VOL.13 NO.7 JULY 2008

香港醫訊
THE HONG KONG MEDICAL DIARY

OFFICIAL PUBLICATION FOR THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG

www.fmshk.org

ISSN 1812 - 1691

醫聯成員一家親 · 市民健康齊關心

SKINCEUTICALS PREVENT

WHY USE SKINCEUTICALS TOPICAL VITAMIN C ANTIOXIDANT SERUMS?

Aging skin is the result of more than just years on the calendar, Exposure to environmental elements causes photoaging in skin, leading to the formation of lines, wrinkles, discoloration, and for more - even serious conditions like skin cancer. SkinCeuticals has developed a full menu of super-antioxidant formulas for all skin types including C E Ferulic and AOX+ advanced antioxidant technology serums - designed to improve even the most environmentally challenged skin.

SKINCEUTICALS

Contents

Published by
The Federation of Medical Societies of Hong Kong

Design and Production
A-PRO MULTIMEDIA www.apro.com.hk

Editorial

Dr. Walter WK King

Editor

Dr. Walter WK King

In this July issue of the Hong Kong Medical Diary, various authors have contributed updates and advances in the field of Plastic & Reconstructive & Aesthetic Surgery. Demand for these surgeries is continuing to rise largely due to an increase in patients' expectations and requests to look and feel at their best after being set back by birth defects, accidents, injuries, diseases, cancer, surgery, ageing or simply significant deviation of their appearances from the norm. The demand for Plastic Surgery has also been facilitated by easy access to qualified Plastic Surgeons who work to provide Plastic Surgery that is cost effective, minimal invasive, low risk and durable.

Dr. Andrew Burd's article on Plastic Reconstructive and Aesthetic Surgery serves to point out that Plastic Surgeons are well trained to serve different needs arising from different sectors, i.e. the fee for service private sector and the tax payer subsidized public (Hospital Authority) sector. It is not surprising that simple, low risk cosmetic surgery are more likely to be done in the private sector, while complex and very expansive reconstructive surgery are done more readily in the public sector where manpower and resources are more easily coordinated and organized; although all plastic surgeons in Hong Kong are well-experienced in reconstructive as well as cosmetic surgery. Dr. Otto Au presented his valuable experience in improving the short noses of Asians. His surgical approach epitomizes the crux of plastic surgery, i.e the application of fine surgical technique with knowledge of anatomy, physiology and wound healing such that repaired or reconstructed tissues can heal with minimal scarring. Dr. Kenneth Hui emphasizes in his article on Body Contouring by Liposculpture that liposuction is one of the earliest minimal invasive "keyhole" surgery that can safely sculpture the whole body. In a separate article on Concepts in Classical Abdominoplasty, Dr. Daniel Lee and Dr. Victor Noronha argue that in well selected patients, aggressive surgery with skin and fat excision by abdominoplasty usually produces the most body slimming effect. Dr. King gave an update on the use of silicone gel implants for breast augmentation & reconstruction. Last but not least, Dr. Peter Pang reviewd the management of skin cancer which is timely as early detection and treatment by surgery usually results in cure for both basal cell and squamous cell cancer.

Hong Kong International
Medical & Health Care Fair

HONG KONG INTERNATIONAL Medical & Health Care Fair 香港國際醫療及保健服務展

14-18/8/2008

Hong Kong Convention and Exhibition Centre

www.hkmedicalhealthcarefair.com

- Over 6,700 trade visitors attended the 2007 fair
- Over 110 exhibitors from 20 countries & regions at last year's event
- Take advantage of our Public Forum presented by industry experts
- Held concurrently with HKTDC International Conference & Exhibition of the Modernization of Chinese Medicine & Health Products 2008, HKTDC Food Expo 2008 and HKTDC Hong Kong International Wine Fair 2008

Major Exhibits

- Health Care and Personal Care Products
- Medical and Health Care Equipment
- Medical and Health Care Services (Hospital Service, Dental Care Service, Elderly Care Service, Health Check Service, Health Insurance, Physiotherapy)
- Research, Development and Applications
- Other Medical and Health Care Related Services

Organisers:

HKTDC 香港貿發局

Hong Kong Trade Development Council - Exhibitions Department
Unit 13, Expo Galleria, Hong Kong Convention and Exhibition Centre,
1 Expo Drive, Wanchai, Hong Kong
Tel: (852) 2584 4333 Fax: (852) 2824 0026
E-mail: exhibitions@tdc.org.hk
Website: www.hktdc.com/hktradefairs

CP EXHIBITION CHINA PROMOTION LTD. 華進

China Promotion Ltd
Room 1703, Tung Wai Commercial Building,
109 Gloucester Road, Wanchai, Hong Kong
Tel: (852) 2511 7427 Fax: (852) 2511 9692
E-mail: cp@cpexhibition.com
Website: www.cpexhibition.com

Register Today!
Don't miss the opportunity to pre-register online – before 23 July 2008 for buyers from outside Hong Kong and before 7 August 2008 for local buyers – to receive your **free admission badge** by mail.

Concepts in Classical Abdominoplasty: Radical Surgery is More and Better

Dr. Daniel Lee
MBBS (HK) 1979, FRCS (EDIN) 1985, FCSHK 1990, FHKAM (SURGERY) 1993
Specialist in Plastic Surgery

Dr. Victor Noronha
MBBS (UNSW) 1995, FRCS(EDIN) 1998, FCSHK 1998, FHKAM (SURGERY) 2002
Specialist in Plastic Surgery


Dr. Daniel Lee Dr. Victor Noronha

This article is a concise discussion of abdominoplasty which involves the excision of redundant skin (dermolipectomy), suction-assisted lipectomy (SAL), repair of diastasis of rectus abdominus (RA) and transposition of umbilicus (umbilicoplasty). Patient selection, possible complications and post-operative care will also be briefly outlined.

History of Abdominoplasty

The history of abdominoplasty dates back to 1899 where a horizontal mid-abdominal incision was described by Kelly.[1] In the next few decades different techniques have evolved to cater for different patients' individualised requirements.[2, 3]

Many different techniques vary in their design and extent in skin excision. Despite the big number of techniques, the lower abdominal skin incision approach has become most popular.[3] Indeed the increasing popularity of SAL since the 1980's has contributed a great deal to body-contouring techniques and the typical abdominoplasty package. Nonetheless some authorities maintain that SAL should not be done in conjunction with abdominoplasty.[4]

The other reason for the numerous techniques that have been developed may stem from the strive towards being "minimally invasive". Today minimally invasive is chic and almost the universal norm. Indeed many variations of abdominoplasty have evolved and these include mini-abdominoplasty[5, 6] and even endoscopic abdominoplasty[7]. However these techniques cannot address the patient with more severe laxity of the abdominal skin together with other associated complaints.

Surgical Anatomy and Pathology

The **musculature** of the abdominal wall comprises of the paired RA. These are each enclosed in a fascial sheath and are joined in the midline at the linea alba which is a condensation of anterior and posterior rectus sheaths and also the aponeurosis of the oblique muscles. The RA runs from the medial aspect of the costal margins to the pubis. The lateral aspect of the abdominal wall musculature comprises of the external oblique, the internal oblique and the transversalis abdominus.

The **vascular supply** of the abdominal wall is conveniently divided into 3 zones, namely the epigastric, the lower abdominal and lateral. The epigastric zone is supplied by the deep superior epigastric artery, the lower abdominal zone by the external iliac arteries and the lateral abdominal zone by the intercostal and lumbar arteries. The venous drainage of the abdominal wall follows the arterial supply.[8, 9]

The term "ventral hernia" has often been incorrectly used to denote the separation of the linea alba. The pathology is not a true hernia.[9] The correct term to use is **diastasis of the RA** which represents weakness of the linea alba and presents as a midline abdominal protrusion in between the paired RA.

During pregnancy or rapid gain in weight due to other reasons, substantial abdominal skin stretching can occur. In areas where the dermis is broken, striae are observed. Subsequently post-partum or after weight loss, the abdominal skin becomes lax with loss of elasticity.

Preoperative Assessment and Caution

The indications of classical abdominoplasty are typically a combination of redundant abdominal skin with laxity, abdominal lipodystrophy, diastasis of the muscular system in a lady with a history of multi-parity (Fig. 1, 2, 3 and 4). Type I denotes an abdomen with isolated lipodystrophy. Type II deformity has mild skin laxity and lipodystrophy in the lower abdomen with diastasis of the (RA). Type III denotes significant skin laxity with lipodystrophy and often the presence of striae in the lower abdomen in the presence of diastasis of the RA. Type IV deformity has severe skin laxity and lipodystrophy in the upper and lower abdomen with significant diastasis of the RA.[9,10] These patients are often mildly to moderately obese with the umbilicus located below the iliac crest.

Patients with type III and IV severity are ideal candidates for classical abdominoplasty. Fig 1 shows a patient with marked droopy skin on a protruding abdomen, simulating an abdomen of a lady who is 4 to 5 months pregnant.

Assessment is an important aspect in planning surgery. Striae may be observed especially in the lower abdominal skin. A pinch test determines the thickness of skin and subcutaneous fat to determine the extent of SAL necessary.[9] Note if the umbilicus is centred or deviated and if there is an associated umbilical hernia. The presence of fullness and rolls in the flank regions should be determined. Previous abdominal surgery and related scars must be sought since they may compromise the abdominal flap in abdominoplasty. The contour of the abdomen during relaxation and Valsalva's manoeuvre should be compared. The patient should be made aware of all these findings.

Figure 1. Pre-operative picture of subject A, anterior view

Figure 2. Pre-operative picture of subject A, lateral view

Figure 5. Post-operative picture of subject A, anterior view

Figure 6. Post-operative picture of subject A, lateral view

Figure 4. Pre-operative picture of subject B, lateral view

Figure 3. Pre-operative picture of subject B, anterior view, showing wrinkled and saggy skin in the peri-umbilical and lower abdominal region

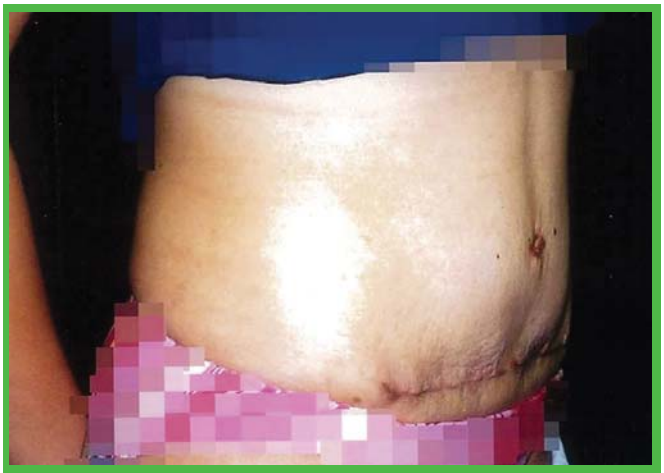


Figure 7. Post-operative picture of subject B, lateral view, at 2 months post-operatively

Figure 8. Post-operative picture of subject B, anterior view, at 9 months post-operatively

The patient is then asked to lie down and assume a leg-lift posture. This manoeuvre will contract her RA and also raise her intra-abdominal pressure. Diastasis of the RA may now be appreciated. One may insert fingers into the midline diastasis to convince the patient of this additional problem. One should pinch and pull as much lower abdominal skin as possible to get an idea of how much excessive skin needs to be excised without undue tension on subsequent closure.

Patient Expectation

If the patient is a potential candidate for abdominoplasty one should determine if she is ever going to be pregnant again and if she will be sensible enough postoperatively as not to binge drink or eat. The patient should be explained that abdominoplasty and SAL do not remove intra-abdominal fat and secondly the possibility that striae-bearing lower abdominal skin may not be totally excised. The implication of remaining striae is that the latter may widen further after abdominoplasty. The position and the resultant lengthy scar which may be pulled upwards should be discussed.[9] This is always facilitated by showing the patient post-operative abdominal pictures of other previous patients (Fig. 5, 6, 7 and 8). Patients with unrealistic goals and poor self-motivation should be screened out to avoid undergoing abdominoplasty.

Contraindications and Informed Consent

The absolute contraindications and precautions are listed in tables 1 and 2.

Table 1

Absolute Contraindications
Significant cardiovascular disease, significant pulmonary disease, bleeding diathesis

Table 2

Precautions
Obesity, aspirin, Chinese herbs, vitamin E, contraceptive pill, smokers, poor scar formers, allergy to Elastoplasts

The patient should be thoroughly explained the risks[11] of dermolipectomy, SAL, repair of diastasis of the RA and umbilicoplasty. Risks can be categorised[12, 13] into systemic and local complications as in tables 3 and 4. The overall risks of a general anaesthesia should also be mentioned. An important point to discuss is that pulmonary function like vital capacity may temporarily decrease after diastasis of RA is repaired and the abdominal skin is tightened.

Table 3

Systemic Complications
Temporary decreased vital capacity, deep vein thrombosis, pulmonary embolism, fat embolism, massive fluid shifts, lidocaine toxicity

Table 4

Local Complications
Haematoma, seroma, wound infection, wound dehiscence, contour irregularities, skin flap necrosis, umbilical deviation, umbilical necrosis, dog-ears, temporary decreased sensation of the abdominal skin, recurrence of diastasis of RA

The patient should be fully explained that abdominoplasty is not a weight-losing[14] but a body-contouring procedure. Secondly the fact that abdominoplasty and SAL are not a substitute to dieting and exercise should be emphasised. Lastly the infrequent possibility of secondary surgery to revise scars and SAL to improve contouring should also be explained.[9] Thorough pre-operative discussion with the patient is the key to prevent post-operative disagreement and disharmony.

Surgical Procedure

Skin marking of the costal margins, areas for SAL and the tentative elliptical dermolipectomy in the abdomen is performed while the patient stands. The abdominal aesthetic units consist of the upper abdomen, flanks, umbilicus, lower abdomen and the mons.

The **surgical plan** follows the sequence of markings, flap-raising to the umbilicus, SAL, flap-raising to the costal margins, dermolipectomy, repair of diastasis of RA, umbilicoplasty and lastly wound closure.

Incision is made in the lower curvature in the abdomen all the way through the Scarpa's fascia (Fig. 9) to just short of the rectus sheath, preserving a flimsy membranous layer of Gallaudet's fascia above the rectus sheath. Preservation of this Gallaudet's fascia helps to minimise seroma formation. The abdominal skin flap is raised superiorly to the level of the umbilicus with diathermy knife. The major abdominal arterial perforators are carefully identified and ligated. The native umbilicus is dissected with preservation of its neurovascular stalk. Before raising the abdominal flap further, one should then proceed to tumescent SAL of the focal areas of lipodystrophy of the abdomen.[15]

Figure 9. Cadaveric dissection demonstrating Scarpa's fascia

Superficial **SAL** should be done in the upper abdomen whereas extensive SAL is performed in the flanks. SAL of the mons should also be done judiciously. This minimises differential wound thickness on subsequent seamless wound closure. After SAL, the pre-marked lower abdominal skin flap is excised.

Thereafter the abdominal flap is raised further with diathermy knife all the way to the xiphisternum with preservation of the Scarpa's fascia especially in the lateral region of the abdomen. This preserves blood supply and lymphatic drainage of the flap. Only raising the

abdominal flap to the xiphisternum and costal margins affords full assessment and **proper repair of the entire diastasis of RA** (Fig 10).

The medial edges of the diastased RA should be marked before repair. The widest of the diastased RA is usually at or near the level of the umbilicus. The diastased RA is repaired in 2 layers with strong nylon from xiphisternum to pubis. Care should be exercised to avoid strangulating the umbilical stalk. After the repair, the entire abdominal aponeurotic musculature is visually and palpably firm. The width of the waistline is also reduced.

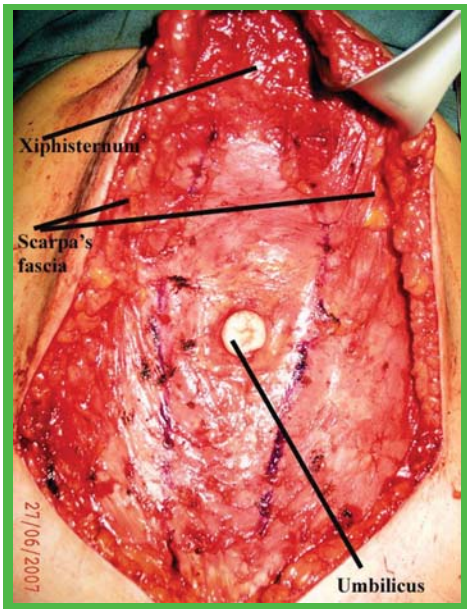


Figure 10. Intra-operative picture, showing medial edges of diastased RA, which has been marked

Before proceeding to **umbilicoplasty** and wound closure, the operating table should break to about 20 degrees to flex the trunk of the patient. This facilitates closure of the wound without tension. A simple 2 cm transverse or V-shaped slit is made for transposition of the native umbilicus to the new opening. The final suturing of the umbilicoplasty is completed in 2 layers.

