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*Otorhinolaryngology*





# Certificate Course on Updates on Allergic Diseases



## Jointly organised by



The Federation of Medical Societies of Hong Kong



The Hong Kong Institute of Allergy

## Objectives

In Hong Kong, the prevalence of allergic rhinitis is about 20% and that of asthma about 10% in children and 5% in adults. These allergic conditions not only pose health issues for the individual but also raise public health concerns as they are closely linked with the environment. This course "Updates on Allergic Diseases" aims at providing a clinical overview of the various allergic diseases including allergic rhinitis, asthma, eczema, urticaria, food allergy, and drug allergy, reviewing the practical approaches to the diagnosis, treatment, and prevention of these conditions. The faculty consists of experienced specialists in Allergy and Immunology, Dermatology, Otorhinolaryngology, Pediatrics, Respiratory Medicine, as well as Chinese Medicine. The course would be of educational value to clinicians in general practice, and nurses and allied health professionals who work in the ambulatory care setting.

4 May 2010

**Session Topics** General approach to allergy  
1. Overview  
2. Desensitization  
**Speaker** Dr. Adrian Y.Y. Wu

11 May 2010

**Session Topics** Asthma  
1. The approach to the wheezy child  
2. Management of asthma in the adult  
**Speakers** Dr. Leung Ting Fan  
Dr. Fanny W.S. Ko

18 May 2010

**Session Topics** Allergic rhinitis  
1. Aspirin allergy and allergic rhinitis  
2. Management of nasal polyposis  
**Speakers** Dr. William P.T. Yip  
Dr. Wong Lap Ching

25 May 2010

**Session Topics** Skin allergy  
1. Management of urticaria  
2. Management of Eczema  
**Speakers** Dr. Nicola P.Y. Chan  
Dr. Yeung Chi Keung

1 June 2010

**Session Topics** Food & Drug allergy  
1. Common food allergies  
2. Drug allergy : An overview  
**Speaker** Dr. Helen H.L. Chan

8 June 2010

**Session Topics** Other considerations  
1. Virus and asthma  
2. Traditional Chinese Medicine for allergic disorders  
**Speakers** Dr. Jane C.K. Chan  
Dr. Tse Tak Fu

<b>Time</b>	7:00 p.m. – 8:30 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>	Cantonese (Supplemented with English)
<b>Course Fee</b>	HK\$750 (6 sessions)
<b>Certificate</b>	Awarded to participants with a minimum attendance of 70%
<b>Enquiry</b>	The Secretariat of The Federation of Medical Societies of Hong Kong

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



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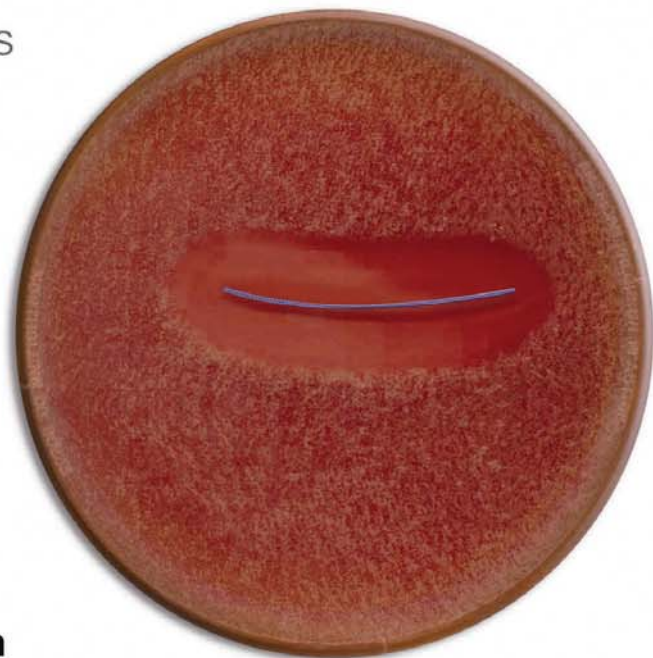
Photo taken by Miss Cannis Chau, secretary in the ENT Department, Queen Mary Hospital while she was travelling in Kenya, Africa in August 2009. Elephants have large ears and long noses. The specialty of otorhinolaryngology, head and neck surgery cares for these organs and more; we also manage ENT and related diseases for the young and the elderly."

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# Editorial

## Prof. William I. WEI

MS, FRCS, FRCSE, FRACS(Hon), FACS, FHKAM(ORL)(SURG)  
Chair in Otorhinolaryngology, Li Shu Pui Professor of Surgery,  
The University of Hong Kong

**Editor**

Prof. William I. WEI

Otorhinolaryngology or in simple terms ENT surgery is traditionally recognised as a surgical discipline dealing with localised pathologies related to the ear, nose & throat. In the last 2 decades, the specialty has evolved to deal with pathologies from the skull base to the thorax. Thus the surgical discipline has been redefined as otorhinolaryngology, head and neck surgery with well-established subspecialties. In the present issue of scientific seminars, we have specialists presenting the current spectrum of diseases managed by contemporary otorhinolaryngologists.

In otology, cochlear implants can restore hearing for those profound deaf patients, Dr. Buddy Wong has highlighted the recent advances in ear surgery. In laryngology, the development of laryngoplasty has improved the voice of patients with unilateral vocal cord palsy and different materials can be injected to give good results. Dr. Paul Lam also mentions that with the application of CO2 laser in laryngeal surgery, it reduces injury to the mucosa and thus gives better functional results. With the application of microvascular free flap reconstruction, we can remove more advanced staged head and neck cancers and, good functional and aesthetic results can be achieved. Dr. K.H. Ma, our College President has outlined the developments in head and neck surgery including surgery of the thyroid gland, which is within the domain of all ENT surgeons. Paediatric otolaryngology is now a well-established subspecialty managing congenital airway problems, congenital deafness and drooling in addition to the traditional adenoidectomies and tonsillectomies. Dr. Birgitta Wong has shown that all these patients, many of them are neonates can be managed successfully nowadays. The development of facial plastic surgery is new in our specialty. Dr. Victor Abdullah has highlighted the essentials of this subspecialty. Rhinoplasties are performed aiming at aesthetic and functional restoration; facial trauma, local flaps and rhytidectomy are all done competently by ENT surgeons as these have become part of the training programme. The use of endoscopes has revolutionised the field of rhinology. Lesions from the paranasal sinuses extending to the skull base and the brainstem can be managed successfully. Dr. W.K. Ho has outlined in his article concisely all these developments.

Contemporary ENT surgery has evolved to a surgical discipline that manages complicated as well as common problems from the skull base to the thorax. Otorhinolaryngologists will continue to collaborate with other specialties aiming to deliver the best care for our patients.

# Facial Plastic Surgery in Otorhinolaryngology

## Dr. Victor ABDULLAH

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Dr. Victor ABDULLAH

*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 30 April 2010.*

Facial plastic surgery has recently been formally incorporated into the training curricula of Otorhinolaryngology in Hong Kong. Facial plastic surgery would now be an integral part of the exit examination in ENT. This has been worrying many higher surgical trainees in ENT. The truth is that the aesthetic and restorative surgery which used to be taught in small separate doses as parts of rhinological, otological and head & neck surgical training would now be packaged and delivered as a focused subject, with extension to cover relevant complementary aesthetic principles and techniques. There is still a long way to go for Hong Kong, though already much delayed from the time when surgeons, mostly Otolaryngologists, in the United States of America formed the American Academy of Facial Plastic and Reconstructive Surgery over 40 years ago. The European Academy of Facial Plastic Surgery has now been established for over 30 years. In June 2009, the Asian Facial Plastic Surgery Society (AFPSS) was born during the Asian Pacific Rhinoplasty Expert Forum in Seoul. This is a very positive step forward and will serve the Asian Pacific region well in encouraging friendship and communication. A consensus curriculum for training and standard regulation will in time be perfected.

Facial plastic surgery does not cover procedures below the clavicle except for the axial and microvascular free flaps frequently employed in head & neck cancer surgery. Aesthetic facial surgery is not, contrary to what is the common perception, reserved for the 'Rich, Vain and Famous' as is frequently portrayed by the media. Indeed, many from this group would seek advice for the better self image. Today, plastic surgeons, ENT surgeons, dermatologists, ophthalmologists or even trained technicians under appropriate guidance with their lasers can all deliver good quality results in cosmetic refinement. In actual fact, aesthetic facial surgery, in addition to cosmetic refinement, plays an important role in a wide spectrum of congenital, infective, traumatic and neoplastic conditions in ENT. In such, mostly challenging cases, it is all about the patient, his/her self esteem and global well being. 'Normality' is what these patients seek for and cosmetic refinement, if appropriate, could be a major bonus.

Harmony and symmetry form the basis of facial aesthetics. Of all procedures on the face, 'rhinoplasty'

best illustrates this point. Functional and aesthetic rhinoplasty is a procedure an ENT specialist would have acquired substantial skill in during his training. Proportions, profile, radix depth, nasolabial angle, nasal base triangulation and angle of projection (nasofacial angle) etc. are important guidelines to where the nose should be on the face and how much it should project to achieve harmony and symmetry. The Asian Chinese nose is typically one with low and broadened bridge, flattened tip, elliptical nostrils and poor definitions of the lower lateral cartilages. In a much Westernised city like Hong Kong, preservation of ethnicity in the nose, as is requested by some Negroid patients, is generally not a perceived demand yet psychological and social preoccupation with the Caucasian looking nose tends to be significant. Augmentation of the nasal bridge and tip with silicone implants are hence popular cosmetic procedures.

Closed and open rhinoplasty techniques have each their supporters. Most learn from open and with experience over the years, do less of to minimise scarring and reach their own balance between the two procedures depending on the nature of their practice.

In the public institutions, complex traumatic cases and congenital deformity at the appropriate age are much better handled via the external approach functionally and aesthetically. The nasal deformity in cleft palate patients illustrates this well (Figure 1-7). The complex deformity of the nasal tip can be clearly viewed and accurately corrected. The complex septal deviation can be corrected effectively for airway patency via the open technique with significant functional improvement. The low nasal bridge places the card into the surgeon's hands as an augmentation rhinoplasty in such deformed noses often camouflages. This greatly enhances self esteem as the Western look overwhelms their long term stigma. Augmentation using either the patient's costal cartilage or meticulously shaped Gortex, the author's preference, can achieve pleasing results. Costal cartilage may sometimes be insufficient and can change shape. Auricular cartilage is too soft and minimal in quantity to achieve adequate augmentation and is more appropriate for filling minor defects. As a general principle, grafts to the nasal tip should always be cartilaginous, best rib, and foreign implants should remain on the dorsum only which would minimise complications. Admittedly, the nose after surgery does





change with time over years and as the skin tightens, sharp irregular edges do show if not attended to meticulously at time of surgery, which would then require revision.

