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*MEDICAL DIARY*

VOL.16 NO.8 AUGUST 2011

*Plastic Surgery*



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## Contents

### Editorial

- **Cosmetic Surgery & Medicine in Hong Kong** 2  
*Dr. Walter WK KING*

### Medical Bulletin

- **Restoration after Childbirth** 4  
*Dr. Walter WK KING* CME
- **MCHK CME Programme Self-assessment Questions** 5
- **Upper Blepharoplasty** 7  
*Dr. Philip Cheung HSIEH*
- **Lip Improvement Surgery** 11  
*Dr. Man-kuong TUNG*
- **Plastic Surgery for Facial Injury and Facial Skin Lesions / Tumours** 14  
*Dr. Chun-on MOK*
- **Lower Blepharoplasty: How to Avoid Complications** 20  
*Dr. Vincent KH KWAN*

### Dermatological Quiz

- **Dermatological Quiz** 12  
*Dr. Ka-ho LAU*

### Society News

24

### Federation News

25

### Medical Diary of August

26

### Calendar of Events

- **Course / Meeting** 28

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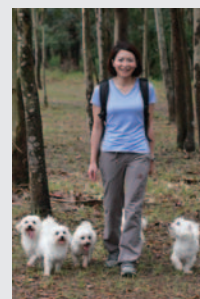
## The Cover Shot



I took this photo in Morocco when I was travelling with my Grandma sometime ago. "Young and old"- was, and still is, the question in my mind. What will I look like when I grow old? Will these wrinkles make me wiser?

"Love all the parts of yourself, and if you can't love them, change them. If you can't change them, then accept them as they are."...Cherie Carter - Scott, "If Love Is a Game, These Are the Rules"

"Que Sera, Sera...Whatever will be, will be...."  
An old song keeps echoing in my mind.



**Ms. Flori LAM**

APN  
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## Cosmetic Surgery & Medicine in Hong Kong

### Dr. Walter WK KING

Specialist in Plastic Surgery

#### Editor



Dr. Walter WK KING

Since the worldwide inception of Cosmetic Surgery as an integral part of Plastic Surgery in the early 1900's complete with structured training, examination and continuing education, Cosmetic Surgery & Medicine has developed into an increasingly important and vital portfolio of Specialists in Plastic Surgery whose training and examination in Hong Kong is well established under the auspices of the College of Surgeons of Hong Kong.

While our professors in the early years have laid down the foundation for the growth and development of Cosmetic Surgery and Medicine, it remains for us to continue to advance, refine, distillate, evolve, research and study the many aspects of Cosmetic Surgery and Medicine.

In this August issue of the Hong Kong Medical Diary, members of the Hong Kong Association of Cosmetic Surgery present updates and advances in many areas of Cosmetic Surgery and Medicine that are commonly requested by people living in Hong Kong, the Mainland and overseas:

- Dr. Philip Hsieh: Upper Eyelid Cosmetic Surgery (Upper Blepharoplasty)
- Dr. Kin-hung Kwan: Lower Eyelid Cosmetic Surgery (Lower Blepharoplasty)
- Dr. Chun-on Mok: Plastic Surgery for Facial Injury & Facial Skin Lesions/Tumours
- Dr. Man-kwong Tung: Lip Improvement Surgery
- Dr. Walter King: Restoration after Childbirth  
(Laser Surgery, Radiofrequency Therapy, Scar Improvement Surgery, Nipple Improvement Surgery, Breast Surgery, Body Contouring by Liposuction and Abdominoplasty)

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\* R5 Narins et al. Dermatol Surg 2011; 37: 1-7 "Persistence of Nasolabial Fold Correction with a Hyaluronic Acid Dermal Filler with Retreatment: Results of an 18-month Extension Study"



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## Restoration after Childbirth

### Dr. Walter WK KING

Plastic & Reconstructive Surgery Centre, Hong Kong Samatorium & Hospital, Hong Kong



Dr. Walter WK KING

*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 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 August 2011.*

Women after childbirth face physiological and structural alterations in their appearance and shape that may require repair in order to restore their physical and psychological well-being.

Post-partum women may develop one or more of the following problems outside the uro-genital system after childbirth: hyperpigmentation of face and areolae; striae and hypertrophic scars; laxity of abdominal skin; elongated or inverted nipples; atrophic and sagging breasts; weakness and protrusion of abdominal wall; adiposity. Restoration work to correct these alterations after completion of childbirth nowadays can be carried out safely and effectively by Specialists in Plastic Surgery.

### Hyperpigmentation of Face & Areolae

Facial pigmentation e.g. freckles, melasma, Hori's nevus and areolar pigmentation darkens after pregnancy. Pigment-reducing lasers (e.g. Nd:YAG laser, Ruby laser, long-pulsed Alexandrite laser and pulsed dye laser) in 5 to 10 treatment sessions at 4 weeks apart can reduce the increased pigmentation with appropriate medicated skin creams. Reduction of areolar pigmentation similar to the reduction of dark circles of the eyes or the reduction of striae usually yields minor improvements only and expectations cannot be high.

### Striae & Hypertrophic Scars

Both striae or stretch marks and hypertrophic scars when appearing in reddish colour with erythema are best treated by a series of pulsed dye laser which can reduce the capillary proliferation present in the scars. For hypertrophic scars, triamcinolone injection as well as scar revision surgery may be required.

### Laxity of Abdomen Skin

Radiofrequency especially the classic high energy, unipolar system (Thermage) incorporated with many safety and pain-relief features offers the best non-invasive approach to tightening and firming of abdomen skin by the heating of dermal collagen till contraction occurs.

### Elongated or Inverted Nipples

With breast feeding, post-partum women may develop elongated and drooping nipples that can be surgically restored by a 'sleeve resection' of the expanded skin. Inverted nipples acquired from internal scarring and fibrosis can be corrected by specially designed "suture lift" surgery that leaves no external scars.

### Atrophic & Sagging Breasts

Breast augmentation surgery with cohesive silicone gel implants or less commonly done with autogenous fat grafting can effectively restore breasts to their previous or larger sizes. To a certain extent, sagging breasts will be improved by breast augmentation surgery (Fig 1). For large size breasts or very sagging breasts, breast lift surgery can be carried out in the same sitting to improve the shape of the breasts.



Fig 1

### Adiposity

After pregnancy many women complain of weight retention or weight accumulation. Adiposity tends to be localised in the upper and lower abdomen, the flanks, the medial and lateral thighs and the upper arms. Liposuction is most effective in reducing these localised fat deposits that may be resistant to dieting or exercise. Syringe liposuction allows superficial suctioning for skin tightening as well as the collection of viable fat tissues for fat injection to improve the face or body shape.



