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THE HONG KONG 香港醫訊  
*MEDICAL DIARY*

VOL.14 NO.7 JULY 2009



# Certificate Course on

**CME/CNE Course**

# Clinical Ophthalmology

Jointly organised by:

Course No. C148



**The Federation of  
Medical Societies of Hong Kong**



**The Hong Kong  
Ophthalmological Society**

Objectives: This course aims to provide an overview and update in the diagnosis and management of common and important eye diseases. After attending the course, attendees will learn how to deal with common ophthalmic conditions and when to refer patients to ophthalmologists.

Date	Topic	Speaker
2 September 2009	Cataract 白內障	Dr. Siu-Wah YUEN 袁紹華醫生
	Refractive Errors and Refractive Surgeries 屈光不正及手術	Dr. Kenneth W.H. NG 吳永浩醫生
9 September 2009	Squint 斜視眼	Dr. Joan S.K. NG 吳少琮醫生
	Corneal and External Eye Diseases 角膜及外眼疾病	Dr. Alvin L. YOUNG 楊樂叟醫生
16 September 2009	Common Ophthalmic Eye Drops 常用眼科滴眼液	Dr. Carol S. YU 余珊醫生
	Glaucoma 青光眼	Prof. Clement C.Y. THAM 譚智勇教授
23 September 2009	Paediatric Ophthalmology 兒童眼疾	Dr. Chung-Yin CHU 朱仲賢醫生
	Red Eyes, Ocular Trauma and Emergencies 紅眼, 眼部創傷及眼科急症	Dr. Suk-I CHIU 趙淑義醫生
30 September 2009	Diseases of Eye Lids, Lacrimal System and Orbit 眼瞼, 淚管及常見眼眶疾病	Dr. Pak-Man CHENG 鄭柏文醫生
	Neuro-ophthalmology 視神經眼科	Dr. Andy C.O. CHENG 鄭智安醫生
7 October 2009	Retinal Detachment and Diabetic Retinopathy 視網膜脫落及糖尿病眼病	Dr. Barbara S.M. TAM 譚秀雯醫生
	Common Macular Diseases 常見黃斑點疾病	Dr. Alvin K.H. KWOK 郭坤豪醫生

Dates: 2 September 2009 - 7 October 2009 (Every Wednesday)  
 Time: 7:00 p.m. - 8:30 p.m.  
 Venue: Lecture Hall, 4/F., Duke of Windsor Social Service Building,  
 15 Hennessy Road, Wanchai, Hong Kong  
 Language Media: Cantonese (Supplemented with English)  
 Course Fee: HK\$750 (6 sessions)  
 Certificate: Awarded to participants with a minimum attendance of 70%  
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### CME / CPD Accreditation in application

A total of 9 CNE points for the whole course and the points will be awarded according to the number of hours attended.  
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## Contents

### Editorial

- **Recent Advances in Minimally Invasive Surgery** 2

*Dr. Angus CW CHAN  
Dr. Wing-tai SIU*

### Dental Bulletin

- **Recent Development in Minimally Invasive Colorectal Surgery** 5

*Dr. CC CHUNG*

- **MCHK CME Programme Self-assessment Questions** 7

- **Minimally Invasive Thyroid and Parathyroid Surgery** 9

*Dr. Brian HH LANG*

- **Transanal Endoscopic Operation (TEO)** 13

*Dr. Kevin KK YAU*

- **Technical Pearls in Laparoscopic Myomectomy** 19

*Dr. Choi-man YAN*

### Dermatological Quiz

- **Dermatological Quiz** 16

*Dr. Ka-ho LAU*

### Society News

24

### Foundation News

24

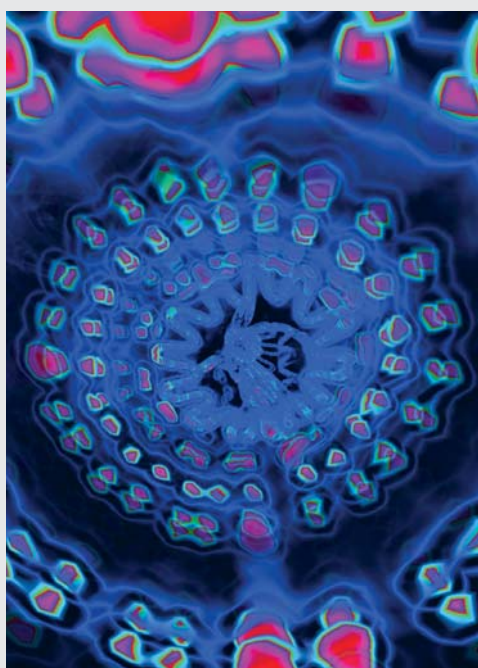
### Medical Diary of July

26

### Calendar of Events

- **Meetings** 28
- **Courses** 28

## The Cover Shot



### C'est la vie

Life is full of dynamism and ever evolving. There are entities that are tangible and within reach. Yet there are entities that are less tangible and evasive, such as love. We may leave a few sparkles along our path. It seems never ending until one day we suddenly realise that we have to face our eventual destiny. There are times when we have to choose between two paths and you never know whether you have made the right choice. There is no turning back.

I try to assimilate all these feelings into this artwork created from artistic rendering of 3D computed tomography (CT). It is a virtual endoscopic view looking downwards inside the upper part of a Zenith bifurcated abdominal aortic stent graft that has been implanted into a patient suffering from abdominal aortic aneurysm using minimally invasive surgery. The openings to the upper ends of the two limbs of the stent graft can be seen in the centre.



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**Recent Advances  
in Minimally  
Invasive Surgery**

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Dr. Angus CW CHAN

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Minimally invasive surgery (MIS) performed through small incisions reduces the trauma of wound access, improves the outcomes and hastens the recovery of many operative procedures. The advancement in technical skills and equipment innovation prompt the development of various surgical approaches in the management of different diseases entities. In the last decade, the indications and applicability of minimally invasive technique continue to broaden. This issue of the Medical Diary examines the recent advances in the minimally invasive surgical approach to a variety of disease conditions, ongoing areas of controversy, and future directions.

Laparoscopic colectomy for certain colorectal conditions, from what was initially regarded as a highly specialised operation performed only by a few enthusiastic surgeons, has evolved to become a standard procedure in many centres throughout the world. Nowadays, MIS has also been gradually incorporated into the clinical pathway of rectal cancer management.

Minimally invasive locoregional surgical treatment has been advocated for patients with early rectal cancers to achieve the same oncological clearance with less morbidity and better functional outcomes than major ablative surgery. Transanal endoscopic operation (TEO) was developed by incorporating with the existing laparoscopic instruments to perform endoluminal excision of early invasive cancers or pre-malignant lesions in the rectum.

The authors in this issue also address the recent development and various minimally invasive techniques for thyroid and parathyroid surgery. Technical pearls in laparoscopic myomectomy for uterine fibroids are thoroughly described in another section.

Undoubtedly, minimally invasive surgery revolutionised and became an integral part of surgical practice in the last two decades. Notwithstanding increasing number of minimally invasive procedures will be routinely applied for patient care in the foreseeable future, open surgery will continue to play a complementary role in managing patients who are not suitable for minimally invasive surgery or when conversion becomes necessary.

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# Healthcare Information Exchange – How Public Meets Private?

Workshop  
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This conference aims to provide an elaboration on the concept of HIE to doctors, IT Professionals and medical administrators. It serves as a forum for exchanging views on the establishment of a common e-patient data bank between public and private medical sectors. Experienced medical practitioners and current users of HIE technology from both local and overseas medical institutes are invited to share their valuable experience in using HIE systems. In addition, the conference includes a demonstration of current HIE technology so that participants will have a concrete idea of the latest technology available in the medical industry.

For more information, please visit : [www.cmcmgt.com.hk](http://www.cmcmgt.com.hk)

	Workshop	Conference
Date :	15 Jul 2009 (Wed)	
Time :	9:30am - 12 noon	2:30pm - 5:45pm
Venue :	15/F, VTC Tower, 27 Wood Rd, Wanchai, HK	HKCEC Meeting Room S421
Fee :	HK\$500	HK\$800
	HK\$1,200 for both (including lunch at HKCEC)	

## Topics\*

- How Public meets Private? An Overseas Experience
- Pilot Experience of PPI in Private Sector
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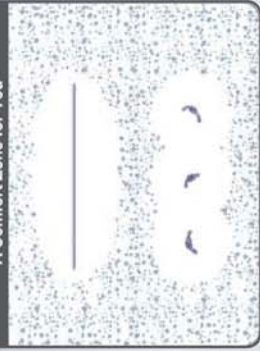
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# Recent Development in Minimally Invasive Colorectal Surgery

**Dr. CC CHUNG**

Consultant Surgeon and Chief of Lower GI Surgery, Pamela Youde Nethersole Eastern Hospital  
President, Hong Kong Society for Coloproctology



Dr. CC CHUNG

*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 2009.*

The development of minimally invasive surgery (MIS) in colorectal disease began with the first report of laparoscopic assisted colectomy in 1991<sup>1</sup>. There is now a wealth of evidence indicating the laparoscopic approach confers definite short term benefits to patients<sup>2,3</sup>. Even for colorectal cancer, a common malignant condition worldwide, evidence from randomised trials and large prospective studies fail to demonstrate any detriment in oncological parameters such as disease recurrence and patient's survival consequent to a laparoscopic approach<sup>2</sup>. As oncological feasibility is no longer a concern, MIS is increasingly developed and practised in patients with various colorectal conditions. This article attempts to summarise the recent development of MIS in the field of coloproctology.

## MIS for Rectal Cancer

As dissection deep down in the pelvis is technically demanding, early reports on laparoscopic rectal cancer surgery were dominated by high anterior resection (i.e. resection for tumours around rectosigmoid junction) and sphincter-ablating resection (i.e. abdomino-perineal resection)<sup>4-6</sup>; in the latter case the lateral or circumferential margin is usually dictated by the perineal surgeon rather than the laparoscopic surgeon. Progress in technology and skills, however, has finally led to the extension of MIS techniques to distal rectal cancer with sphincter preservation<sup>7</sup>. Although the number of randomised studies is still limited, the available evidence from large prospective series demonstrates its safety in experienced hands and an oncological clearance comparable to that of the open counterpart<sup>8-12</sup>.