Rhinoplasty is often not the only procedure required to achieve harmony. The Asian Chinese, perhaps less so of cleft palate patients, often desire nicely defined eyelid creases, parallel or tapered, to eradicate the typical 'mousy' suspicious look a single eyelid tends to convey. In part, it is the body image desire for the Western look once again. Blepharoplasty is often a complementary procedure to rhinoplasty. The same would be true of a silicone chin implant, to achieve a better balanced profile after augmentation rhinoplasty. Chin implants may be inserted intraorally or transcutaneously and the latter is the preferred approach for placement.

How much or how little, the 'Entire Plan', should always be based on careful and meticulous analysis with prudent surgical planning which cannot be overemphasised.

The face is a familiar territory to most surgeons. A multitude of disciplines are well equipped with the skills to eradicate a lesion on or rejuvenate the face. Excision of basal cell carcinoma and its defect reconstructed with a local random or axial flaps e.g. the forehead flap based on the supratrochlear artery for the nose or the Abbe or Eastlander swings for carcinoma of the lip etc. require no detailed elaboration. Rejuvenation of the face is very much an integral of Facial Plastic Surgery. Rytidectomy, endoscopic brow lifts are surgical procedures not without their prices and are best reserved for more severe cases of facial laxity or sagging. Laser treatment, chemical skin peel, use of Botox type A for the glabella, crow's feet, horizontal and perioral dynamic lines can achieve much in less severe cases of wrinkles without the scalpel. Botox A is licensed by the FDA for use in the dynamic lines of the glabella and detailed consent should be obtained for its use for other sites. A maximum dose of 400 units per session 3 months apart should not be exceeded. For static facial lines, fillers are more appropriate. The popular temporary fillers are hyaluronic acid (Restylane) which lasts approximately 4 months and poly-L-lactic acid (Sculptra) which lasts 18 months. The permanent fillers include examples like polyacrylamide (Aquamid) or polymethylacrylate (Artecoll). Fillers are also useful for touching up minor nasal bridge deficits after augmentation and lip asymmetry which is useful in certain cleft palate patients.

Otoplastic work dates back a long way to the 19th century. Protruding ears are present in approximately 5 % of the population but the author has not perceived a concern for this in the Hong Kong Chinese population which reflects a clear cultural difference. In the West, pinnaplasty is a weekly routine operation for the trainee. Microtia at its different grades is a much more deforming condition and reconstructive procedures using costal cartilage, Medpore and prosthetic ears via osseointegrated implants are all suitable procedures with the former two slightly set back by the tendency of keloid formation in our local population. Keloid formation tends to be less when the procedure is done at 6 years of age as compared to teenage or later. The

author prefers the Medpore implant for the better shape and projection though exposure requiring surgical trimming can be problematic.

Aesthetic deficits of the ears, the nose and the Head & Neck defects after tumour resection will continue to challenge the Otorhinolaryngologists in the 21st Century. It is nonetheless encouraging to see the coming together of Otolaryngologists from countries of the Asian Pacific region to brave this challenge. Perfection is probably difficult to achieve in most cases. The secret of joy in facial plastic and restorative work lies in the tremendous enhancement or revival of the sense of global well being in the patient when excellence is aimed for by the surgeon each time.



Fig. 1



Fig. 2



Fig. 3



Fig. 4



Fig. 5



Fig. 6



Fig. 7

*Legends for Figures 1-7*

*Cleft nasal deformity before and after Gortex Augmentation and costal cartilage tip reconstruction via external approach.*



**MCHK CME Programme Self-assessment Questions**

Please read the article entitled "Facial Plastic Surgery in Otorhinolaryngology" by Dr. Victor ABDULLAH 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 30 April 2010. 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. Gortex is a suitable material for Augmentation of the nasal dorsum.
2. Nasal tip is best reconstructed in cases of congenital deformity or trauma via an open approach utilizing Gortex .
3. Botox A is totally safe and can be liberally used for facial plastic work.
4. External nasal shape and profile can continue to change over many years.
5. Bat ears are present in approximately 5% of the population.
6. Microtia is classified into different grades.
7. Microtia should always be reconstructed with a prosthetic osseointegrated implant.
8. Keloid formation can be a problem in Auricular reconstruction in our local Chinese population.
9. Functional rhinoplasty should always accompany aesthetic rhinoplastic work.
10. Protruding nasal tip and dorsal humps are characteristic Chinese ethnic nasal features.

**ANSWER SHEET FOR APRIL 2010**

Please return the completed answer sheet to the Federation Secretariat on or before 30 April 2010 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

**Facial Plastic Surgery in Otorhinolaryngology**

**Dr. Victor ABDULLAH**

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**Answers to March 2010 Issue**

The Roles of Dental Professionals in the Management of Obstructive Sleep Apnoea

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Reference: 1. Results based on a subset of a blinded, national, random survey of 597 physicians representative of the AMA master file, conducted by Harris Interactive Inc from November 17, 2003, through January 9, 2004. 2. Results are based on a blinded, national, random survey of 493 physicians representative of the AMA master file, conducted by Harris Interactive Inc. April-June 2007. 3. Based on a response from 57 cardiologists in a Harris Interactive Survey of 489 physicians, sampled from the American Medical Association master file, conducted from April 2007-June 2007. 4. IMS Top 15 Global Products (2008). 5. Lipitor Hong Kong Packing Insert (Dec 2007). Detailed information is available upon request.



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## Recent Advances in Laryngology

### Dr. Paul Kin-yip LAM

MS, FHKAM(ORL), FHKCORL, FRCS Edin (ORL), MBChB

Honorary Clinical Assistant Professor, University of Hong Kong Medical Centre



Dr. Paul Kin-yip LAM

### Introduction

Three areas of substantial evolution are covered in this review: the use of bioimplantable materials in glottic insufficiency, improvement in therapeutic strategies for laryngeal papillomatosis and surgical organ/function-preservation treatment of laryngeal malignancy. Overall, the discipline of laryngology continues to evolve and will become increasingly important with exciting technological advancements, yet the future of this emerging subspecialty is still full of challenges.

### Bioimplantable Materials for Treating Glottic Insufficiency

Glottic insufficiency may result from vocal fold bowing due to ageing, paresis or paralysis, or from the loss of the superficial lamina propria as a result of vocal fold scarring or sulcus vocalis. The most noticeable symptoms of glottic insufficiency are hoarseness and vocal fatigue, and these are especially debilitating in professional vocal users like singers. Adequate closure of glottic insufficiency can also improve airway protection and decrease aspiration. The two main modalities of treatment nowadays include medialisation thyroplasty and injection laryngoplasty. Medialisation thyroplasty has been used extensively to treat glottic insufficiency since its introduction by Isshiki et al.<sup>1</sup> Implants like silicone, Gore-Tex, titanium or calcium hydroxyapatite have been used to approximate the vocal folds. It is invasive and requires longer operation time in contrast to injection laryngoplasty.

Injection laryngoplasty provides a "quick-fix" to glottic insufficiency and can be carried out as an office-based procedure. Autologous materials like fat and fascia offer promising results and excellent biocompatibility, yet they will all be reabsorbed by the body with equivocal long-term efficacy. Cymetra (micronised acellular human cadaveric dermis) is metabolically compatible with the human body and readily available in an injectable form. However its cadaveric origin raises considerable concern despite tight scrutiny for viral and bacterial infectious diseases. Hyaluronic acid like Restylane seems to offer excellent biocompatibility without the risk of allergic reactions.<sup>2</sup> Its similarity to the superficial lamina propria, which is essential for normal vocal fold vibration, makes hyaluronic acid an attractive treatment option for vocal fold reconstruction. The duration of graft survival in the human body is however unpredictable. Up till now most injectable materials

are for temporary vocal fold augmentation. Radiance FN (calcium hydroxyapatite formulated in microspheres suspended in an aqueous polysaccharide gel) has a longer lasting effect. It has been approved recently by the US Food and Drug Administration for injection laryngoplasty and is supposed to be long-lasting. However, so far there is no literature investigating the survival of this material in the vocal folds.

### New Paradigms in Management of Recurrent Laryngeal Papillomatosis

The traditional treatment of recurrent laryngeal papillomatosis (RLP) is surgical excision with microlaryngoscopy, which is mostly accomplished by cold steel instruments, carbon dioxide (CO<sub>2</sub>) laser, or microdebrider. Cold instruments are still advocated by many surgeons due to the avoidance of thermal injury and thus better preservation of vocal fold function. However there is more blood loss and possibly a higher chance of lower airway contamination by the fragments of viral-infected tissue. CO<sub>2</sub> laser has been used extensively for laryngeal papillomatosis. Its precise excision and ability at vaporising superficial tissues at a low power setting offers accurate excision of the glottal papillomatosis. Recently both 585-nm pulsed dye laser (PDL) and 532-nm pulsed potassium titanyl phosphate (KTP) laser have provided an alternative treatment. Both these treatment measures can cause regression of the papilloma by photoangiolytic of the sublesional microcirculation and selective eradication of the tumour microvasculature. Complications of CO<sub>2</sub> laser such as vocal fold scarring and thus the loss of pliability of the vocal folds can be avoided.

Many patients also require some form of adjuvant therapies, particularly those with repeated surgeries within a short period of time, distant disease migration, and airway compromise. Interferon is a biologic response modifier that stimulates existing host defences, modulates immune responses, inhibits cell growth and induces several enzyme systems. Gerein et al. demonstrated maximal effectiveness of interferon-alpha therapy in RLP patients with HPV 6 as compared with HPV 11 in a 20-year follow-up study.<sup>3</sup> Thus they suggested HPV typing in RLP patients after the first biopsy.

Combination of intralesional injection of cidofovir with surgical excision have shown promising results in some literatures, but it has also been criticised for its possibly carcinogenic effects in humans. Although other adjuvant



pharmacotherapies for RLP including acyclovir, ribavirin, intralesional injection of mumps vaccine and photodynamic therapy have been proposed, viral persistence occurs following these adjuvant treatments. All these trials were of small scale, making it difficult to assess clinical benefits and risks in a systematic fashion.

### Surgical Organ/Function-preservation Treatment of Laryngeal Malignancy

Chemoradiation dramatically improves the quality and saves the lives of selected laryngeal cancer patients. Although the laryngopharynx can be preserved, the function however might be significantly compromised. Besides, there are concerns about the toxicities and long term complications like radiation-induced sarcoma.