## Weakness & Protrusion of Abdominal Wall

The increase in abdominal girth that occurs during pregnancy can lead to stretching and thinning of the midline abdominal fascia, thus aggravating pre-existing diastasis of the rectus muscle. The separation between the midline pair of rectus muscles can result in herniation or protrusion of abdominal contents. Careful examination of the patient in both supine and sitting up positions are required in order to confirm the presence of this post-partum medical condition which can be repaired by fascia placcation. Full abdominoplasty is the repair or tightening of the midline abdominal fascia and excision of lower abdominal skin and subcutaneous tissues affected by stretch marks, laxity and wrinkles.

Mini-abdominoplasty is the repair of the abdominal fascia below the umbilicus and limited suprapubic abdominal skin excision usually including the previous Caesarean section scar. For extensive abdominal wall weakness, full abdominoplasty offers the most tightening of the whole abdomen. Transabdominal insertion of breast implants for breast augmentation can be done at the same time, obviating the need for a separate areolar or axillar incision.(Fig 1)

In conclusion, the many anatomic changes outside the uro-genital system that occur after pregnancy can be repaired or restored by high-tech machines or time-honoured plastic surgery.

### MCHK CME Programme Self-assessment Questions

Please read the article entitled "Restoration after Childbirth" by Dr. Walter WK KING and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 August 2011. 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. Women after childbirth may suffer from alterations of their body shape
2. Facial pigmentation may become darker after childbirth
3. Striae & Caesarean scars will disappear & become invisible with time
4. A single laser treatment can eliminate most facial pigmentations
5. Pulsed dye laser is used to treat red hypertrophic scars
6. Radiofrequency (RF) heats up dermal collagen leading to collagen contraction and hence skin tightening
7. Breast augmentation can be achieved by either insertion of silicone implants or fat transplant
8. Abdominoplasty is the insertion of a plastic prosthesis to strengthen the abdominal wall
9. Liposuction is not effective in reducing localised fat deposits in the body
10. Transabdominal breast augmentation with silicone implants can be done at the time of abdominoplasty

### ANSWER SHEET FOR AUGUST 2011

Please return the completed answer sheet to the Federation Secretariat on or before 31 August 2011 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

## Restoration after Childbirth

**Dr. Walter WK KING**

*Plastic & Reconstructive Surgery Centre, Hong Kong Sanatorium & Hospital, Hong Kong*

1  2  3  4  5  6  7  8  9  10

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### Answers to July 2011 Issue

Spasticity - Orthopaedic Perspectives

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



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**References:**

- 1 Nanns et al. J Am Acad Dermatol 2010;62:448-62.
- 2 <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/Recently-ApprovedDevices/ucm176124.htm>
- 3 Data on file.

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# Upper Blepharoplasty

## Dr. Philip Cheung HSIEH

MBBS, FRCSE, FHKAM(Surgery), FHKCS  
Specialist in Plastic Surgery

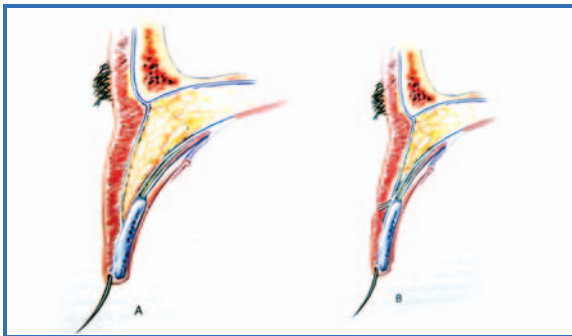


Dr. Philip Cheung Hsieh

In the world of Plastic and Cosmetic Surgery in Asia, upper blepharoplasty must rank as the commonest operation for a plastic surgeon.

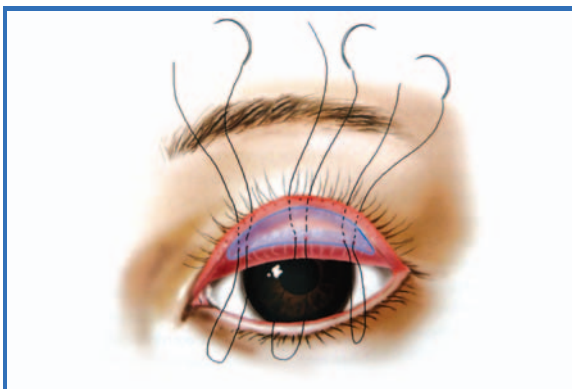
When we speak about this, the majority of the operations are for the creation of a "double Lid". I shall concentrate on this particular aspect of upper lid surgery in this issue of the Medical Diary.

Most Asians are not born with a double eye-lid and most of that is hereditary. The reason for the lack of a double lid crease is due to the orbital septum fusing with the levator aponeurosis below the superior tarsal border. This prevents the levator end-fibres to get an attachment to the overlying skin and it is this skin attachment that produces the double lid skin crease.



For those who want that fold (thus making the eyes look larger), our job is to create this attachment.

The operation for the creation of a double lid goes back to 1896 when a Japanese surgeon, named Mikamo, described a suture method.



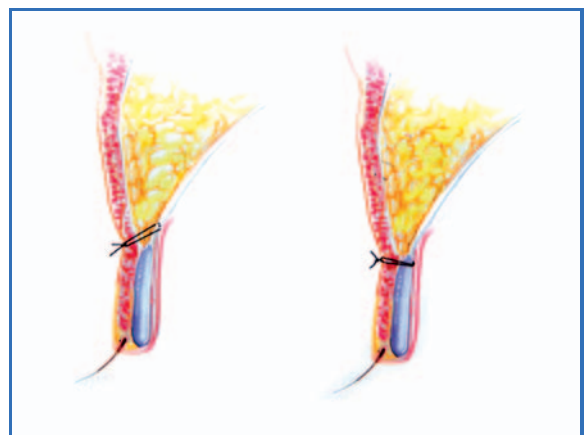
After that, ways to produce similar results have been published by many and most of them use an incisional method with tissue excision.

Their radical methods, over the years, are getting less favoured. Nowadays most patients prefer the close or suture methods. They usually give similar results but patients have the benefit of less down time, an important factor to consider in the present career-orientated commercial world.

## Blepharoplasty in the Younger Population

The creation of an adhesion between the skin and the underlying tissue is the plastic surgeon's primary concern. Most patients prefer the suturing method.