Wound haemostasis and irrigation with antibiotic solution precede **wound closure**. A size 10 drain is inserted. The wound closure is done in 3 layers, paying careful attention to the approximation of the upper and lower wound edges. An option is to close the superficial fascia with 4O absorbables, the deep dermis with 4O absorbables and the skin with 5O subcuticular continuous monofilament, preferably colourless. The lateral ends of the wound should be trimmed, extended or contoured with SAL in order to avoid unsightly dog-ears. An inverted T closure should be avoided.

Postoperative Care

The wound is dressed and the entire abdomen is taped to minimise bleeding, seroma formation and post-operative swelling. Adequate analgesia is provided and prophylactic antibiotics are continued for 5 days. The patient is encouraged to ambulate the next day. The drain is usually removed within a week after surgery when the output is under 30cc per 24 hours.

The patient is instructed to use their hands to guard and support their abdomen when they get in and out of bed, and during coughing. This manoeuvre minimises stress to the repaired RA and reduces post-operative pain. A pressure garment is worn for comfort and support for 2 to 3 weeks.

Discussion

Many a time a patient with a slack tummy (diastasis of RA) may deliberately simulate a firmer abdomen by contracting the abdominal musculature voluntarily.This conscious effort is very tiring. In the old days, one solution was to wear a corset. Today after an abdominoplasty procedure, a good contour of the abdomen can be attained even when the patient is fully relaxed without the slightest effort.

In some aesthetic surgeries like Asian blepharoplasty and facial contouring, there is a move towards lesser surgery for greater aesthetic improvements. However good results can only be achieved with radical abdominoplasty for types III and IV severities.

The combination of SAL, dermolipectomy and repair of diastasis of RA all require careful preoperative evaluation and planning.[16, 17] Vessel and lymphatic conserving dissection with minimal undermining and preservation of the Scarpa's fascia in the upper and lateral abdomen is the key to avoid flap necrosis. SAL should be extensive but selective in the upper abdomen. Diastasis of the RA is repaired radically from the xiphisternum to pubis. The avoidance of excessive skin tension with multiple layer closure minimises skin wound complication and reduces scar formation. All these factors will contribute to and augment the overall aesthetic contour of the abdomen.

References

1. Kelly HA: Report of gynecological cases. John Hopkins Med J 1899; 10: 197
2. Pitanguy I: Abdominal dermolipectomy: An approach to it through an analysis of 300 consecutive cases. Plast Reconstr 1967; 40: 384
3. Regnault P: Abdominoplasty by the W technique. Plast Reconstr Surg 1975; 55: 265
4. Lucus AA, Hunstad JP, Saltz R, Toledo LS: Issues in abdominoplasty. Aesth Surg J 2000; 20: 403
5. Matarasso A: Minimal-access variations in abdominoplasty. Ann Plast Surg 1995; 34:255
6. Greminger RF: The mini-abdominoplasty. Plast Reconstr Surg 1987; 79: 356
7. Lockwood TE: Rectus muscle diastasis in males: primary indication for endoscopically assisted abdominoplasty. Plast Reconst Surg. 1998; 101: 1685
8. Markman B, Barton FE Jr: Anatomy of the subcutaneous tissue of the trunk and lower extremity. Plast Reconstr Surg 1987; 80: 248
9. Mathes SJ: Plastic Surgery. Vol VI; 121: 87
10. Bozola AR, Psillakis JM; Abdominoplasty: a new classification for treatment. Plast Reconstr Surg. 1988; 82: 983
11. Khan UD: Risk of seroma with simultaneous liposuction and abdominoplasty and the role of progressive tension sutures. Aesth Plast Surg 2008; 32: 93
12. Huges CE: Reduction of lipoplasty risks and mortality: an ASAPS survey. Aesthetic Surg J 2001; 21: 120
13. Kim J. Stevenson TR. Abdominoplasty, Liposuction of the Flanks, and Obesity: Analyzing Risk Factors for Seroma Formation. Plast Reconstr Surg.
2006; 117: 773
14. Must A, Spandano J, Coakley EH, et al: The disease burden associated with overweight and obesity. JAMA 1999; 282: 1523
15. Metarasso A: Liposuction as an adjunct to a full abdominoplasty revisited. Plast Reconstr Surg 2000; 106: 1197
16. Matarasso A. Swift RW, Rankin M, Abdominoplasty and Abdominal Contour Surgery: A National Plastic Surgery Survey. Plast Reconstr Surg. 2006; 117: 1797
17. Pitanguy I: Evaluation of body contouring surgery today: a 30-year perspective. Plast Reconstr Surg 2000; 105: 1499

Wake Up Your Skin

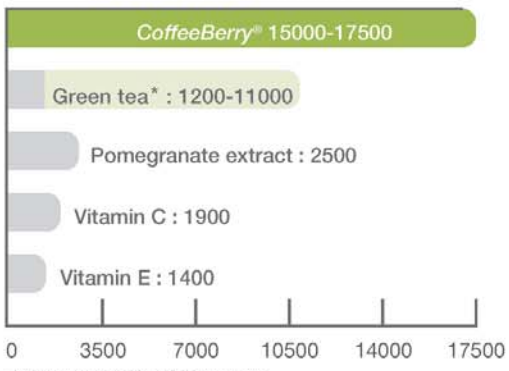
Introducing REVALÉSKIN™

Science meets nature in the only anti-aging skin care line formulated with *CoffeeBerry*®

Vitality — *CoffeeBerry*® is a naturally potent super-antioxidant

Rejuvenation — REVALÉSKIN™ with 1% *CoffeeBerry*® is clinically proven to reduce the signs of aging*

Exclusivity — REVALÉSKIN™ is available only through aesthetic physicians



*Includes commercially available green teas.

CoffeeBerry® is the uniquely potent, clinically proven ingredient found in Stiefel Laboratories' new professional anti-aging skin care line -REVALÉSKIN™.

ORAC - The Oxygen Radical Absorbance Capacity score is the US Dept of Agriculture-developed and -accepted scientific measure of antioxidant potency for naturally occurring sources and extracts.

The ORAC score of *CoffeeBerry*® is higher than the most popular natural antioxidants[1,2].

revaléskin™
Reveal the Younger You

To learn more about REVALÉSKIN™ please reach out to your local REVALÉSKIN™ representative, call + (852) 3718 6666 or 6072 3140

References: 1. VDF FutureCeuticals, Inc. Data on file. 2006. 2. McBride J. ORAC levels of some common foods. http://optimalhealth.cia.com.au/OracLevels.htm. Accessed April 9, 2007.

*In a blinded study, marked improvement was demonstrated in the appearance of fine lines/wrinkles, skin pigmentation, and texture (roughness/dryness) compared to vehicle control. (Data on file. *CoffeeBerry*® Clinical Report. January 2, 2007.)

STIEFEL®

Skin Cancer Management

Dr. Peter CW Pang

MBChB, FRCS(Ed), FHKAM(Surgery)
Specialist in Plastic Surgery

Dr. Peter CW Pang

This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded one CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 July 2008.

Introduction

Skin cancer is usually not a life threatening condition but yet causes disfigurement. There is compelling evidence that radiation damage to DNA is the cause of squamous cell carcinoma and perhaps basal cell carcinoma. Hence 95% of the skin cancers happen in the head, neck and hand area. Ablative surgery and reconstruction, radiotherapy or their combination are the common treatment modalities. Due to the compact nature of the face, reconstruction for form and function are necessary in order to optimise patients' quality of life after treatment. Factors dictating the degree of complexity of surgery are the lesion size, site, facial subunits involvement and if important organs are affected. Early identification of cancer and availability of reconstruction options are important for optimising the result.

Common Skin Cancers

The commonest skin cancer is Basal cell carcinoma (BCC). Squamous cell carcinoma (SCC) accounts for a quarter of BCC incidence. Melanoma is uncommon in the Chinese locality and yet the common occurrence of naevi in Chinese raises the concern in the pigmented lesions by patients. Careful examination and in depth explanation is necessary to alleviate patients' concern.

Basal Cell Carcinoma (BCC) Fig 1

BCC is the commonest malignant tumour of skin. It is a slow growing malignancy arising from the stratum basalis. It is also known as rodent ulcer or "mariner's disease in the 19th century. According to the Tasmanian Cancer Registry[1] in Australia, the incidence was 161/100,000 per year. Most of them occur between the ages of 40 to 80. 85% occurs in highly exposed area such as head and neck, back of hands, lower limbs in women and ears in men. Though it is thought to be a non-metastatic tumour, yet over 200 cases of metastatic BCC have been recorded.

BCCs are classified as localised, superficial or infiltrative types. Diagnosis can usually be made from the slow clinical course and the appearance of a pearl like pinkish lesion with telangiectasia at the periphery. In Chinese, pigmented BCC with the appearance of an ulcerative mass is a common presentation. Incisional biopsy is useful in case the definitive diagnosis is necessary when major reconstruction is anticipated.

Surgical excision with a 2 - 5mm margin is adequate. Lesions with indistinct margins require wider excision. For instance, BCC less than 1cm in diameter in a low risk area, a surgical margin of 4mm of normal skin gives 98% clearance[2]. For primary BCC excision, up to 30% of the specimen showed incomplete excision. When deep margin is involved, re-excision is advocated as the monitoring for recurrence is more difficult. Only 30% of the re-excision of incomplete excised tumour showed tumour. So this has to be discussed during the informed consent for re-excision. Mohs' surgery is useful in achieving histological control of excision margins using frozen section analysis. It is the treatment of choice for recurrent (previously treated) BCC[3], though it involves a longer surgery and on-site pathological margin examination. This is the safest way to preserve most of the surrounding tissues without compromising the margin. Lesions smaller than 1cm can be treated with superficial radiotherapy and the efficacy is comparable to surgery. Cryotherapy, curettage, and 5 fluro-uracil creams are used for multiple superficial lesions, which are more common in Caucasians.

Fig 1. Basal Cell Carcinoma

Squamous Cell Carcinoma (SCC) Fig 2

SCC originates from the stratum spinosum of the epidermis. Sun exposure is the most important environmental risk factor. It often occurs in an area of abnormal skin due to sun damage, keratin horn, and actinic keratosis. Face, scalp and dorsum of hands are the common involved areas. Clinical appearance depends on the degree of differentiation of the tumour. Well differentiated SCCs exhibit keratin horns while less well differentiated lesions are fresh and ulcerated. Incision biopsy is necessary if a definitive diagnosis is needed as differential diagnosis would include verruca vulgaris, actinic keratosis and Bowen's disease. Regional lymph nodes should be checked carefully and additional radiology studies are necessary if in doubt clinically.

SCCs are prone to local recurrence and metastasis. Well differentiated SCCs have a 7% risk of local recurrence while poorly differentiated lesions have a 28% risk of local recurrence rate. Overall occult lymph node metastasis at time of presentation is 2-3%.

Surgical excision with a margin of 0.5 to 1cm is recommended in most cases. Bad prognostic factors are increased depth of invasion, vascular, perineural and lymphocytic infiltration. Regional lymph node dissection is necessary when lymph node metastases are evident. Radiotherapy is used as an adjunct therapy when the lesion is greater than 2cm or histology shows perineural spread[4].

Patients should be followed up regularly to check for local and regional recurrence.

Fig 2. Squamous Cell Carcinoma

Melanoma Fig 3

Melanoma is the most deadly form of skin cancer, affecting 51400 Americans and killing more than 7800 in the year 2001. The incidence is doubled since 1970 and there is a high occurrence rate for Caucasians living in Queensland, Australia with the rate 1 in 14. The incidence of melanoma in Chinese remains low with 43 primary cutaneous melanomas during the 19-year period from 1964 to 1982[5]. There are pre-malignant conditions such as atypical naevus syndrome. Yet most melanomas occur in atypical naevus syndrome arise de novo instead from pre-existing moles. Therefore prophylactic removal of abnormal naevi does not improve survival.

The clinical types of melanoma in Caucasians include superficial spreading (60%), nodular (30%), arising from lentigo maligna (7%), Amelanotic (<1%) and Acral lentiginous (<2%). Chinese patients usually have acral lentiginous types with most of them arising on palms or soles or the subungual area. Clinical appearances for melanoma are Asymmetry (A) in diameter, irregular Border (B), irregular Colour (C) and Diameter (D) larger than 6mm.

The subsequent management and prognosis depend on the Breslow thickness. Other staging techniques such as Clark's level, TMN staging are less commonly employed. Differential diagnoses include acquired melanocytic naevi, dysplastic naevi, dermal melanocytoses, pigmented BCCs, pigmented actinic keratosis. The diagnostic confirmation is excisional biopsy with a margin of 2mm. This can confirm the diagnosis and assess the Breslow thickness. Incisional or shaving biopsy should not be performed in suspected melanomas as this will make the Breslow thickness assessment impossible.

Surgical excision[6] is the mainstay of treatment. The recommended excision is as in Table 1.

Prophylactic lymph node dissection for primary cutaneous melanoma of intermediate thickness (tumour 1-4mm thick) showed no survival benefit in prospective randomised clinical trials. Sentinel lymph node biopsy enhances metastatic staging for patients with intermediate-thickness or deeper primary melanomas and provides a more accurate determination of the patients' prognosis. Its therapeutic benefit has not yet been established.

Although chemotherapy is generally not effective for melanoma, it is used for symptom relief or survival extension in some stage IV patients. Immunotherapy drugs such as interferon alpha and interleukin 2 may be used in combination with chemotherapy. Radiation therapy is not commonly used to treat primary tumour of melanoma but may be considered as an adjuvant therapy in some patients and in recurrence conditions.

Fig 3. Melanoma

Table 1	
Breslow thickness	Excision margin
Melanoma in situ	Complete excision with margin of 5 - 10mm
<1mm	10mm
1-2mm	10mm - 20mm
>2mm	20mm

Reconstruction

Reconstruction after ablation surgery is crucial as its availability can allow uncompromised margin of excision of the tumour. The head and neck are common areas for the occurrence of skin tumours. The face in particular is compact in form and functions. Asymmetry and obvious scar after surgery will greatly affect the patients' satisfaction after surgery and hence options in reconstruction are necessary to provide the optional aesthetic results.

Options of reconstruction depend on the characteristics of the area to be treated. These are the number of aesthetic units involved, thickness of tissue to be reconstructed, the possibility of realignment of scar along the line of resting skin tension or the sym line of the facial aesthetic units. Methods of reconstruction ranges from primary closure, secondary healing, skin grafting, local flaps, pedicle flaps and distant flaps.

Small lesions over the forehead and cheek can generally be closed primarily along the line of resting skin tension with satisfactory results. Though defects less than 4mm diameter over the tip of the nose can be allowed to heal secondarily with good cosmetic result, post excision of tumours with adequate margins often renders local flaps such as bilobed flap[8]. Temporal area skin defects can be reconstructed with skin grafting. Commonly performed local flaps on the face include the rhomboid flap and advancement flap. The Mustarde flap[7] is useful in lower eyelid reconstruction. Complex full thickness reconstruction involving a large area such as the whole cheek needs flaps. Commonly used local pedicle flaps are the temporalis flap and buccal cheek flap. Free flaps depend on the bulk of tissues required. The free radial forearm flap is still the work horse for thin tissue coverage while the anterolateral thigh flap is useful for bigger tissue coverage.

Conclusion

Skin lesions are common complaints during consultation and skin cancer should be considered as one of the differential diagnoses. BCCs and SCCs are the commonest skin tumours. Though they are usually not devastating to life, yet late treatment will cause more morbidity to the patients' appearance and various reconstruction methods would help in optimising the aesthetic results.