Transoral laser surgery has gained widespread acceptance for patients with early-stage glottic cancer, but is progressively assuming popularity for more advanced diseases. It has the privileges of formal open resections without the necessity of reconstruction. The whole procedure is simply done through the mouth with the overlying tissues and laryngeal framework spared. Steiner has shown the successful use of transoral CO<sub>2</sub> laser as a curative organ-preserving procedure in both early-stage and advanced-stage recurrent glottic cancers after radiotherapy.<sup>4</sup> However, both open partial surgery and endoscopic transoral laser surgery require great surgical expertise and careful patient selection, particularly in advanced-stage laryngeal cancers.

Transoral robotic surgery (TORS) allows precise tissues handling and more agile instrument movements instead of the current long and cumbersome minimally invasive surgical instruments. TORS just simply brings the surgeon's hands through a tight opening to the surgical field as if one is doing an open operation. It may be too early to say if TORS will bring a new paradigm shift in head and neck cancers and even skull base surgeries. The University of Pennsylvania is currently conducting human clinical trials with the application of TORS in various head and neck cancers.<sup>5</sup> The preliminary results are encouraging with gentle tissue handling and effective dissection in various oropharyngeal and laryngeal cancers.

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## Head and Neck Surgery

### Dr. Raymond KH MA

President, Hong Kong College of Otorhinolaryngologists



Dr. Raymond KH MA

Little do I realise that the specialty of Ear Nose and Throat is involved in management of the diseases of the head and neck in the early days of my medical career when I was a medical officer in the Medical and Health Department in the early eighties. I chose ENT as my career at first sight in those days as I thought that the duty as an ENT trainee was light, and did not have to attend to busy night calls. Life did not turn out to be so during my training. Often hours had to be spent assisting my consultant in performing complicated head and neck surgeries.

As ENT surgeons, or more specifically, Otorhinolaryngologists, we are concerned with management of diseases of the Ear, Nose and Throat and related structures of the head and neck from the skull base down to the neck. This is our specialty description since the formation of the Hong Kong Academy of Medicine. We are trained in the examination and diagnosis of lesions of the skull base down to the neck, in the earlier days with mirrors for indirect examination, and now direct vision with rigid and flexible endoscopes. We are fully familiar with the head and neck anatomy and this has enabled us to perform resections of lesions and reconstructions of defects of the head and neck confidently and competently. In this ever expanding field of Otorhinolaryngology, we work with specialists in other fields and in particular, neurosurgeons, plastic surgeons, maxillofacial surgeons, when the need arises to deliver the best care to our patients.

With interdisciplinary collaboration, complex head and neck resections are no longer stories of the past and are now commonplace in our surgical practice. We are now able to perform extensive ablative surgeries followed by meticulous techniques of reconstruction, on our own or with collaboration from the plastic surgeons. When there is involvement of the skull base as in sinonasal tumours, we resect the tumour en bloc with the involved anterior skull base together with the neurosurgeons. Pedicled flaps have largely been replaced by free flaps in reconstruction of defects of the head and neck. Nevertheless, they still play an important role in less complex reconstructions or in localities where free flap reconstructions are not readily available.

As Otorhinolaryngologists, our training in using the operating microscope and loupes in magnification has an added advantage in surgeries of the head and neck. Parotid surgery, especially revisional parotid surgery, is an example. The identification of the facial nerve at the stylomastoid foramen remains a difficult task in the face

of extensive scarring from previous surgery or a large tumour at that site. Positive identification of the facial nerve in the vertical portion in the mastoid bone with our operating microscope and otology, an alternative technique to retrograde dissection, sometimes provide a timely rescue to the helpless surgeon at this point.

Our understanding in speech and swallowing rehabilitation has helped patients with vocal cord mobility disorder either after surgery or other causes. The development of surgical methods in rehabilitation of the paralysed vocal cord is an important development. This has improved significantly the swallowing and speech problems of patients with such disorders after recurrent nerve damage from various causes. In this regard, thyroidectomies are not to be taken lightly as recurrent laryngeal nerve damage is an ever present risk of the operation. Meticulous identification of the recurrent laryngeal nerve at the entry point into the larynx remains the best way to safeguard the nerve from damage. In the event of an inadvertent injury to the nerve, the technique of vocal cord medialisation is a valuable adjunct to improve the voice and reduce aspiration rather than a wait-and-see policy.

A discussion of head and neck surgeries would be incomplete without a touch on minimally access surgery development. Where there is a natural orifice, transluminal surgeries of the upper aero-digestive tract assisted by the operating microscope or endoscope where necessary, are now realities rather than open surgeries of the past, which required long hospital stays. Transoral surgeries of the upper aerodigestive tract, involving the tongue, hypopharynx, and the larynx, are now possible with the carbon dioxide laser. Such surgeries have avoided a lot of open resections, making hospital stays shorter and enabling faster rehabilitation. Endoscopic thyroid surgery<sup>1</sup> is another example. The employment of robotic surgery<sup>2,3</sup> in surgeries of the head and neck is another important breakthrough.

Based on more precise imaging and staging of head and neck tumours, we are now able to resect tumours with better oncological clearance and target our therapy to encompass the tumour more accurately. These modern imaging techniques include the CT, MR and now the PET scan. The use of selective neck dissections has enabled us to stage the neck more accurately for planning adjunctive therapy to the neck. Our understanding of tumour molecular pathogenesis including the p53 mutations may have significant impact on our approach of management of head and neck cancers. For example, when there are genetically altered







cells, despite achieving microscopically clear resection margins, the chance of a recurrent or a new tumour may be substantially increased<sup>4,5</sup>. The employment of human adenovirus-p53 gene therapy to head and neck cancers with p53 mutations may have a role in improving survival<sup>6</sup>. The implication of HPV in the causation of a subset of head and neck tumours and their better response to chemotherapy may have future applications<sup>7</sup>.

The road to combat against head and neck cancers is long and tortuous. We, as Otorhinolaryngologists, definitely and should play a pivotal role to better the management of patients with head and neck cancers. We should strive to play an important role in future research, and training of our future generation of Otorhinolaryngologists with interest in head and neck surgery. With concerted efforts from specialists in other fields, we are confident that we can conquer this disease and improve the quality of life and survival of our affected patients.

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\* Vaccination against HPV 16 & 18 alongside regular Pap smear screening is the best preventive measure for women against cervical cancer.<sup>1,8</sup>  
<sup>1</sup>Duration of protection has been demonstrated for up to 7.3 years.  
<sup>2</sup>CIN1, CIN2, ASC-US  
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# Developments in Paediatric Otorhinolaryngology

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## Introduction

Paediatric otorhinolaryngology is an important subspecialty in many parts of the world like in the United States, United Kingdom and Australia. It was described as the care for 'special children with special ENT problems at a special place'. With the advances in medical technology, we are now managing neonates and infants with complicated upper airway problems, congenital head and neck tumours, profound hearing loss, obstructive sleep apnoea, drooling, allergic rhinitis, voice and swallowing disorders. In this review, I would discuss on the latest developments in this field and to share our experience.

## Congenital Upper Airway Problems

Stridor is the main symptom of upper airway obstruction in infants. Common causes include laryngomalacia, vocal cord palsy, subglottic stenosis, subglottic haemangioma, laryngeal cleft and laryngeal papillomatosis. Although laryngomalacia accounts for 80% of infantile stridor, 20% of laryngomalacia are associated with secondary airway lesions (SAL). Persistent stridor deserves detailed investigation first with a flexible laryngoscopy to assess the dynamic function of the larynx and to diagnose conditions like laryngomalacia and vocal cord dysfunction. In severe cases, rigid laryngotracheobronchoscopy (LTB) will be performed. The procedure will be carried out in the operation theatre with a paediatric anaesthetist maintaining the infant under spontaneous ventilation with the tubeless technique. This allows a complete examination of the larynx in particular the subglottis and the trachea. The subglottis can be sized in suspected cases of subglottic stenosis while the arytenoid joints can be palpated in vocal cord palsy. Besides, surgical intervention can be performed such as supraglottoplasty with CO<sub>2</sub> laser for laryngomalacia, laser ablation of subglottic haemangiomas and laryngeal papillomas, laser resection and balloon dilatation for subglottic stenosis and repair of laryngeal cleft under the microscope. Diagnostic laryngotracheobronchoscopy is currently performed in our centre as a day surgery while infants with laser surgery will have one night of monitoring in the paediatric intensive care unit.

One area of recent advances is the treatment of subglottic haemangioma. 85% of subglottic haemangiomas presented by 6 months of age as inspiratory or biphasic stridor. 50% of these infants

have concomitant cutaneous haemangiomas. Unilateral subglottic haemangiomas can be successfully treated with CO<sub>2</sub> laser ablation and systemic steroid. In the past, the majority of circumferential haemangiomas required tracheostomies although open submucosal resection has been performed in large centres. A paper was published in 2008 on the first successful use of oral propranolol for cutaneous haemangiomas in 11 children<sup>1</sup>. This was followed by 2 papers of propranolol therapy on subglottic haemangiomas<sup>2,3</sup>. The mechanism of action is that propranolol induces apoptosis and decreases the production of endothelial vascular and fibroblastic growth factors (VEGF and FGFs)<sup>1</sup>. Although propranolol therapy appears to be effective, one should be aware of potential side effects such as bradycardia, hypotension, bronchoconstriction and masking of hypoglycaemic symptoms. Future large scale studies on the recommended duration of treatment and benefits comparing months of propranolol treatment to a few sessions of laser surgeries are needed.

Congenital head and neck tumours can lead to upper airway obstruction in newborns. Accurate diagnosis, well-planned delivery and early resection can decrease morbidity and mortality. Differential diagnoses include teratomas, haemangiomas, lymphatic malformations and neuroglial heterotopia. Nowadays, these tumours can be detected early with antenatal ultrasound while detailed assessment of the severity of airway obstruction can be done with foetal MRI. We have carried out the EXIT (Ex-utero intrapartum treatment) procedure for a newborn with anticipated airway obstruction by a compressive neck mass during birth in 2007. This is an extension of standard Caesarean section with the baby partially delivered while the umbilical cord was kept intact to maintain maternal-foetal circulation to allow time for intubation and to secure the airway. The EXIT procedure requires multidisciplinary management by a team of obstetric and paediatric anaesthetists, obstetricians, neonatologists, radiologists and ENT surgeons.

## Paediatric Obstructive Sleep Apnoea

Adenotonsillar hypertrophy has been the commonest cause of OSA in toddlers and older children. However, recent studies are focusing on treatments beyond adenotonsillectomy and sleep-disordered breathing (SDB) in neonates and infants. Radiofrequency turbinectomy was performed in OSA children with nasal obstruction<sup>4</sup> while radiofrequency tongue base reduction was performed in Beckwith-Wiedemann





Syndrome and Down's syndrome with macroglossia and OSA<sup>5</sup>. Laryngomalacia, being the main cause of stridor, is also a major cause of OSA in children younger than 1 year<sup>6</sup>. Supraglottoplasty or laser aryepiglottoplasty have shown to significantly reduce the AHI in laryngomalacia-related OSA<sup>7</sup>. Craniofacial anomalies like hypoplastic mandible as a cause of infantile OSA in Pierre Robin Sequence and Treacher Collin Syndrome can be treated with mandibular distraction surgery<sup>8</sup>. Adenotonsillectomy being the cardinal treatment, new techniques are now available to reduce blood loss such as radiofrequency tonsillectomy and adenoidectomy, suction diathermy adenoidectomy and intracapsular tonsillectomy.