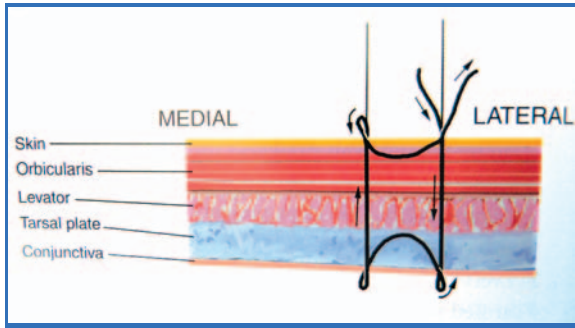
One can have a fixation of the skin to the tarsal plate or to the levator aponeurosis. The method of fixation, therefore, depends on the operator's preference. As there are so many types of suturing method, there is no rule saying which is better. The diversity of operations speaks for itself. An individual surgeon has his own pick as it usually works best for him.



The operation of suturing is mostly preferred by the younger generation and most of them are suitable as they do not have the added problem of skin redundancy. We will encounter this when patients in their 50s come in for advice.



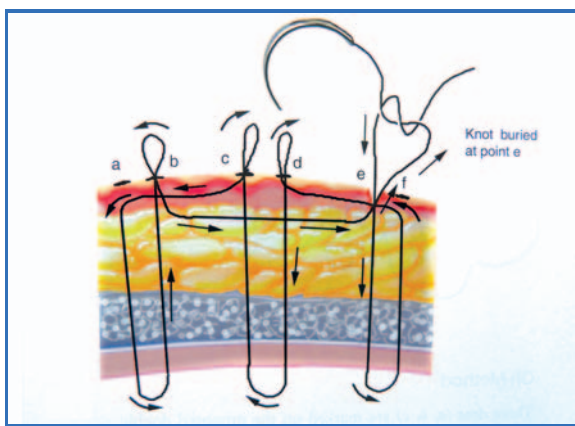
Suturing can be simple: Like the single suture technique



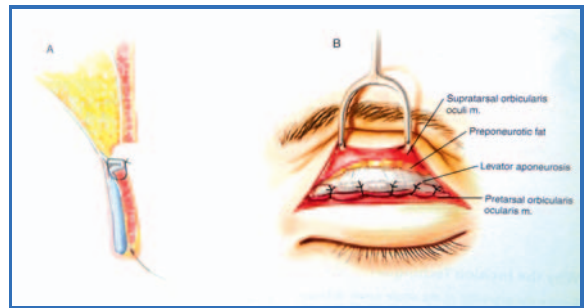
Some upper lid fat may be removed at the same time as well if required.



Multiple sutures may be used and they can be most complicated.



For a small percentage of cases the open method still has its place. Some plastic surgeons still use it as their mainstay because in experienced hands, the results are just as good if not better than the suturing method. Even the post-operation recovery period can be just as short and uneventful. This type of procedure sometime does better when there are some skin laxities or in patients with significant supra-tarsal fat.



## Blepharoplasty in the Older Age Group

The older age group of patients present to us with a different problem. They usually see us because of drooping eye-lids that cause them to look old. Their previously present double fold disappears or has become less obvious. The lateral hooding, associated with the excessive skin, gives them a sad look. The way to tackle the problem is the removal of this excessive skin, and sometimes the excessive fat as well. This is where the suturing technique cannot tackle the problem of skin redundancy.

The primary cause must be removed, and for that, the open method should be used.



The amount of skin removal must be proportional to the individual and it is here that experiences in assessment are of primary importance.

Excessive skin removal would mean a persistent 'startled-look'. Inadequate trimming, on the other hand, will not give patients the result that they want.

## Conclusion

To give the best results in Upper Blepharoplasty, the pre-operation assessment and the advice on possible results that one can achieve are the two most important duties the surgeon must do. They are just as important as his skill and knowledge of the procedure.





A well trained plastic surgeon can notice developmental asymmetry, which is far commoner than one thinks, in patients at consultation. With that information, he can advise the patients what can or cannot be changed. The eye-lid is such a small area that, during surgery, a slightly mis-placed incision or suture, even with the best of planning and marking, can produce results which are, on detailed scrutiny, slightly out of balance. Patients must be fore-warned. Acceptance will be needed. Luckily, minor flaws do settle with time.

The initial communication is of the utmost importance. There must be adequate understanding of the patient's wants. If the request is far from usual and you do not feel suitable for the patient, a refusal would be the better part of valour.

Upper Blepharoplasty operation is full of pitfalls and only time and experience can prevent you from falling into the obvious. My teacher always reminds me the following words "the more eye-lids you do, the more you will find yourself fascinated by the complexity and diversity of problems that you may face".

Adequate training and working on enough cases should be the prerequisite before one embarks on one's own.

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Full prescribing information is available upon request.

**References:**

1. The CAFE investigators. Differential impact of blood pressure-lowering drugs on central aortic pressure and clinical outcomes. Principal results of the Conduit Artery Function Evaluation (CAFE) study. *Circulation* 2006;113:1213-1225. 2. Ichihara A, Kaneshiro Y, Sakoda M, et al. Add-on amlodipine improves arterial function and structure in hypertensive patients treated with an angiotensin receptor blocker. *J Cardiovasc Pharmacol* 2007;49:161-166. 3. Smith RD, Yokoyama H, Averill DB, et al. Reversal of vascular hypertrophy in hypertensive patients through blockade of angiotensin II receptors. *J Am Soc Hypertens* 2008;2:165-172. 4. Stumpe KO, Agabiti-Rosei E, Zielinski T, et al. Carotid intima-media thickness and plaque volume changes following 2-year angiotensin II-receptor blockade. The multicentre olmesartan atherosclerosis regression evaluation (MORE) study. *Thromb Haemostas* 2007;107:197-206. 5. Chrysant SG, Melino M, Karki S, et al. The combination of olmesartan medoxomil and amlodipine besilate in controlling high blood pressure: COACH, a randomised, double-blind, placebo-controlled, 8-week factorial efficacy and safety study. *Clin Ther* 2008;30:587-604.





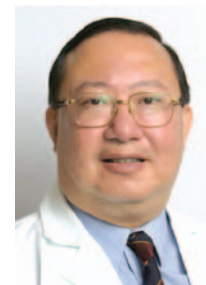
# Lip Improvement Surgery

## Dr. Man-kwong TUNG

MBBS(HKU), FCSHK, FRCS(Edin), FRCS(Glas), FHKAM(Surgery)

Specialist in Plastic Surgery

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Dr. Man-Kwong TUNG

Lip improvement surgery aims to improve the lip outlook in the static & dynamic states in:

1. Congenital deformities
2. Post-trauma conditions
3. Aesthetic needs

Before planning the lip improvement surgery, it is important to examine the patient's face first:

1. Is the lip in good ratio with other parts of the face, like the nose & eyes? (the golden proportion)
2. How is the symmetry?
3. How is the nose?
4. Are the teeth in good colour, mal-aligned, or are there too much / little bony structures?
5. Comparison with family photos, & what's the ethnic grouping?
6. Relationship with other scars on the face?