In the last decade, MIS has been gradually incorporated into the clinical pathway of rectal cancer management. Investigators have shown that MIS in patients with prior neoadjuvant chemo-irradiation is safe and carries similar short term benefits as in patients without chemo-irradiation<sup>13</sup>. Even for tumour within 5cm from the anal verge, successful sphincter-preserving excision has been described using a combined laparoscopic and transanal technique<sup>14</sup>.

## MIS in Obstructive Colorectal Tumours

Like other advanced laparoscopic procedures, laparoscopic colectomy was only described and practised

in elective, "cold" cases before the turn of the century. The presence of intestinal obstruction, a common acute surgical emergency complicating colorectal malignancy, was generally considered as a contraindication for laparoscopic approach owing to limited access and poor exposure as a result of distended bowel. The advent of self-expanding endoluminal prosthesis (SEMS)<sup>15</sup>, yet another minimally invasive 'device', provided a logical solution and had tremendous impact in this surgical scene. Initially used as a palliative alternative for treating inoperable colon cancer, SEMS was subsequently used to decompress the acutely obstructed colon and serve as a 'bridge' to subsequent elective, laparoscopic resection. A recent randomised controlled study focusing on this combined, 'endo-laparoscopic' approach was just finished, and the results suggested significantly more patients in the 'endo-laparoscopic' group (as compared to conventional group who received emergency laparotomy) underwent successful one-stage operation, with fewer patients ending up in permanent stoma<sup>16</sup>. Most importantly, this 'endo-laparoscopic' approach allows patients with acute malignant large bowel obstruction to enjoy the full benefits of minimally invasive surgery.

In another prospective study SEMS was also found to be useful in patients with locally advanced, stenotic rectal cancer, in whom neoadjuvant chemo-irradiation is planned<sup>17</sup>. These patients might have otherwise required temporary faecal diversion before definitive surgery for fear of impending obstruction aggravated by radiotherapy.

## NOTES and Robotics in Colorectal Surgery

Clearly much of the development in MIS is brought about by advancement in technology. For instance, hand-assisted devices<sup>18</sup> were developed with a view to shorten operating time and to facilitate dissection in locally advanced, bulky tumours, though data from the literature so far remain conflicting<sup>19,20</sup>. Possibly inspired by transanal endoscopic microsurgery championed by Buess<sup>21</sup>, investigators have tried to develop other kinds of natural orifice transluminal endoscopic surgery (NOTES)<sup>22,23</sup>. Some of these procedures involve a 'hybrid' technique, combining laparoscopic and transluminal techniques; the first report of using this



kind of hybrid technique to perform 'incisionless' colectomy with intra-corporeal anastomosis in humans was just lately reported<sup>24</sup>. At the same time there is a recent enthusiasm for transanal endoscopy operation (TEO), as the new device is system-compatible with most MIS suites. This minimally invasive technique is suitable for benign tumours or early invasive cancer in the rectum.

Another recent development in this field related to technology is robotic-assisted colorectal resection. Hashizume et al from Japan were the first to publish their experience with telerobotic-assisted colorectal resections in 2002<sup>25</sup>. The first Da Vinci surgical system in China was installed in November 2005 in Hong Kong, with the first telerobotic-assisted laparoscopic abdomino-perineal resection performed in August 2006<sup>26</sup>. So far 5 centres in Hong Kong have installed or are planning to install the robotic system. Undoubtedly, the system can benefit the surgeons by providing excellent 3-D vision and ergonomics, but at the expense of inferior tactile feedback. Whether these benefits can be translated into better patient outcomes in a cost-effective way still needs further evaluation.

## Conclusion

Minimally invasive colorectal surgery has gone a long way since 1991. As we unfold the history, laparoscopic colectomy, from what initially a highly specialised operation performed only by a small group of privileged surgeons in research or university centres, has evolved to become now a more or less standard procedure in many centres throughout the world. The development was further catalysed by progress in technology, which has brought in new elements and concepts of MIS besides laparoscopy, as well as revolutionised significantly the management of certain colorectal conditions. The indication and applicability of MIS technique continue to broaden.

Minimally invasive colorectal surgery will continue to flourish in the coming decades. This is reflected by the establishment of various endo-laparoscopic operating suites<sup>27</sup>, robotic surgery centres, and training centres on laparoscopic surgery and NOTES. The next generation of colorectal surgeons will be entering a new era - the era of endo-laparoscopic surgery and robotic-assisted laparoscopic surgery. And this will be soon approaching.

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## MCHK CME Programme Self-assessment Questions

Please read the article entitled "Recent Development in Minimally Invasive Colorectal Surgery" by Dr. CC CHUNG 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 2009. 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. In treating colorectal cancer, laparoscopic approach is advantageous over open surgery in terms of oncological outcomes.
2. The main benefit of laparoscopic colectomy over open surgery is that it is associated with better short term outcomes in terms of patient recovery.
3. Data from multiple, large-scale randomised trials have confirmed laparoscopic excision for rectal cancers results in equivalent or better oncological clearance when compared to open surgery.
4. Patients with locally advanced rectal cancer requiring neoadjuvant radiotherapy should be excluded from laparoscopic technique after neoadjuvant treatment.
5. Abdomino-perineal resection (APR) is recommended for all rectal adenocarcinomas within 5cm from the anal verge.
6. Self-expanding endoluminal prosthesis (SEMS) is only used as a palliative treatment for inoperable colorectal cancers.
7. SEMS can help to relieve acute obstruction in patients with obstructing colonic cancer, and allows these patients to undergo elective laparoscopic excision under full bowel preparation at a subsequent stage.
8. Hand-assisted devices can greatly help shorten operative time during laparoscopic colectomy.
9. TEO provides a good alternative for poor risk patients suffering from early rectal cancers.
10. Robotic system provides better 3-D vision, ergonomics, as well as tactile feedback when compared to laparoscopic surgery.

## ANSWER SHEET FOR JULY 2009

Please return the completed answer sheet to the Federation Secretariat on or before 31 July 2009 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

### Recent Development in Minimally Invasive Colorectal Surgery

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1  2  3  4  5  6  7  8  9  10

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### Answers to June 2009 Issue

Overview and Update on Treatment of Common Temporomandibular Joint Disorders

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



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# Minimally Invasive Thyroid and Parathyroid Surgery

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Dr. Brian HH LANG

## Introduction

Since the 1980s, minimally invasive surgical techniques have attracted immense interest in all surgical specialties, including abdominal, thoracic and most recently head and neck surgery. This article aims at reviewing the emergence of minimally invasive thyroidectomy (MIT) and parathyroidectomy (MIP) and their applications to benign thyroid and parathyroid diseases respectively. For the purpose of this review, MIT and MIP will be considered separately as they deal with different pathologies.

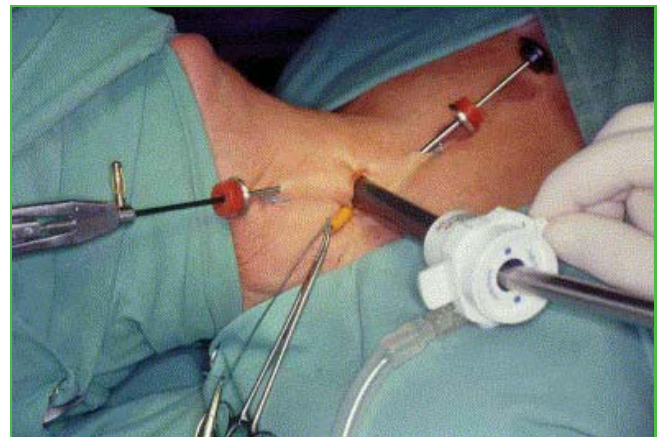
## MIT

The conventional thyroidectomy by making a skin crease incision in the anterior neck just over the thyroid gland has been the most efficacious way of treating a variety of thyroid pathologies as it provides good direct surgical access to facilitate safe dissection and is associated with low morbidity in experienced hands. However, some patients are still left with a relatively long scar in the neck. Furthermore, the majority of patients are women and they are understandably concerned about the aesthetic appearance of the scar. As a result, there has been an immense interest among thyroid surgeons to make smaller neck incisions or even to make "invisible" incisions (i.e. incisions outside the neck such that they are covered by clothing). The concept of MIT really gained momentum in 1996 when Gagner et al. performed a totally endoscopic subtotal parathyroidectomy for a 37 year old man suffering from familial hyperparathyroidism.<sup>1</sup> Although the operation took over 5 hours, it was a success. Since then, a variety of MIT techniques has been described. They can be grouped into two broad approaches with each having their own advantages and disadvantages and they are:

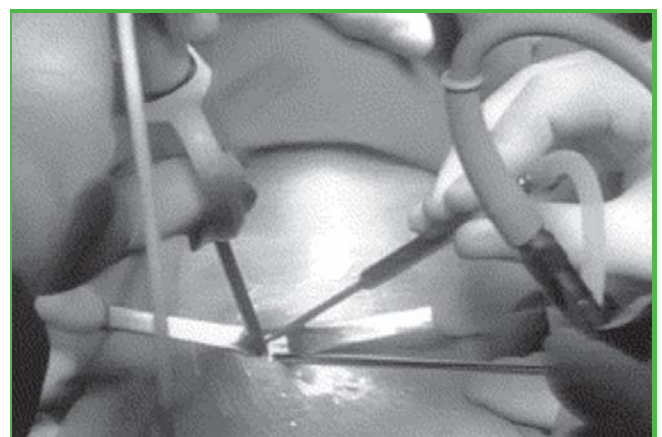
## The Cervical / Direct Approaches

These involve placing small, almost stab-like incisions in the anterior neck. The operating space is usually created by blunt dissection and maintained either with low pressure (6-8mmHg) CO<sub>2</sub> insufflation or by external skin retraction. Conventional laparoscopic instruments are often used. These approaches come in different forms and under different names. They include anterior cervical approach, lateral cervical approach (**Picture 1**) and video-assisted approach (**Picture 2**). The main advantages are the direct access to the gland and shorter neck incisions (usually < 1.5 to

2cm). To date, all published series reported less postoperative pain, better cosmesis and shorter hospital stay.<sup>2,3</sup> However, since incisions are made in the neck, for some, they remain "visible" and are prone to hypertrophy / keloid. Furthermore, some surgeons would argue that given the strict selection criteria used such as nodule size  $\leq 3$ cm in diameter or thyroid volume  $\leq 30$ ml, an open approach using a similar length incision is also possible.<sup>4</sup> This partly led some to pursue the extracervical / indirect approaches.