## Management of Drooling

Drooling is common in children with cerebral palsy and neurological disorders. It can lead to social embarrassment, skin irritation, aspiration and chest infection. These children require intensive oromotor training and anticholinergic medications. For severe cases, we often perform submandibular duct relocation and salivary gland resection. Recent development is on Botox injection into salivary glands. This can be safely done under ultrasound guidance with botox injected into the submandibular and parotid glands. The effect is temporary compared to surgery but can be a treatment alternative for those who are contraindicated for general anaesthesia.

## Neonatal Hearing Screening and Cochlear Implant

With the introduction of Universal Neonatal Hearing Screening in our hospital, all newborns are investigated for hearing impairment on the first or second day of life with AABR (Automatic auditory brainstem response). Failed patients will be referred to our audiologist for BAER (Brainstem auditory evoked response). Patients who failed the BAER will be assessed by ENT surgeon. The objective of this programme is to achieve early identification of hearing loss in children to allow early aiding and development of normal speech. Children with bilateral profound hearing loss will be actively assessed in our Cochlear Implant Clinic comprising of a team of ENT surgeons, audiologists, speech therapists and social workers. Most of these children are implanted early for better speech development and to attend mainstream school. Recently, bilateral implantation is increasingly considered for congenital profound hearing loss and children with hearing loss after meningitis. Results are encouraging with improved sound localisation and speech perception in noisy conditions<sup>9</sup>.

## Conclusion


The advances in paediatric specialties and medical technologies hasten the development of paediatric otorhinolaryngology. Successful management depends on understanding of parental concerns and close collaboration with paediatricians, paediatric anaesthetists, audiologists and speech therapists.

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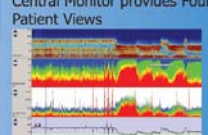
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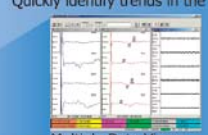


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# Endoscopic Sinus Surgery Venturing Outside the Nose

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Dr. Wai-kuen HO

## Introduction

More than 3 decades have elapsed since Messerklinger<sup>1</sup> reported his detailed physiological studies of the mucociliary clearance of the paranasal sinuses. With the understanding of the recovery potential of even the most severely diseased paranasal sinuses, endoscopic sinus surgery (ESS), rather than destructive exenteration surgery, is now generally accepted for the treatment of inflammatory sinus diseases that are resistant to medical treatment. Terms like *FESS* (Functional Endoscopic Sinus Surgery) are commonly used to describe these operations to emphasise the minimally invasive access nature of the procedure and the *functional* concept to preserve normal mucosa, in contrast to previous exenteration types of operations, for early recovery of mucociliary clearance<sup>2,3</sup>. With advance in surgical techniques, development of a new generation of video equipment and advent of computer-assisted surgery, the endoscopic sinus procedure ESS has understandably extended outside the nose and sinuses and might not be minimally invasive and functional anymore in its true context. This article describes the development of these extended endoscopic procedures through the nose.

## Oncological Surgery through the Nasal Cavity Assisted or Completely Performed with the Nasoendoscope

It was very logical that ESS techniques were employed to resect nasal/sinus neoplasms by rhinologists when the techniques used for inflammatory nasal diseases became mature. The commonest nasal tumour resected by the nasoendoscopic route reported in the literature is probably the inverted nasal papilloma<sup>4</sup>. These benign tumours have a high propensity for recurrence and a significant potential of association with malignancy. Transnasal endoscopic resection has the benefit of avoiding a major facial scar and also provides close magnified views of the surgical field to facilitate a complete and clear resection. These tumours usually arise from the lateral nasal wall and an endoscopic medial maxillectomy is required (Figure 1). Good ESS technique is mandatory especially in the maintenance of a bloodless field during surgery to provide a clear view during resection. Experience so far shows that outcomes and recurrence rate are at least comparable to open surgical resection if not better.

The commonest malignant nasal/sinus neoplasm is squamous cell carcinoma. There are other possibilities

like haemangiopericytoma, undifferentiated carcinoma, adenoid cystic carcinoma, adenocarcinoma and mucosal melanoma. Selected malignant nasal/sinus tumours might be amendable to a minimally invasive access for tumour resection by the ESS technique alone without a facial scar (Figure 2). This would not be a functional surgery and all oncological principles for tumour resection have to be followed. Whether the tumour is delivered en bloc or in stages, resection must be complete with adequate clear resection margins. And like open surgery, adjuvant treatment, further radiotherapy +/- chemotherapy have to be given if there is a high chance of local or systemic recurrence. It is usually the site of the tumour rather than the histological type that dictates if an exclusive ESS approach would be possible. Tumours arising more near the midline: nasal septum, nasal cavities, lateral nasal wall are more amendable to transnasal ESS approach. Tumours involving the subcutaneous tissue, skin, contents of the orbit, intracranial cavity are not suitable for an exclusive ESS resection.

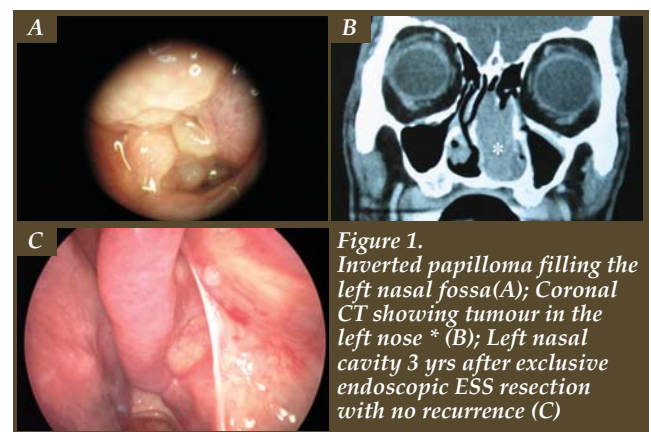


Figure 1. Inverted papilloma filling the left nasal fossa (A); Coronal CT showing tumour in the left nose \* (B); Left nasal cavity 3 yrs after exclusive endoscopic ESS resection with no recurrence (C)

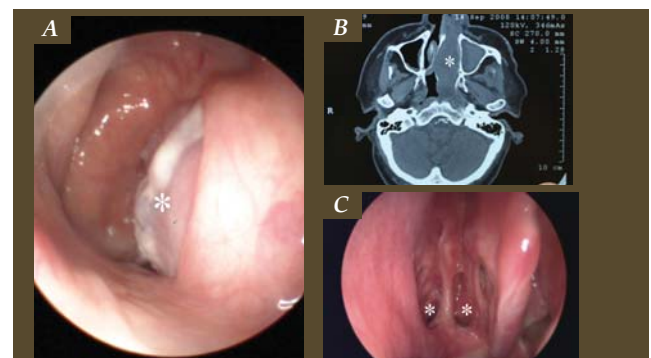


Figure 2. Haemangiopericytoma\* arising from the nasal septum, viewed from the right side of the nasopharynx (A); Axial CT showing the tumour\* (B); Operative site with nasal septum resected, viewed from the right nasal cavity 4 months after surgery (C) (\* normal right and left sphenoid sinus ostium)





Tumours of the anterior skull base often present in the Clinic as nasal masses with bleeding. Common anterior skull base neoplasms include olfactory neuroblastoma, ethmoidal squamous carcinoma and undifferentiated sinonasal carcinoma. To have a complete clearance of the tumour, the anterior skull base including the cribriform plate, the frontal sinuses, the ethmoidal roof and sphenoid roof have to be resected. Classically this can be resected through a combined craniofacial resection with separate incisions on the scalp by a neurosurgeon and rhinotomy incision on the face by an ENT surgeon. With the advance of ESS techniques, the facial incision can now be spared and the nasal part of resection can be exclusively performed through the endoscopic transnasal route (CraniNasal Resection)<sup>5</sup>. The exact extent of oncological resection as performed with the open technique can now be achieved with ESS with a much decrease in morbidity (Figure 3). Exclusive transnasal endoscopic resection of anterior skull base tumours, e.g. olfactory neuroblastoma, without a scalp incision has also been reported in the literature<sup>6</sup>. The question at the moment is whether these approaches could have an adequate local control rate over a prolonged period of follow-up when compared with the traditional open craniofacial approach<sup>7</sup>.

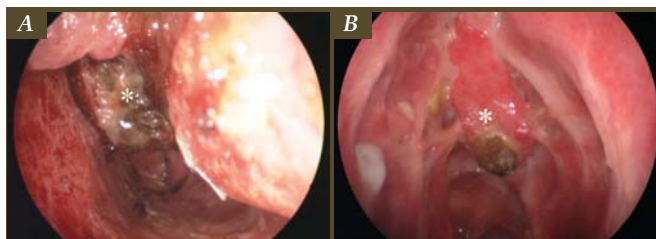


Figure 3. Nasal mucosal melanoma in the left nasal cavity \*(A); 2 months after a combined craniotomical ESS resection (B) (\*showing the site of anterior skull base repair)

Transnasal, transphenoidal endoscopic ESS resection of pituitary tumours is already an established technique in the ENT/NeuroSurgical community. Compared with the classical transphenoidal approach with the microscope, the ESS approach does not require any surgical steps in the nasal septum and the angled nasoendoscopes can provide additional off-midline views of the surgical field which is not possible if one works with the surgical microscope which can only give a straight view ahead.

Recently tumour resection with ESS has also been extended to the posterior midline structures of the nasopharynx (Figure 4), the clivus, and the lateral structures of the pteryopalatine fossa and the infratemporal fossa<sup>8</sup>. Preliminary experience shows that these are all feasible except that new surgical instruments may have to be designed.