Lip improvement may not be fully accomplished with soft tissue surgery of the lip alone. Very often the expert management of a Dental Surgeon, an Orthodontist & an Oral & Maxillofacial Surgeon are required for any surgery on the soft tissues of the lip. In reality many patients do not have the resources to solicit the help from so many experts. Sometimes it is the nose that needs improvement rather than the lip. It is our duty to inform them what can be done with present available technology & make adjustments in our surgical planning.

## Lip Improvement Surgery in Congenital Deformities

1. In primary complete cleft lip repairs, use the method that does not need to discard the so called "excess tissue". The writer uses the Millard's method.
2. For post-cleft deformities of the lip, interested readers can refer to my earlier article on "Management of Post Cleft Deformities of Lip & Nose" in VOL.12 NO. 11 NOVEMBER 2007 of THE HONG KONG MEDICAL DIARY.
3. For unilateral macrostomia (lateral cleft lip), one can use the measurements from the normal side for reference & planning of the incision lines. The orbicularis oris muscle on the cleft side must be realigned. It is vital to make sure that the edges for skin closure should be free from mucosal tissues; &

this can only be marked up accurately before you inject your diluted Adrenaline solution. Accessory auricle(s), if present, should be dealt with in the same operation session. Associated facial nerve involvement, hemi-facial delayed bony development & microtia should be tackled at older ages.

4. For bilateral macrostomia, there is no reference point available for the surgical planning. The appreciation of the golden proportion will be most important. The writer has no regret using this in surgical planning for his half dozen patients, whether immediate post-op or seeing them again 5 to 16 years later.

## Lip Improvement Surgery in Trauma Conditions

- A. For the primary management, after all the cleansing & removal of foreign bodies, it is essential to preserve as much tissue as possible. Head & neck areas have a very good blood supply; & the recovery of those "devitalised tissues" is always a big surprise to the maturing surgeons. Align the muscles correctly before paying attention to the skin & mucosa. As for the skin & mucosa, one needs to realign the vermilion border. When that is done, the rest will be just trivial formalities. Do not consider scar revision before the scar is mature & the patient is psychologically ready.
- B. For the secondary management i.e. scar revision, with always the aim for symmetry, the following principles can be considered:
  1. Contractures can be released by Z-plasty or a local flap
  2. Scar direction can be realigned by scar excision & W-plasty; so that some of the limbs of the W can be parallel to the skin lines. Furthermore the W-plasty scar can neutralise the wedge in & out effects of a linear scar during movement.
  3. Tissue deficiency can be replaced by fat injection, subcutaneous tissue graft & injection of artificial fillers. At this time, safe fillers are still of temporary effect.
  4. Various kinds of laser machine can further smooth out the scar surface & improves the colour.
  5. Training by professional makeup artists (for both male & female patients) will be the final touch up of the problem.



## Lip Improvement Surgery for Aesthetic Reasons

1. A short upper lip can be lengthened by release of the frenulum, transverse incision of the mucosa about 5mm from the sulcus & closed longitudinally. Make sure the incision is balanced on both sides, & the depth is adequate & even
2. The vermilion tubercle can be made more obvious by VY-plasty. Again the need of symmetry is essential. The effect can be supplemented by fat injection, subcutaneous tissue graft & injection of artificial fillers.
3. A thick upper lip can be thinned up by tissue excision. Preoperative good doctor-patient communication is essential plus good medical notes. It is important in the preoperative assessment to see the family photos, understand the patient's need & expectation, input the surgeon's opinion, & refuse any unrealistic requests. The patient must be informed of any asymmetry of the lip noticed before the operation. The reference line is the vermilion border. Calipers will be helpful & all measurements should be made before the Adrenaline injection & tissue cut. Make sure the

depth & amount of the tissue cut are as identical as possible. The approximate location of the labial artery should be noted. Always remember one can cut less than requested because you can always re-operate; & it will be most regrettable if the patient considers you cut more than the request.

4. A thin upper lip can be thickened up by fat injection, subcutaneous tissue graft & injection of artificial fillers, & even transfer tissues from the lower lip in staged operations. Again good doctor-patient communication is essential.
5. Few people want to thicken up the lower lip.
6. Many want to thin up the lower lip. The procedure is similar as for the upper lip except it is essential to tighten up so that post-operatively the lower lip mucosa can touch the lower incisors. Avoid the "dropping out" effect on the lower lip.

Lip improvement surgery is fine art work & needs serious & detailed preoperative planning. It should not be consider as an occasional minor procedure.



## Dermatological Quiz

### Dermatological Quiz

#### Dr. Ka-ho LAU

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



Dr. Ka-ho LAU



Lesions at the perivulval area

This 45-year-old woman complained of these mildly itchy and painful skin lesions at her vulval and perianal areas for six months. The skin lesions increased in number and size progressively and bled frequently. She was treated as genital warts with topical treatment by a private doctor with no improvement. An incisional biopsy at the vulval lesion showed a vascular proliferation in the dermis with overlying epidermal hyperplasia. The dermal collection of blood vessels was lined by cobblestone-like epithelioid endothelial cells with abundant dense eosinophilic cytoplasm which contained vacuoles, bulging into the lumen of larger sized vessels. Abundant eosinophils are readily found in the dermis.

#### Questions:

1. What is your diagnosis or possible differential diagnoses?
2. Name one blood test which may help to support your clinical diagnosis?
3. What is the treatment for her skin condition?

*(See P.29 for answers)*

# Take the Heat Off

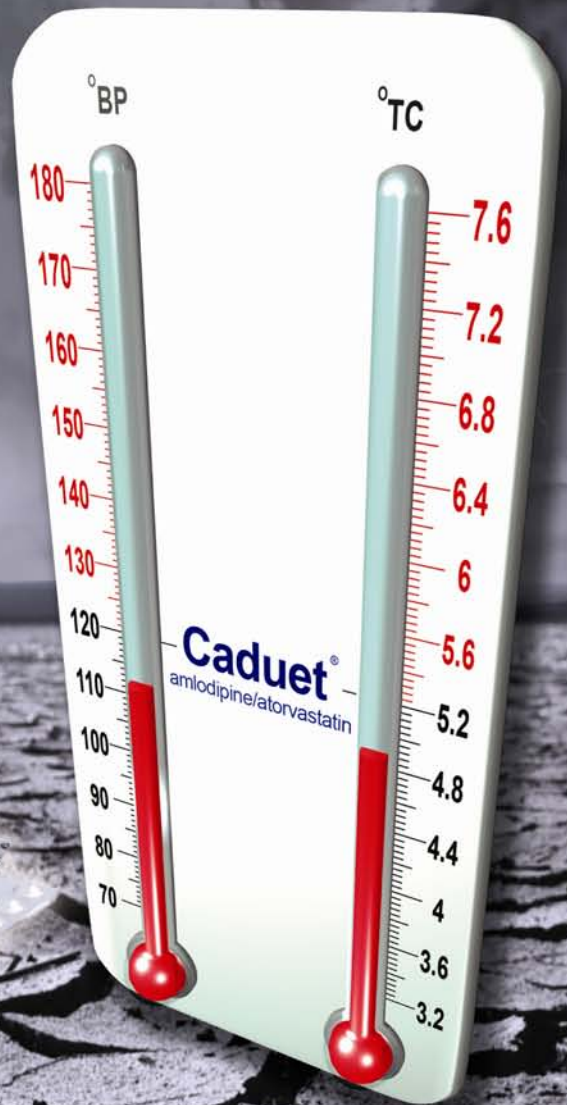
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Reference:

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2. Kate McKeage and M. Asif A. Siddiqui. Amlodipine/Atorvastatin fixed-dose combination – a review of its use in the prevention of cardiovascular disease and in the treatment of hypertension and dyslipidemia. *Am J Cardiovasc Drugs* 2008; 8(1): 51-67



# Plastic Surgery for Facial Injury and Facial Skin Lesions / Tumours

## Dr. Chun-on MOK

MBBS(HK), FRCS(Edin), FRACS, FCSHK, FHKAM(Surgery)

Specialist in Plastic Surgery



Dr. Chun-on MOK

Surgery on the face is always demanding as most patients would expect a pleasing result in this exposed and most noticeable part of the body. To ensure good healing and an inconspicuous scar on the face, plastic surgeons have to take into consideration the following characteristics in facial surgeries.

- (1) The facial structures have very good blood supplies, hence facial wounds usually heal well and fast. Infection is not common unless the wound is contaminated and poorly prepared.
- (2) The human face is complicated and filled with a number of facial features in the centre. Special care has to be taken not to distort the position of the nearby facial features as well as to ensure symmetry of the face.
- (3) The anatomy of the face is also complex with variations in the thickness, texture and tension of the skin in different areas. The underlying facial muscles responsible for the facial expressions will produce wrinkle lines (relaxed skin tennis lines) when we age. In planning for any facial surgery, considerations have to be taken into account of the skin crease alignment and skin quality to produce an inconspicuous linear fine line scar.

## Facial Injury

Facial lacerations are common after road traffic accidents, accidental falls, sports injuries and assault incidents. The facial wounds should be managed at the earliest available time slot. Small and superficial wounds can be dealt with under local anaesthesia while large, extensive and complicated injuries would best be treated under general anaesthesia. The facial wounds should be irrigated and cleaned with chlorhexidine solution and the wound explored thoroughly to remove any foreign bodies and to determine the extent of the injury. Large bleeding vessels should be ligated and small bleeders coagulated with needle tip diathermy.

The facial wounds should be repaired anatomically in layers. Every effort should be made to approximate the structures in the correct layers with absorbable sutures. These will help to restore the anatomical defect, eliminate dead space and to hold up the tension of the wounds. The superficial skin layers would then be sutured with fine non-absorbable mono-filament sutures to be removed early. The skin edges can be trimmed smooth if they are irregular or rugged. En-mass closure of a facial wound with thick sutures should be avoided to prevent a wide uneven scar with poor contour and

marked stitch marks. (Fig. 1) If noticed early, such wound can be taken down and repaired in layers with fine sutures again. (Fig. 2) In areas with extensive superficial skin abrasions or skin loss, healing by second intention with regular dressing changes can be carried out. The resulting red and irregular wound can be improved later with scar revision and laser treatment. (Fig. 3, 4)



Fig. 1 Forehead laceration sutured with thick silk stitches en-mass



Fig. 2 Early removal of the thick sutures and wound sutured with fine nylon sutures again



Fig. 3 Irregular and red forehead scar resulting from secondary healing of abrasion injury from traffic accident





Fig. 4 Erythema and scarring improved after a few sessions of laser resurfacing and pulsed-dye laser treatment



Fig. 7 Right cheek trap-door scar with uneven contour

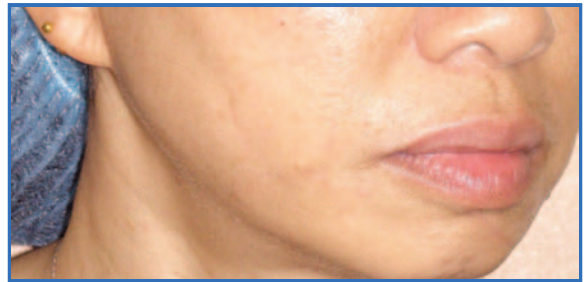


Fig. 8 Scar taken down and re-sutured in layers

### Scar Revision and Laser Treatment

For various reasons, unsightly scars may result after the facial wounds have healed. Surgical revision and laser treatment can be done to improve the facial scars, if present.

Surgical revision aims at improving the scar by:

- (1) Surgical excision of a wide and irregular scar and re-sutured with fine stitches in layers to form a fine linear scar.
- (2) Scars running across the wrinkle lines (relaxed skin tension lines) would be pulled to become widened by the underlying muscles and are re-aligned to run-parallel to the lines to prevent recurrence of scarring.
- (3) Skin and tissue can be fitted in to reduce the tension in the wound that may cause a hypertrophic scar.
- (4) Scars with uneven contour can be assembled again and the contour restored by correctly re-attaching the deeper structure again. (Fig. 5, 6, 7, 8)

Irregular & rugged skin surface from scarring can be planed off by the use of CO<sub>2</sub> Laser or Erbium-Yag Laser with high energy pulses and short pulse widths. Excessively red and hypertrophic scars can be improved with the pulsed dye laser. (Fig. 9, 10)



Fig. 5 Oblique laceration of the chin resulting in uneven contour scarring



Fig. 9 Multiple facial scars after windscreen injury in traffic accident

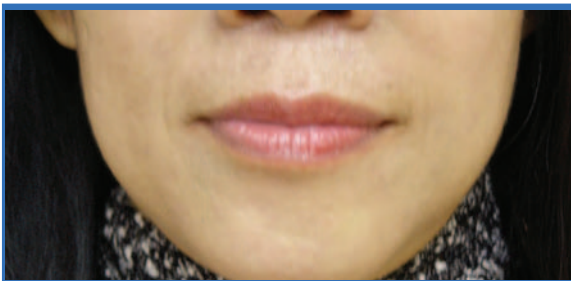


Fig. 6 Scar revision done



Fig. 10 Appearance after multiple scar revisions and resurfacing with erbium-Yag laser

Lumps and bumps are also common on the face. Most patients with benign facial lesions request surgical treatment either for cosmetic reasons or for a definitive diagnosis. Hence the expectation from these patients will usually be high and they would not accept any noticeable scar on the face. Patients with malignant skin lesions like basal cell carcinoma or squamous cell carcinoma usually worry about the complete removal of the cancer and would be more willing to accept some disfigurement on the face.