**Picture 1: Total endoscopic thyroid lobectomy using the lateral approach**



**Picture 2: Video-assisted thyroid surgery with central skin incision**

## The Extracervical / Indirect Approaches

These involve placing incisions outside the neck. Depending on preference and experience, some prefer making them in the axilla or chest while others prefer both. Nonetheless, extensive dissection under the skin

and subcutaneous layer is inevitable because incisions are made away from the thyroid gland. As a result, some authors reported prolonged paresthesia under the flap and muscle stiffness. In terms of the technique, similar to the cervical approaches, the operating space is maintained either by CO<sub>2</sub> insufflation (**Picture 3**) or external retraction by specially designed skin retractors (**Picture 4**). Undoubtedly, the operation is technically more demanding because of the limited operating space and is therefore associated with a significant learning curve.<sup>5</sup> However, having said so, several large series have been reported in various Asian countries with favourable outcomes.<sup>6-8</sup> This approach has yet to become standard, particularly in the West. The main controversy lies in the fact that these procedures involve extensive dissection (and therefore, the name "MIT" might be inappropriate) and are often performed for "softer" indications.<sup>9</sup> Nevertheless, the procedure is technically feasible and will no doubt have a promising role in the future as some patients will continue to demand a scarless (in the neck) procedure.



*Picture 3: Trans-axillary thyroidectomy with CO<sub>2</sub> insufflation*



*Picture 4: Gasless trans-axillary thyroidectomy*

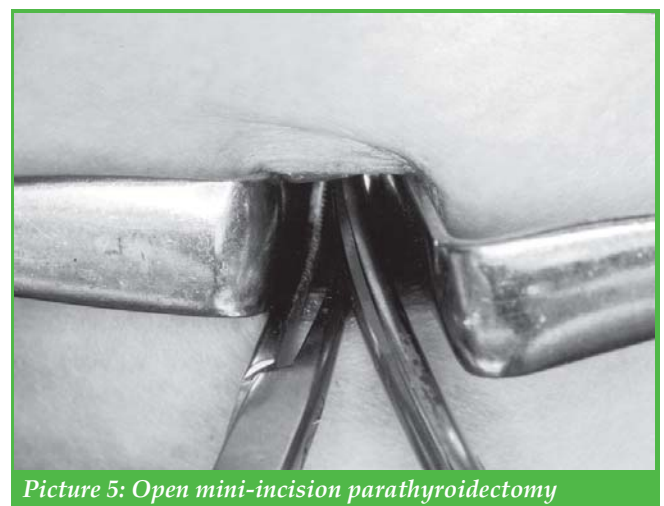
## MIP

In comparison to MIT, MIP has been better accepted and less controversial. It is the treatment of choice for patients diagnosed with primary hyperparathyroidism or pHPT due to solitary parathyroid adenoma. Again, they come in a variety of forms including total

endoscopic approach, video-assisted approach, radio-guided approach and mini-incision approach (**Picture 5**) but in principle, they are similar as they all involve operating through a small neck incision and excising one single abnormal parathyroid gland without exposing the other 3 parathyroid glands. This is made possible because over 80-90% of patients with pHPT suffer from a solitary parathyroid adenoma and therefore by removing it, they are potentially cured of their disease. MIP is an operation associated with low morbidity and with a high success rate (>95%) so long as the operating surgeon is meticulous, familiar with the anatomy and experienced. However, unlike the traditional open method where all 4 parathyroid glands are explored, MIP must have accurate preoperative localisation of the abnormal parathyroid gland before it can be attempted. This is because in MIP, the operating surgeon would not have the benefit of examining the other 3 parathyroid glands and therefore, there is a possibility of missing underlying multiglandular disease such as double adenomas or 4-gland hyperplasia. In our experience, over 70% with newly diagnosed pHPT will be eligible for MIP because of a positive preoperative localisation by Tc99m sestamibi and /or ultrasound (**Picture 6**).<sup>10</sup> To further improve the surgical success of MIP and to minimise the possibility of persistent or recurrent HPT after MIP, some have advocated the use of a variety of surgical adjuncts such as radioguided probe, quick intraoperative parathyroid hormone assay at the time of operation but to date, their routine use remains questionable because of the marginal benefit and the high "cost to benefit" ratio. Nevertheless, MIP with or without the use of adjuncts when performed in experienced hands has an equivalent success rate of greater than 95% as the conventional 4-gland exploration and has all the benefits one expects from minimally invasive surgery.

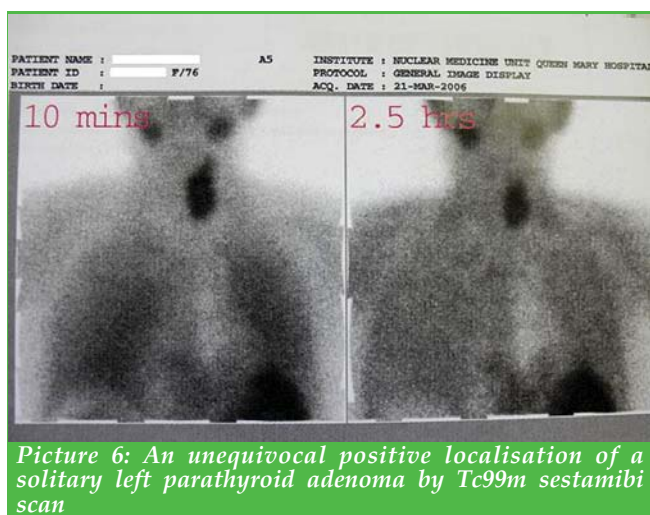
## Conclusions

Increasing variety of MIT techniques have been reported in the literature. Both standard open thyroidectomy and MIT will continue to complement each other in the future but the question of whether MIT will become the standard approach in the future remains to be seen. On the other hand, various MIP techniques have become accepted as a standard procedure for pHPT caused by a localised solitary parathyroid adenoma.



*Picture 5: Open mini-incision parathyroidectomy*





Picture 6: An unequivocal positive localisation of a solitary left parathyroid adenoma by Tc99m sestamibi scan

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# Transanal Endoscopic Operation (TEO)

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Dr. Kevin KK YAU

## Background

In 2006, colorectal cancer has become the 2nd commonest cancer in Hong Kong. Despite significant advancement in surgical techniques and chemotherapeutic agents in the last decade, more than 40% of the patients still died from the disease<sup>1</sup>. Moreover, there was an observed increasing trend of the disease in the last ten years (Figure 1).

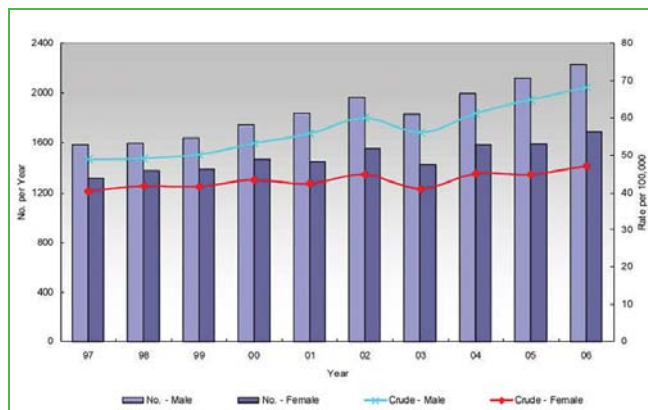


Figure 1: Incidence Trend of Colorectal Cancer from 1997-2006 (Source: Hong Kong Cancer Registry, Hospital Authority)

Radical surgical operation is regarded as the good standard treatment for carcinomas of the rectum.<sup>2-5</sup> A multicentre Dutch study has shown that a properly performed total mesorectal excision (TME) for T1-2, N0 tumours can achieve a local recurrence rate of less than 1%.<sup>6</sup>

However, TME is a major undertaking and can associate with significant morbidity and even mortality.<sup>7-9</sup> In addition, the quality of life may be impaired in terms of bowel, bladder and sexual function disturbances.<sup>10-12</sup>

In the past two decades, locoregional treatment for early rectal cancers has been advocated with much less morbidity and better functional outcomes. In certain groups of patients i.e. T1 rectal cancers with favourable characteristics, the oncological outcomes can actually be comparable to conventional radical surgery.<sup>13-15</sup>

The advent of transanal endoscopic microsurgery (TEM) technique that was developed and described by Prof. Gerhard F. Buess in the early 80's further flourished the use of locoregional treatment of early rectal cancers in the last 15 years.

TEM has been introduced into Hong Kong since 1995. Local experience also echoes the findings in those

literature reviews<sup>16</sup>. However, its clinical application in Hong Kong is still not popular. One of the possible reasons might be the expensive instruments that are required.

In the past decade, laparoscopic surgery was well established and equipped in most surgical units in Hong Kong. By simple modification, a new transanal resectoscope - Transanal Endoscopic Operation (TEO) was introduced by incorporating with readily available laparoscopic instruments to make it as effective and precise as compared with TEM.

## Introduction

Transanal Endoscopic Operation (TEO) is a modification of the well established procedure - Transanal Endoscopic Microsurgery (TEM) which was first introduced by Professor Buess<sup>17-21</sup>. This is a form of transanal excision for rectal tumours, either benign or malignant. A specially designed rectoscope (8 or 15cm in length, 4cm in diameter) incorporated with ordinary laparoscopic imaging system allows precise dissection under magnifying view (Figure 2,3). TEO is performed with constant carbon dioxide insufflation. High definition optics guarantee brilliant view and specific instrumentation allows precise dissection, full thickness resection and suturing of the defect. Furthermore, the more ergonomic operating position can save surgeons from occupational health hazards.



Figure 2: TEO instruments. Noted the angulated tip design allow precise manipulation of tissue within narrow working space.