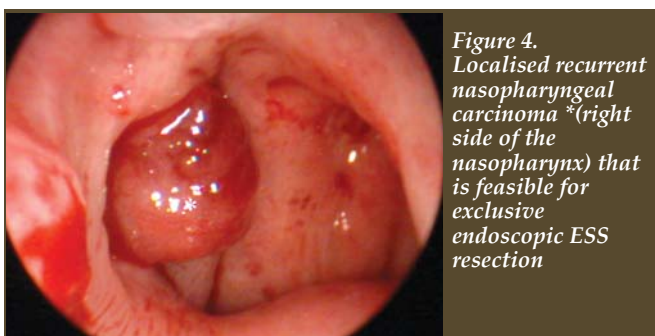


Figure 4. Localised recurrent nasopharyngeal carcinoma \*(right side of the nasopharynx) that is feasible for exclusive endoscopic ESS resection

## CSF Rhinorrhoea and Repair of Anterior Skull Base Defects

Skull base defect and CSF rhinorrhoea can be idiopathic, following trauma like skull base fractures after injury or iatrogenic like inadvertent penetration during sinus surgery or a defect after anterior skull base resection. This usually presents as clear rhinorrhoea with the amount increases on exertion. This carries the potential risks of meningitis and serious intracranial infections if not detected and repaired. Traditionally, repair can be performed through a craniotomy from above. With the advance in ESS techniques, the site of CSF leakage can now be identified with a nasoendoscope from the nasal cavity (Figure 5) and the defect repaired by free or pedicled mucosal grafts<sup>9</sup>. The outcome of transnasal ESS repair of the skull base is at least as good as open techniques and without the morbidity accompanying a craniotomy<sup>10</sup>.

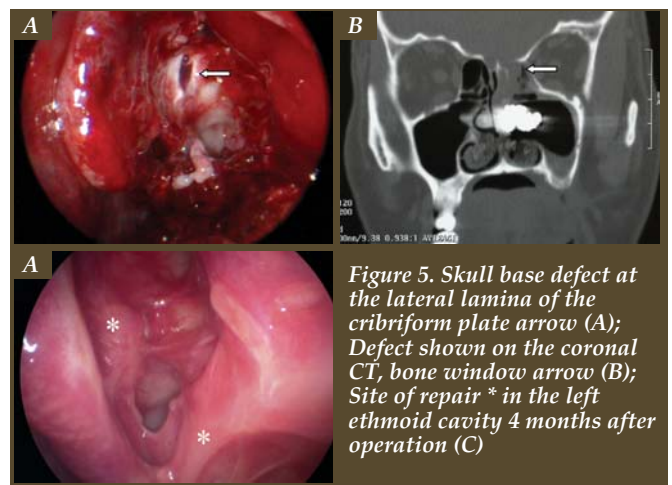


Figure 5. Skull base defect at the lateral lamina of the cribriform plate arrow (A); Defect shown on the coronal CT, bone window arrow (B); Site of repair \* in the left ethmoid cavity 4 months after operation (C)

## Orbital Surgery with ESS: Endoscopic DCR, Endoscopic Orbital Decompression

Nasolacrimal duct obstruction is a result of trauma, infection or of idiopathic causes. Patients present with chronic epiphora (excessive tearing) and recurrent dacryocystitis (infection of the lacrimal sac). With an external incision near the medial canthus, conventional surgical treatment with external dacryocystorhinostomy (DCR) opens up a new pathway of drainage anterior to the insertion of middle turbinate in the nasal fossa. With the guidance of a light probe through the canaliculi by an ophthalmologist, DCR can now be performed with an intranasal endoscopic ESS approach without a facial incision (endoscopic DCR)<sup>11</sup>. The success rate is comparable to conventional external DCR (Figure 6).



Figure 6. Drainage of fluorescence from a right DCR, post-operative image (nasoendoscopic view)

Thyrotoxic exophthalmos is usually related to Grave's disease. This may persist even if the primary thyroid problem is under control. Abnormal deposition in the orbit results in exophthalmos with exposure keratitis and risk of permanent blindness. An increase in intraorbital pressure would also lead to pressure symptoms and more importantly, compression on the optic nerve. For patients resistant to medical treatment and requiring prolonged systemic steroid therapy, orbital decompression with surgery is indicated. Approaches to the orbit include those with open external ethmoidectomy with a skin incision near the medial canthus of the eye (medial approach), lateral approach with a skin incision near the lateral canthus, inferior approach through the maxilla (transantral) or superior with a craniotomy. Endoscopic ESS orbital decompression is now the approach of choice<sup>12,13</sup>. Transnasal ethmoidectomy is first performed with the ESS approach and medial decompression of orbital content into the ethmoidal sinus follows (Figure 7). Besides being a minimally invasive access procedure with no facial incision required, endoscopic orbital decompression has the virtue of achieving extensive decompression by removing 2 orbital walls - the lamina papyracea (medial wall) and the medial floor of the orbital cavity with more reliable results.

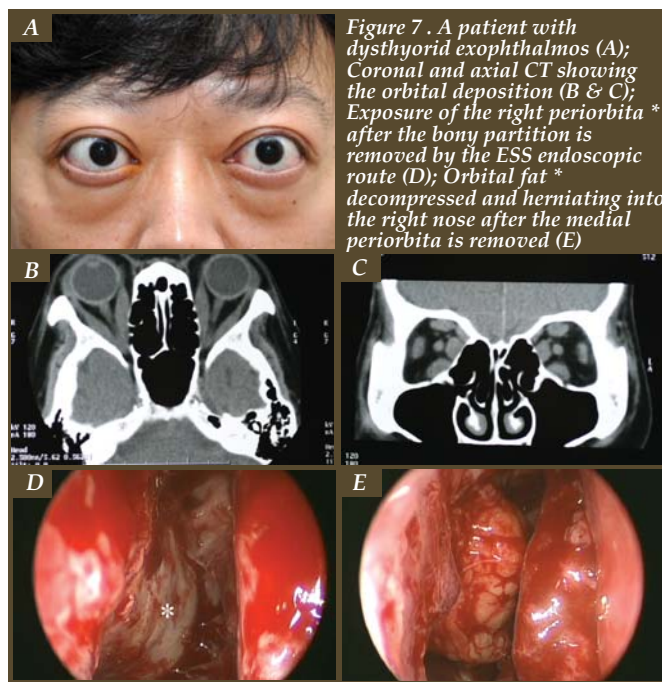


Figure 7. A patient with dysthyroid exophthalmos (A); Coronal and axial CT showing the orbital deposition (B & C); Exposure of the right periorbital \* after the bony partition is removed by the ESS endoscopic route (D); Orbital fat \* decompressed and herniating into the right nose after the medial periorbital is removed (E)

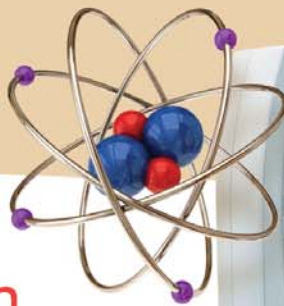
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## Summary

With the experience gained in managing inflammatory diseases, endoscopic sinus surgery ESS techniques have ventured outside the nose and sinuses and have been applied in tumour resection around the nose and anterior cranial fossa, used in repairing skull base defects and worked around the orbits as a technique with minimally invasive access. Depending on the target of therapy, the actual ESS surgery may be extensive and invasive and non-functional. ESS has been developed as one option of surgical approach where selection of patient, selection of the site of diseases and follow-on with oncological principles are all required in order to have an optimal outcome.





# Certificate Course on Nuclear Medicine & PET/CT

Jointly organised by



The Federation of Medical Societies of Hong Kong

Hong Kong Society of Nuclear Medicine

## Objectives

This course aims to explain the use and misuse of nuclear medicine imaging including PET/CT, as well as therapy in the daily clinical practice. The strengths and weaknesses of different imaging modalities in the management of a wide diversity of clinical problems will be discussed. After attending the course, the attendees will learn how to choose the best imaging modality for a particular clinical problem, and when to refer for a nuclear medicine diagnostic or therapeutic procedure.

Date	Topic	Speaker
15 May 2010	<ol style="list-style-type: none"> <li>1. Nuclear medicine and PET/CT: basic principles, radiation level and safety</li> <li>2. An overview of NM services in Hong Kong and the trends in other countries</li> <li>3. Applications of nuclear medicine and PET in common neuro-psychiatric conditions</li> </ol>	Dr. CHOI Pak Tat, Frankie Consultant, Pamela Youde Nethersole Eastern Hospital Dr. NGAI Wai Tat Consultant, Hong Kong Baptist Hospital
22 May 2010	Applications of nuclear medicine in the chest and abdomen: pulmonary, nephro-urological, gastrointestinal and hepatobiliary conditions	Dr. HO Wai Yin Consultant, Queen Mary Hospital
29 May 2010	The role of nuclear medicine and PET/CT in diagnosis and follow-up of cancer patients	Dr. AU-YONG Ting Kun Senior Medical Officer, Queen Elizabeth Hospital
5 June 2010	<ol style="list-style-type: none"> <li>1. Nuclear cardiology: where are we now?</li> <li>2. Clinical indications of skeletal scintigraphy and SPECT/CT</li> </ol>	Dr. CHEUNG Shing Kee, William Associate Consultant, Pamela Youde Nethersole Eastern Hospital Dr. CHOI Pak Tat, Frankie Consultant, Pamela Youde Nethersole Eastern Hospital
19 June 2010	<ol style="list-style-type: none"> <li>1. How nuclear medicine can help patients with thyroid, parathyroid or other endocrine disorders?</li> <li>2. Common paediatric applications of nuclear medicine and PET/CT</li> <li>3. The role of nuclear medicine and PET in infection &amp; pyrexia of unknown origin</li> </ol>	Dr. NGAI Wai Tat Consultant, Hong Kong Baptist Hospital Dr. LOK Chiu Ming Associate Consultant, Princess Margaret Hospital
26 June 2010	Treating your patients by nuclear medicine: radionuclide therapies	Dr. Thomas CHENG Honorary Consultant, Hong Kong Sanatorium & Hospital

Date	15 May 2010 – 26 June 2010 (Every Saturday, Except 12 June 2010)
Time	2:30 p.m. – 4:00 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. Application form can be downloaded from website: <http://www.fmshk.org>



# Otology in Hong Kong, a Personal Reflection

**Dr. Buddy YK WONG**

MH, MBChB, MSc, FRCS( Eng and Canada), FHKAM(ORL)  
*Vice President, Hong Kong Society for the Deaf*



Dr. Buddy YK WONG

## Introduction

30 years of practice seem to have flashed by. Otology in Hong Kong has progressed but much has remained the same. This is a personal reflection of an ENT surgeon who has a special interest in otology. In a review like this, it is necessary to concentrate on certain areas of importance and relevance to the author.

Clinical otology seems to be concerned with 2 major areas; eradication of acquired diseases of the ear and provision or restoration of hearing. As the former declines the latter has increased in importance.

In eradication of acquired diseases of the ear I will consider management of acute and chronic suppurative otitis media.

In restoration of hearing I will consider provision of hearing aid services, and introduction of cochlear implants.