## Benign Facial Lesions

Small benign lesions involving the full thickness of the facial skin are best treated by close elliptical excision and linear closure along the RSTL. (Fig. 11, 12) With adequate skin edge mobilisation and layered closure with fine sutures, most of these facial wounds would heal with acceptable scars.

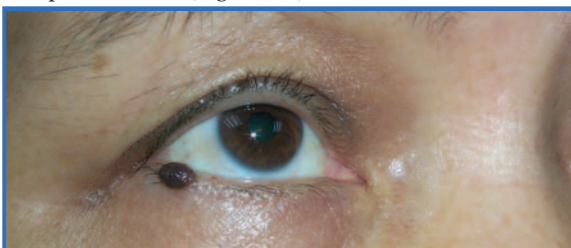


*Fig. 11 Pigmented naevus over medial canthus of upper eyelid*

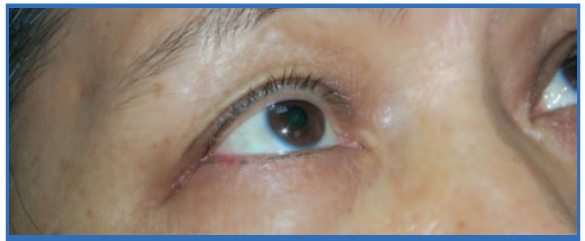


*Fig. 12 Minimal scarring and distortion of upper eyelid after complete excision*

In some situations when the lesions are close to the facial structures like the eyelids, nasal tip etc, and when the lesions are superficial to the dermal layer, removal by Erbium-Yag Laser may produce excellent results without the distortion of the facial features and a conspicuous scar. (Fig. 13, 14)



*Fig. 13 Pigmented naevus over edge of lower eyelid*



*Fig. 14 Complete removal with laser without surgical excision*

In lesions deep to the skin, short incisions along the skin crease directly over the lesions would usually give good results. (Fig. 15, 16) In some demanding patients who prefer to have no scar on the facial skin, hair-line incisions or sub-brow incisions may hide the incision line and the lesion removed under a raised skin flap. (Fig. 17, 18, 19, 20)



*Fig. 15 Large forehead lipoma*



*Fig. 16 Local excision via a short frontal skin incision*



*Fig. 17 Frontal mass, patient prefers no incision on frontal skin*





Fig. 18 Frontal mass removal via an incision within the hairline

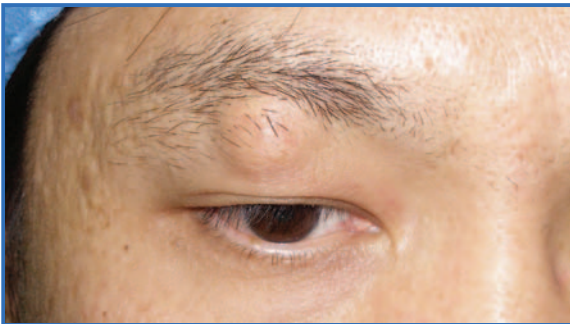


Fig. 19 Upper eyelid epidermoid cyst

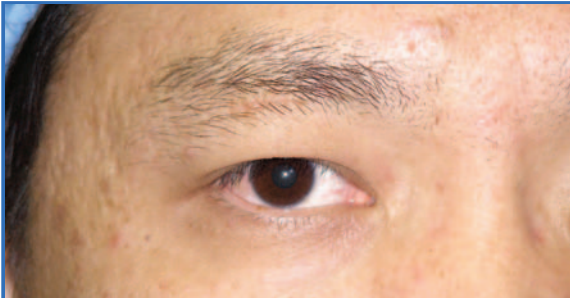


Fig. 20 Sub-brow incision removal of the cyst

## Malignant Facial Lesions

Basal cell carcinoma and squamous cell carcinoma are the commonest skin cancer on the face especially in the elderly. Small skin cancers distant from important facial features can usually be comfortably removed with adequate margins by simple excision and primary closure. Frozen section determination of a clear margin is usually recommended. In larger skin cancers or cancers close to the facial structures like the eyelids, nasal tip, cancer clearance should not be compromised by limiting the resection to facilitate primary closure. (Fig. 21, 22) Usually local flaps are adequate to close most of the resection wounds without facial distortion and with good colour and texture matching. (Fig. 23, 24, 25, 26, 27, 28) Skin grafting is seldom necessary and the colour-match and contour would not be pleasing. Microvascular free flaps are usually reserved for closure of radical resection for recurrent or advanced cancer lesions and the cosmetic result is less favourable.



Fig. 21 Basal cell carcinoma of the nose



Fig. 22 Wide excision of the full thickness of nasal skin with the aid of frozen section

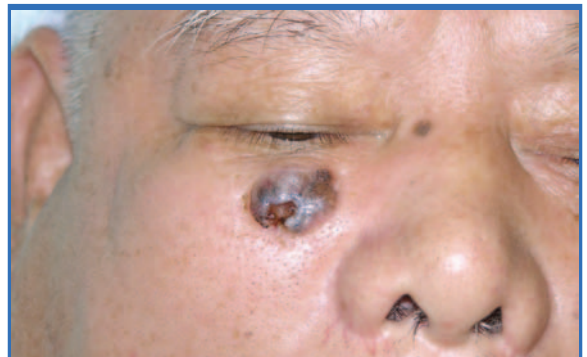


Fig. 23 Large nodular basal cell carcinoma of lower eyelid due to delay in treatment



Fig. 24 Complete excision of the cancer with adequate margins



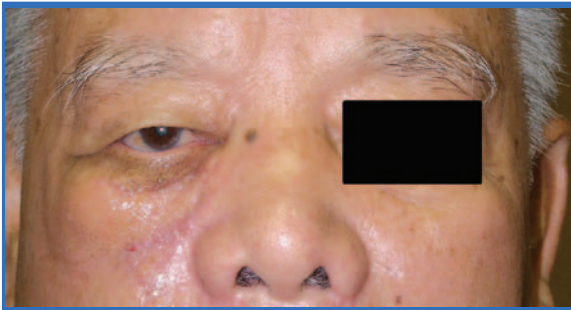


Fig. 25 Lower eyelid defect closed with local transposition skin flap



Fig. 27 Surgical defect after wide excision

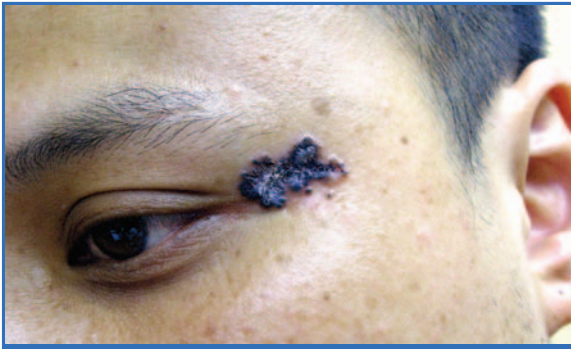


Fig. 26 Pigmented basal cell carcinoma with delay in treatment



Fig. 28 Wound closure with local transposition skin flap

### Hong Kong Reference Frameworks for Diabetes and Hypertension Care for Adults in Primary Care Settings

Two locally developed reference frameworks entitled the “Hong Kong Reference Framework for Diabetes Care for Adults in Primary Care Settings” and “Hong Kong Reference Framework for Hypertension Care for Adults in Primary Care Settings” for the care of patients with diabetes and hypertension are available to healthcare professionals practising in primary care settings in Hong Kong.