Experience from TEM in the treatment of early rectal cancers demonstrates that T1 cancers with good or moderate differentiation completely resected have recurrence rate of less than 5% and with a good chance for salvage radical re-operation<sup>22-27</sup>. In experienced centres, the recurrence rate of adenoma is low (3-4%). There is a demonstration for the high preciseness of the procedure and much lower recurrence than after any other local procedure (recurrence rates after resection by using a retractor is around 30% in the literature)<sup>28-31</sup>.

TEO is well tolerated by patients with no external wound, less pain, less life-threatening complications and shorter hospital stay. Stoma is not required as the anal sphincter is saved.

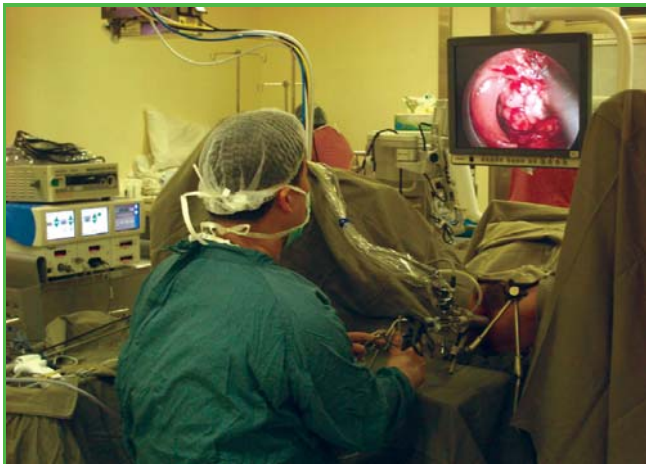


Figure 3: Operative view of Transanal Endoscopic Operation. Noted the ergonomic position of surgeon and the clear endoluminal view.

### Indication of TEO

#### Early Stage Rectal Tumours

TEO has emerged as an improved method of transanal excision of neoplasms because its enhanced visibility, superior optics, and longer reach permit a more complete excision and precise closure (Figure 4).

Proper case selection is mandatory for the success of TEO in the curative treatment of early rectal carcinomas. Endorectal ultrasonography allows very precise and accurate tumour and regional lymph node staging (Figure 5). Only patients with sonographic stage of T1, i.e. without invasion of muscularis propria, will be suitable for this procedure for curative intent. TEO treatment of T1 rectal cancers is safe and can achieve low local recurrence and high survival rates as compared with conventional local excisional surgery<sup>22-27</sup>.

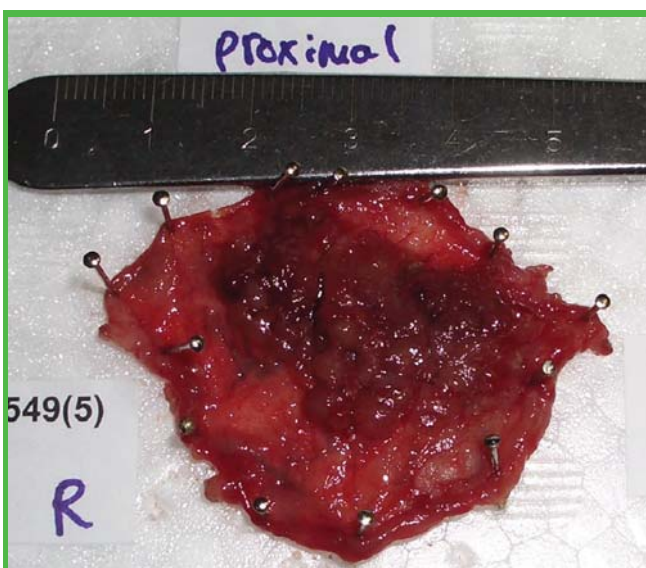


Figure 4: Precise full thickness excision of early rectal cancer is important for the tumor T-staging.



Figure 5: Endorectal Ultrasound examination confirmed T1 early rectal cancer.

#### Large Villous Adenomas

Large villous tumours frequently occur in the rectum and have a significant incidence of harbouring truly invasive carcinomas. The presence or absence of malignancy and its subsequent tumour staging can only be made by complete full thickness excision. Presence of invasive carcinoma on pathologic examination requires further surgical intervention appropriate for that diagnosis.

Recurrence depends on the technique used for tumour removal. It is highest for fulguration and local excision and lowest for operations that excise all or part of the rectum. Because most recurrences can be managed with local measures and the risk of malignancy in recurrences is relatively low, the procedure with which the tumour can be completely excised with the least morbidity should be used.

TEO allows full thickness excision with precision and the rectal defect can be closed with absorbable stitches (Figure 6). Most lesions in the mid and low rectum can be dealt with by this technique.

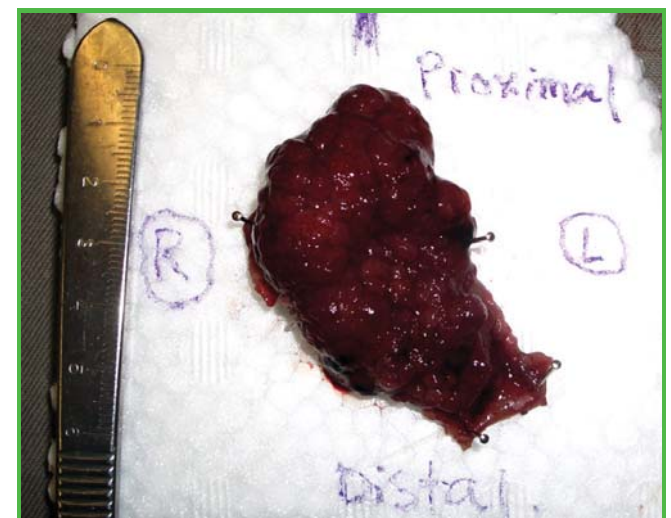


Figure 6: Large villous adenoma up to 7cm size was resected by TEO.





## Rectal Carcinoid Tumors

Rectal carcinoids are becoming more common. This is probably related to the increase use of colonoscopic examination for those patients who have lower gastrointestinal tract symptoms.

Endorectal ultrasonography is useful in determining the size and depth of penetration of the tumours and for detecting local lymph node metastases. Tumours of less than 10 mm in size that have not infiltrated the submucosa can be removed easily by TEO with curative intent. However, when invasion of lymph or blood vessels or lymph node metastases are found, radical surgery is still indicated.

## Palliative Treatment for Advanced Rectal Carcinomas

Palliative treatment is important to improve the quality of life in patients with locally advanced or metastatic rectal tumours that preclude curative treatment. Stoma can temporarily relieve symptoms of intestinal obstruction. However, local symptoms such as tumour bleeding and tenesmus can be very frustrating. By using TEO, local excision of T2 or T3 tumours is possible in selected patients under regional anaesthesia (Figure 7) and can significantly relieve symptoms including obstruction, bleeding or tenesmus in the remaining life time of these terminal patients.

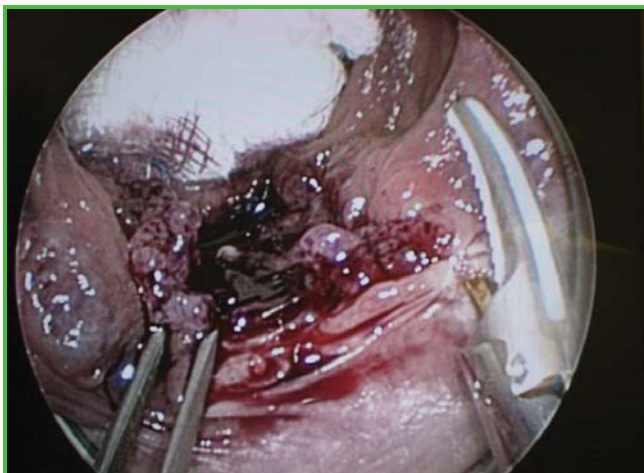


Figure 7: Palliative resection of T3 rectal tumour by TEO

## Extended Indication of TEO: Natural Orifice Transluminal Endoscopic Surgery (NOTES)

Laparoscopic colectomy has become more and more popular nowadays and some centres even take it as routine surgery for left side colonic tumours. However, specimen retrieval still necessitates a mini-laparotomy wound which may result in more wound related complications such as pain, bleeding and infection. Recently, our centre has published a new surgical technique of 'Endo-Laparoscopic Colectomy' without mini-laparotomy, where specimen retrieval and colorectal anastomosis can be safely achieved with the use of TEO device<sup>32</sup> (Figure 8). This technique is suitable for patients with tumour size less than 4cm in left side of the colon or upper rectum. Initial results are quite promising.

## Conclusion

Although a formal government-led screening programme for colorectal cancers has not been promulgated in Hong Kong, people are now aware of the increasing trend in colorectal cancers through different media. More and more patients will prefer to have colonoscopy done when they get lower gastrointestinal tract symptoms. Consequently, more pre-malignant and small sized rectal lesions will be found. Among these patients, certain highly selected cases will definitely be benefited from TEO. Nevertheless, the author doesn't believe that TEO will be the single panacea to solve all problems. We have different modalities of treatment options available nowadays: from medical to surgical treatment and from conventional open radical surgery to minimally invasive surgery. The most important point is to tailor-make our treatment strategy so that our patients can fully enjoy the benefit of the medical advancement in the new era. With this TEO device, both the surgeon and the patient are now given a choice!

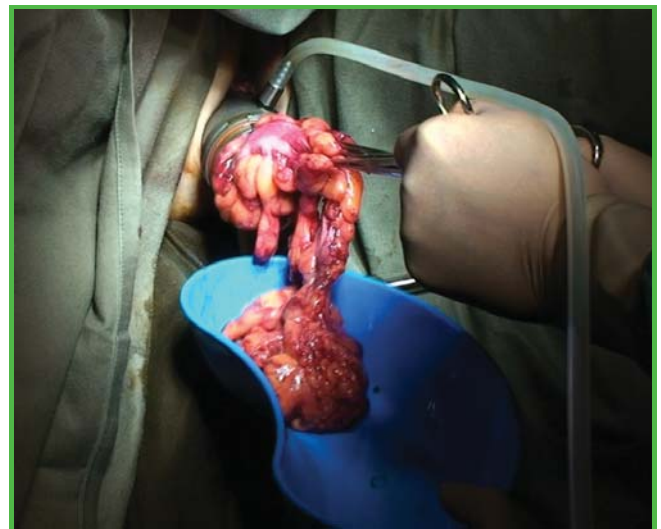


Figure 8. The resected colon was being delivered out of the TEO so that a mini-laparotomy wound can be avoided.