References

1. Non-melanoma skin cancer: ten years of cancer-registry-based surveillance. Int J Cancer 1993 Jul 9;54(5):887
2. Surgical margins for basal cell carcinoma. Wolf DJ Zitelli JA. Arch Dermatol 1987;123:387-94
3. Mohs surgery is the treatment of choice for recurrent (previously treated) basal cell carcinoma. Rowe DE, Carroll RJ, Day CD. J Dermatol Surg Oncol 1989;15:424-31
4. Squamous cell carcinoma of skin with perineural invasion. Cottel LN. J Am Acad Dermatol 1994;31:30-3
5. Melanoma in the Chinese of Hong Kong. Emphasis on volar and subungual sites. Cancer 1984 Oct1;54(7):1482-8
6. Reintgen D. Establishing a standard of care for the patient with melanoma. Ann Surg Oncol. 2001;8:91
7. Mustarde JC. Repair and reconstruction in the orbital region. A practical guide. Baltimore: Williams & Wilkins, 1966
8. Esser JFS. Gestielte loakle Nasenplastik mit zweizipfligen Lappen, Deckung des sekundaren Defektes vom ersten Zipfel durch den Zweiten. Dtsch Zschr Chir. 1918;143:385.

MCHK CME Programme Self-assessment Questions

Please read the article entitled "Skin Cancer Management" by Dr. Peter CW Pang , and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded 1 CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 July 2008. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please answer T (true) or F (false)

1. Sun exposure is one of the important risk factors for the development of squamous cell carcinoma.
2. Most of the skin cancers happen on the back.
3. The complexity of reconstruction after ablative surgery for skin cancer on the face depends on number of facial subunits involvement.
4. Basal Cell Carcinomas in Chinese patients are sometimes pigmented.
5. Basal Cell Carcinomas never metastasis.
6. Mohs' surgery must be used in excision of all Basal Cell Carcinoma.
7. Squamous Cell Carcinoma always have keratinized surface.
8. Melanomas occurs in patients with atypical naevus syndrome are arising from the pre-existing naeuvs.
9. Suspected melanoma should undergo excisional biopsy.
10. Post ablative surgery for BCC over forehead with a defect of one centimeter should allow to heal with secondary intention.

ANSWER SHEET FOR JULY 2008

Please return the completed answer sheet to the Federation Secretariat on or before 31 July 2008 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Skin Cancer Management

Dr. Peter CW Pang

MBChB, FRCS(Ed), FHKAM(Surgery)
Specialist in Plastic Surgery

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Name (block letters):_____ HKMA No.: _____

HKID No.:___ ___ - ___ ___ ___ ___ X X (x) DUHK No.: _____

Contact Tel No.:_____ CDSHK No.: _____

Answers to June 2008 issue

What is the Role of Carotid Intimal Media Thickness (CIMT) in the Management of Atherosclerosis?

1. F 2. T 3. F 4. T 5. T 6. F 7. T 8. F 9. T 10. T

Update on Silicone Gel Implants for Breast Augmentation & Reconstruction

Dr. Walter WK King

BA (Hon, Wisconsin), MD (Vanderbilt), MCPS (Manitoba), FRCS, FRCS (Edin), FCSHK, FHKAM (Surgery)
Specialist in Plastic Surgery, Plastic & Reconstructive Surgery Centre,
Hong Kong Sanatorium & Hospital

Dr. Walter WK King

While it took the FDA 15 years to again approve the use of silicone gel implants for breast augmentation as well as breast reconstruction, the quality of silicone gel implants has continued to advance significantly since 1960's. These technological advances produced a better shaped, safer and more durable cohesive silicone gel implant that is meeting wide approval by users.

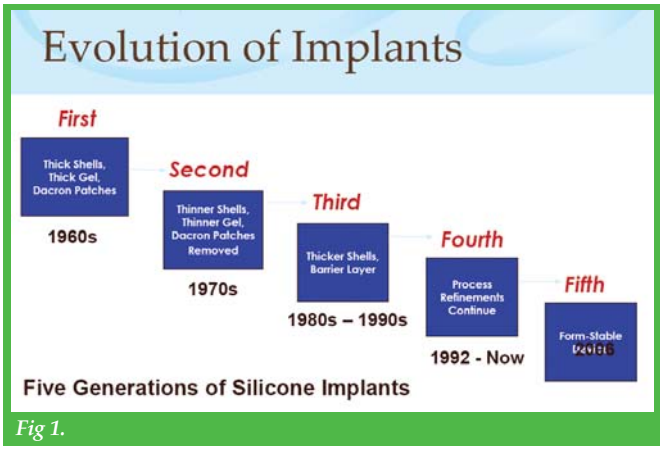


Fig 1.

The new tear drop shaped cohesive silicone gel implant has a low leakage rate of 1-2% (compared to a leakage rate of >6% for saline implants) and represents the 5th generation of silicone breast implants (Fig 1). The cohesiveness of the silicone gel means that when the implant envelope has ruptured, the silicone gel will stick together and stay within the breast area (Fig 2 & 3).

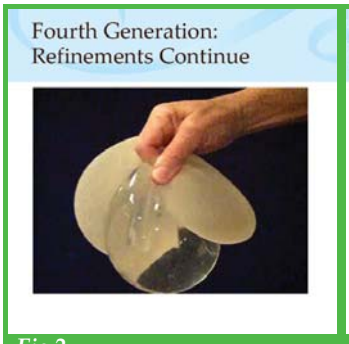


Fig 2.

Fig 3.

During the recent three years period 2005-2007, we have carried out breast augmentation (primary or secondary) and reconstruction with round or tear drop shaped breast implants in 87 Asian patients. Surgery was by either peri-areolar approach (31Patients) or by transaxillar endoscopic approach (42 patients), or by inframmary approach for breast reconstruction after mastectomy (14 patients). The age ranged from 25 to 61 and the mean age is 37. Both round textured saline and gel breast implants were used in 2005. Between 2006 and 2007, all breast implants inserted were of the tear drop shaped cohesive silicone gel type(Fig 4). All surgery were done under general anesthesia (Fig 5) and patients were generally discharged after 1-2 hospital days. There were no acute complications. One patient with peri-areolar approach required re-positioning and change to larger size implant at one month. Due to the short follow up period, significant capsular contracture (thickening or firming of the tissues surrounding the implant) was not seen. Patients were generally satisfied with the softness of the silicone gel implant as compared to the firmer saline breast implant.

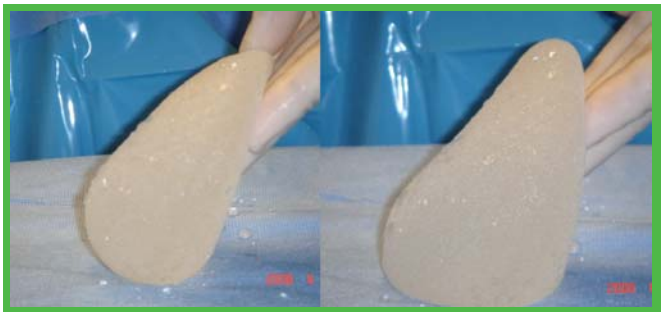


Fig 4. Cohesive Silicone Gel Tear Drop Shaped

Fig 5. Transaxilla Endoscopic Breast Augmentation

In conclusion, cohesive silicone gel implants represent improved breast implants that are safe, soft and durable. The new implants will continue to have significant impact on user satisfaction (Fig 6) - (before and after photos supplied by implant manufacturer).

Fig 6. Breast Augmentation with Tear Drop Shaped Silicone Gel Implant (Before & After)

Medical & Dental Directory of Hong Kong, 8th Edition

Corrigendum/Updates to the Medical & Dental Directory of Hong Kong (8th Edition)

Page No.	Particulars
442	Qualification attained by HO Hung Kwan, Michael should read as "MB BS (**Syd**) 1994"
455	"KONG Hot Tai" should read as "KONG **Hoi** Tai"
478	"LAU The Shan" should read as "LAU **Teh** Shan" and the Chinese name should read as **劉德譆**
519	Qualifications attained by MING Shiu Kow should read as "MB ChB(Bristol) 1973, DRCOG 1974, **DABIM 1978**, DABFP 1978, **DABIM (Rhu) 1980, FHKCP** 1998"; and His Practice should read as "Private; **Associate Professor of Medicine, The Chinese University of Hong Kong, Medicine, 1996-1998**"
646	Email Address of CHAN Wing Kin should read as "wk**a**chan@hotmail.com"
658	Qualification year attained by LI Wai Hon should read as "MB BS (HK) **1991**"
716	Tel no. of WONG Wing Kam should read as 2395 40**3**1
766	"LEUNG Chi Tat, Anthony" should read as "LEUNG Chi Tat, **Antony**"
774	Practice Address of HO Sai Wah, David should read as "**3309**, Bank of America Tower, 12 Harcourt Road, Central District"
789	Qualifications attained by IP Wing Kin should read as "MB BS (HK) 1982, MRCP (UK) 1990, FHKCP 1992, FHKAM (Medicine) 1995, FRCP (Lond) 1997, FRCP (Edin) 1997, **FRCP (Glasg) 2001**"
838	Chinese name of CHAN Tin Yau, Teddy should read as "**陳天佑**"
872	Practice Address of CHAN Tung Fei, Tony should read as "**10/F Wai Fung Plaza, 664 Nathan Road, Mongkok**"; and Tel should read as "**2780 0869**"
875	Qualifications attained by CHOW Hing Ping should read as "MB BS (HK) 1969, FRCS (**Edin**) 1975, FCSHK 1990, FHKAM (Surgery) 1993
962	Email address of CHIU Hung Leung, Albert should read as "dralbertchi**u**@yahoo.com.hk"
1028	Qualifications attained by YU Jerome should read as "BDS (HKU) 1988, MFGDP (UK) 1996, FRACDS 1999, MSc (Dental Public Health) (Lond) 2003, DDPH RCS (Eng) 2003
1041	Chinese name of YIP Kar Leung, Daniel should read as **葉嘉梁**

If you have submitted your data but not yet received a copy, please contact our Secretariat on 2527 8898 to check the delivery status.

If you wish to purchase extra hard copies and/or CD ROM, please fill in the order form and return to our Secretariat at 4/F Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai.

Surgical Treatment of Short Nose

Dr. Otto YT Au

MD (JEFFERSON, USA) 1957, MCPS (MANITOBA) 1963, FHKAM (SURGERY) 1995
Diplomate American Board Plastic Surgery

Plastic Surgery Specialist

A nice looking nose contains certain elements; it should have an adequate length, proper nasal labial angle, proper nasal bridge height, normal size nostrils and nasal tip with pleasing projection. This article deals with the length of the nose, and the treatment of the short nose.

The proper length of the nose should be one third of the longitudinal length of the face. If one divides the face into 3 parts, the upper $\frac{1}{3}$ is from the frontal hair line to the glabellar nasal angle (the level of the brow), the middle $\frac{1}{3}$ is from the glabellar nasal angle to the tip and the lower third is from the tip to the lower border of the chin. (Figure 1)

Figure 1 – Length of face to be divided to 3 parts.

The normal looking length of the nose may also be determined visually.

Gunther stressed that it is "impossible to give an exact quantitative measurement for normal nasal length, since the desired length will vary depending on the size and proportion of other facial features". The rule is that the ratio of nasal length to tip projection should be 1:06. A better measurement for evaluating the short nose is the nasalabial angle, the ideal nasalabial angle is 95 - 105° in Caucasian women and 90 - 95° in Caucasian men, in the Orientals, this angle is 85.4°

The causes of the short nose may be congenital, scar contracture from trauma, burns or in the cases of failed nasal augmentation, scar contracture may also occur from reaction to the injected foreign bodies such as liquid silicone.

There are not too many writings in the treatment of short nose; the number of cases treated as reported by different surgeons were only a handful, usually not more than thirty.

The techniques of lengthening the nose can be listed as follow:

1. creation of length with an illusion such as inserting a thin prosthesis beyond the golden angle.
2. pulling the skin downward by freeing the skin from the glabella to the tip.
3. Rotating the tip foreward.
4. the main techniques call for lengthening the nasal frame works :
   a) Section the cephalic bony frame work of the nose, filling the gap with bone graft.
   b) Division of the junction of the upper and lower lateral cartilage, filling the gap with gulf wing shape composite conchal graft taken from the anterior conchal areas, Dr. Dingnan succeeded to elongate the nose as much as 2cm by this procedure together with the additions of a L-shape rib bone and cartilage graft, he did his operations with closed rhinoplasty. (Figure 2)

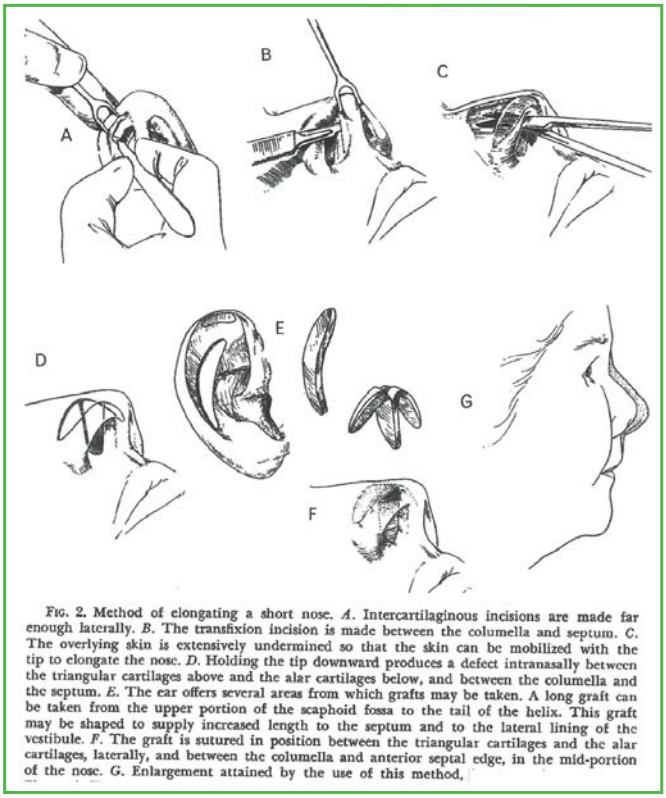


FIG. 2. Method of elongating a short nose. *A*. Intercartilaginous incisions are made far enough laterally. *B*. The transfixion incision is made between the columella and septum. *C*. The overlying skin is extensively undermined so that the skin can be mobilized with the tip to elongate the nose. *D*. Holding the tip downward produces a defect intranasally between the triangular cartilages above and the alar cartilages below, and between the columella and the septum. *E*. The ear offers several areas from which grafts may be taken. A long graft can be taken from the upper portion of the scaphoid fossa to the tail of the helix. This graft may be shaped to supply increased length to the septum and to the lateral lining of the vestibule. *F*. The graft is sutured in position between the triangular cartilages and the alar cartilages, laterally, and between the columella and anterior septal edge, in the mid-portion of the nose. *G*. Enlargement attained by the use of this method.

   c) Section of the lower lateral cartilage and caudal section of the septal columellar junction, filling the gap with 2 pieces of gulf wing type of composite grafts taken from anterior conchal areas, Dr. Yooho Lee et all succeeded with this

technique in 6 patients with closed rhinoplasty, he obtained much improvement of the nasalabial angle, the average improvement was from 116 degree to 104 degree, the mean follow up was 8.7 months of the graft, there was no gross absorption or exposure of the dorsal only graft. Dr. Lee stressed that the reason for anterior approach to take the graft from the ear is that the skin at the anterior conchal area is thinner and easier to survive as composite graft. (Figure 3)

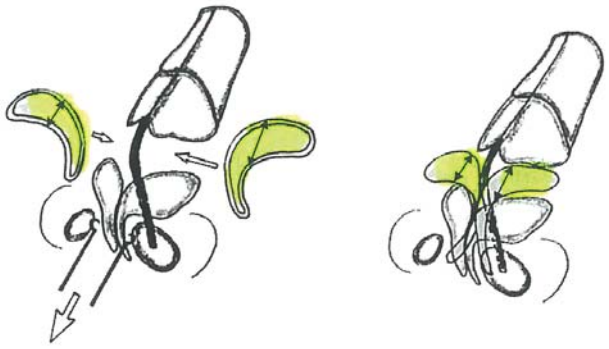


FIG. 3 The gull-wing concha chondrocutaneous composite graft. (*Left*) After the incisions and dissection, the columella and lower lateral cartilages are released maximally by traction on the tip by the skin hook. The released gap is measured, and each unit of the gull-wing graft (*yellow*) is harvested according to the size of the defect. Each unit is inserted one by one and makes the gull-wing shape after the inset of two units. (*Right*) Each unit is widest at the junction of septum and lateral wall (*black arrow*). Therefore, the lengthening is maximal at the tip, and we can correct the cephalic rotation of the tip and obtuse nasolabial angle simultaneously.