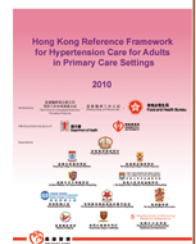
The two reference frameworks were developed by the Task Force on Conceptual Model and Preventive Protocols of the Working Group on Primary Care. Adopting a population approach in the prevention and control of diabetes and hypertension across the life course, the reference frameworks aim to provide evidence-based and appropriate recommendations to local primary care settings. Each reference framework consists of a Core Document and a series of Modules, which cover information on primary prevention, early identification of diseases, treatment and care, management of complications, as well as patient education and empowerment.

The reference frameworks and their patient versions are now available at the websites of the Food and Health Bureau and the Primary Care Office (PCO) of the Department of Health (DH) at:

- [http://www.pco.gov.hk/english/resource/professionals\\_diabetes\\_pdf.html](http://www.pco.gov.hk/english/resource/professionals_diabetes_pdf.html)
- [http://www.pco.gov.hk/english/resource/professionals\\_hypertension\\_pdf.html](http://www.pco.gov.hk/english/resource/professionals_hypertension_pdf.html)
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The PCO has produced various health educational materials to support patient management. Doctors and dentists who have enrolled in the Primary Care Directory are encouraged to obtain these materials from the PCO for distribution to their clients. Please visit PCO website at [www.pco.gov.hk](http://www.pco.gov.hk) for details. For those doctors and dentists who have not yet joined the Directory, you are invited to enrol on-line at [www.pcdirectory.gov.hk](http://www.pcdirectory.gov.hk).

Primary Care Office, Department of Health



CERTIFICATE COURSE FOR GENERAL PRACTITIONERS,  
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CME/CNE Course

Course No. C179

# Certificate Course on Management of Common Diseases in Older Persons



The Federation of Medical  
Societies of Hong Kong



The Hong Kong  
Geriatrics Society

## Objectives:

This course aims to enhance medical knowledge of health care professionals involved in elderly care. Upon completing this course, participants will be better equipped to recognise and differentiate geriatric syndromes commonly encountered in community setting, as well as having a better idea on how to formulate an initial diagnostic work-up plan for our senior citizens. They will also have a better understanding on features and management of common diseases occurring in older persons.

Date	Topics	Speakers
16 Sep 2011	Approach to Cognitive Impairment	Dr. John Jong-hoh CHIU Department of Medicine & Geriatrics Princess Margaret Hospital
30 Sep 2011	Movement Disorders in Older Persons	Dr. Bun SHENG Department of Medicine & Geriatrics Princess Margaret Hospital
14 Oct 2011	Approach to Functional Impairment	Dr. Kar-kui SO Department of Medicine & Geriatrics Princess Margaret Hospital
28 Oct 2011	Falls and Fracture Prevention in Older Persons	Dr. Wai-ming WONG Department of Medicine & Geriatrics Tuen Mun Hospital
11 Nov 2011	Blood Pressure Abnormalities in Older Persons	Dr. Ching-yu LAM Department of Medicine Queen Elizabeth Hospital
25 Nov 2011	Managing COPD in Older Persons Managing DM in Older Persons	Dr. Pan YEUNG Department of Medicine & Geriatrics Princess Margaret Hospital Dr. Kwan-mo YEUNG Department of Medicine & Geriatrics Princess Margaret Hospital

**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@fmskhk.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.fmskhk.org>

# Lower Blepharoplasty: How to Avoid Complications

**Dr. Vincent KH KWAN**

MBChB, FRCS(Ed), FHKAM(Surgery)

Specialist in Plastic Surgery



Dr. Vincent KH KWAN

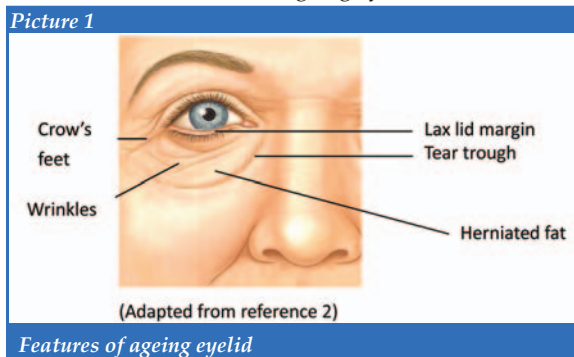
## Introduction

Eyes are the key stone of facial beauty. Since early history eyes are well known as the windows of the soul. Through the action of the peri-orbital tissue, the eyes can reflect the emotional status of people. As the most attractive and fascinating feature of the face, it is the eyes and their surround tissues first render to the process of ageing.

## Ageing of Lower Eyelid

Rhytids, lower lid laxity, and crow's feet are due to the progressive loss of soft tissue around the orbits. Attenuation of the orbital septum results in herniation of fat and appearance of an eye bag. Tear trough deformity is a triangular depression at the medial aspect of the lower eyelid. It is caused by the attenuation of soft tissue over the maxilla. Eye bags make people appear tired and dissipated. Tear troughs makes eye bags look worse.

Picture 1 shows features of ageing eyelid



## Lower Eyelid Beauty

A young and beautiful attractive lower eyelid should be smooth and wrinkle-free. It should be of a lazy S shape and tilt upwards at an angle of 3-4 degrees from the medial to lateral canthus. The lid margin should touch the limbus at the midline and the lowest point should be located under the lateral limbus. There should not be any fat herniation.

## Purpose of Lower Blepharoplasty

Through lower blepharoplasty, eyelids can restore their

former beauty. It is one of the commonest operations performed by plastic surgeons.

The aims of lower blepharoplasty are to correct fat herniation, improve skin and lid margin laxity and to correct tear trough deformity.

Lower blepharoplasty is not a sophisticated operation. However, in wrongly selected patients, patient satisfaction is lower. Although complications are uncommon, some of them are catastrophic.