## Acute Otitis Media ( AOM)

Much of the diseases of the ear are related to the general health of the population. In acute otitis media the incidence of which seems to have declined as the general health of the young has improved. Other factors having influence to this trend are the rising general standard of living, almost universal immunisation and effective antibiotics. Surgical intervention for treatment for acute otitis media is uncommon nowadays. In my 30 years of practice I have carried out one cortical mastoidectomy for an acute mastoid abscess and that was in the early days.

The incidence of otitis media with effusion (OME) has also declined together with AOM. In the past, myringotomy and tubes (grommets) were carried out frequently. At one time it was the most frequently performed surgery for children in the USA.

However I think a more conservative approach to OME may be appropriate. Most OME can be treated expectantly unless there are significant hearing loss due to the fluid, acute episodes of AOM upon chronic effusion and atrophic changes in the tympanic membrane such as formation of retraction pockets.

I expect further decline in acute otitis media with the introduction of immunisation against pneumococcus in young children. The pneumococcus bacterium is the most common causative agent for AOM.

## Chronic Suppurative Otitis Media (CSOM)

Management for chronic suppurative media has remained largely the same. As the incidence of acute otitis media has declined so has CSOM for very much the same reasons.

CSOM can be divided into 2 types: those with a perforated ear drum, the tubotympanic type and those with a cholesteatoma, the atticofacial type.

Surgical repair of the tympanic membrane has reached maturity and a competent ear surgeon can offer the procedure, tympanoplasty, with a success rate of around 90%. Whereas repair of ossicles, ossiculoplasty, if they are also diseased, carries a much lower success rate with regard to improvement to hearing. Over 90% of repair of tympanic membranes are now done with the temporalis fascia.

To me the objectives of tympanoplasty are as follow. If the tympanic membrane is successfully grafted then recurrent otitis media will disappear. Most likely hearing deterioration will stop and hopefully there will be improvement in sound perception.

Management of cholesteatomata has remained also the same i.e. excision. Mastoidectomy may be radical, removal of all middle ear structures except the stapes. In the case of modified radical mastoidectomy the principles are to remove all cholesteatomatous disease, preservation of middle ear structures and reconstruction of ossicles (ossiculoplasty) to improve hearing. In some favourable situations it may be possible to entertain intact canal wall mastoidectomy, thus avoiding a mastoid cavity but at the risk of an occult recurrence of the cholesteatoma. Developing this intact canal wall technique, though not so often used for the management of cholesteatomata, is now used in almost all cases of cochlear implant.

## Restoration of Hearing

### Hearing Aids

Restoration of hearing has been the goal for otologists for many years. The most commonly used method is provision of hearing aid and there has been much development and improvement in this area. The emergence of digital hearing aid technology has undoubtedly benefited those with a moderate to severe hearing deficit. Wearing of a hearing aid has become





more comfortable acoustically and otherwise due to technological improvements as well as the higher standard of hearing aid provision. Many hearing aid centres are now open, staffed by audiologists who are properly trained.

For those, for whatever reason, who cannot wear hearing aids but with a conductive hearing loss, they may be offered bone anchored hearing aids; (BAHA). BAHA is particularly useful in those patients with congenital atresia of the external and middle ear.

### **Cochlear Implant (CI)**

Cochlear implant is the surgical introduction of a multichannel electrode into the cochlea and stimulating the nerve endings of the auditory nerve directly, with sounds picked by a microphone and converted into electrical impulses by a speech processor.

This has been the most important development in restoration of hearing in the last 20 years. The provision of cochlear implant is now the procedure of choice for those with bilateral profound hearing loss.

It was first introduced for those with bilateral acquired profound hearing loss that was beyond the help from hearing aids; generally speaking those with 90dB plus hearing loss. These are the patients who have developed language but suffered bilateral profound hearing loss i.e. post-lingually deafened for various reasons, CSOM, post irradiation for nasopharyngeal carcinoma, post ototoxic medications, etc. Sometimes the exact cause is unknown.

More important CI has been shown to be most useful for those who are born with bilateral profound hearing loss, i.e. prelingually deaf, as long as it is done early and

the earlier, the better. Most of these children that have been implanted before age five can expect to develop adequate speech, to go to mainstream schools, instead of the school for the deaf and to use a telephone. These are astounding results. To me, with experience of how deaf children, their parents and their teachers toiling for years with speech and hearing training and leading to only meager outcome.

On the positive side, most implant surgeries have happy outcomes. With each new generation of CI, it becomes more reliable and has better performance, more effective outcome can be expected. On the more cautious side we have to consider the long term effects as we are implanting them into patients at a very early age. Most CI proponents recognise that each CI implanted has a limited life span, perhaps 15 to 20 years. That implies many re-implantations are to be expected and many more implant surgeons will be needed in future.

Cochlear implant has been a success in Hong Kong but not so in many other countries due to the high cost in terms of money and expertise. In the province of Guangdong I was once told there are, in each year, 2000 deaf children born. Yet so far approximately only 400 CIs have ever been done. Measured in public health terms CI has not been so successful.

### **Conclusion**

It has been a rewarding 30 years' experience especially in the field of restoration of hearing. May be the next 30 years will be even better with the prospect of stem cell therapy and gene therapy.



## **Rental Fees of Meeting Room and Facilities at The Federation of Medical Societies of Hong Kong**

(Effective from October 2009)

Venue or Meeting Facilities	Member Society (Hourly Rate HK\$)			Non-Member Society (Hourly Rate HK\$)		
	Peak Hour	Non-Peak Hour	All day Sats, Suns & Public Holidays	Peak Hour	Non-Peak Hour	All day Sats, Suns & Public Holidays
Multifunction Room I (Max 15 persons)	150.00	105.00	225.00	250.00	175.00	375.00
Council Chamber (Max 20 persons)	240.00	168.00	360.00	400.00	280.00	600.00
Lecture Hall (Max 100 persons)	300.00	210.00	450.00	500.00	350.00	750.00
<b>Non-Peak Hour: 9.30 am - 5.30 pm Peak Hour: 5.30pm - 10.30pm</b>						
LCD Projector	500.00 per session					
Microphone System	50.00 per hour, minimum 2 hours					



# The Art of Bubbles

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The pages of the calendar turn toward a new year, accompanied by the distinctive 'pop' as bottles of Champagne are opened just before the stroke of midnight. Little do we know that the wine containing millions of tiny bubbles which we gratuitously consume was created as a result of great skill, finesse and an amazing gift from Nature. The French, as great protectors of their domestic produce, can tell you that not all bubbles are created equal. The European Union has long ago protected the designation of *Champagne* as belonging to the wine produced by a specific process in the French region of *La Champagne*. Champagne is not the only sparkling wine on Earth, but it is without doubt the grandest. As in all success stories, the tale of *le Champagne* (referring to the wine) and fortunes of the *Champenois* (the inhabitants of this now - famous region in the North of France) had humble beginnings.

The agricultural region of Champagne is situated approximately 150 kilometres northeast of Paris. The grapes which are used to make the sparkling wine come from 321 designated villages. The majority of Champagne houses are based either in the cathedral city of Rheims, or the smaller towns of Epernay or Ay. *La Champagne* is not only the northernmost wine growing area in France, but also one of the world's northernmost viniculture regions. With a mean annual temperature of around 10°C, grapes retain a lot of acidity: suboptimal for still wines but ideal for sparkling types. The soil in Champagne is predominantly limestone and chalk. It retains water poorly. This property which makes the soil poor for conventional food crops is an advantage for vines, since the pores in the soil prevent their deep-set roots from water damage. The cool climate and chalky soil are the leading factors which make Champagne special. Champagne is based on three grape varieties: Pinot Noir, Pinot Meunier and Chardonnay. They are produced in 321 designated villages (commonly known as *crus*) widely distributed around the region, with diverse terrains and growing conditions. Each Champagne house creates its own blend from as many as 50 or more different wines from those villages. This simply explains the complexity of flavours when tasting Champagne. The flavours are further accentuated by the slow fermentation of the wine in cool and dark underground cellars, some dating back to Roman times.

With its distinct geographical location and amazing variety, the scene appeared to be set for *la Champagne* to make its world famous bubbly. Or did it?

Wine had been made in Champagne for nearly two

millennia. Save for the last 300 or so years, it was of unremarkable quality. Bubbles had been observed by early winemakers in Champagne as well as in other parts of France, in Italy as well as in England well before the advent of the famous drink we know today. The re-fermentation which produced the carbon dioxide in the bubbles was even considered a fault in the process. The phenomenon can be explained by the cold winters in the Champagne region, which arrests the conversion of grape sugar to alcohol. Fermentation resumes with the arrival of spring, resulting in the buildup of carbon dioxide in the bottle. 17<sup>th</sup> century winemakers in Champagne suffered from countless exploding bottles until they adopted stronger glass (a novelty from England).

Things were not looking good in Champagne until the year 1668, when a young Benedictine monk named Dom Pierre Pérignon took up the job of cellarer at the Abbey of Hautvillers. For the next 40 or so years until his death, Dom Pérignon harnessed the bubbles in the wine of his abbey to its advantage by developing production methods which we see today. With a remarkable palate, he was a master blender of wines, even when totally blind in the latter years of his life, balancing the various elements from different grapes to create a fine wine. He was also known to eat grapes from different villages before breakfast so as to base his blends from the results of his tastings. Dom Pérignon firmly believed that although two of the three grape varieties in Champagne were black (in fact dark blue in colour), a white wine would be more elegant in style; hence he perfected the method of obtaining white wine from black grapes. Most important of all, he championed the use of strong glass for his bottles and stoppers made of cork!

*Méthode Champenoise* or the Champagne Method as we know today is a highly complex process, more complex than making still wine. It starts with the winemaker creating a base wine (or *cuvée*) from up to or more than 50 still wines from various growers in concordance with the 'style' of the House. A mixture of yeast and sugar in a wine solution (*liqueur de tirage*) is added to the bottle of base wine. As the bottle is laid down horizontally in the cool and dark cellar, a second fermentation begins. Carbon dioxide forms in the bottle during the second fermentation. *Lees*, the dead yeast cells in the bottle, also build up during second fermentation. The wine would be left to age for many months (15 at the very least), if not years, to allow for some interaction between the wine and the *lees*. The result: an *autolytic* character of distinctive aromas and flavours peculiar to Champagne.





At the end of ageing, the bottles of Champagne contain a fair amount of solid particles, mainly lees, which must be removed by a complex set of manoeuvres of shaking and turning called *remuage*. The ultimate aim is to work the solid particles in the bottle down to the cork, so that the sediment can be completely removed. More traditional and smaller winemakers still employ manual *remuage*, which involves hand-turning the bottle very slightly, shaking it briskly for a moment, and slightly tilting the bottle cap - down as it is replaced in its holding position upside down. The process is repeated every two to three days for up to three months, right until the sediment lies in the neck of the bottle. Larger winemakers use computer - controlled machines for this rather tedious and labour - intensive process. Bottles are aged upside down for another few months before the sediment is removed by *dégorgement*.