d) Section the junction of upper and lateral cartilage, filling the gap with either gulf wing type of composite conchal cartilage graft or just the cartilage graft without the skin from the posterior conchal area, the reason for such approach is to avoid the scar anteriorly as in my series. (Figure 7)

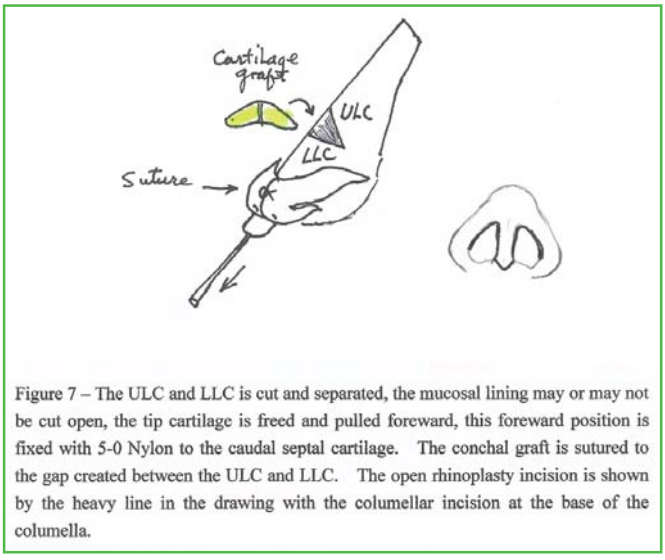


Figure 7 – The ULC and LLC is cut and separated, the mucosal lining may or may not be cut open, the tip cartilage is freed and pulled foreward, this foreward position is fixed with 5-0 Nylon to the caudal septal cartilage. The conchal graft is sutured to the gap created between the ULC and LLC. The open rhinoplasty incision is shown by the heavy line in the drawing with the columellar incision at the base of the columella.

e) Dr. Guyuron suggested a technique to lengthen the nose with septal spreader graft and conchal cartilage graft to the caudal end of the septum, he can add 1-2mm to a mild deficiency, 3-5mm in a moderate deficiency, he claimed he can add more than 5mm to elongate the nose. (Figure 4)

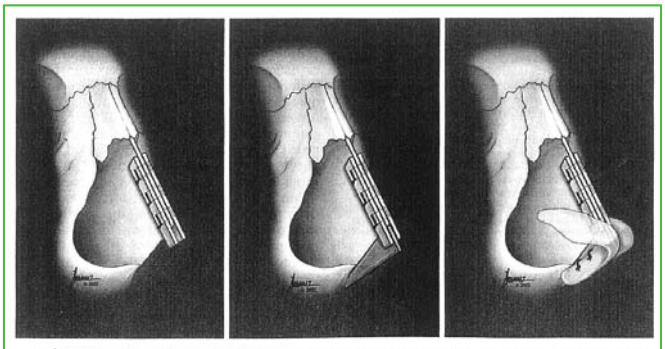


FIG. 4 Two spreader grafts extending caudal to the septum proportional to the requisite elongation are placed on either side of the septum and are fixed in position using three 5-0 polydioxanone sutures. (*Left* and *center*) The columella strut is placed in position. (*Right*) The strut is sutured to the medial crura only, using at least two sutures, guided by the tattoo marks.

f) Lengthen the nose by adding a 3 layer stacked conchal ear cartilage graft to the tip at the caudal end of the tip cartilage as proposed by Dr. Hamra. (Figure 5)

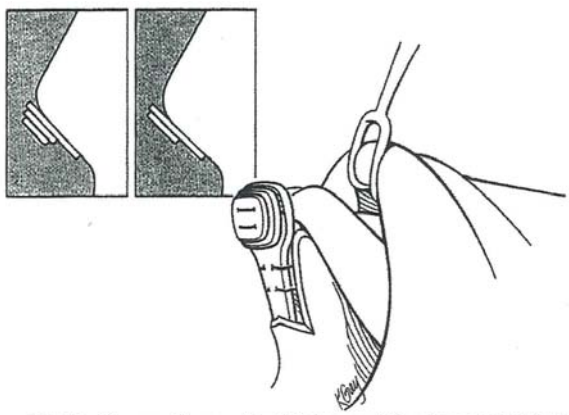


FIG. 5 Depending on the thickness of the donor cartilage and the requirements of the patient, one or two grafts are sutured to the primary graft.

g) Gunther lengthens the nose with a technique to lower the nasal dorsum by rasp, release the lower lateral cartilages and nasal septum, resection of the posterior caudal septum, rotation and stabiliszation of the tip cartilages in an inferior direction with careful post-operative splinting. His technique basically is to decrease the top projection with a lower dorsum to create an illusion that the tip defining points is increased and the nose appears to be longer in 10 of his 12 patients so operated (Figure 6).

Ten of 12 patients so operated demonstrated a significant visual lengthening and improved

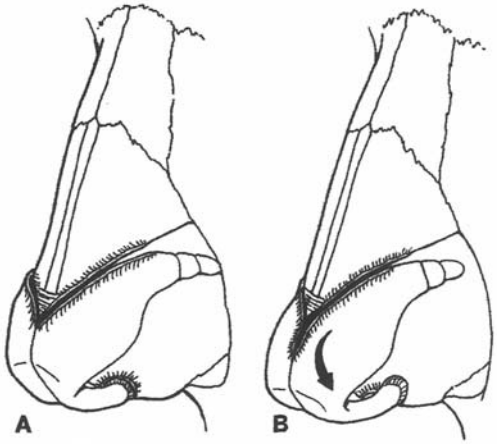


FIG. 6 (*A*) Lower lateral cartilages released from their attachments to the upper lateral cartilages, suspensory ligament, and septum. (*B*) Direction of rotation of lower lateral cartilages after release of all attachments.

The technique I used were not unlike the gulf wing conchal cartilage graft, with the exception that dorsal onlay L-shape silicone prosthesis with a soft tip is used instead of autogenous rib graft. (Figure 7) In the beginning I used composite graft, lately if the nose is not too short, I used solely conchal cartilage graft to fill the gap created at the junction of the upper and lower cartilage, most cases had additional augmentation with L shape soft tip silicone prosthesis, one of the secret is to free the fibrous attachment of the tip cartilage to the underlying structure to gain as much length of the nose as possible and to fix the tip to the caudal end of the septal cartilage.

Technique is as follow:

1. 10 mgm of valium is given orally 30 - 45 minutes pre-op.
2. the ear and nose were prepared with Betadine and draped.
3. Ketalar IV and valium IV infiltration with the appropriate amount.
4. local infiltration to the ear and the nose with 2% xylacaine with 1:80,000 adrenaline.
5. open rhinoplasty with the lower columelar transverse incision at the columellar-lip junction and the rim incision.
6. The skin envelope was prepared by dissecting all the way up to the low glabellar region, at the nasal bone area the dissection is subperiosteally if the insertion of silicone prosthesis is needed, otherwise it is on top of the periosteum.
7. The junction of the upper and lower lateral cartilage was severed with care not to break the mucosa in a moderate short nose case, a double hook was used to pull the nasal tip caudally and the fibrous attachment of the tip cartilage was freed by careful dissection with fine scissor, the tip cartilage is pulled caudally, this way the tip can be advanced to a great amount. A 5-0 Nylon is used to fix the tip cartilage to the caudal septal cartilage as I mentioned earlier. (Figure 7)

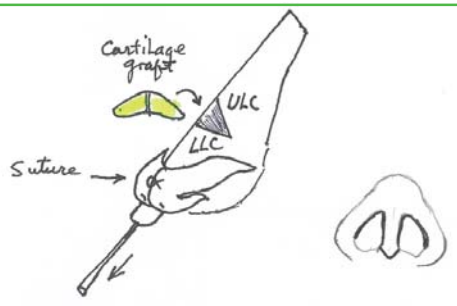


Figure 7 – The ULC and LLC is cut and separated, the mucosal lining may or may not be cut open, the tip cartilage is freed and pulled foreward, this foreward position is fixed with 5-0 Nylon to the caudal septal cartilage. The conchal graft is sutured to the gap created between the ULC and LLC. The open rhinoplasty incision is shown by the heavy line in the drawing with the columellar incision at the base of the columella.

8. A longitudinal incision is made from the posterior surface of the ear, a piece of conchal cartilage graft or a composite graft with the size corresponding to the defect at the gap between the ULC and LLC is harvested, the wound is closed with 5-0 Vicryl and 6-0 Nylon.
9. The gulf wing conchal cartilage graft or the composite graft depending on the cases needed is sutured to the gap created between the upper and lower cartilage with 6-0 Nylon. At this point, it is better to make sure the graft is sutured evenly to prevent uneven bulging, should the nasal mucosa be broken accidentally during dissection, it should be repaired with 6-0 Vicryl. If a composite graft is used, the skin portion is sutured to the nasal mucosa with 6-0 Vicryl with the knot in the nasal cavity, the cartilage part of the graft is sutured to the cut edge of the ULC and LLC with 6-0 Nylon.

A proper size L-shape soft tip prefabricated silicone prosthesis is then laid on the nose subperiosteally at the area of the nasal bone, the open rhinoplasty wound is closed with 6-0 and 7-0 Nylon. A splint is put on the nose for 3 days and the sutures are removed in 7-days.

Oral antibiotic is given for 7-days and ice pack is used for 48 hours in waking hours.

Materials

24 females with the age of 18 to 50 were included in this series, with an average of 30.5 years, they all had nasal lengthening operation, some were primary cases whose nose looks short and flat, some had contracture due to failed augmentation with silicone prosthesis, and one had nasal contracture due to an auto accident. Most had their noses lengthened with conchal cartilage graft with or without the composite component, if needed a soft tip L-shape silicone is inserted at the same time for augmentation to improve the flat nose look.

Case Report

Case 1

20 years old female, requests augmentation rhinoplasty, her nose looks short and with a wide nasal labial angle, her nose was lengthened by 5mm with conchal cartilage graft and augmented with L-shape soft tip silicone prosthesis.

a 20 years old female had augmentation with L-shape soft tip prosthesis and nasal lengthening, the nose is lengthened 5mm.

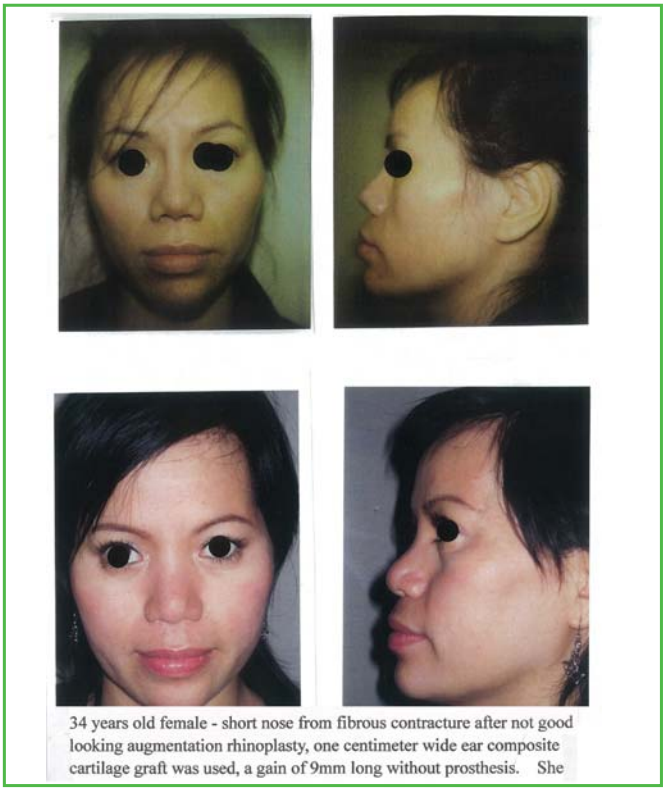
Case 2

A 20 years old female requests augmentation rhinoplasty, her nose looks short with the nostrils showing; her nose was lengthened by 5mm with composite graft and augmented with a soft tip L shape prosthesis.

a 20 years old female – had nasal augmentation with soft tip L-shape prosthesis, the nose is lengthened 5mm.

Case 3

A 34 years old female who had a nasal augmentation with a L-shape silicone prosthesis, she requests a better looking nose, the prosthesis was removed and her nose was lengthened by 9mm composite ear cartilage graft, she also had fat injection to have a better facial contour.



34 years old female - short nose from fibrous contracture after not good looking augmentation rhinoplasty, one centimeter wide ear composite cartilage graft was used, a gain of 9mm long without prosthesis. She

Case 4

A 33 years old female who requested augmentation, she was advised to have the nose lengthened, composite ear cartilage graft was used, the nose was lengthened by 6mm.

33 years old female - ear cartilage graft to elongate nose, 10 years follow-up, nose was elongated 6mm.

Case 5

A 22 years old female, who had severe tip scar and short nose from extruded nasal prosthesis, a delay of 3 months was used to repair the scar and a further delay of one year before the nose was lengthened, a 1cm composite graft was used, the nose was lengthened by 8mm.

22 year old female, severe scar at tip from extruded nasal augmentation, a delay of one year and 3 months before the nose was lengthened with 1 cm wide composite graft, the nose gains 8mm.

Case 6

A 40 years old female who had impending extrusion of nasal prosthesis, the prosthesis was removed, a delay of 3 months, the nose was lengthened with 6mm conchal cartilage graft, the depression on the tip scar was elevated with stacked conchal cartilage graft, the nose was lengthened by 5mm.

Case 7

A 35 years old female had scar contracture of her nose due to extruded nasal prosthesis, the nose was lengthened with 1cm wide composite ear cartilage graft, and the nose was 6.5mm longer.

40 years old female – extrusion in an augmented nose, prosthesis was removed and the nose was lengthened 5mm, dented tip augmented with ear cartilage.

35 years old female – had extruded augmentation rhinoplasty, nasal contracture was severe, 1cm wide composite graft was done; nose was lengthened 6.5mm, 10 years follow-up.

Summary

Surgical treatment of short nose is presented, the technique mentioned basically is a need to release the contracted nasal tissue by separating the junction of the upper and lower lateral cartilage, this creats a gap at the ULC and LLC junction and it is covered with either conchal cartilage alone or with composite graft. If the gap is smaller than 3 - 5mm, the mucosal lining is kept intact, if the gap is wider than 5mm, the mucosa has to be cut open, then a composite ear conchal cartilage graft is used, additional lengthening is gained by freeing the fibrous attachment of the tip cartilage to the underlying tissues and fixing it with suture to the septal cartilage. If the nose needs augmentation, a soft tip L shape prosthesis is used for this purpose. Open rhinoplasty techniques are used with the columellar incision at the base of the columellar rather than the mid columellar area.

Discussion

The technique is labour intensive but not complicated, in case of primary aesthetic case, no delay is needed, in the failed augmentation rhinoplasty cases, sometimes a delay of several months or longer is needed to allow the scar at the tip to heal and wait until the tip tissue becomes softer. The taking of the composite graft from behind the ear has the advantage of less visible scaring but the skin there is thicker compared to that from the anterior conchal area, furthermore, a large defect at the anterior conchal donor site is hard to repair, the repair may need some complicated flaps covering from the adjacent posterior ear tissue, there is no loss of the composite graft or any graft in my experience. The suturing of the graft to the gap mentioned should be meticulous to avoid uneven bulging post-operatively in the mid nose.

In case of the need to augment the nose, patients are extremely hesitant to use autogenous material taken from the rib, for this reason I use silicone soft tip L shape prosthesis. In my series, there were 3 cases of extrusion, 2 cases are a pair of twins, one was suffering from L-E syndrome, perhaps in this kind of case, augmentation with foreign material is unwise or contra indicated, another case was a female who suffered severe scarring of the nose in an auto accident and the prosthesis was extruded, therefore a healthy tissue bed is a requirement for extensive nasal surgery and augmentation with synthetic material done together. In general, the result is gratifying for the patients, too often patients with a short nose, if the underlying pathology is not corrected, augmentation simply with a prosthesis may make the deformity worse, unfortunately, it happens too often specially by the untrained physicians.