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**Dermatological Quiz**

# Dermatological Quiz

**Dr. Ka-ho LAU**MBBS(HK), FRCP(Glasg), FHKCP, FHKAM(Med)  
*Yaumatei Dermatology Clinic, Social Hygiene Service*

Dr. Ka-ho LAU

**Fig.a Necrobiosis lipoidica****Fig.b Necrobiosis lipoidica**

This 45-year-old woman complained of these non-itchy non-tender skin lesions at her shins for three years (Fig.a&b). The skin lesions increased in size in both shins progressively despite various topical creams she bought over the counter. In recent months, she also lost 10 pounds in weight.

**Questions:**

1. What is your diagnosis or possible differential diagnoses?
2. How will you confirm your clinical diagnosis?
3. Name one investigative test which is relevant to her skin problem and her weight loss.
4. What is the treatment for her skin condition?

*(See P.29 for answers)*



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# Technical Pearls in Laparoscopic Myomectomy

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Dr. Choi-man YAN

## Introduction

The benefits of laparoscopic approach in gynaecological surgery are well recognised.<sup>1</sup> Compared with conventional open surgery, it is associated with small incisions and better cosmetic results, less blood loss, less tissue trauma, less post-operative pain, shorter hospital stay, faster recovery with an earlier return to work and full activity, and fewer post-operative adhesion formation. The major concern about laparoscopic myomectomy (LM) is suboptimal tissue apposition during repair of myometrial defects leading to uterine rupture in subsequent pregnancies. However, if the myometrial repair is performed with the same degree of care as it would be at open myomectomy, there appears to be no reason why the rate of uterine rupture should be higher after LM.<sup>2</sup> An Italian multicentre study on complications of LM provided prospectively acquired data on the complications associated with 2050 LMs. The favourable clinical results and extremely low conversions rate of 0.34% suggested that LM is a safe and reliable procedure, even in the presence of multiple or enlarged myomas.<sup>3</sup> We are now entering the age of robotic surgery. At the moment, though robotic myomectomy leads to less blood loss and shorter hospital stay when compared with the conventional approach, it is more costly.<sup>4</sup> Moreover, most myomectomies can be accomplished laparoscopically without the need for robotic technology.

Owing to the inherent characteristics of laparoscopic surgery including decreased tactile sense, limited direction of access towards targets and degrees of freedom of movement, difficulties may be encountered during the performance of LM. The technical aspects of LM are discussed in this article.

## Case Selection

Correct case selection is vital to the success of LM. LM is suitable for a single fibroid smaller than 10cm in diameter and, for multiple fibroids, the sum of diameters should not exceed 15cm.<sup>5</sup> In the case of big fibroids, preoperative fibroid shrinkage with Gonadotrophin releasing hormone analogues (GnRHA) may be used so that the selection criteria can be met. Use of GnRHA prior to myomectomy reduces intra-operative blood loss, too.<sup>6</sup> However, it may lead to blurring of the surgical planes and hence difficulty in enucleation of the fibroids.

## Pre-operative Mapping

Because of reduced tactile sense, small intramural

fibroids may not be located during laparoscopy. Preoperative mapping with ultrasonogram, and even magnetic resonance imaging (MRI), is very important so that small fibroids are not missed during the operation.<sup>7</sup> MRI is also particularly useful in differentiating fibroids from adenomyomas. Laparoscopic resection of adenomyomas can be a nightmare for the gynaecologic laparoscopist since there is no capsule or a clear margin for dissection and therefore the resection may be difficult and incomplete.

## Basic Techniques of Laparoscopic Myomectomy (Figure 1)

Caution should be exercised in positioning the patient. The hip flexion and abduction should be such that the trunk-to-thigh angle is approximately 170 degrees and never more than 180 degrees to prevent nerve injury.<sup>8</sup> Steep Trendelenburg position is adopted to allow the bowels to fall away from the pelvic organs. Uterine manipulator may be used to optimise exposure and stabilise the uterus.

Intra-umbilical port is used to introduce the laparoscope. Many surgeons use the diamond-shaped port placement where the accessory ports are sited in the bilateral lower quadrants and suprapubic region. The chief surgeon then works through the ipsilateral lower quadrant port and supra-pubic ports. The author employs the so-called ultra-lateral port site placement by creating side ports in the left and right lower quadrants just medial to the anterior superior iliac spines, and left paramedian region under direct laparoscopic guidance. The right-handed surgeon works through the left side ports while the assistant holds the laparoscope and works through the right side port. Their positions may be exchanged if the surgeon is left-handed. Ultra-lateral port siting is less tiring for the surgeon since it allows the surgeon's upper and forearms to be adducted and the wrist and hand motion to be natural. It also allows the laparoscopic instruments to approach the target in a horizontal plane as in open surgery, eliminating the fulcrum effect.<sup>9</sup> Besides, it avoids injuries to the inferior and superficial epigastric vessels.

The maximum volume of pitressin (20units diluted in 100ml normal saline) in millilitres that can be used is approximately equal to the patient's body weight in kilograms. After injecting the vaso-constrictor, the author uses the ultrasonic scissors to resect the uterine fibroids. The direction of line of uterine incision is designed so as to facilitate the subsequent myometrial repair. One should always leave sufficient serosa and myometrium,

even overlapping layers, to avoid excessive tension on the sutures.

After enucleation of the fibroids, layered repair of the uterine defects is carried out using vicryl 0 sutures. Where the endometrial cavity is entered, vicryl 30 suture is used for closure. Events leading to uterine scar dehiscence in subsequent pregnancies are thought to include suboptimal suturing of the uterine incision and/or impaired wound healing from extensive use of coagulation or any tissue-destroying modality. There are no data suggesting that any one suturing technique is superior in minimising this risk-whether continuous or interrupted sutures are placed, whether the knots are tied intracorporeally or extracorporeally, or whether the suturing is done by hand or a suturing device. Sutures with shorter half-lives or ones that may lose strength in the presence of infection (e.g. chronic) should most likely not be used. All in all, careful closure of the uterine incision with minimal coagulation is most critical.<sup>10</sup>

The specimens are retrieved through one of the accessory ports after morcellation. Alternatively, the specimens may be put into an endobag which is then delivered through a posterior colpotomy. In addition, all fibroid fragments should be meticulously removed after morcellation to prevent the rare complication of parasitic peritoneal leiomyomatosis.<sup>11</sup>

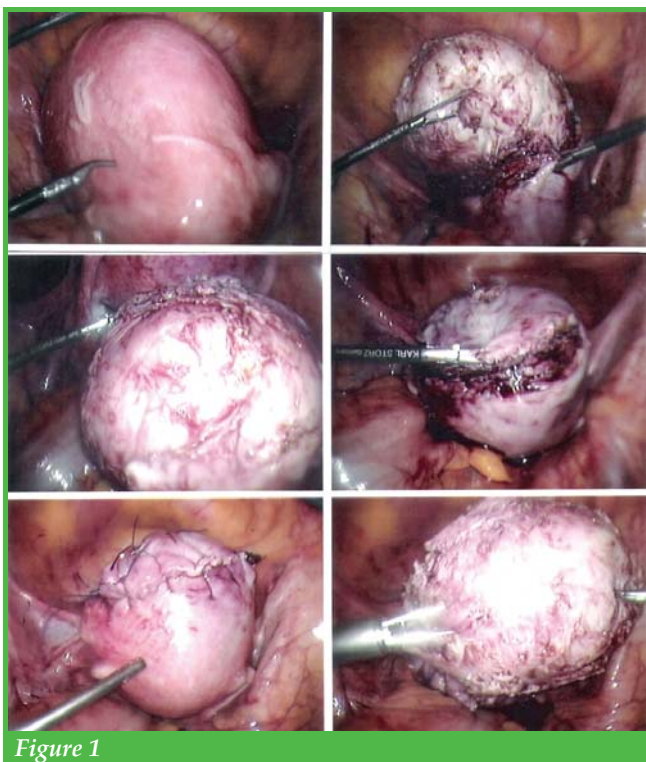


Figure 1

## Patients with Contraindications to the Use of Vaso-constrictors

In patients with contra-indications to vaso-constrictors, interruption of the uterine blood supply is used to reduce intra-operative blood loss. The uterine artery can be traced by first identifying the ureter and then tracing along it distally. The uterine artery is then seen lying above the ureter. The uterine artery may also be identified by retrograde dissection of the obliterated hypogastric artery-the obliterated hypogastric artery is

traced on the anterior abdominal wall and dissection is carried out cephalad to identify first the superior vesical artery and then the uterine artery.<sup>12</sup> The uterine arteries are then obliterated with bipolar electrocautery or ligated. However, this method is only suitable for those who desire no further pregnancies since the effect of bilateral uterine artery obliteration on the subsequent pregnancies is not known.

## Big Uterus

For a big uterus, supra-umbilical, instead of intra-umbilical, port should be used for the introduction of the laparoscope-usually the port is sited 2cm above the uterine fundus so that there is sufficient space for optimal visualisation. Enucleation and morcellation of big fibroids can be very demanding and tedious. Sinha et al described a method to deal with a large fibroid by morcellating the fibroid while it is still attached to the uterus and enucleating only to about one-fourth of its circumference.<sup>13</sup> As electromechanical traction by the claw forceps causes progressive separation of the myoma from the uterus, morcellation completes the enucleation while removing the myoma from the abdominal cavity. Caution should be exercised during morcellation not to damage the normal myometrium.

## Cervical Fibroids

Dissection of the bladder is usually necessary before myomectomy for fibroids at the cervical region. In order to avoid bladder injury, it is important to keep the dissection close to the uterus and point the tip of the scissors towards the uterine side. The 30 degree laparoscope is very useful in visualising fibroids in such an awkward position as the cervical fibroids. The ability to perform suturing with both hands is vital for proper repair of the uterine defect at the cervical region.