In the *dégorgement* process, the sediment is frozen as the necks of the bottles pass through an ice - cold brine solution. The temporary cork is removed; the frozen sediment, as it is propelled by carbon dioxide inside the bottle, goes flying in the air. If performed skillfully, very little if any Champagne is lost. The vast majority of Champagne makers then add a small amount of a flavouring sugar solution to the bottle: a process called *dosage*, before sealing it with a permanent cork. Exceptionally a few makers add no sugar at the end: so - called *brut zero*, but the product is considered too harsh for most palates.

Thus ends the journey from vine to shop. Nature's blessing could not be materialised without the ingenuity of Dom Pérignon and fellow *Champenois*. On the other hand, tradition meets technology as much of the tedium (and labour costs) of the complex *Méthode Champenoise* is replaced by automation. Critics may mourn the dying arts of manual *remuage* and *dégorgement* at the expense of economy. However, I believe that most of us would appreciate a piece of affordable luxury, be it a light - bodied Taittinger Vintage Brut or a rich and round Veuve Clicquot Vintage Reserve Brut. One could save the Moët & Chandon Cuvée Dom Pérignon for a very special occasion. In any case, this legendary wine, often imitated but never bettered, will make all *Champenois* proud.



## 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



Skin lesion at left chest

A 50-year-old man with an one-month-history of gout complained of sudden onset of this itchy painful skin rash around his whole body and four limbs extensively. The skin rash progressed rapidly and was associated with fever and generalised unwellness. His mouth and eyes were also involved with multiple erosions.

#### Questions:

1. What is your provisional diagnosis or differential diagnoses?  
What physical signs can be elicited to help your clinical diagnosis?
2. What other important history you would like to ask?
3. How will you manage this patient?

(See P.29 for answers)





# The Federation Spring Gathering cum Open House

The event was successfully held on 12 March 2010 with many distinguished guests including Dr. the Hon LEUNG Ka Lau, Dr. the Hon PAN Pey Chyou, Dr. Gloria TAM, Dr. Homer TSO, Prof. George WOO, and old friends of the Federation.

Welcoming the guests in the lift lobby were artistic pieces of our Members that had been published as cover photos of the Hong Kong Medical Diary. Our President, Dr. Raymond LO, delivered a welcome address in our newly refurbished Lecture Hall. Dr. LO highlighted some of the coming events of the Federation, and called for support and donations from all friends and colleagues. Following the speech, the guests were shown to the various exhibits of the Federation archives.

In the Council Chamber, the past and present publications of the Federation were on display. The Hong Kong Medical Diary had been in print for over 30 years, and the archives witnessed the change in size from a 4 x 7" to today's B5 size; the pages increased from 24 pages to today's 40, and the 2 colour printing to today's 4C. Other than the Medical Diary, the Medical and Dental Directory of Hong Kong was another great publication of the Federation. The eight editions throughout the years updated the information from time to time and served as a handy reference book for medical professionals.

In our Multi Function Room, there was a slide show of past Federation events, and precious old photos were also shown. The photos not only recalled the guests of the work that the Federation had done over the years, but also the young faces of many renowned medical professionals back in those days.

Last but not least, the presidency photos on display in the memory lane have definitely recalled memories of many old friends of the Federation; and introduced the history of the Federation to new ones.

For more photos of the event, feel free to browse through our photo gallery on [www.fmskhk.org](http://www.fmskhk.org).







# Certificate Course on Management of Common Psychiatric Disorders

Jointly organised by



The Federation of Medical  
Societies of Hong Kong



The Hong Kong College of  
Psychiatrists

## Objectives

Common mental disorders have been found to be affecting more than 10% of the general population at any time around the world. This course aims to enhance medical doctors' and allied health professionals' understanding in the aetiology, natural course and management of these disorders. After attending the course, the participants will not only have better knowledge and skills in the early detection of these illnesses, but also in facilitating timely intervention and prevention of subsequent complications.

Date	Topic	Speaker
7 May 2010	Anxiety and Phobias	Dr. Dicky CHUNG
14 May 2010	Child Birth and Mental Health	Dr. Bonnie SIU
28 May 2010	Adjustment Disorders and Chronic Depression	Dr. Elisabeth WONG
4 June 2010	Sleep Problems and Management	Dr. Kwok-Chu TSO
11 June 2010	Risk Assessment of Mental Disorders	Dr. Amy LIU
18 June 2010	Assessment for Elders with Subjective Cognitive Complaints	Dr. Jess LEUNG

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%
Enquiry	The Secretariat of The Federation of Medical Societies of Hong Kong

**Tel: 2527 8898**

**Fax: 2865 0345**

**Email: [info@fmshk.org](mailto:info@fmshk.org)**

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



Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				★ FMSHK Officers' Meeting ★ HKMA Council Meeting		
<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
★ HKMA Yau Tsim Mong Community Network - Preventing the Preventable (Nephrology) ★ MPS - Mastering Adverse Outcomes	★ CME - Thinking and Acting on Obesity	★ HKMA Kowloon West Community Network - CME Lecture	★ HKMA - Wuhan Project "Practical Health Informatics Course for Doctors" (Session I) ★ MPS - Mastering Adverse Outcomes	★ MPS - Mastering Your Risk	★ HKMA Shatin Doctors Network - Certificate Course in Rehabilitation Medicine (III)	★ MPS - Mastering Your Risk
<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>
★ MPS - Mastering Your Risk ★ HKMA Certificate Course on Family Medicine 2010 ★ HKMA Snooker Tournament ★ A One-day Course on Common Paediatric Dental Problems - A Review		★ MPS - Mastering Adverse Outcomes ★ HKMA Central, Western & Southern Community Network - Short Certificate Course in Urology for Primary Healthcare Providers - Management of Common Urological Problems (I)		★ HKMA HKECN - Certificate Course: Practical Psychiatry for the General Practitioners (IV) ★ HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2010 - Management of Prostate Cancer ★ FMSHK Executive Committee Meeting		★ MPS - Mastering Your Risk ★ Refresher Course for Health Care Providers 2009/ 2010
<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>
★ MPS - Mastering Your Risk ★ HKMA Snooker Tournament			★ HKMA - Wuhan Project "Practical Health Informatics Course for Doctors" (Session II)	★ HKMA HKECN - Certificate Course: Practical Psychiatry for the General Practitioners (V) ★ HKFMS Foundation Meeting	★ HKMA Shatin Doctors Network - Certificate Course in Rehabilitation Medicine (IV)	★ MPS - Mastering Adverse Outcomes
<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>	
★ MPS - Mastering Your Risk ★ HKMA Snooker Tournament			★ MPS - Mastering Your Risk ★ HKMA - Wuhan Project "Practical Health Informatics Course for Doctors" (Session III)	★ HKMA HKECN - Certificate Course: Practical Psychiatry for the General Practitioners (VI) ★ HKMA New Territories West Community Network - CME Lecture on "Mood Disorder"		





Date / Time	Function	Enquiry / Remarks
<b>1</b> 8:00 pm - 10:00pm <b>THU</b>	<b>FMSHK Officers' Meeting</b> Organiser: 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. Paulina TANG Tel: 2527 8898 Fax: 2865 0345
8:00 pm	<b>HKMA Council Meeting</b> Organiser: 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, Wanchai, Hong Kong	Ms. Christine WONG Tel: 2527 8285
<b>8</b> (10, 17, 18, 25, 28) <b>THU</b>	<b>MPS - Mastering Your Risk</b> Organiser: The Hong Kong Medical Association, Speakers: Dr. Justin CHENG & Dr. CHEUNG Kit Ying Andy, Venue: (1) The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong & (2) Mongkok	Miss Viviane LAM Tel: 2527 8452 2.5 CME Points
<b>9</b> 1:00 pm <b>FRI</b> (23)	<b>HKMA Shatin Doctors Network - Certificate Course in Rehabilitation Medicine (III &amp; IV)</b> Organiser: HKMA Shatin Doctors Network, Speakers: Ms. Sammi TSUI & Ms. Grace LUNG, Venue: 1/F, Jasmine Room, Royal Park Hotel, Shatin	Dr. MAK Wing Kin Tel: 2648 4466 1.5 CME Points
<b>11</b> 2:00 pm <b>SUN</b>	<b>HKMA Yau Tsim Mong Community Network - Preventing the Preventable (Nephrology)</b> Organiser: HKMA Yau Tsim Mong Community Network; Kwong Wah Hospital, Chairman: Dr. HO Chung Ping, MH, Speakers: Various, Venue: Lecture Theatre, 10/F., TWGHs Yu Chun Keung Memorial Medical Centre, Kwong Wah Hospital, Kowloon	Miss Alice TANG & Miss Carman WONG Tel: 2527 8285
(24)	<b>MPS - Mastering Adverse Outcomes</b> Organiser: The Hong Kong Medical Association, Speaker: Dr. CHEUNG Kit Ying Andy, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Viviane LAM Tel: 2527 8452 2.5 CME Points
<b>12</b> 1:00 pm <b>MON</b>	<b>CME - Thinking and Acting on Obesity</b> Organiser: The Hong Kong Medical Association, Speaker: Prof. Ian CATERSON, Venue: Tsim Sha Tsui, Kowloon	Miss Viviane LAM Tel: 2527 8452 1 CME Point
<b>13</b> 2:00 pm <b>TUE</b>	<b>HKMA Kowloon West Community Network - CME Lecture</b> Organiser: HKMA Kowloon West Community Network, Venue: Crystal Room I-III, 30/F, Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, New Territories	Miss Alice TANG Tel: 2527 8285
<b>14</b> 1:00 pm <b>WED</b> (21, 28)	<b>HKMA - Wuhan Project "Practical Health Informatics Course for Doctors" (Session I, II &amp; III)</b> Organiser: The Hong Kong Medical Association, Speakers: Mr. Edmund TSE; Mr. Michael CHIU & Ir. Clifford TSE, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Carman WONG Tel: 2527 8285
6:00 pm (20)	<b>MPS - Mastering Adverse Outcomes</b> Organiser: The Hong Kong Medical Association, Speaker: Dr. Justin CHENG, Venue: Mongkok	Miss Viviane LAM Tel: 2527 8452 2.5 CME Points
<b>15</b> 1:00 pm <b>THU</b> (22, 29)	<b>HKMA HKECN - Certificate Course: Practical Psychiatry for the General Practitioners (IV, V &amp; VI)</b> Organiser: HKMA Hong Kong East Community Network, Hong Kong Society of Biological Psychiatry and Lundbeck Institute Hong Kong, Speakers: Various, Venue: Regus Conference Centre, 35/F., Central Plaza, 18 Harbour Road, Wanchai, Hong Kong	Ms. Jaclyn LEE & Ms. Carrie CHEUNG Tel: 2877 1106 1.5 CME Points
2:00 pm	<b>HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2010 - Management of Prostate Cancer</b> Organiser: The Hong Kong Medical Association, Speaker: Dr. Wong Wai Sang, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Viviane LAM Tel: 2527 8452 1 CME Point
8:00 pm - 10:00 pm	<b>FMSHK Executive Committee Meeting</b> Organiser: 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>17</b> 2:30 pm <b>SAT</b>	<b>Refresher Course for Health Care Providers 2009/ 2010</b> Organiser: The Hong Kong Medical Association, Speaker: Dr. Stephen CHAN, 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>18</b> 9:15 am - 5:45pm <b>SUN</b>	<b>A One-day Course on Common Paediatric Dental Problems - A Review</b> Organiser: Hong Kong Society of Paediatric Dentistry, Speaker: Dr. Angus C CAMERON, Venue: Lim Por Yen Lecture Theatre, HKAM Jockey Club Building, 99 Wang Chuk Hang Road, Aberdeen, Hong Kong	Ms. Zinnia PANG Tel: 2859 0251 Fax: 2559 3803
2:00 pm	<b>HKMA Certificate Course on Family Medicine 2010</b> Organiser: The Hong Kong Medical Association, Speakers: Dr. Ip Kit Kuen & Dr. CHOI Kin Gabriel, Venue: Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 3 CME Points
2:00 pm (25)	<b>HKMA Snooker Tournament</b> Organiser: The Hong Kong Medical Association, Venue: Prat Billiard Club	Ms. Dora HO Tel: 2527 8285
<b>20</b> 1:00 pm <b>TUE</b>	<b>HKMA Central, Western &amp; Southern Community Network - Short Certificate Course in Urology for Primary Healthcare Providers - Management of Common Urological Problems (I)</b> Organiser: HKMA Central, Western & Southern (CW&S) Community Network; Department of Surgery, The University of Hong Kong, Speaker: Dr. LEE Chan Wing Francis, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Alice TANG Tel: 2527 8285
<b>22</b> 8:00 pm - 10:00 pm <b>THU</b>	<b>HKFMS Foundation Meeting</b> Organiser: 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>29</b> 1:00 pm <b>THU</b>	<b>HKMA New Territories West Community Network - CME Lecture on "Mood Disorder"</b> Organiser: HKMA New Territories West Community Network, Venue: Plentiful Delight Banquet (喜尚嘉喜酒家), Yuen Long, New Territories	Miss Alice TANG Tel: 2527 8285