References

1. Gunter, T.P., and Robrich, R.J. Lengthening the aesthetically short nose, PRS surg.83.793,1989
2. Dingman, R.O. and Walter C. Use of composite ear grafts in correction of the short nose, PRS 43:117,1969
3. Yooho Lee, M.D. PhD., Jih Yuk Kim M.D., and Euitae Lee M.D. JPRS Vol 105#6.2190-2201
4. Bahman Guyuron, M.D. and AminVarghi, B.S. JPRS Vol. 111, No. 4, April 1, 2003 P.1533 - 1539
5. SamT. Hamra, M.D., Lengthening the Joreshortened Nose, PRS. Aug 2001, Vol 108#2, P.547-549
6. Ronald Gruber, M.D. Lengthening the Short Nose. JPRS. Vol 91.#7.P1252 - June 1993 P.1252-1258

Body Contouring by Liposculpture

Dr. Kenneth C Hui

MBBS(Lon), FRCS(Ed), FACS, FHKAM(Surgery)
Specialist in Plastic Surgery

Dr. Kenneth C Hui

Introduction

Body contouring by liposculpture is everyone's dream of a slimmer figure with minimally invasive approach. The fact is that the number of fat cells in our body is regulated by our genetic predisposition that may deviate only in cases of morbid obesity. This translates to the possibility of permanent fat cell reduction by cell destruction or removal. The fat removed, will not regenerate. However, drastic body weight loss can only be achieved by dietary control, regular exercise and perhaps short-term medications. More drastic surgical treatment may include mechanical regulation of food intake or creation of a malabsorption state. In other words, beauty can be related to a combination of favourable genetic code, appropriate dieting and lifestyle and a certain lucky probability.

The common misconceptions that body fat cells migrate are also untrue. Should we indulge in gastronomic over consumption after liposculpture, the entire body may expand due to increase of size of individual fat cells, and the non-treated areas do not grow significantly out of proportion.

Whether the patient is a candidate for liposculpture depends on the distribution of white fat. Extraperitoneal or subcutaneous fat can be treated whereas intraperitoneal cannot.

Obesity

Obesity is defined as over development of fat in comparison to total body mass. It is not strictly equated to "overweight", since fat is only a possible component of such. Overweight in particular, increases the individual's risk of death and heart disease. This particularly applies to patients with central or "android" obesity rather than peripheral or "gynoid" type of fat distribution. The Body Mass Index (BMI), a measurement of the square of height and weight (in metres and kilogram units) can be helpful in determining whether one is obese or overweight.

BMI = 20-25 normal weight
BMI = 25-30 overweight
BMI > 30 obese

Complications of obesity may include cardiovascular, hepatobiliary, gynaecological, metabolic and, mechanical problems.

Secondary Fat

Before contemplating in treatment, one must distinguish and rule out the possibility of treatable medical causes of Secondary fat.

Conditions may include the followings: hypothyroid, Cushing's syndrome, insulinoma, hypogonadism and a few rare congenital syndromes such as Stein-Leventhal syndrome, Frolich syndrome.

Cellulitis/ "Cellulite"

To distinguish from the general term to describe infection or inflammation, "cellulite" can best be described by fat cells caught within fibrous septi connection between skin and muscle fascia. The aetiology is not known except it is more likely to occur in females with thin skin. Various treatment methods have been described and mentioned below but the results are often unpredictable.

Possible Methods of Fat Cells Reduction

A. Fat melting injections-Mesotherapy

Being the least invasive treatment, injection lipolysis is gaining momentum. The first report was for correction of xanthelasmas around the eyes by Dr. Maggiory in 1988 by injecting phosphatidylcholine. At present, full scientific evidence of the mechanism is still missing and research is ongoing. A variation of the chemical with a solvent and benzylalcohol is often used. Tiny fat particles are produced which is then turned into monoglycerides and transported to the liver for final breakdown and excretion.

It is noted that the subcutaneous use of phosphatidylcholine is still "off-label" and not approved by the FDA in the US. Injections to the wrong tissue such as muscle or connective tissue lead to irritation and inflammation. On the other hand, it is reported to be effective in treating fat embolism after multiple injuries and collapsed alveoli of newborn. The effect on treatment of cellulite reduction and spot fat reduction is often promoted. However, an experimental study by the department of dermatology at University of Southern California failed to show any clinical proof of such improvement.

Even in appropriate application, mesotherapy has reported to cause allergic reactions, necrosis, infection, and panniculitis. Other reports have shown soft tissue

infection due to non-tuberculous mycobacteria following mesotherapy, systemic lupus erythematosUs after acetyl-L-carnitine injections.

The American Society for Aesthetics Plastic Surgery cautioned its use in an advisory message last year. To sum up, Dr. Rod Rohrich, chief of plastic surgery at the University of Texas, Southwest Medical Center, indicated injection lipolysis is "scientifically unproven, lacking objective data on safety and efficacy."

B. Laser Lipolysis

Nd:Yag laser was recently introduced to Japan and USA after wide acceptance in Europe and Latin America. A Japanese study compared the 1,064 nm lasers at 40Hz and 150mJ and 100 microseconds-long pulses and compared histological study with control group of regular liposuction without irradiation. The tissue was scanned by EM and showed laser "SmartLipo" to be effective in destruction of human fat tissues. However, another report from University of Chile compared randomised double blind clinical trial comparing laser-assisted lipoplasty with regular suction. Analysis of patient and surgeon satisfaction, postoperative recovery evaluation, procedure time, free fatty acids, and DNA proteins was performed. More damage to adiposities was seen in laser-assisted cases. The conclusion was that there were no major clinical differences between the two techniques. Also of note was higher concentration of free fatty acids after laser lipoplasty alert to potential hepatic and renal toxicity.

"SmartLipo" is generally promoted as minimally invasive since surgery can be performed under local anaesthetics via small incisions. However, due to the size of canula used in fat removal is smaller in comparison (1-2mm), comprehensive fat extraction is more difficult compared to regular liposuction. As a result, seroma, haematoma and wound infection in large-scale lipolysis is more likely. Skin puckering and sagging is also reported. On the positive side, the heat generated can result in skin tightening. Although less invasive than traditional liposuction, it is still considered as regular surgery, and carries the same risks. Another report showed complications included bruising, infection, haematoma and scarring. Less common risks are burns of skin, although rare.

SmartLipo is reported to be effective in removal of small pockets of fat collection such as knees, chin, face or neck. It is not intended to replace traditional liposuction

Another report on "low-level laser" by 635-nm diode laser is reported to generate no heat and causes less tissue damage. Combined with tumescent injections of local anaesthetics, it can be performed without general anaesthetics. It is currently used, as "off label" in the U.S. Further evaluation is still ongoing. Another report from Columbia showed similar results with the 635 lasers.

Another report compared the efficacy of 980 nm diode lasers with 1064 nm Nd: Yag. Histological studies were similar between the two wavelengths at equivalent energy settings. Higher total energy is more effective in removing larger volume of fat, high power 980 nm diode can be an alternative to the 1064 nm laser. Other laser technologies include the 1320 nm "CoolLipo" and 1319 nm "ProLipo", using similar applications.

C. Liposuction

In the mid 1980s, liposuction was performed with dry suction technique with aspirators alone. This has resulted in high percentage of blood loss in proportion of fat aspiration. Large volume liposuction was not possible without significant anaemia and risks of hypotension and other complications associated with hypovolaemia.

The introduction of tumescent injections by klein greatly reduced the above risks. This involved infiltration of subcutaneous fat prior to liposuction with a ratio of more than 1:1 of infiltrate to aspirate. Although the formula varies, the components usually contain a dilute volume of lidocaine, adrenaline and bicarbonate. The volume introduced often creates a firm soft tissue swelling for better precision liposculpture, while providing local anaesthetics and the adrenaline reduces bleeding.

The introduction of subdermic liposuction by gasperoni using smaller cannula in the superficial plane in addition provides better contouring of the body, by causing more skin retraction.

In 1987, Scuderi and D'Andrea introduced the technique of ultrasonic liquefication of fat prior to liposuction. This was the introduction of modern liposculpture, which has since evolved into the "third generation". The ultrasound generated at the tip of the canula can break down fat easily since 90% of fat mass volume is made up of liquid. Ultrasound waves generate expansion and compression cycles. Micro bubbles are generated on expansion cycle. Compression cycle, on the other hand, exerts negative pressure. Very thick tissues such as bone and muscle, the cohesion is so high that very high energy is needed to cause tissue destruction. The principle of modern ultrasonic generators are designed for lower energy application only, therefore, more selective to fat cells destruction.

The biological effect of ultrasound can be divided as follows

1. Cavitations phenomenon: as described
2. Micro mechanical effect: direct effect of ultrasound on chromosomes break down and disruption of acro-molecules
3. Thermal effect: electric heat energy, in addition to frictional heat and absorptive acoustic heat

A closer look at the arrangement suggests that compared to fat, denser materials such as muscle can transmit the sound wave faster but due to the intrinsic lower impedances, the energy is passed on with much less damaging effect.

This method not only enables more comprehensive fat destruction and removal, but also reduces the risks of unevenness in traditional liposuction. Also, very fibrous fatty tissues such as the buttocks and back areas and gynaecomastia can be removed with minimal effort. In certain cases, the fibrous septa that contains the fat lobules can be divided and hence reducing the

appearance of "cellulite" skin dimpling.

However, the procedure is much complex and the ultrasound liposuction is divided into three parts:

1. Tumescent infiltration: Larger quantity is needed to reduce heat build up and the maximum safe duration of ultrasound application is dependent in a close ratio to the total volume of infiltrate used.

2. Ultrasound treatment: The introduction of "VASER" (vibration amplification of sound energy at resonance), also known as third generation ultrasound, enables the use of ultrasound to superficial fat. This is possible due to the wider choice of size of canula, the different number of rings at the tip and the choice of pulsed versus continuous mode. The rings are designed to distribute the ultrasound wave sideways, allowing better skin tightening without burning through the skin in appropriate use of the energy. Pulsed mode allows tissue better thermal recovery. Hoyos and Millard described the technique as "high-definition liposculpture", giving better definition of abdominal wall muscle profile in patients. No skin necrosis was reported but the procedure was time consuming and a high learning curve for the technique.

   Pinto described the VASER as more tissue selective, preserving more blood vessels and nerves, causing less haematoma and pain, better fat emulsification and more tunnelling was possible. The combination of using smaller canula, reduction of ultrasound energy and better logistics is the reason behind.

   Richards warned the use of VASER for superficial sculpturing is unforgiving and the result is more operators dependent than previous devices. However, if used appropriately, the results are far superior in body lifts, breast reductions and abdominoplasties. The operating time, however, is twice as long as "power assisted liposuction".

   Jewell and Fodor reported 77 cases of VASER liposuction with no major complications, compared to 4.9% with 1st and 2nd generation ultrasound liposuction. Meticulous attention is recommended in "superwet" tumescent, skin protection and correct choice of mode of ultrasound.

3. Aspiration of emulsion: Adequately lysed fat should then be removed with appropriate canula, moving symmetrically and evenly in the same subcutaneous plane for optimal results. Previous practice of simultaneous aspiration with ultrasound may not be advisable due to constant reduction of tumescent fluid enhancing the cavitational effect. This is judged to be the most challenging step to obtain a fine result.

Postoperative care may involve one or more of the following: suction drainage, foam pads, compression garment and Endermologie/ lymphatic drainage.

Application: The most common and effective areas of treatment are for abdomen; lower back (love handles), chin/neck areas. For ladies, buttocks, thighs, upper back, upper arms, knees and may be breasts (controversial in view of the possibility of long term micro calcification seen in mammogram). For men, it is useful for reduction of gynaecomastia or in combination with surgical excision.

Complications:

Ultrasound assisted liposuction has been relatively safe with no serious complications, and the satisfaction rate is high due to minimally invasive and yet effective technique.

Short-term complications may include thermal injury and skin discoloration. Seroma is the most common problem, reported to be less than 3% and usually self-limiting. With appropriate training and experience, most of the thermal injury complications can be avoided.

Long-term complications have not been reported. Serum triglycerides have been measured before and after ultrasound liposuction and noted interesting enough, the postoperative level is lower, proving that the technique does not increase the risk of fat embolism.

Conclusions

Numerous articles can be seen daily concerning body liposculpture. It is no doubt that appropriate diet control; adequate exercise and body tuning such as Pilatus and aerobics can provide a long lasting nice body contour. Equal number of ideas and suggestions are written without scientific evidence and proven clinical trial in peer-reviewed journals. While it is almost equally disprove to disprove those unrealistic suggestions, we have to reply on our judgement and locally thinking, and not to believe in everything that is written. Even so, some of us are born with certain fat pockets in the body that simply cannot be removed without intervention, no matter how thin. There have been cases while the patient can lose enough weight to create a slim waist and abdomen, the concomitant excessive facial fat loss results in "looking ill" and malnourished.

Liposculpture by mesotherapy is a promising proposition. However, for lack of clinical papers in large volume fat dissolution and the concern with safety of the chemicals is used, we are still waiting for more research data. Laser assisted lipolysis has been approved by the FDA in the US recently. However, reports so far suggested its best application is in small volume fat removal, such as the face, neck and arms. Since it can be performed with local anaesthetics in doctor's office, it may be most attractive in certain cases, when large volume fat extraction is not necessary.

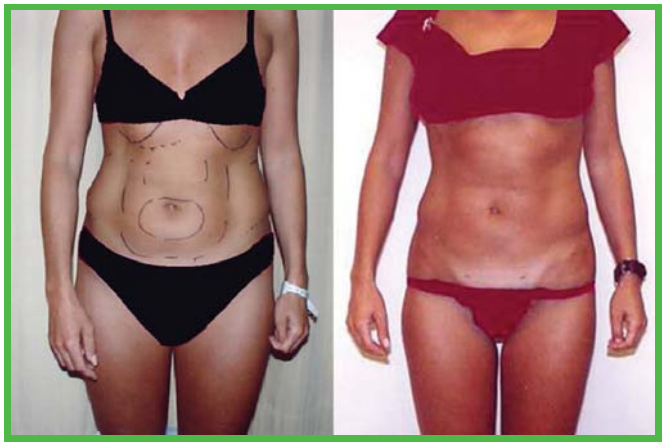
The most proven and effective method of minimally invasive liposculpture is perhaps ultrasound-assisted liposuction. The principles are sound and the results can be duplicated.

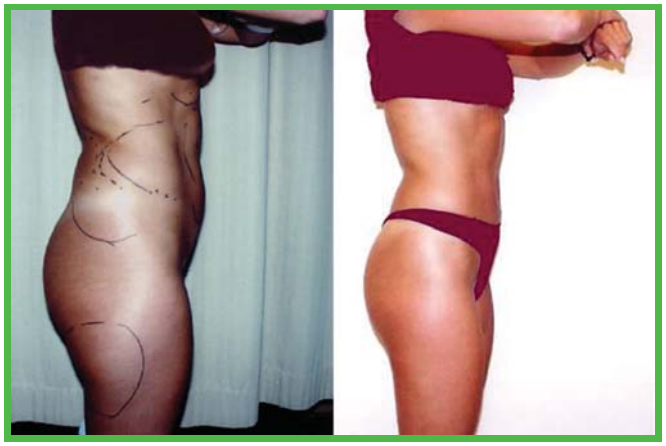
For the abdomen, only two (3-4mm) incisions are necessary, and while only one is needed for treating the lower back "love handles". Recovery is quick, day surgery is possible or an overnight hospital stay is recommended for extensive areas. One can expect to return to non-strenuous work within a few days and delay heavy exercise for 3-4 weeks. This is suitable for

people with thick subcutaneous fat and minimal skin excess/laxity.

However, in selected cases, ultrasound liposuction can be combined with abdominoplasty, plication of the rectus diastasis and skin excision at the same time for ladies after pregnancy. For man with gynaecomastia, it can be combined with subcutaneous mastectomy for optimal reduction of enlarged breasts. Liposuction is also useful in removing large subcutaneous lipomas.

Although the technique is complex, involving three steps: tumescent infiltration (wetting), vaser ultrasound application and fat removal, the results are far superior to other means. The most common complications are aesthetic problems: asymmetry, residual fat, skin dimpling, and prolonged seroma. Serious complications are very rare.

