (1-27%) Genitourinary infection (female: 10%- 11%; male: 4%) Urinary tract infection (6%) Polyuria (5%)	Urinary tract infection (females: 18%; males: 4%) Increased LDL cholesterol (5%-7%)

Table 1| SGLT2 Inhibitors available in SPH

SU: sulphonylurea. Hypoglycemia risks data and adverse effects listed above are not exhaustive. Please refer to individual package inserts or other references for more information.

Place in Therapy and Clinical Considerations

SGLT2 inhibitors, unlike the other hypoglycaemic agents, act independently of insulin. The efficacy and safety have been evaluated as monotherapy, combination or add-on therapy with metformin and/or other hypoglycaemic agents. From short- and mid-term data of the trials, SGLT2 inhibitors were associated with a 0.66% reduction in HbA1c and had glycaemic efficacy similar to that of dipeptidyl peptidase 4 inhibitors.

The use of SGLT2 inhibitors has been incorporated into American Diabetes Association, European Association for the Study of Diabetes (EASD) and other international guidelines and treatment algorithms. The guidelines recommend metformin remains the mainstay and first-line agent for the pharmacological management of T2DM. SGLT2 inhibitors could be considered as second-line or third line agent if HbA1c target cannot be achieved after three months of monotherapy or dual therapy. In refractory patients, i.e. inadequate control with three months of triple therapy or combination injectable therapy, SGLT2 inhibitors can be considered as add-on therapy for more stringent glycaemic control.

Despite the above recommendations, other clinical considerations should be taken into account. As the mechanism of action of SGLT2 inhibitors is dependent on the kidneys, they are less efficacious if eGFR is less than 45–60mL/min/1.73m^2. However, deterioration of renal function is common as T2DM progresses, limiting the role of SGLT2 inhibitors. Moreover, recently released FDA Drug Safety Communication reported cases of acute kidney injury with canagliflozin or dapagliflozin use. Discontinuation of the drug was necessary and some cases required hospitalization and dialysis. In addition, the drug's diuresis action could lead to dehydration and hypotension, with increased risks in elderly, patients taking diuretics or other antihypertensive medications.

From March 2013 through October 2014, 19 cases of life-threatening urosepsis and pyelonephritis, which patients required hospitalization or ICU care, were reported. Seventy three cases of euglycaemic diabetic ketoacidosis (DKA), i.e. ketoacidosis with plasma glucose <250 mg/dL, have also been reported during March 2013 to May 2015. These two safety concerns resulted in the addition of *Warnings and Precautions* in SGLT2 inhibitor labels. Physicians should be alert of predispositions to DKA, including pancreatic insulin deficiency, caloric restriction, alcohol abuse, and acute illness (e.g. UTI, urosepsis, gastroenteritis, influenza, or trauma). If DKA is evident, SGLT2 inhibitors should be discontinued accordingly.

Furthermore, increased risk of bone fracture has been reported in post-marketing surveillance of canagliflozin. The interim analysis of *Canagliflozin Cardiovascular Assessment Study (CANVAS)* clinical trial revealed that the risk of leg and foot amputations with canagliflozin was twice as often than with placebo. Monitoring of any new pain, tenderness, sores, ulcers, or infections in legs or feet with the use of SGLT2 inhibitors is highly warranted.

Cardiovascular Safety Profile

Among the three SGLT2 inhibitors in the market, empagliflozin is associated with lower rates of death from cardiovascular causes (3.7% vs 5.9% in the placebo group; 38% relative risk reduction) and hospitalization for heart failure (2.7% vs 4.1% in the placebo group; 35% relative risk reduction). However, due to limited data, the relationship of the cardiovascular benefits as a class effect is yet to be evaluated and the results of long-term cardiovascular safety trials are awaited.

SGLT2 inhibitors are characterized for having intermediate efficacy, a low risk for hypoglycemia, benefit of weight loss and modest systolic blood pressure reduction. Yet, SGLT2 inhibitors are considered as third-line agents in treatment of T2DM due to the limitations associated with patient's renal function, the potential adverse effects and the lack of long-term evidence. Further evaluation on efficacy, safety and role in T2DM management should be conducted when results of the ongoing trials are available.