## Broad Ligament Fibroids

Broad ligament fibroids are situated in the pelvis where the ureters lie. The ureters may be at jeopardy if they are not clearly visualised. Ureteric dissection should therefore always be carried out before attempts to remove the uterine fibroids. The ureter in the pelvic side wall can be dissected by one of the following three approaches. The pelvic approach consists of visualising the ureter directly in its natural position on the pelvic side wall through the peritoneum of the broad ligament. The peritoneum is incised lateral to the ureter which is then dissected inferiorly to close to the uterus. In the cephalad approach, the peritoneum just medial to the infundibulopelvic ligament is opened to expose the ureter at the pelvic brim. On the left side, sometimes, the congenital adhesions of the sigmoid colon have to be divided. Once the ureter has been identified, it is then progressively dissected off the medial leaf of the broad ligament until the uterine vessels are reached. In the caudad approach, the obliterated hypogastric artery, which is easily identified on the anterior abdominal parietal peritoneum, is dissected superiorly. The superior vesical artery is encountered before the origin of the uterine artery is located from the internal iliac artery. The ureter is then easily identified underneath the uterine artery in the medial border of the pararectal space. After





the ureter has been identified, the subsequent resection of the fibroids is usually easy and, many a times, suturing is not needed because the fibroids are pedunculated.

## Management of Adenomyomas Detected Intra-operatively

Despite tremendous efforts to differentiate uterine fibroids from adenomyomas, one should always be prepared to perform an incidental laparoscopic adenomyomectomy. Takeuchi et al performed adenomyomectomy by first making a transverse incision through the adenomyotic tissue down to the endometrium. The adenomyotic tissue was then excised by slicing in layers with a monopolar needle on 70W incision mode. They counteracted the substantial loss in the muscle layer after adenomyomectomy by overlapping the normal muscle layer on the serosal membrane side and below the incision line as serosal flaps.<sup>14</sup>

Laparoscopic hysterectomy is another option for the incidental finding of adenomyosis during the attempt to extirpate uterine fibroids. Preoperative counselling for possible hysterectomy is of paramount importance and so is the ability to carry out laparoscopic hysterectomy.

## Conclusions

LM is a feasible and safe alternative to the conventional open myomectomy in many instances. It should start with careful case selection and meticulous preoperative mapping. Optimal tissue apposition with good laparoscopic suturing skill is the key to a successful LM. One should also learn the techniques to deal with

difficult situations such as patients with contraindications to vasoconstrictors, big uteri, cervical and broad ligament fibroids. Furthermore, one should be prepared to perform laparoscopic adenomyomectomy and even laparoscopic hysterectomy in all cases of intended LM.

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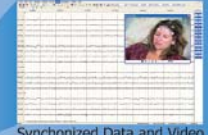
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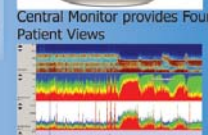
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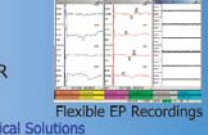
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# Certificate Course on Measures Against Drug Abuse at School

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**Objectives :** Drug abuse has become a social problem not only in the community but also at schools. Drug education is vital to prevent drug abuse at young age. This series of lectures aims to give an introduction on drugs and their adverse effects on physiology and psychology, the ways to motivation and stop substance abuse, preventing relapse, and case intervention. This course is designed for teachers and social workers that are working for school children.

社會一直存在濫用藥物的問題，而近年已蔓延至社區及校園裏。因此，我們需加強反濫藥教育，防止濫藥風氣繼續蔓延下去。這個課程是專為學校老師、輔導主任，以及社會工作者而設，使他們認識到一般被濫用的藥物及毒品種類，它們對濫藥人士在生理上造成之禍害，以及如何協助濫藥人士戒除濫用藥物及重染惡習。

Date	Topic	Speaker
22 July 2009	Motivational enhancement : how to motivate people to stop substance abuse 如何協助濫藥人士有效地戒除毒癮	Ms. Martina CHEUNG 張嬋玲小姐 臨床心理學家
29 July 2009	Psychiatric manifestations of psychoactive substances misuse 濫用精神物品的精神病理徵狀	Dr. TSANG Fan-Kwong 曾繁光醫生 青山醫院高級醫生
5 August 2009	Relapse prevention : how to help people keeping abstinence 如何協助及防止已康復的濫藥人士重染毒癮	Ms. Martina CHEUNG 張嬋玲小姐 臨床心理學家
12 August 2009	Case Intervention for substance abusers 濫用藥物個案介入及處理	Ms. CHENG Oi-Kwan, Silvia 鄭靄君小姐 單位主任(明愛容園中心)
19 August 2009	Educating against drug abuse 禁毒教育	Ms. LI Tip, Grace 李蝶小姐 機構主管(社區藥物教育輔導會)
26 August 2009	Anti-drugs strategy at Schools - Perspective from Law Enforcement 校園禁毒 — 從執法角度出發	Mr. LEUNG Kin-Man 梁健民先生 毒品調查科高級偵緝督察

**Dates:** 22 July 2009 - 26 August 2009 (Every Wednesday)  
**Time:** 7:00 p.m. - 8:30 p.m.  
**Venue:** Lecture Hall, 4/F., Duke of Windsor Social Service Building,  
15 Hennessy Road, Wanchai, Hong Kong  
**Language Media:** Cantonese (Supplemented with English)  
**Course Fee:** HK\$750 (6 sessions)  
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## News from Member Societies

### Hong Kong Society of Transplantation

Updated office-bearers for the year 2009-2010 are as follows: President: Prof. Philip Kam-tao LI; Honorary Secretary: Dr. See-ching CHAN; Honorary Treasurer: Dr. Ming-kwong YIU

The FMSHK would like to send its congratulations to the new office-bearers and look forward to working together with their societies.

## Welcome New Members

### Hong Kong Society for Ultrasound in Medicine Limited

Office-bearers for the year 2009-2010 are as follows: President: Dr. K.Y. LEUNG; Hon. Secretary: Dr. William W.K. TO; Hon. Treasurer: Dr. Ernest H.Y. NG

The FMSHK would like to welcome Hong Kong Society for Ultrasound in Medicine Limited as associate member of the Federation.



an affiliated member of



HKSUM was registered as a company limited in 2006, and exemption under Section 88 of the Inland Revenue Ordinance was granted in 2007.

HKSUM consists of radiologists, obstetricians & gynaecologists, and cardiologists. Radiographers, nurses and other professionals are welcome to join HKSUM as associate members. At present, we have 36 members and 18 associate members.

The objectives of HKSUM are to:

- (a) advance the art and science of ultrasound in medicine and research
- (b) promote good medical ultrasound practice
- (c) promote postgraduate training in ultrasound in medicine

HKSUM has been holding scientific meeting regularly since 2006. Members can enjoy a discount in the registration fee for the World Federation for Ultrasound in Medicine and Biology (WFUMB) Congress, receive information from WFUMB and the Asian Federation of Societies For Ultrasound in Medicine and Biology (AFSUMB), and apply for the sponsorship offered by AFSUMB. Information is posted on our web site [www.hksun.com](http://www.hksun.com). Online CME activities will be provided soon.

HKSUM will act as a body for the purpose of consultation in matters of education or public interest related to medical ultrasound. Dr Lilian Leong, Dr. William So, Prof. CP Lau, Dr. Adolphus Chau is our spokesman for general ultrasound, O&G ultrasound, adult cardiology, and paediatric cardiology respectively.

KY Leung  
President



## Smoking Cessation Carnival

Sponsored by Rotary Club of Hong Kong Northwest and co-organised with Aplichau Kaifong Primary School (AKPS) and Hong Kong Shuttlecock Association Limited (HKSA), a Smoking Cessation Carnival - 扶老攜幼踢走支煙 was held at Aplichau Kaifong Primary School in Aplichau, Aberdeen on Saturday, 16th May 2009. The event was a success with a turnout of around 400.

We were honored to have Dr. Ronald LAM, Head of Tobacco Control Office, Department of Health; Mr. Roger LEE, Assistant Governor (Area 5) of Rotary International District 3450; Mr. Alec TSANG, President of Rotary Club of Hong Kong Northwest; Professor Eva LAI, Director of English Language Centre, United International College, Beijing Normal University - Hong Kong Baptist University; Ms. FUNG Pik Yee, Headmistress of Aplichau Kaifong Primary School; Dr. Dawson FONG, President of The HKFMS Foundation Limited; Dr. Maureen WONG, Chairlady of the organizing committee officiated at the opening ceremony.

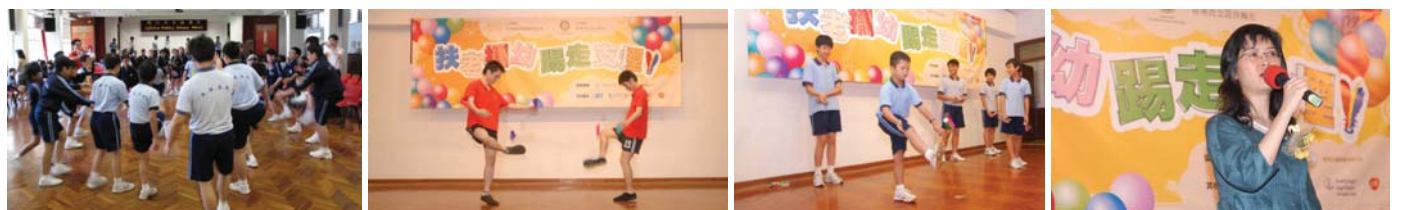




Following the addresses delivered by our distinguished guests, in no time at all, Ms. Purple Lee (紫昕姐姐), engaged and excited the young audience with her iconic medley of children songs. The lively performance from AKPS school choir further spiced up the event with the cartoon-styled theme song "齊齊來踢走支煙" specifically composed by Dr. Hilda WONG.



To help kick the bad habit of smoking - "踢毽, 踢毽, 踢走支煙" - shuttlecock was used both as a medium and pun to bring out the essence of the programme. Training classes delivered by the HKSA prior to event day paved road to revive interest among students in that ancient yet timeless and healthy sport. The subsequent amazing onstage performance by HKSA and AKPS students only bore testimony to their enthusiasm, alongside the vibrant rhythms and lyrics of our theme song that reverberated around.