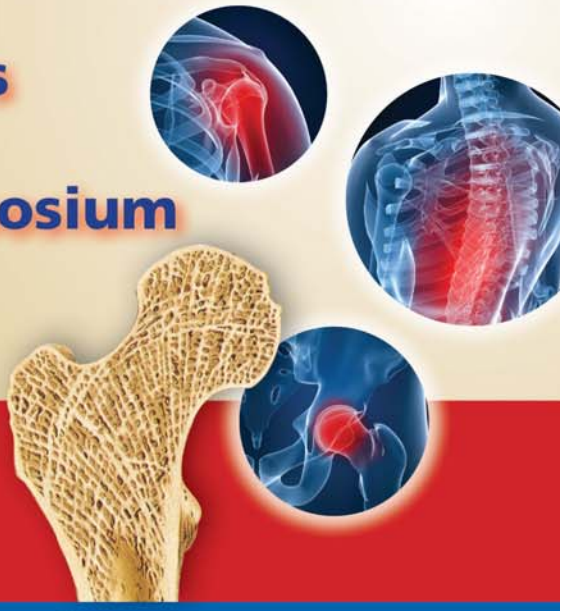




References

1. Rotunda AM, Avram MM, Avram AS; Cellulite: Is there a role for injectables?; J Cosmet Laser Ther 2005; 7:147-54
2. Franz Hasengschwandtner; Fat melting injections-state of the art
3. Tan J, Rao B; Mesotherapy-induced panniculitis treated with dapsone: case report and review of reported adverse effects of mesotherapy.; J. Cutan Med Surgery: 10:92-5
4. Spencer A. Brown; The science of mesotherapy: Chemical anarchy; Aesthetic Surgery Journal. Vol. 26, Issue 1. Jan. 2006: 95-98
5. Rivera-Olivero IA, Guevara A. et al; Soft-tissue infections due to non-tuberculous mycobacteria following mesotherapy. What is the price of beauty? Enferm Infecc Microbiol Clin 2006; 24; 302-6
6. Colon-Soto M, peredo RA, Vila LM; Systemic lupus erythematous after mesotherapy with acetyl-L-carnitine.; J Clin Rheumatol 2006; 12;261-2
7. Plastic Surgery News. Feb. 2008
8. Ichikawa K, Miysaka M, Tanaka R, et al; Histological evaluation of the pulsed Nd;YAG laser for laser lipolysis.; Lasers Surg Med 2005; 36;43-6
9. Prado A, Andrades P, et al; A prpspective, randomized, double-blind, controlled clinical trial comparing laser-assisted lipoplasty with suction-assisted lipoplasty. Plast Reconstr Surgery 2006; 118; 1032-45
10. Worcester S.; Low-level laser could 'revolutionize' liposuction.; Skin & Allergy News, 2002. Vol. 33, issue 5, P. 14
11. S. Mordon, AF Eymard-Maurin, et al; Histological evaluation of laser lipolysis; pulsed 1064-nm Nd;YAG laser versus cw 980-nm diode laser.; Aesthetic Surgery J, May 2007, Vol. 27; 3: 263-68
12. R. Neira, C. Ortiz-Niera; Low-level laser-assisted liposculpture: Clinical report of 700 cases.; Aesthetic Surg J, Sept 2002, Vol. 22; 5: 451-55
13. Gasperoni C, et al; Subdermal liposuction.; Aesth Plast Surg.; 1990 14:137
14. Scuderi N, et al; Nuove prospettive nella liposuzione: la lipoemulsificazione. ; Giorn Chir Plast ricostr Estet.; 1987 2:1
15. A.E. Hoyos, J. A. Millard; VASER-assisted high-definition liposculpture, Aesthetic Surg J, Nov. 2007 Vol. 27; 6:594-604
16. de Souza Pinto EB, Abdala PC et al; Liposuction and VASER; Clin Plast Surg 2006; 33:107-15, vii
17. M.E. Richards.;Commentary.;Aesthetic Surgery J; Nov 2007 Vol. 27, 6:6-5-6
18. M.L. Jewell, P.B. Fodor, et al; Clinical application of VASER-assisted lipoplasty: A pilot clinical study. Aesthetic Surg J.; Mar 2002, Vol. 22, 2:131-46

Joint Asian Pacific Osteoporosis Foundation and International Osteoporosis Foundation Symposium "Osteoporosis in Asia: Challenges and Controversies"



10 August 2008 (Sunday) • 09:30 – 16:45

Hong Kong Academy of Medicine
Pao Yue Kong Auditorium, G/F HKAM Jockey Club Building
99 Wong Chuk Hang Road, Aberdeen, Hong Kong

Organizers: **International Osteoporosis Foundation**
Asian Pacific Osteoporosis Foundation

International Osteoporosis Foundation

Asian Pacific Osteoporosis Foundation

Chairman: **Dr Edith Lau, MD**
Founding President, Asian Pacific Osteoporosis Foundation
Board Member, International Osteoporosis Foundation

Co-chairman: **Dr Suthorn Bavonratanvech, MD**
President, Thai Orthopaedic Association
Founder Member, Thai Osteoporosis Foundation

Agenda

Epidemiology and risk assessment for osteoporosis Asia

Dr Edith Lau, MBBS, FHKAM, FHKCCM, MFCM, MSc, FFPHM, FRCP, MD
Director, Center for Health and Medical Research, Hong Kong
Founding President, Asian Pacific Osteoporosis Foundation
Board Member, International Osteoporosis Foundation

Bisphosphonates for fracture prevention?

Professor Ego Seeman, BSc, MBBS, FRACP, MD
Professor of Medicine, University of Melbourne, Australia
Board Member, International Osteoporosis Foundation
Endocrinologist

SERM, strontium ranelate and teriparitide for the treatment of osteoporosis

Professor Philip Sambrook, MD, LLB, FRACP
Professor, Institute of Bone and Joint Research, Royal North Shore Hospital, Australia
President, Asian Pacific Osteoporosis Foundation

Kyphoplasty for the treatment of vertebral fracture

Dr Dicky Lam, MBBS, FRCS, FHKCOS, FHKAM
Director, Hong Kong Orthopaedic and Osteoporosis Center for Treatment and Research
Specialist in Orthopaedics and Traumatology

Controversies in the field of osteoporosis

Professor Steve Cummings, MD
Director, San Francisco Co-ordinating Center
Professor of Medicine and Epidemiology, California Pacific Medical Centre Research Institute, University of California, USA
Board Member, International Osteoporosis Foundation

Interactive case discussion and presentation of certificates to attendees

Academic accreditations:

- College of Surgeons of Hong Kong
- Hong Kong College of Community Medicine
- Hong Kong College of Family Physicians
- Hong Kong College of Obstetricians & Gynaecologists
- Hong Kong College of Orthopaedic Surgeons
- Hong Kong College of Physicians
- Hong Kong College of Radiologists
- MCHK Programme

Registration fee: ***HK$200*** *(full day)*

For more information, please contact:

Secretariat
CMPMedica Pacific Limited
Unit 901-903, AXA Centre
151 Gloucester Road, Wan Chai, Hong Kong
Tel: 2116 4333 Fax: 2559 6910
E-mail: gladys.wong@asia.cmpmedica.com

Plastic, Reconstructive and Aesthetic Surgery

Prof. Andrew Burd

Prof. Andrew Burd (博昂志)

MD, FRCS

Chief and Professor, Division of Plastic, Reconstructive and Aesthetic Surgery, Department of Surgery, The Chinese University of Hong Kong, Prince of Wales Hospital.

Twenty years ago I was proud to call myself a Plastic Surgeon. The specialty has brought so much to the world of medicine, always being at the cutting edge and using innovation to overcome the immense challenge of rebuilding bodies broken and ravished by disease and trauma. We have Plastic Surgeons to thank for our understanding of transplantation and immunology; as well as the clinical implementation of tissue engineering.

At the same time the very concept of Plastic Surgery has been cheapened and devalued by Hollywood, the media and the often scandalous and unscrupulous pursuit of money through the application of Plastic Surgical principles and procedures in the field of Cosmetic Surgery. Today, everyone wants to be a Plastic Surgeon and so it is time for the real Plastic Surgeons to move on. This is a global problem although perhaps even more acute in Hong Kong as we are the youngest of the surgical specialties and few, both lay and fellow professional appreciate the rich diversity and essential nature of the work we do. It was astonishing to see written in a draft document looking at Manpower Planning for 2007-8, prepared by the College of Surgeons of Hong Kong; "Plastic Surgery - The number of specialists remains static at about 48. The main workload is cosmetic surgery in private sector."

I think that members of the specialty have to accept some of the blame about the misunderstanding and misconceptions about what we do. In the UK where the specialty has always been very aware of the evolving and competitive nature of specialisation, the British Association of Plastic Surgeons (BAPS) hired a professional marketing consultancy to advise on a more effective rebranding of the specialty, particularly with regard to obtaining resources in the National Health Service. The advice was comprehensive and much was intuitively obvious. The quickest way to rebrand is to change your name. And so, just two years ago the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) was born. At the same time the British Journal of Plastic Surgery (BJPS) ceased to be and the official journal of BAPRAS is now the Journal of Plastic, Reconstructive and Aesthetic Surgery (JPRAS). This is no longer a 'British' journal but an 'International Journal of Surgical Reconstruction'. I am very proud to be the Chief Editor of this journal and I have deputy editors in the UK, Canada and New Zealand. Our Editorial Advisory Board has fifty members drawn from around the world. It is a very exciting time to be associated with such evolving initiatives. The specialty also continues to push back the boundaries with such clinical procedures as partial face transplants and basic science and early clinical studies in stem cell applications in wound healing and repair. It is interesting to note (Fig 1) the old cover of the BJPS and the Feb 2008 issue of JPRAS. The cover of the BJPS shows the Coat of Arms of the Association which contained a lizard standing on a rock. The Lizard was chosen because of its ability to regenerate its tail when that part had been lost. Such regeneration being the 'as yet unachievable technique for replacing lost tissue'. When a new logo was being considered for BAPRAS a truly inspired choice resulted in the Salamander being the new symbol. The lizard is a reptile and the most common reason for losing the tail as an autoamputation as part of an anti-predator strategy. The problem for the tail-less lizard is they have to increase their basal metabolic rate by 36% to synthesise a new tail and this was the only appendage that could be replaced. The salamander is an amphibian and in evolutionary terms more primitive. It is, however, unique amongst all adult vertebrates in being able to regenerate any lost or damaged limb together with lost skin and other tissues. The cut limb of the salamander is now truly at the cutting edge of science[2].

Figure 1 The covers of the old BJPS and the new JPRAS. The small salamander logo is a permanent feature of the cover. The larger logo just appeared in the February 2008 issue to accompany an editorial[1].

Returning to rebranding, the Hong Kong specialty society is now known as the Hong Kong Society of Plastic, Reconstructive and Aesthetic Surgeons (www.plasticsurgery.org.hk/) and discussions are ongoing to review other areas where the name could usefully be changed. At the same time, whilst it is more difficult to change the mindset of some of the more

senior members of the Medical Profession who have never had any real exposure to Plastic Surgery as a defined specialty, we can ensure that the doctors of the future have a better idea of who we are and what we do.

I am delighted to say that at the Medical School of the Chinese University of Hong Kong all final year medical students have a designated attachment to the Division of Plastic, Reconstructive and Aesthetic Surgery which is one of the Specialty Teams in the University Department of Surgery. We have had to consider carefully what to teach in the little time available[3] but the first point to consider is that Plastic Surgery is an overall and inclusive term (Fig 2).

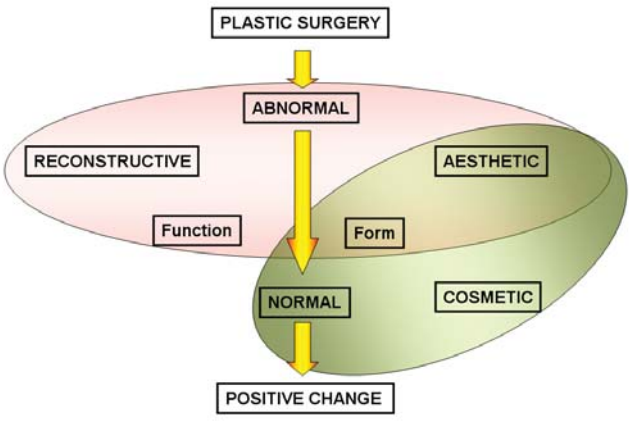


Figure 2 This Venn diagram indicates the essential difference between Reconstructive Plastic Surgery and Cosmetic Plastic Surgery. Both are based on similar Aesthetic principles but the Reconstructive patient presents with some 'abnormality' which is going to be corrected. The Cosmetic patient presents essentially within the range of normality and their features are going to be enhanced.

'Plastic' is the term that was originally used to describe the malleable properties of the skin and soft tissues that could be harnessed in the processes of closing defects in the skin and/or changing deformities due to scarring. I like to think of Plastic Surgery as a specialty whose goal is to produce of positive change in form and function using a variety of surgical and non-surgical techniques that are primarily, but not exclusively, applied to the skin and soft tissues. The essential message then is that Plastic Surgery is a surgical specialty restricted neither by age, sex or regional anatomy whose principal goal is to enhance quality of life. So what about the applications of the specialty?

Again this can be simplified into terms of the condition of the patient at the commencement of the Plastic Surgical intervention. If the patient is in a state of abnormality or deficiency and the goal is to reconstruct what is lost or deficient and produce a result which is nearer to perceived normality then we can call this Reconstructive Plastic Surgery. If the patient or subject of the Plastic Surgical intervention presents in a generally perceived state of normality and the goal is to enhance the appearance then we would regard this as Cosmetic Plastic Surgery.

Surgical interventions and goals of both Reconstructive and Cosmetic Plastic Surgery are predicated on well defined Aesthetic principles of beauty, harmony, shape and form as well as less tangible but equally functional equivalents of grace and naturalness.

There is far more to Plastic Surgery than just the technical aspects of surgery. The Plastic Surgeon has to deal more intimately with the psychological dimensions of the patient more than in other specialty of surgery.

In recent issues of the Hong Kong Medical Diary the rich diversity of the Reconstructive Plastic Surgical Practice has been highlighted. Table I lists areas of specialisation where the Reconstructive Plastic Surgeon has specialised training and expertise to deliver the state of the art care in the Public Sector.

Table I Reconstructive Procedures

• Head and Neck Reconstruction
• Breast Reconstruction
• Acute and Reconstructive Burns Care
• The Management of Vascular Malformations
• Cutaneous Surgical Oncology
• The Management of Congenital Anomalies of Skin, Soft Tissues and the Cranio-facial Skeleton
• The Management of Maxillo-facial Trauma
• Complex Soft Tissue Reconstruction after Extensive Urogenital Cancer Extirpation
• The Management of Chronic and Complex Wounds

None of the applications of Plastic Surgery listed in the table can be considered Cosmetic Surgery. All of them are essential aspects of a comprehensive healthcare service and require appropriate resource allocation. This allocation is, however, not forthcoming if the perception of the specialty is devalued. It is most unfortunate to hear our professional colleagues and hospital executives who do not understand what the specialty has to offer and describe it dismissively as 'just cosmetic surgery'. This is unfortunate on two counts: Reconstructive Plastic Surgery is very different from Cosmetic Plastic Surgery. Equally important is that Cosmetic Surgery is, in its own right an extremely demanding branch of Plastic, Reconstructive and Aesthetic Surgery. Table II lists some of the procedures currently available which can be considered to be 'Cosmetic'.

Table II Cosmetic Procedures

• Arm Lift	• Body Contouring
• Body Lift	• Botox & Tissue Fillers
• Breast Augmentation	• Breast Lift
• Brow Lift	• Chemical Peel & Dermabrasion
• Chin Surgery	• Ear Surgery
• Eyelid Surgery	• Facelift
• Facial Implants	• Hair Replacement
• Liposuction	• Nose Surgery
• Skin Rejuvenation & Resurfacing	• Thigh Lift
• Tummy Tuck	

This list is by no means exclusive and new procedures and strategies are being added on a regular basis. The major concern is to ensure the safety and efficacy of such procedures. The HKSPRAS played a major role in raising public awareness about the use of polyacrilamide hydrogels for breast and other soft tissue augmentation.

Within the context of the specialty of Plastic, Reconstructive and Aesthetic surgery the Reconstructive, and Cosmetic, Practices are but two sides of the same coin. Both aspects bring rich professional rewards in terms of challenge and fulfillment. Of course there is the potential to reap rich financial rewards in the private sector but this does not come without a professional price; patients are very demanding and the margin of error is extremely limited. In the public sector the reconstructive challenges are much greater and require vision and commitment to deliver the state of art

management the patients deserve. The specialty is going through a somewhat painful transition phase in the public sector as we seek to establish our rightful place in the distribution of resources. In our surgical practice we learn to take a long term view and 'vision' is a very important attribute for the successful Plastic, Reconstructive and Aesthetic Surgeon. That patience and 'vision' can give us comfort that the specialty is going to survive and thrive as an essential part of 21st Century Health Care.

References

1. Burd A. Salamanders, lizards and ubiquitous stem cells. J Plast Reconstr Aesthet Surg 2008;61:121-123.
2. Kumar A, Godwin JW, Gates PB, et al. Molecular basis for the nerve dependence of limb regeneration in an adult vertebrate. Science 2007;318(5851):772-777.
3. Burd A, Chiu T, McNaught C. Plastic surgery in the undergraduate curriculum: the importance of considering students' perceptions. Br J Plast Surg 2004;57:773-779.