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Pharmaceutical Update

After Drug and Therapeutics Committee (DTC) Meeting in March 2017, the following new drugs are approved:

Approved drugs	Indication(s)	Usual dosage	Note
Fresubin 2kcal Drink	For the dietary management of patients with or at risk of malnutrition, in particular those with increased energy and protein needs or fluid restrictions.	As per patient's nutritional status	This is a high energy density (2kcal/mL) and protein nutritional drink which is clinically free from lactose and gluten. Order on request.
Fresubin Jucy Drink (orange/apple)	For the dietary management of patients with or at risk of malnutrition, in particular for those with fat malabsorption and/or increased energy needs.	As per patient's nutritional status	This is a juicy-style high caloric (1.5kcal/mL) and 100% whey protein nutritional drink, which is fat and fiber free and clinically free from lactose and gluten. Order on request.
Brilinta 60mg tablet	To be administered with aspirin for a maximum of three years, for the prevention of atherothrombotic events in adult patients with a history of myocardial infarction of at least one year and a high risk of developing an atherothrombotic event	60mg twice daily	-

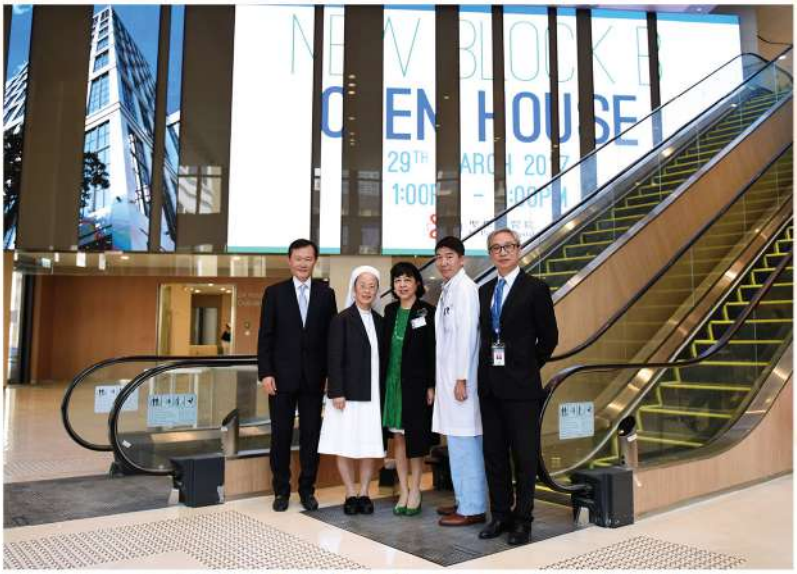
INTRODUCTION Of New Faces

Hi everyone, I'm Cheung Chi Yeung, Dick. It's my great honor to join the family of St. Paul's Hospital as a Consultant Cardiologist. I started my cardiology training in North District Hospital and completed my fellowship in Pamela Youde Nethersole Eastern Hospital in 2006. I had my further overseas training in Intervention Cardiology in Monash Medical Centre, Australia in 2009. My main focus is on percutaneous coronary intervention (PCI), especially complex coronary intervention and primary PCI for AMI. Besides, I am also interested in various cardiac or vascular interventions like pacemaker or ICD implantation and carotid stenting. I wish I can serve my patients with what I have learned, and hope to work with all of you in St. Paul's Hospital with great satisfaction.

Dr. Cheung Chi Yeung
Specialist in Cardiology

Dr. Yuen Ho Chuen
Specialist in Cardiology

Hello, I am Yuen Ho Chuen Johnny, a new Consultant Cardiologist in St. Paul's Hospital. I am so glad to join this big family and begin my new page of life. Prior to the present appointment, I was the associate consultant in Department of Medicine in Princess Margaret Hospital. I graduated from the University of Hong Kong in 2003 and obtained my fellowship in Cardiology in 2010. My major practice is focused on percutaneous coronary intervention, cardiac pacing and catheter ablation. I received my overseas training in Korea University Medical Centre for catheter ablation for arrhythmia. I am currently the honorary secretary of Hong Kong Inter-Hospital Network of Pacing and Cardiac Electrophysiology (HKINPACE) which aims at promoting awareness of arrhythmia in Hong Kong. I am looking forward to challenges ahead and I will try my best to serve my patients and colleagues in St. Paul's Hospital.



新B座大樓開放日

聖保祿醫院新B座大樓已於四月十五日正式啟用，為增加對新大樓的了解，醫院特地於三月二十九日舉行開放日，邀請了各修女、醫院顧問、駐院及訪院醫生到訪；並開放部分樓層，包括內鏡中心、手術室及部分高層病房供參觀及安排醫護人員講解新設施。新大樓環境寬敞舒適，各參觀者均期待其啟用能為病人提供更優質醫護服務。




二零一七年國際護士節

為表揚一眾為社會及醫院服務的護士，國際間將每年五月十二日訂為「國際護士節」。今年的護士節，張柱見修女、Sr. Pauline NGUYEN、李業鴻先生及羅沛欽先生到各層病房為護士們送上精美文具作為小禮品，感謝他們一年來的辛勞，不辭勞苦為病人提供護理服務。