Finally, a health talk to imprint parents and kids with importance and tips to stay away from smoking was delivered, before the crowd swarmed to the playground for more fun, information, gifts and souvenirs at the specially-themed game booths, exhibition boards and health check stations. Hopefully, the action-packed event through shuttlecock, with our message of "NO SMOKING" will etch on the mind of those youngsters and their families.





Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<ul style="list-style-type: none"> <li>★ Islands Hopping Tour in Yan Chau Tong</li> <li>★ Joint Professional Tennis Tournament</li> </ul> <p style="text-align: right;"><b>5</b></p>	<p style="text-align: right;"><b>6</b></p>	<ul style="list-style-type: none"> <li>★ HKMA Tai Po Community Network CME - When and How to Use Insulin?</li> <li>★ FMSHK Officers' Meeting</li> </ul> <p style="text-align: right;"><b>7</b></p>	<p style="text-align: right;"><b>1</b></p> <ul style="list-style-type: none"> <li>★ HK Neurosurgical Society Monthly Academic Meeting - Pineal Tumor</li> <li>★ HKMA - Shatin Doctors Network - Certificate Course on Osteoporosis</li> <li>★ HKMA Orchestra Rehearsal</li> </ul> <p style="text-align: right;"><b>8</b></p>	<ul style="list-style-type: none"> <li>★ HKMA Council Meeting</li> </ul> <p style="text-align: right;"><b>2</b></p> <ul style="list-style-type: none"> <li>★ HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2009 - Current Update on Shoulder Pain</li> <li>★ Care at the Moment of Death (Code no. SE-CMD-0902)</li> </ul> <p style="text-align: right;"><b>9</b></p>	<ul style="list-style-type: none"> <li>★ Joint Surgical Symposium - Breast Cancer Biology and Its Application</li> </ul> <p style="text-align: right;"><b>3</b></p>	<ul style="list-style-type: none"> <li>★ Taoyuan Project Pilot Tester Sharing Session</li> </ul> <p style="text-align: right;"><b>4</b></p>
<ul style="list-style-type: none"> <li>★ Joint Professional Snooker Tournament</li> <li>★ HKMA Certificate Course on Family Medicine 2009</li> </ul> <p style="text-align: right;"><b>12</b></p>	<p style="text-align: right;"><b>13</b></p>	<ul style="list-style-type: none"> <li>★ FMSHK Executive Committee Meeting</li> </ul> <p style="text-align: right;"><b>14</b></p>	<ul style="list-style-type: none"> <li>★ HKMA Orchestra Rehearsal</li> </ul> <p style="text-align: right;"><b>15</b></p>	<ul style="list-style-type: none"> <li>★ HKMA Annual General Meeting</li> </ul> <p style="text-align: right;"><b>16</b></p>	<p style="text-align: right;"><b>17</b></p>	<ul style="list-style-type: none"> <li>★ HKMA - KECN &amp; UCH - Management of Poisonous Bite &amp; Sting</li> <li>★ Pre-Hospital Trauma Life Support (PHTLS) Provider Course</li> <li>★ Hong Kong Surgical Forum - Summer 2009; Minimally Invasive Surgery</li> </ul> <p style="text-align: right;"><b>18</b></p>
<ul style="list-style-type: none"> <li>★ Photo Sharing Session</li> </ul> <p style="text-align: right;"><b>19</b></p>	<p style="text-align: right;"><b>20</b></p>	<p style="text-align: right;"><b>21</b></p>	<ul style="list-style-type: none"> <li>★ HKMA Orchestra Rehearsal</li> </ul> <p style="text-align: right;"><b>22</b></p>	<ul style="list-style-type: none"> <li>★ (1) Bubbles, Bubbles, Bubbles (2) TB or not TB</li> <li>★ HKFMS Foundation Meeting</li> </ul> <p style="text-align: right;"><b>23</b></p>	<p style="text-align: right;"><b>24</b></p>	<p style="text-align: right;"><b>25</b></p>
<ul style="list-style-type: none"> <li>★ Pre-Hospital Trauma Life Support (PHTLS) Provider Course</li> <li>★ HKMA Structured CME Programme with PMH Year 2009 (6 - i) Common Upper Limb Orthopaedic Problems ii) Common Orthopaedic Foot Problems</li> </ul> <p style="text-align: right;"><b>26</b></p>	<p style="text-align: right;"><b>27</b></p>	<ul style="list-style-type: none"> <li>★ HKMA - YTM CN - When &amp; How to Start Insulin</li> </ul> <p style="text-align: right;"><b>28</b></p>	<ul style="list-style-type: none"> <li>★ HKMA Orchestra Rehearsal</li> </ul> <p style="text-align: right;"><b>29</b></p>	<p style="text-align: right;"><b>30</b></p>	<p style="text-align: right;"><b>31</b></p>	





Date / Time	Function	Enquiry / Remarks
<b>2</b> THU 8:00 pm	<b>HKMA Council Meeting</b> Organised by: The Hong Kong Medical Association, Chairman: Dr. H.H. TSE, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Christine WONG Tel: 2527 8285
<b>3</b> FRI 8:00 am - 9:00 am	<b>Joint Surgical Symposium - Breast Cancer Biology and Its Application</b> Organised by: Department of Surgery, The University of Hong Kong and Hong Kong Sanatorium & Hospital, Chairman: Prof. Simon LAW, Speakers: Dr. Ava KWONG & Dr. CHAN Yu-Wai, Venue: Hong Kong Sanatorium & Hospital, Hong Kong	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 Fax: 2892 7511 1 CME Point (Active)
<b>4</b> SAT 2:00 pm	<b>Taoyuan Project Pilot Tester Sharing Session</b> Organised by: The Hong Kong Medical Association, Venue: HKMA Wanchai Premises, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Miss Alice TANG Tel: 2527 8285
<b>5</b> SUN 10:00 am 6:00 pm	<b>Islands Hopping Tour in Yan Chau Tong</b> Organised by: The Hong Kong Medical Association, Venue: Yan Chau Tong	Ms. Dora HO Tel: 2527 8285
<b>7</b> TUE 1:30 pm 8:00 pm - 10:00pm	<b>HKMA Tai Po Community Network CME - When and How to Use Insulin?</b> Organised by: HKMA Tai Po Community Network, Speaker: Dr. KONG Pik Shan Alice, Venue: Tai Po  <b>FMSHK Officers' Meeting</b> Organised by: The Federation of Medical Societies of Hong Kong, Venue: Gallop, 2/F., Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Ms. Sandra CHU Tel: 2387 8555 1 CME Point  Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345
<b>8</b> WED 7:30 am 2:00 pm 8:00 pm (15,22,29)	<b>HK Neurosurgical Society Monthly Academic Meeting - Pineal Tumor</b> Organised by: Hong Kong Neurosurgical Society, Chairman: Dr. HUNG Kwan Ngai, Speaker: Dr. TSE Yat Hang, Venue: Seminar Room, G/F, Block A, Queen Elizabeth Hospital, Kowloon  <b>HKMA - Shatin Doctors Network - Certificate Course on Osteoporosis</b> Organised by: HKMA - Shatin Doctors Network, Venue: Shatin  <b>HKMA Orchestra Rehearsal</b> Organised by: The Hong Kong Medical Association, Venue: Pui Ching Education Centre	Dr. Y.C. PO Tel: 2990 3788 Fax: 2990 3789 2 CME Points  Miss Alice TANG Tel: 2527 8285  Ms. Candy YUEN Tel: 2527 8285
<b>9</b> THU 2:00 pm 6:30 pm - 9:30 pm	<b>HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2009 - Current Update on Shoulder Pain</b> Organised by: The Hong Kong Medical Association and Hong Kong Sanatorium & Hospital, Chairman: Dr. KONG Kam Fu James, Speaker: Dr. WONG Wai Kwok Jimmy, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong  <b>Care at the Moment of Death (Code no. SE-CMD-0902)</b> Organised by: College of Nursing, Hong Kong, Speaker: Ms. SHIU Sin Man Vicky	Miss Viviane LAM Tel: 2527 8452 1 CME Point  Secretariat Tel: 2572 9255 Fax: 2838 6280 3 CNE Points
<b>11</b> SAT 2:30 pm	<b>Refresher Course for Health Care Providers 2008/ 2009 - Approach to elderly with frequent falls</b> Organised by: The Hong Kong Medical Association and Our Lady of Maryknoll Hospital, Chairman: Dr. CHEUNG Pui Shan, Speaker: Dr. LAU Sze Ting, Venue: 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 CME Points
<b>12</b> SUN 2:00 pm 2:00 pm	<b>Joint Professional Snooker Tournament</b> Organised by: The Hong Kong Medical Association, Venue: General Snooker Club  <b>HKMA Certificate Course on Family Medicine 2009</b> Organised by: The Hong Kong Medical Association, Speakers: Prof. WONG Yeung Shan Samuel & Dr. LAM Tzit Yuen David, Venue: Queen Elizabeth Hospital, Kowloon	Ms. Dora HO Tel: 2527 8285  Miss Viviane LAM Tel: 2527 8452 3 CME Points
<b>14</b> TUE 8:00 pm - 10:00 pm	<b>FMSHK Executive Committee Meeting</b> Organised by: The Federation of Medical Societies of Hong Kong, Venue: 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
<b>16</b> THU 9:00 pm	<b>HKMA Annual General Meeting</b> Organised by: The Hong Kong Medical Association, Chairman: Dr. H.H. TSE, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Christine WONG Tel: 2527 8285
<b>18</b> SAT 1:30 pm (26)	<b>HKMA - KECN &amp; UCH - Management of Poisonous Bite &amp; Sting</b> Organised by: HKMA KECN & UCH, Chairman: Dr. LAU Fei Lung, Speaker: Dr. CHAN Yiu Cheung, Venue: Lecture Theatre, G/F, Block P, United Christian Hospital, Kowloon  <b>Pre-Hospital Trauma Life Support (PHTLS) Provider Course</b> Organised by: Department of Surgery, Queen Mary Hospital; Hong Kong Chapter of the American College of Surgeons & Hong Kong St. John Ambulance Association, Venue: St. John Ambulance Association, 2 Macdonnell Road, Mid-Levels, Hong Kong  <b>Hong Kong Surgical Forum - Summer 2009: Minimally Invasive Surgery</b> Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong; Queen Mary Hospital & Hong Kong Chapter of American College of Surgeons, Venue: Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong	Mr. Gary WONG Tel: 3513 4821  Hong Kong St. John Ambulance Association Tel: 2530 8020 Email: assn@stjohn.org.hk Web site: <a href="http://www.hku.hk/surgery">http://www.hku.hk/surgery</a>  Forum Secretary Tel: 2855 4885 / 2855 4886 Fax: 2819 3416 E-mail: <a href="mailto:hksf@hkucc.hku.hk">hksf@hkucc.hku.hk</a> Web-site: <a href="http://www3.hku.hk/surgery/forum.php">http://www3.hku.hk/surgery/forum.php</a>
<b>19</b> SUN 2:00 pm	<b>Photo Sharing Session</b> Organised by: The Hong Kong Medical Association, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Ms. Dora HO Tel: 2527 8285