How I Spend My Time After Work

Dr. Man-kwong Tung

MBBS(HKU), FCSHK, FRCS (Edin), FRCS (Glas), FHKAM (Surgery), Specialist in Plastic Surgery

Associate Director, Plastic & Reconstructive Surgery Centre,
Hong Kong Sanatorium & Hospital

Dr. Man-kwong Tung

Most of the Hong Kong doctors of my generation have had experience working in the Medical & Health Department, followed by the Hospital Services Department or the Department of Health, then finally either the Department of Health or the Hospital Authority, before working directly in the community. During these periods, our minds & behaviour are very much shaped by the working styles of the successive administrations; i.e. from dedication, diligent & whole-hearted service to the very modern, unemotional & cost conscious attitude. The statement made by one of the Chief Executives in his official forum to the staff: "**I want you to work smart, not to work hard!**" gave the greatest shaping effect. Fellow colleagues became more punctual & time conscious. Those engaged in "on call = stand by" roster would keep their pagers on, respond or delegate by phone; instead of anticipation in their hospitals. Thanks to this "Work Smart" Chief Executive, a new horizon has now opened up to us & we have more time to families & ourselves than before.

The remaining part of this paper is a summary account of how I spend my time after work. Fellow colleagues are welcomed to e-mail me if they want further elaboration on interesting areas in this paper.

During weekdays, I end my work in the hospital around 5 PM & drive back home enjoying either RTHK 4 FM 97.6 - 98.9 or Metro Finance FM 102.4 - 106.3. After going through my mail & mark out the journals' bits that need serious reading, I set the TV to a news channel. If I feel tired, I will lie down on the sofa & flip through the channels before I doze off till dinner is ready around 7:00 to 7:30 PM. If I am not tired, I will sit up, watch the TV & read during the advertising programmes. There is a strong reading lamp placed near the sofa. Other than the journals, my usual reading material at this hour is either the信報 Hong Kong Economic Journal or the飲食男女 Eat & Travel Weekly. I have been reading the 信報Hong Kong Economic Journal for over a decade. There are all the information & commentaries on investments, economy & political situations as well as a lot of columns on gourmets, travel, art, history, personal hobbies etc. The 飲食男女 Eat & Travel Weekly is also very interesting & informative, though I only consider the commentaries from the non- advertising pages.

Once a week I pick up my wife at the residence gate & we go to the supermarket at Festival Walk or at Lok Fu Centre to replenish the home rations & our snacks. As there are apartment stores, bookshop & food outlet in the same area, we can always make unplanned changes for our evening arrangements.

After dinner I will return to my usual sofa position & watch my TV. There is no special favourite; just changing the channels until something interesting turns up; & if not I will doze off again. With clock like precision my 80+ pounds golden Labrador will start to rouse me up at 9:00 PM so that I will take him out for his night walk. The stroll along Prince Edward Road takes about half an hour. After the stroll, I will go to enjoy a relaxing shower.

The second part of my evening programme starts after the shower, usually in my library. The desktop, TV & the surround sound audio system connected to them will all be switched on. The recent installation of the Olevia Digital Terrestrial Receiver & HDTV Digital Antenna (indoor antenna) has resulted in the rejuvenisation of the old cathode tube TV, giving a much sharper, & shadowless image. (your mansion needs to be within 慈雲山Temple Hill transmission area) Having very good illumination & sitting on a comfortable chair with headrest, I start to read my newspaper, journals & magazine; & again doze off prn. If I come across any useful information, I will use my Planon Colour Docupen to scan the page & transfer to harddisk files later. This hand held scanner is very convenient, just the size of a long fat ball pen. One can bring this into any place to retrieve the information you come across on printed material; independent from immediate computer support & up to 2 Giga bites. When there is a restaurant or place I find interesting, I can use the中原地圖www.centamap.com to locate the exact position, car parks nearby & the satellite photos. More information on the restaurant can be retrieved from web sites like開飯喇Openrice at www.openrice.com. Then I will check my e-mail & may send out a reply.

Around 10:30 PM my third part of the evening programme starts with may be a few games of tennis with my wife using Wii Sport software of the Nintendo Wii TV Game. It provides to this middle aged couple with the same purpose of exercise in the tennis court without having to leave home. The exercise is never too vigorous to make you sweat in the cool weather or in the air-conditioned living room in the hot summer. After the game I will read my fiction, either the printed versions or through the website. The stories I like are related to combat (WW II or WW III scenario), espionage (WW II or cold war scenario), Chinese

martial arts & crime. For the printed versions, they are more economical to buy English (it's cheaper word for word). However printed versions still cost & occupy space in the limited bookshelves; & need maintenance. In recent years, there are a lot of websites that provide fictions of different types for reading (available in Chinese & English). The Chinese websites seem to suit my need more comprehensively. One can find various kinds of stories at亦凡公益圖書館 www.shuku.net, & combat stories at鐵血網www.tiexue.net. They are in simplified Chinese characters & if you find them a bit difficult to read you can download free conversion software from南極星at http://www.njstar.com. One of my favourite short combat stories is the 新甲午風雲at www.shuku.net/novels/wars/xjiawufengyun/jwfy.html. As for long combat stories I like the 石油咽喉保衛戰 (修改稿) at http://book.tiexue.net/Chapter/10429/. You will be emotionally motivated to continue reading till the last page. If you like Tom Clancy's writing, then you will definitely love those I have mentioned, & they are free of charge! You will share the writers' passion & emotion, & sense the historical responsibilities passed on to us in traditional Chinese families.

The hospital work on Saturdays ends around 1:00 PM & I can meet my family in Causeway Bay for lunch. My usual places are the brunch of Dickens Bar at The Excelsior Hotel, 合發茶餐廳or 泉章居. Dickens Bar has a cozy environment. It is relatively quiet & well lighted for newspaper & magazine (from the rack), books & journal reading, or personal gaming devices. Wireless internet service is available for your computer at reasonable charge. The brunch is from 11:30 AM to 4:00 PM. The buffet food is English style breakfast & curry lunch; off course you can order separate. At present there is also smoking area after 1:00 PM for you further relaxation & enjoyment. As a nonsmoker I consider ventilation to be excellent. 合發茶餐廳is well organised & the food is prepared with passion. This restaurant has been commented by 信報in one of its articles on good corporate management. I like the curry choices, the club sandwich & the 大排檔 milk tea. 泉章居needs no introduction. You can get table easily on Saturdays after 2:00 PM & there are more choices other than the lunch & dinner usual. To me the 霸王雞 is a must; even for the religious vegetarian. After lunch we will go shopping for a while, may be to buy some cold rations from 和興行. Back home I will spend my time in my library doing the usual things or enjoy my siesta with the whole family. We dine out on Saturdays & will usually be late because of the late & possibly heavy lunch; unless we choose to eat buffet. The rest of the evening is similar to the third part of my evening programme on weekdays. We share the bed with the dog on Saturdays so that it will sleep soundly & not call us up loudly at 7:00 AM.

For me, life on Sundays starts around 9:30 AM. From time to time we will bring the dog to Sai Kung Pier area around 10 AM, so that it can meet its fellow dogs, run around; & finish the outing with the enjoyment of a soft ice cream cone. Otherwise I will spend time in my library till about 11:30 AM when I will call up everyone in the family & set out for lunch by noon. We tend to eat light on Sunday afternoons usually at 鹿鳴春 Spring Deer Restaurant in Tsim Sha Tsui, Dickens Bar or another restaurant that serves buffet. It is impossible to book鹿鳴春for dinner less than 2 weeks ahead; but for lunch on Sundays you only need to book 2 to 3 days ahead for large table. A table for 2 is usually available if you arrive before noon. The items are voluminous & delicious. The service is good as nearly all waiters are stockholders of the restaurant. If we eat light, then it will be at 地茂館in the Kowloon city; may be just a bowl of wan tong soup & a bowl of congee. We may also have lunch according to recommendation by飲食男女 Eat & Travel Weekly. Once or twice each month, we like to wander around鴨寮街Apliu Street, Golden Computer Centre & Golden Computer Arcade. The Golden Computer Centre & Golden Computer Arcade are similar to but much larger & sell cheaper than the Wan Chai 298 Computer Centre & the Causeway Bay Windsor House computer shops. The Apliu Street is a special kind of shopping paradise, especially for men. One can buy all sorts of mobile phones, electrical & electronic gadgets, optical instruments, audio & video devices, & instruments for domestic repair/maintenance. There are a lot of small restaurants & food stores selling delicious meals & snacks, for example at the junction of Apliu Street & Kweilin Street you can taste the best deep fried pig colon 炸大腸in town. We will be back home around 5 to 6 PM & the rest of the programme will be similar to Saturday.

I wake up on every weekday at 6:20 AM. All the formalities in the bright washroom would be completed by 7:00 AM; including the morning newspaper. Then I get changed, while watching the TV news, before taking my dog for the morning walk. By 7:35 AM I start my journey to hospital & avoid the traffic congestion; & enjoying my favourite radio programmes.

The community has changed a lot in the past decades. Working after office hours is considered an inefficiency rather than dedication; so we might as well enjoy the off work hours everyday as if this is the last day of our life. Who will know what happens tomorrow. Just as the lyrics from Doris Day's song says: **'whatever will be will be, the future not our eyes to see, kay sara sara, what will be will be, kay sara sara'.**

Dermatological Quiz

Dr. Lai-yin Chong

MBBS(HK), FRCP(Lond, Edin, Glasg), FHKCP, FHKAM(Med)

Yaumatei Dermatology Clinic, Social Hygiene Service

Dr. Lai-yin Chong

Fig 5 : Inflammed vesiculo-pustular plaque at dorsum of right hand

A 30-year-old fishmonger developed a tender erythematous plaque at dorsum of the right hand for three months. He noticed some purulent discharge from the lesions. He could not recall any history of injury at the site of lesion. Past health was good. He had been treated with ampicillin and cloxacillin without any response.

Questions:

1. What is your provisional diagnosis or differential diagnosis?
2. What investigations will you perform?
3. What is the commonest causative organism of your provisional diagnosis?
4. What is the treatment?

(See P. 35 for answers)

Federation News

On 30 May, the Federation organised a forum on the HealthCare Reform Consultation Document. It has been our honour to have Mrs. Ingrid Yeung, the Deputy Secretary for Food and Health (Health), Dr. the Hon Kwok Ka Ki and Dr. the Hon Joseph Lee, Legislative Council Members, and Mr. Peter Tam, the Chief Executive of Hong Kong Federation of Insurers as our guest speakers to share their views on the healthcare reform. More than 20 representatives from 13 Member Societies joined the discussion. The Forum has been successful in providing opportunities for the direct dialogue among Bureau representatives, Legislative Council members, insurance field leader and our medical and health professionals. There were enthusiastic discussions that not only allow members to express their concern directly to the government officials but also facilitated mutual understanding among all parties.

News from Member Societies:

The Hong Kong Society for Immunology
Updated office-bearers for the year 2008-2009 are as follows: Chairman: Dr. Liwei LU; Honorary Secretary: Dr. Wenwei TU; Honorary Treasurer: Dr. Danny LEUNG

The Hong Kong Neurosurgical Society
Updated office-bearers for the year 2008-2010 are as follows: President: Dr. Chi-keung WONG; Honorary Secretary: Dr. Yin-chung PO; Honorary Treasurer: Dr. Kwong-yui YAM

Society's Message

The Society of Anaesthetists of Hong Kong


Dr. Steven Wong

The Society of Anaesthetists of Hong Kong is one of the oldest medical societies in Hong Kong. Founded in 1954 by Dr. Z. Lett, our Society has nurtured the development of the specialty of anaesthesia in Hong Kong. Over the past half a century, the Society has strived to uphold the standard of practice of anaesthesia to attain international recognition.

With the establishment of the Hong Kong College of Anaesthesiologists in 1989 as the official organization to provide professional training and accreditation, the Society now serves to provide continued education to our fellows, provide the public with knowledge related to the field of anaesthesia, critical care and pain medicine, and foster fraternity within our specialty as well as with our sister societies both locally and internationally.

The Society, joined by the College, holds annual scientific meetings. The theme this year is "Mother, Baby and Anaesthesia". It will be held on 22 - 23rd November 2008. We are also proud to announce that we will be bidding to host the World Congress of Anaesthesiologists in Hong Kong in the year 2016. For more updated information on our activities, please visit our website at www.sahk.hk.

Dr. Steven Wong
President
The Society of Anaesthetists of Hong Kong

Hong Kong Society of Flow Cytometry

Hong Kong Society of Flow Cytometry, a non-profit making scientific and educational organization, was established in 1994 by a group of flow cytometry enthusiasts working in different disciplines of biomedical research. The primary objective of the Society aims at promoting research, development and applications in the field of flow cytometry and providing a platform for local scientists and medical professionals to update their knowledge and to share their expertise in this rapidly advancing technology.

Annual scientific meeting and annual general meeting are usually held in the first quarter of each year, followed by occasional seminars, workshops and symposiums. The Society's newsletter, Flow News, is published annually and distributed to members for dissemination of flow cytometry-related news and views.

Office-bearers for the year 2007-2008 are as follows: President, Dr. Danny Leung; President-Elect, Prof. CK Wong; Hon. Secretary, Dr. Samantha Lun; Hon. Treasurer, Ms. Yonna Leung; Council members: Prof. KM Lau, Prof. Karen Li, Prof. Ken Liu, Prof. Liwei Lu, Prof. Jennifer Wan.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		* Sports & Health Exhibition - New Concepts & New Technology in a Modern Society (1 - 31 July 08) 1	* HKMA Orchestra Rehearsal 2	* HKMA Council Meeting 3	4	* Infectious Diseases - Diagnosing Common Infections in General Practice 5
* HKMA Structured CME Programme at Queen Elizabeth Hospital Year 08/09 (IV) - ENT * HKMACF Charity Concert 6	* Workshop on Facilitating Communication in Children with Autistic Features * A Miserable Lady with Miscrable Urinary Symptoms 7	* FMSHK Officers' Meeting * HKMA - Tai Po Community Network CME Lecture on New Treatment Tips on the Management of COPD 8	* HKMA Orchestra Rehearsal 9	* HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2008 (VII) 10	* Mid-Year Scientific Meeting * Hong Kong Surgical Forum, Summer 2008 11	* Hong Kong Surgical Forum, Summer 2008 * Refresher Course for Health Care Providers 2007/2008 (XI) - Contraception and New Developments 12
* HKMA Tenpin Bowling Tournament 13	* Workshop on Facilitating Communication in Children with Autistic Features 14	15	* HKMA Orchestra Rehearsal 16	* FMSHK Executive Committee Meeting * Annual General Meeting 17	18	* HKMA Orchestra Concert 19
* Joint Professional Badminton Tournament 20	* Workshop on Facilitating Communication in Children with Autistic Features 21	22	* HKMA Orchestra Rehearsal 23	* FMSHK Foundation Meeting 24	25	26
* 6th Summer Vigor 2008 Mini Dragon Boat Races * Hong Kong Surgical Laser Forum 2008 and Advanced Certificate Course in Lasers, Light & Radiofrequency 27	* Workshop on Facilitating Communication in Children with Autistic Features 28	29	* HKMA Orchestra Rehearsal 30	31		