**Meetings**

13-16/5/2010	<b>11th Regional Osteoporosis Conference - ISCD Bone Densitometry Courses and Certification Examinations 2010 &amp; 1st ISCD Vertebral Fracture Assessment Course in Hong Kong</b> Venue: Novotel Century Hotel Hong Kong and Hong Kong Convention & Exhibition Centre, Enquiry: ROC 2010 Conference Secretariat, c/o International Conference Consultants, Ltd., Tel: (852) 2559 9973, Fax: (852) 2547 9528, Email: roc2010@icc.com.hk, Websites: www.oshk.org.hk / www.hkgerisoc.org
23/5/2010	<b>2010 Paediatric Update No.1 Common Childhood Sleep Disorders - an Update for Practising Paediatricians</b> Organiser: Hong Kong College of Paediatricians, Speakers: Dr. Daniel KK NG & Dr. June Sin Hang CHAN and Prof. Yun Kwok WING, Venue: Hospital Authority Head Office Lecture Theatre, CME Accreditation: 3 points Category A (Hong Kong College of Paediatricians), Enquiry: Vanessa WONG, Tel: 2871 8871, Fax: 2785 1850
20/6/2010	<b>Annual Scientific Meeting 2010</b> Organiser: Hong Kong Society of Dermatology and Venerology, Enquiry: Ms. Chloe WONG, Tel: 2155 8557 / 2116 4348, Fax: 2559 6910, Email: meeting.hk@asia.cmpmedica.com

**Society News****News from Member Societies****Hong Kong Dietitians Association Limited**

Updated office-bearers for the year 2009-2011 are as follows: Chairlady: Ms. Sylvia See-way LAM; Honorary Secretary: Mrs. Heidi CHAN; Honorary Treasurer: Ms. Stephanie YIP

**Hong Kong Nutrition Association**

Updated office-bearers for the year 2010-2011 are as follows: President: Mr. Ho-yan TING; Honorary Secretary: Ms. Rhoda Yin-chee NG; Honorary Treasurer: Ms. Carmela LEE

**Hong Kong Pharmacology Society**

Updated office-bearers for the year 2010-2011 are as follows: President: Prof. Paul VANHOUTTE; Honorary Secretary: Prof. Helen WISE; Honorary Treasurer: Prof. Yu HUANG

**Hong Kong Society for Nursing Education**

Updated office-bearers for the year 2010-2011 are as follows: President: Dr. Sharron Shuk-kam LEUNG; Honorary Secretary: Mr. Tak-fai TONG; Honorary Treasurer: Dr. Vico Chung-lim CHIANG

**Hong Kong Society of Clinical Chemistry**

Updated office-bearers for the year 2010-2011 are as follows: President: Dr. Lap-kay LAW; Honorary Secretary: Ms. Judy Po-shan LAI; Honorary Treasurer: Ms. Yan-ping IU

**Hong Kong Society of Otorhinolaryngology, Head and Neck Surgery**

Updated office-bearers for the year 2009-2011 are as follows: President: Dr. Victor ABDULLAH; Honorary Secretary: Dr. Birgitta Yee-hang WONG; Honorary Treasurer: Dr. Wai-kuen HO

**The Hong Kong Society of Paediatric Endocrinology and Metabolism**

Updated office-bearers for the year 2010-2011 are as follows: President: Dr. Chak-man YU; Honorary Secretary: Dr. Man-yee WONG; Honorary Treasurer: Dr. Wai-fun CHENG

**The New Medico-legal Society of Hong Kong**

Updated office-bearers for the year 2010-2011 are as follows: President: Ms. Diane M. CREBBIN; Honorary Secretary: Mr. Patrick M. BURKE; Honorary Treasurer: Dr. Sheilah E. HAMILTON

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





## Answer to Dermatological Quiz

### Answer:

1. This patient suffered from toxic epidermal necrolysis (TEN). Differential diagnoses include Steven-Johnson syndrome, erythema multiforme, staphylococcal scalded skin syndrome. The extensive tender erythematous, dusky-red, purpuric, or atypical targetoid macules of irregular sizes and shapes at his trunk with a tendency to coalesce together and the mucosal involvement were suggestive of TEN. In the absence of spontaneous epidermal detachment, a Nikolsky sign should be sought by exerting tangential mechanical pressure with a finger on the erythematous zones. The sign is positive if dermo-epidermal cleavage is induced. As the epidermal involvement progresses towards full-thickness necrosis, the dusky-red macular lesions take on a characteristic gray hue. Fluid fills the space between the dermis and epidermis, giving rise to flaccid blisters which can be displaced sideways laterally by slight pressure of the adhesive plaster tape when applied onto the biopsy site as shown (Nikolsky sign). By definition, TEN involves the detachment of large sheets of necrolytic epidermis (>30% of body surface area), leading to extensive areas of denuded skin.
2. Drug use is reported in over 95% of patients with TEN. These include antibiotics especially sulfonamides, NSAIDs, anticonvulsants such as valproic acid and the aromatic anticonvulsants. Allopurinol, as in this patient who received the new drug for his gouty arthritis, is also a common culprit.
3. Optimal management requires early diagnosis, immediate cessation of the offending drug(s), and meticulous supportive care similar to that performed for severe burns preferably managed in an intensive care unit, with special attention to the mucosal area. Specific treatment includes the use of a high dose of intravenous immunoglobulin (IVIG) of 1g/kg/day infusion for three consecutive days. In normal skin, apoptotic cell death is triggered by a Fas signalling pathway. The death receptor Fas and its ligand (FasL) are transmembrane proteins. Fas signalling is triggered in the target cells by receptor tri-merisation induced upon contact with membrane-bound FasL from an adjacent cell resulting in cascade of intracellular signal ending in cellular disintegration and cell death. Normally, low levels of FasL are expressed by keratinocytes and localised intracellularly. In lesional skin of TEN, high levels of FasL are expressed by keratinocytes and localised on the cell surface. Upon contact with Fas, cell surface FasL induces Fas multimerisation and signalling leading to keratinocyte cell death by apoptosis. IVIG contains antibodies against Fas that are able to block the binding of FasL to Fas, hence inhibiting cell death resulting from this pathogenetic process.

**Dr. Ka-ho LAU**

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

### The Federation of Medical Societies of Hong Kong

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Fax: 2865 0943 (Wanchai), 2536 9398 (Central)		
Email: hkma@hkma.org		
Website: http://www.hkma.org		

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Scientific  
Update in the  
LANCET!!

*Clinical data in women  
aged 24 - 45 was first  
published in the LANCET<sup>1</sup>  
and is now included  
in product circular  
of GARDASIL<sup>® 2,\*</sup>*

Help reduce the burden of the  
following diseases:

- Cervical Cancer
- Vulvar Cancer
- Vaginal Cancer
- Genital Warts

caused by HPV 6, 11, 16, 18

\* See Clinical data (efficacy and safety) in Product Circular Section XIII. CLINICAL PHARMACOLOGY and XV. SIDE EFFECTS

**Selected Safety Information:**

GARDASIL<sup>®</sup> [Quadrivalent HPV (Types 6, 11, 16, 18) Recombinant Vaccine] is indicated in 9-26 years old girls and women for the prevention of cervical, vulvar, and vaginal cancers; precancerous or dysplastic lesions and genital warts caused by HPV Types 6, 11, 16 and 18. It should be administered intramuscularly as 3 separate doses at 0, 2nd, 6th month. It is contraindicated in individuals with hypersensitivity to any vaccine ingredients or after a previous dose of GARDASIL and is not recommended for pregnant women. Pregnancy should be avoided during the vaccination period. This vaccine will not protect against diseases that are not caused by HPV and is not intended to be used for treatment of active genital warts; cervical, vulvar, or vaginal cancers; CIN, VIN, or VaIN. Routine cervical screening should be continued. Common adverse reaction in clinical trials were fever, injection-site pain, swelling, erythema, pruritus & bruising which were mild to moderate. Post-marketing reports: dizziness, headache, syncope, nausea & vomiting. **Before prescribing, please consult the full prescribing information.**

**References:**

1. N. Munoz MD, J Luna MD et al. Lancet 2009; 373:1949-57. 2. Product Circular (GARDASIL, MSD)

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