Date / Time	Function	Enquiry / Remarks
<b>23 THU</b> 6:30 pm - 8:00 pm 8:00 pm - 10:00 pm	<b>(1) Bubbles, Bubbles, Bubbles (2) TB or not TB</b> Organised by: Hong Kong Thoracic Society/ACCP(HK & Macau Chapter), Chairpersons: Dr. YU Wai Cho & Dr. WONG Mo Lin, Speakers: Dr. Jones KWOK, Dr. YEUNG Yiu Cheong & Dr. YAU Pak Yuen Anthony, Venue: LG1, Lecture Room, Ruttonjee Hospital, Wanchai, Hong Kong <b>HKFMS Foundation Meeting</b> Organised by: The Federation of Medical Societies of Hong Kong, Venue: Council Chambers, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Dr. James C.M. HO / Dr. Johnny W.M. CHAN Tel: 2855 4999 Fax: 2872 5828 1 CME Point  Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345
<b>26 SUN</b> 2:00 pm	<b>HKMA Structured CME Programme with PMH Year 2009 (6) - i) Common Upper Limb Orthopaedic Problems ii) Common Orthopaedic Foot Problems</b> Organised by: The Hong Kong Medical Association, Speakers: Dr. WONG Hin Keung & Dr. SIU Kwai Ming, Venue: G8 Hall, Princess Margaret Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 2 CME Points
<b>28 TUE</b> 1:30 pm	<b>HKMA - YTM CN - When &amp; How to Start Insulin</b> Organised by: HKMA YTM CN, Chairman: Dr. C.P. HO, Speaker: Dr. IP Tai Pang, Venue: Eaton Hotel, Kowloon	Ms. Sandra CHU Tel: 2387 8555

## Meetings

8/11/2009	<b>International Symposium on Hepatology 2009 / 22nd Annual Scientific Meeting</b> Organised by: The Hong Kong Association for the Study of Liver Diseases, Venue: Hong Kong Convention and Exhibition Centre, Enquiry: Ms. Melissa LEUNG, CMPMedica Pacific Limited, Tel: 2116 4348, E-mail: melissa.leung@asia.cmpmedica.com
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## Courses

14-16/8/2009, 11-13/9/2009, 20-22/11/2009	<b>Advanced Trauma Life Support (ATLS) Student Course</b> Organised by: Department of Surgery, Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons, Venue: The Jockey Club Skills Development Centre, C3, Main Block, Queen Mary Hospital, Pokfulam, Hong Kong, Enquiry: Course Administrator, Tel: 2855 4885 / 2855 4886, Fax: 2819 3416, Email: hnsrg@hkucc.hku.hk, Web site: http://www.hku.hk/surgery
15,22,29/8/2009 2,9/9/2009	<b>Certificate Course on Clinical Teaching and Assessment (Code no: TC-CTA-0903)</b> Organised by: College of Nursing, Hong Kong, Enquiry: Secretariat, Tel: 2572 9255, Fax: 2838 6280, 24 CNE points
15,22,29/8/2009 2,9,23/9/2009	<b>Certificate Course on Interpretation of Electrocardiography (Code no: TC-ECG-0902)</b> Organised by: College of Nursing, Hong Kong, Enquiry: Secretariat, Tel: 2572 9255, Fax: 2838 6280, 24 CNE points
11-12/9/2009, 20-21/11/2009	<b>Advanced Trauma Care for Nurses (ATCN) Provider Course</b> Organised by: Department of Surgery, Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons, Venue: The Jockey Club Skills Development Centre, C3, Main Block, Queen Mary Hospital, Pokfulam, Hong Kong Enquiry: Course Administrator Tel: 2855 4885 / 2855 4886 Fax: 2819 3416 Email: hnsrg@hkucc.hku.hk Web site: http://www.hku.hk/surgery
12-13/12/2009	<b>Advanced Medical Life Support (AMLS) Provider Course</b> Organised by: Department of Surgery, Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons, Venue: The Jockey Club Skills Development Centre, C3, Main Block, Queen Mary Hospital, Pokfulam, Hong Kong, Enquiry: Course Administrator, Tel: 2855 4885 / 2855 4886, Fax: 2819 3416, Email: hnsrg@hkucc.hku.hk Web site: http://www.hku.hk/surgery

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

Date	Course No	Course Name	Target Participants	CME/CNE
6 Aug 09 - 10 Sep 09 (Every Tur)	C141	Certificate Course on Wilderness Medicine	Healthcare Professionals	9 CNE Points ; CME Accreditation in application
12 - 26 Sep 09 (Every Sat)	C147	Certificate Course on Clinical Ethics in Practice	Professionals in Clinical Practice	6 CNE Points ; CME Accreditation in application
2 Sep 09 - 7 Oct 09 (Every Wed)	C148	Certificate Course on Clinical Ophthalmology	General Practitioners & Allied Health Professions	9 CNE Points ; CME Accreditation in application



The Federation of Medical Societies of Hong Kong

## Members' Benefits

The Federation, in cooperation with Kingsway Concept Limited, offers a discount on petrol and diesel purchases of HK\$0.9/litre from **Caltex, Shell, Esso and Sinopec** to members and their families of all Ordinary and Associate member societies under the Federation. Please contact our Secretariat on 2527 8898 and info@fmshk.org or Kingsway Concept Limited on 2541 1828 and kingswayconcept@yahoo.com for further details and terms for this offer.





## Answer to Dermatological Quiz

1. These multiple 0.5 to 3 cm annular violaceous red-brownish/yellowish plaques with palpable peripheral rims and yellow-brown atrophic centres that contained telangiectasia affecting quite symmetrically over patient's shins. The skin lesion, together with a history of recent weight loss, is compatible with necrobiosis lipoidica (NL). NL is three times more common in women than in man with an average age of onset at 30. About 85% of NL involves leg exclusively and 50% have four to eight plaques. Ulceration occurs in 35% and is often precipitated by trauma. Other differential diagnoses of the annular infiltrative eruption on the shin may include granuloma annulare, pyoderma gangrenosum, annular elastolytic giant cell granuloma and rarely sarcoidosis.
2. The definitive diagnosis of necrobiosis lipoidica requires clinico-pathological correlation. Skin biopsy shows the presence of palisading granuloma with histiocytic cells and lymphocytes with their long axes arranged perpendicular to large central areas of necrobiosis containing altered bent, curled and disarrayed collagen in the reticular dermis. In typical presentation, clinical diagnosis can be made with compatible clinical morphology and history to save the patient from skin biopsy on the necrobiotic area which may be difficult to heal.
3. Fasting blood sugar, and if indicated oral glucose tolerance test, is warranted in our patient with NL with recent weight loss. The proportion of NL patients with diabetes mellitus varies from 14 to 65%. Of these diabetic patients, sixty percent of patients have history of diabetes mellitus prior to the onset of skin disease and 25% develop skin lesions with the onset of diabetes. Fifteen percent of these patients with skin manifestations precede the onset of diabetes.
4. The treatment of NL is largely anecdotal and often unsatisfactory. First line therapy includes potent topical corticosteroids for early lesions and intralesional steroids injected into the active borders of established lesions. Short course of oral corticosteroids was reported to be effective in small case series. Other treatments reported with some success include topical tretinoin, oral niacinamide and oral cyclosporin. Surgical excision with split thickness skin grafting may be necessary for refractory ulcerative NL.

### Dr. Ka-ho LAU

MBBS(HK), FRCP(Glasg), FHKCP, FHKAM(Med)  
Yaumatei Dermatology Clinic, Social Hygiene Service

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# Certificate Course on Clinical Ethics in Practice



## Jointly organised by



The Federation of Medical  
Societies of Hong Kong  
香港醫學組織聯會



Hong Kong  
Bioethics Association  
香港生命倫理學會

## Objectives

This lecture series delivered by experienced speakers in the medical and legal fields introduces the current ethical issues facing clinicians and supporting personnel. Speakers will introduce the issues, their causes and provide possible solutions. Examples relevant to Hong Kong will be illustrated. Participants will have an increased understanding of the concerned issues and better equipped to tackle them.

<b>Dates</b>	12, 19, 26 September 2009 (Every Saturday)
<b>Time</b>	2:15 p.m. – 4:30 p.m.
<b>Venue</b>	Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong
<b>Language Media</b>	English (Supplemented with Cantonese)
<b>Certificate</b>	Awarded to participants with a minimum attendance of 2 sessions or above
<b>Course Fee</b>	HK\$500 (3 sessions)
<b>Enquiry</b>	The Secretariat of The Federation of Medical Societies of Hong Kong
<b>Tel.</b>	2527 8898
<b>Fax</b>	2865 0345
<b>Email</b>	info@fmshk.org

Date	Topic	Speaker
12 September 2009	Informed Consent and Respecting Patients' Autonomy	Prof. Edwin HUI
	Privacy and Confidentiality	Ms. Alexandra LO
19 September 2009	Forgoing Life-sustaining Treatment and Euthanasia	Dr. Chun-Yan TSE
	Allocation of Scarce Resources in Clinical Practice	Dr. Derrick AU
26 September 2009	Ethical Issues in Medical Genetics	Dr. Stephen LAM
	Ethical Issues in Neonatology and Paediatrics	Dr. Robert YUEN

## CME / CPD Accreditation in application

A total of 6 **CNE** points for the whole course and the points will be awarded according to the number of hours attended.

**Application form can be downloaded from our website: <http://www.fmshk.org>**