Medical Diary of July

Date / Time	Function	Enquiry / Remarks
Tue-Sat: 10:00 am - 5:00 pm, Sun & PH: 1:00 pm - 5:00 pm, Mon: Closed **1 TUE** *(1 - 31)*	**Sports & Health Exhibition - New Concepts & New Technology in a Modern Society** Organised by: Hong Kong Museum of Medical Sciences & Hong Kong Science Museum # Hong Kong Museum of Medical Sciences, 2 Caine Lane, Mid-Levels, Hong Kong	Mr. NG / Mr. CHAN Tel: 2549 5123 Fax: 2559 9458
8:00 pm **2 WED** *(9,16,23,30)*	**HKMA Orchestra Rehearsal** Organised by: The Hong Kong Medical Association # Pui Ching Education Centre	Ms. Candy YUEN Tel: 2527 8285
8:00 pm **3 THU**	**HKMA Council Meeting** Organised by: The Hong Kong Medical Association Chairman: Dr. K CHOI # HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Christine WONG Tel: 2527 8285
1:30 pm **5 SAT**	**Infectious Diseases - Diagnosing Common Infections in General Practice** Organised by: The Hong Kong Medical Association Chairman: Dr. K CHOI & Dr. Thomas SO Speaker: Dr. LEE Lai Shun Nelson, Dr. HO King Man, Dr. KAM Kai Man & Dr. CHENG Chi Chung Vincent # Hospital Hall, 8/F., Block G, Princess Margaret Hospital	Miss Viviane LAM Tel: 2527 8452
2:00 pm **6 SUN** 7:30 pm	**HKMA Structured CME Programme at Queen Elizabeth Hospital Year 08/09 (IV) - ENT** Organised by: The Hong Kong Medical Association & Queen Elizabeth Hospital Speaker: Dr. CHU Tsun Cheong, Dr. John C.F. CHAN & Dr. LEE Chi Leung **HKMACF Charity Concert** Organised by: The Hong Kong Medical Association Charitable Foundation Chairman: Dr. P.C. CHOW # Concert Hall, Hong Kong City Hall	Miss Viviane LAM Tel: 2527 8452 (Registration fee is required) 3 CME Points Ms. Candy YUEN Tel: 2527 8285
7:00 pm - 8:30 pm **7 MON** *(14,21,28)* 7:30 pm - 8:30 pm	**Workshop on Facilitating Communication in Children with Autistic Features** Organised by: The Federation of Medical Societies of Hong Kong & The Hong Kong Association of Speech Therapists Speaker: Various # Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong **A Miserable Lady with Miscrable Urinary Symptoms** Organised by: Hong Kong Urological Association Chairman: Dr. NG Man Tat Speaker: Dr. LO Ka Lun # Seminar Room, G/F, Block A, Queen Elizabeth Hospital, Kowloon	Ms. June TSANG Tel: 2527 8898 Fax: 2865 0345 Dr. HUNG Hing Hoi / Ms. Siddy MA Tel: 2958 6006 Fax: 2958 6076 1 CME Points
8:00 pm - 10:00pm **8 TUE** 1:45 pm	**FMSHK Officers' Meeting** Organised by: The Federation of Medical Societies of Hong Kong # Gallop, 2/F., Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong **HKMA - Tai Po Community Network CME Lecture on New Treatment Tips on the Management of COPD** Organised by: HKMA - Tai Po Community Network Speaker: Dr. CHAN Ka Wing # Capital Restaurant, Tai Po	Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345 Miss Viviane LAM Tel: 2527 8452 2 CME Points
2:00 pm **10 THU**	**HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2008 (VII)** Organised by: The Hong Kong Medical Association and Hong Kong Sanatorium & Hospital Speaker: Dr. WONG Wai Sang # HKMA Dr. LI Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Cental, Hong Kong	Miss Viviane LAM Tel: 2527 8452 (Registration fee is required) 1 CME Points
12:30 pm - 5:00 pm **11 FRI** *(12)*	**Mid-Year Scientific Meeting** Organised by: Hong Kong Psychogeriatric Association Speaker: Various # 1/F, Block S, Castle Peak Hospital, Tuen Mun, New Territories **Hong Kong Surgical Forum, Summer 2008** Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Centre; Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons # Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong	Ms. NG Tel: 2456 8080 Email: info@hkpga.org Website: http://www.hkpga.org Forum Secretary Tel: 2855 4885 Fax: 2819 3416 Email: hksf@hkucc.hku.hk Website: http://www.hku.hk/surgery
2:30 pm **12 SAT**	**Refresher Course for Health Care Providers 2007/2008 (XI) - Contraception and New Developments** Organised by: The Hong Kong Medical Association & Our Lady of Maryknoll Hospital # Training Room II, 1/F., OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon, Hong Kong	Ms. Clara TSANG Tel: 2354 2440
2:00 pm **13 SUN**	**HKMA Tenpin Bowling Tournament** Organised by: The Hong Kong Medical Association # South China Athletic Association	Ms. Dora HO Tel: 2527 8285
8:00 pm - 10:00 pm **17 THU** 9:00 pm	**FMSHK Executive Committee Meeting** Organised by: The Federation of Medical Societies of Hong Kong # Council Chambers, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong **Annual General Meeting** Organised by: The Hong Kong Medical Association # HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345 Ms. Christine WONG Tel: 2527 8285
8:00 pm **19 SAT**	**HKMA Orchestra Concert** Organised by: The Hong Kong Medical Association # Tsuen Wan Town Hall	Ms. Candy YUEN Tel: 2527 8285
20 SUN	**Joint Professional Badminton Tournament** Organised by: The Hong Kong Medical Association # MMRC	Ms. Dora HO Tel: 2527 8285
8:00 pm - 10:00 pm **24 THU**	**FMSHK Foundation Meeting** Organised by: The Federation of Medical Societies of Hong Kong # Council Chambers, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345
8:30 am **27 SUN** 8:30 am - 5:00 pm	**6th Summer Vigor 2008 Mini Dragon Boat Races** Organised by: The Hong Kong Medical Association **Hong Kong Surgical Laser Forum 2008 and Advanced Certificate Course in Lasers, Light & Radiofrequency** Organised by: Hong Kong Surgical Laser Association Speaker: Various # L'Hotel Nina et Convention Centre, Tsuen Wan, New Territories	Ms. Dora HO Tel: 2527 8285 Ms. Sue CHENG Tel: 6036 9629 Fax: 2301 1362 Email: registration@hkslaser.com Website: www.hkslaser.com

Meetings

10/8/2008	**Joint Asian Pacific Osteoporosis Foundation and International Osteoporosis Foundation "Osteoporosis in Asia: Challenges and Controversies"** Organised by: International Osteoporosis Foundation, Asian Pacific Osteoporosis Foundation, Centre for Health and Medical Research, Hong Kong, Hong Kong Orthopaedic and Osteoporosis Center for Treatment and Research Speakers: Prof. Ego SEEMAN, Prof. Philip SAMBROOK, Prof. Steve CUMMINGS, Prof. Edith LAU and Dr. Dicky LAM Enquiry: Contact secretariat at tel: (852) 2116 4333, fax: (852) 2559 6910, e-mail: gladys.wong@asia.cmpmedica.com
26 - 28 /9/2008	**3rd Regional Conference in Dermatological Laser and Facial Cosmetic Surgery 2008** Organised by: The Hong Kong Association of Specialists in Dermatology and Venereology & Hong Kong Society of Plastic, Reconstructive and Aesthetic Surgeons # Hong Kong Convention and Exhibition Centre, Wanchai, Hong Kong Enquiry: Ms. Ruby LUI Tel: 3151 8813 Fax: 2590 0099 Website: www.dlfcs2008.com
22-25/11/2008	**2nd Asian Preventive Cardiology & Cardiac Rehabilitation Conference cum 7th Certificate Course in Cardiac Rehabilitation** Organised by: Hong Kong College of Cardiology Co-Chairman: Prof. LAU Chu Pak & Dr. LAU Suet Ting Speaker: Various # Hong Kong Convention & Exhibition Centre, 1 Expo Drive, Wanchai, Hong Kong Enquiry: Secretariat Tel: 2527 8285 Fax: 2865 0943 Email: dorahkma@hkma.org Website: http://www.apccrc.com
27-30/11/2008	**Human Dignity in Modern Medicine & 14th Congress of Asian Federation of Catholic Medical Associations** Organised by: The Guild of St. Luke, St. Cosmas and St. Damian Hong Kong Chairman: Dr. Peter AU YEUNG Speaker: Prof. Fr Louis Aldrich SJ & Prof. Luke Gormally # Catholic Disease Centre Enquiry: Congress Secretariat Tel: 2363 0598 Fax: 3764 0579
20-22/2/2009	**CardioRhythm 2009** Organised by: Hong Kong College of Cardiology & Chinese Society of Pacing and Electrophysiology Co-Chairman: Prof. LAU Chu Pak Enquiry: Secretariat Tel: 2899 2035 Fax: 2899 2045 Email: info@cardiorhythm.com Website: http://www.cardiorhythm.com

Courses

9/8/2008	**Colposcopy Workshop 2008** Organised by: The Hong Kong Society for Colposcopy & Cervical Pathology, Department of O&G, Tuen Mun Hospital Chairman: Dr. S.M. CHAN Speaker: Various # The Auditorium, 8/F, Southern Centre, 130 Hennessy Road, Wanchai, Hong Kong Enquiry: Ms. Phyllis KWOK Fax: 2855 0947 CME Accreditation: 3.5 Points (for HKCOG, HKCPath, MCHK, CNE)

Upcoming Certificate Courses of the Federation of Medical Societies of Hong Kong

Date	Course No	Course Name	Co-organiser	Target Participants
7 Jul - 11 Aug 2008	C130	Workshop on Facilitating Communication in Children with Autistic Feathures	The Hong Kong Association of Speech Therapists	General Public
5 Aug - 16 Sep 2008	C132	Common Psychiatric Problems for GPs and Healthcare Professionals	The Hong Kong College of Psychiatrists	General Practitioners & Healthcare Professionals
4 Sep - 25 Sep 2008	C134	Clinical Management of Vertigo	NIL	General Practitioners & Paramedic

Answer to Dermatological Quiz

Answer :

1. Taking account of the clinical features and his occupation, the provisional diagnosis is atypical mycobacterial infection. Other differential diagnoses include sporotrichial infection, leishmaniasis and mycobacterium tuberculosis
2. Skin biopsy for histology, tissue for AFB smear and culture for atypical mycobacteria, mycobacterium tuberculosis and deep fungi.
3. Mycobacterium marinum is the commonest causative organism in atypical mycobacterial cutaneous infection. According to one local survey, it accounts for 52%, followed by M. avium- intracellulare (9%) and M. chelonae (6%).[1] Only about half of the cases can recall a history of injury at the site of lesion.
4. M. marinum infection can be treated with minocycline or co-trimoxazole.

Reference:

1. *Atypical mycobacterial cutaneous infections in Hong Kong: 10-year retrospective study*
Ho MH, Ho CK, Chong LY. Hong Kong Med J 2006;12:21-6.

Dr. Lai-yin Chong
MBBS(HK), FRCP(Lond, Edin, Glasg), FHKCP, FHKAM(Med)
Yaumatei Dermatology Clinic, Social Hygiene Service

How long will you keep her living with melasma?

Melasma can put a woman's life on hold. This cosmetically disfiguring and embarassing condition impacts her self esteem, which in turn affects her work, home and social life.[1]

Tri-Luma™ is the only triple combination cream clinically proven to treat melasma in Asian patients.[2] Now you can take her life off hold.

TRI-LUMA™ Cream is a triple-combination drug containing corticosteroid (fluocinolone acetonide 0.01%), retinoid (tretinoin 0.05%), and bleaching agent (hydroquinone 4%). It was proven safe for the intermittent treatment of melasma, with cumulative treatment time of at least 180 days. Because melasma usually recurs upon discontinuation of TRI-LUMA™ Cream, patients can be re-treated with TRI-LUMA™ until melasma is resolved.[3]

1. Balkrishnan R, Kelly AP, McMichael A et al. Improved quality of life with effective treatment of facial melasma: the pigment trial. *J Drugs Dermatol*. 2004;3:377-81. 2. Chan R et al. Efficacy and Safety Comparison of a Fixed Triple Combination (Fluocinolone Acetonide 0.01%, Hydroquinone 4%, Tretinoin 0.05%) vs Hydroquinone 4% Cream in Asian Patients with Moderate to Severe Melasma. Poster presented at the 2nd Conference of the Asian Society of Pigment Cell Research, Singapore. July 2007. 3. Torok H, Taylor S, Baumann L et al. A large 12-month extension study of an 8-week trial to evaluate the safety and efficacy of triple combinaton (TC) cream in melasma patients previousy treated with TC cream or one of it dyads. *J Drugs Dermatol* 2005;4: 592-7.

GALDERMA
Committed to the future of dermatology

Tri-Luma™ CREAM
Let women be themselves again.

Galderma Hong Kong Limited Unit 1601, 16/F., CRE Building, 303 Hennessy Road, Wanchai, Hong Kong. Tel: 2824 0333 Fax: 2827 7760

LIPITOR®
atorvastatin calcium
tablets

Power. Evidence. Confidence.™

Relax...

Because it provides well-proven CV mortality and morbidity data[1,2,3]

Because it gets 90% of patients to NCEP LDL-C goal[4]

Because it allows you to choose the appropriate start dose (10, 20 and 40mg) to meet your patients' needs[4]

Because it has NO causal association with proteinuria or hematuria[4]

Because it has more than 121 million patient-years of experience[5]

Because it is the No.1 prescribed statin in the world[5]

...Why choose anything else?

Pfizer Corporation Hong Kong Limited

16/F., Stanhope House, 738 King's Road, North Point, Hong Kong
Tel: (852) 2811 9711 Fax: (852) 2579 0599
Website: www.pfizer.com.hk

References: 1. Athyros VG et al. Treatment with Atorvastatin to the National Cholesterol Educational Program Goal Versus 'Usual' Care in Secondary Coronary Heart Disease Prevention. Current Medical Research and Opinion 2002;18(4): 220-228. **2.** Sever PS, Dahlöf B, Poulter N, Wedel H, et al, for the ASCOT Investigators. Prevention of coronary and stroke events with atorvastatin in hypertensive patients who have average or lower-than-average cholesterol concentrations, in the Anglo-Scandinavian Cardiac Outcomes Trial - Lipid Lowering Arm (ASCOT-LLA): a multicentre randomised controlled trial. Lancet. 2003;361:1149-58 **3.** Nissen SE, Tuzcu EM, Schoenhagen P, et al, for the REVERSAL Investigators. Effect of intensive compared with moderate lipid-lowering therapy on progression of coronary atherosclerosis: a randomized controlled trial. JAMA. 2004;291:1071-1080. **4.** Data on file. Pfizer Inc., New York, NY. **5.** IMS Global, March 2006.

Detailed prescribing information is available upon request.

LIP07002P

New

Cetaphil®

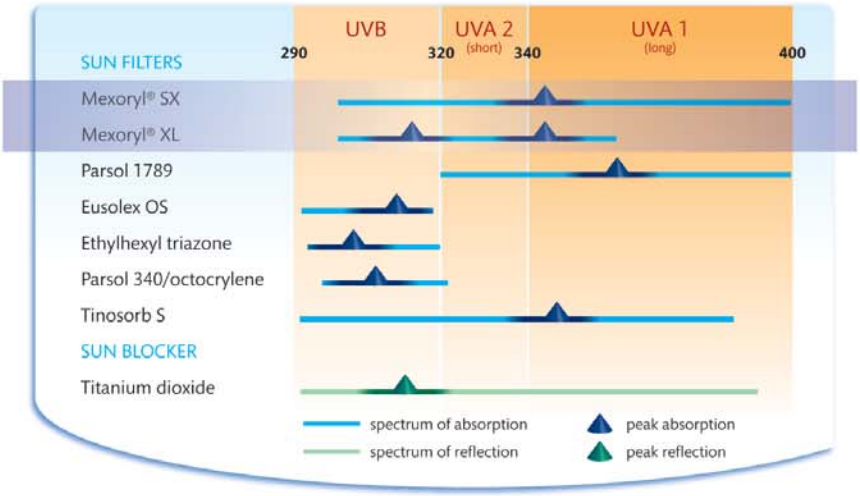
UVA/UVB Defense SPF 50+

Essential Photoprotection

In the management of photodermatoses

- Specifically designed for prescribing by dermatologists
- Water-resistant cream formulation for optimal adherence
- High-tolerance: hypoallergenic, non-comedogenic, fragrance-free[1]

Best-in-class broad-spectrum UV protection With 7 UV filters and 1 UV blocker[2]



Patented state-of-the-art Mexoryl® technology

- Synergistic effect of Mexoryl® SX and Mexoryl® XL for optimal UVA protection[3]
- Photostability of Mexoryl® contributes to the photostability of other filters in the system[2,3]

CTA - AD001 - 0308

References:
1. Cetaphil Defense UVA/UVB SPF 50+ Product Information Leaflet.
2. Guenther L. et al. Mexoryl: broad-spectrum ultraviolet A photoprotection. J Cutan Med Surg 2006;10 (Suppl. 1):S22-5.
3. Lowe N. An overview of Ultraviolet Radiation, Sunscreens, and Photo-induced dermatoses. Dermatol Clin 2006;24:9-17.

Galderma Hong Kong Limited
Unit 1601, 16/F., CRE Building, 303 Hennessy Road, Wanchai, Hong Kong. Tel: 2824 0333 Fax: 2827 7760

GALDERMA
Committed to the future of dermatology