我們感謝每位前線護理人員一直堅守崗位，他們都有一顆溫柔善良的心，無微不至的照顧每位病人。祝願所有護理人員「國際護士節」快樂！身體健康！


職安健及員工健康日

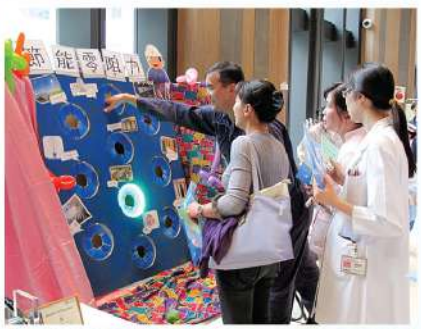
聖保祿醫院一向重視員工的安全和健康，為此，職安健委員會定期舉辦宣傳和教育活動，推廣工作場所的職安健，今年舉辦的職安健及員工健康日已於二零一七年三月九日假B座新大樓順利完成。當日攤位活動由部門同事精心設計，包括放射部、物業(設施)管理部、病理化驗部、藥劑部、復康中心及人力資源部，各攤位設於不同樓層，讓同事可以參觀大樓之餘，亦可透過趣味遊戲，學習職安健和環保知識。

活動開始之前，先進行了一項熱身遊戲，令現場氣氛熾熱。在一輪激烈比賽之後，攤位遊戲於十一時半正式開始，整天活動共吸引了約四百名職員參與。

職安健委員會亦藉此機會向一直支持職安健工作的部門代表頒贈感謝狀，以表揚他們對本院職安健作出的貢獻。

活動得以順利完成，除了多謝贊助商外，實在有懶同事的精心策劃和籌備，感謝他們在繁忙工作之餘抽空協助，當然，還要多謝你的參與！期望大家可以繼續為醫院的職安健盡一分力，多謝大家！

向一直支持職安健工作的部門代表頒贈感謝狀，以表揚他們對本院職安健作出的貢獻。



各攤位設於不同樓層，讓同事可以參觀大樓之餘，亦可透過趣味遊戲，學習職安健和環保知識。

祝聖禮
新B座大樓

二零一七年三月十八日，聖保祿醫院為即將啟用的新大樓舉行祝聖禮。祝聖儀式首先由沙爾德聖保祿女修會省會長張月娥修女向現場來賓致歡迎詞，張修女表示醫院由一所棉花廠演變成今天設備先進完善的醫院，是經過很多不同時期的人努力所得的成果，感謝一直支持及陪伴著聖保祿醫院成長的所有人。

眾人在閻德龍神父帶領下，連同其他十位主禮神父，為教會、修會、醫院全體職員及病人祈禱，祈求病人有足夠力量和忍耐去戰勝病魔，於離開醫院時都能獲得身心健康。

各神父於修女及醫護人員陪同下分別到新大樓不同樓層灑聖水祝聖，祝願醫護人員獲恩賜聖寵，有健康的身體能以恒心不懈的愛德照顧病患。整個祝聖禮結束後，各人一同享用美味的午餐。

各神父於修女及醫護人員陪同下分別到新大樓不同樓層灑聖水祝聖。

CME ANNOUNCEMENT

聖保祿醫院 St. Paul's Hospital

CME/CPD/CNE Programme 2017

Advanced Gastrointestinal Endoscopy

Speakers: **Dr. Cheung Sai Wah**
Specialist in Gastroenterology and Hepatology

Dr. Lee Yuk Tong
Honorary Consultant in Gastroenterology and Hepatology, St. Paul's Hospital

Chairman: **Dr. Lok Ka Ho**
Head of Endoscopy Centre, Staff Consultant in Gastroenterology & Hepatology, St. Paul's Hospital

Date: **11 July 2017 (Tuesday)**

Time:

7:00 pm – 7:15 pm	Reception (light refreshment provided)
7:15 pm – 8:00 pm	"The Black Hole in GI Endoscopy- Small Bowel Enteroscopy" by Dr. Cheung Sai Wah
8:00 pm – 8:45 pm	"Endoscopic Investigation of Pancreatic Mass Lesion" by Dr. Lee Yuk Tong
8:45 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
Tel: 2830 8857, Fax: 2837 5271,
E-mail: sph.sdd@mail.stpaul.org.hk

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

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Personal Particulars

Name of Physician: (IN FULL NAME)

English: _____ Chinese: _____ Physician Code: _____

Correspondence (Please write down changed items only)

Address: _____

Phone: _____ Pager: _____ Mobile: _____

Fax: _____ Email: _____ Effective Date: _____

Others: _____

Signature: _____

Please return the completed form by
1) Fax: 2837 5241 2) Email: vmo@stpaul.org.hk
3) Post: 2 Eastern Hospital Road, Causeway Bay, Hong Kong (Attn: Hospital Management Department)

Thank you!