## Eye Bag and its Associated Lower Eyelid Problems

Patients coming for lower blepharoplasty may have mixed lower eyelid problems. Fat herniation, tear trough deformities, hypertrophic orbicularis muscle, lax skin, wrinkles or even black eye circles are common presentations. Lower blepharoplasty is only indicated in fat herniation as the predominant problem, for the rest of the lower eyelid problems, they can be corrected by non-surgical means.

Table 1 summarises the treatment for various lower eyelid problems.

Table 1: Management of eye bag and its associated problems

Eye bag				
Fat herniation	Tear trough	Hypertrophic orbicularis muscle	Black eye circle	
Lower blepharoplasty	Hyaluronic acid or fat injection	no treatment or Botox injection	Good resting, no smoking or topical treatment	Laser/RF/dermal peeling

Picture 2 shows a patient with prominent tear trough deformity and mild fat herniation. She was treated with hyaluronic acid injection.







Picture 3 shows a patient with marked soft tissue loss in the eyelid and prominent tear trough deformity. She was treated with fat injection.

Picture 3



## Surgical Approaches

Lower blepharoplasty can be performed under local or general anaesthesia. It can use the transcutaneous or transconjunctival approach.

### 1. Transcutaneous Lower Blepharoplasty

The lower eyelid is infiltrated with local anaesthesia. An incision is placed 1.5 mm below the level of the orbital rim. A skin-muscle flap is raised to the level of the orbital rim. The orbital septum is opened. Protruding central, nasal and lateral fat pads are removed or redraped over the orbital rim to correct any tear trough deformities. Lower lid laxity can be corrected at the same operation. Canthopexy is the tightening of the lateral canthal tendon without dividing it. Canthoplasty is the shortening and reattachment of the lateral central tendon. The skin is redraped and any excessive lower eyelid skin is excised. The wound is closed with fine nylon stitches.

Picture 4 shows a patient presented with fat excess and skin laxity but without horizontal laxity. Transcutaneous lower blepharoplasty was done.

Picture 4



### 2. Transcutaneous Lower Blepharoplasty

The advantage of this approach is to avoid any scar in the skin and leaves the orbicularis muscle undisturbed. It is indicated in patients with fat excess with no skin excess.

The lower eyelid and conjunctiva is infiltrated with local anaesthesia. The conjunctiva is incised with diathermy or carbon dioxide laser. A skin-muscle flap is raised. The orbital septum is opened. Protruding central, nasal and lateral fat pads are removed. Suture closure of the conjunctiva is generally not required as it will heal up nicely within a few days.

Picture 5 shows a patient with fat excess and no skin laxity. Transconjunctival lower blepharoplasty was done.

Picture 5



## Complications

Complications are usually transient or self-limiting. These complications are: subconjunctival haemorrhage, epiphora, conjunctivitis, dry eye syndrome, lagophthalmos, temporary visual blurring and lower eyelid discoloration. However serious complications may occur. These complications are: ectropion and scleral show, inferior oblique muscle injury, retrobulbar haematoma, sunken eyelid and corneal injury.

### Ectropion and Scleral Show

Ectropion is the eversion of the lower eyelid resulting in exposure of the palpebral conjunctiva. Scleral show refers to visible white sclera below the lower limbus. Failure to recognise lower lid laxity and too much skin excision are the main causes of this complication.

### Inferior Oblique Muscle Injury

The inferior oblique muscle originates from the anterior medial orbital floor and inserts in the sclera. It separates the nasal and central fat pads. Function of the inferior oblique muscle is to turn the eyeball upwards and laterally. The inferior oblique muscle can be damaged during fat removal or haemostasis irrespective to its anatomy. Injuries can result in diplopia.

### Retrobulbar Haematoma and Blindness

Poor haemostasis or reactionary haemorrhage causes bleeding. Bleeding into the orbits results in elevation of the orbital and ocular pressures. Elevation of orbital and ocular pressures in turn diminishes blood flow in the branches of the ophthalmic artery. Prolonged nerve or retinal ischaemia results in blindness.

### Sunken Eyelid

One of the main aims of lower blepharoplasty is to remove excessive orbital fat. However, too much fat removal will result in hollowness of the lower eyelid. Patients will have a cachectic or cadaveric look.

### Corneal Irritation and Injury

Corneal injury is caused by rough handling of instruments. This causes direct injury of the cornea. Prolonged exposure of the cornea without protection will result in corneal desiccation and irritation.

### Prevention of Complications

Prevention of complications depends on a good pre-operative assessment, meticulous operation technique, adequate knowledge of lower eyelid anatomy and proper post-operative care.

## Pre-operative Assessment

### 1. Medical History

History of hypertension, bleeding diathesis, thyrotoxicosis, arteriosclerosis, concurrent aspirin or anticoagulants predispose patients to reactional haemorrhage.

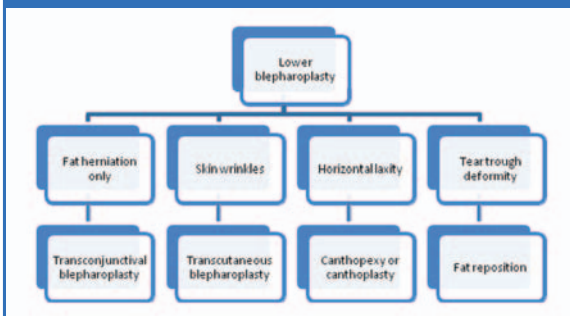
Thyrotoxicosis, autoimmune disease, poor tolerance to contact lens are the risk factors of corneal irritation or injury.

Scarring resulting from previous eye disease or trauma makes the inferior oblique muscle more vulnerable to injury.

### 2. Physical Examination

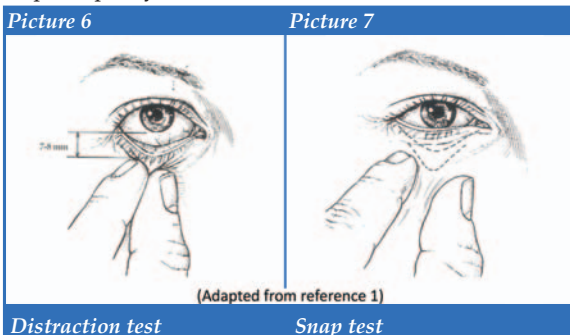
Careful examination of the peri-orbital tissue helps to decide on the surgical approach. Fat excess with good lower eyelid skin quality is indicative of the transconjunctival approach, fat excess with lax skin the transcutaneous approach and poor lid tone with presence of tear trough other auxiliary procedures. Table 2 shows this clinical pathway of lower blepharoplasty.

Table 2: Clinical pathway of lower blepharoplasty



Examine for any occult diplopia, asymmetry, mark the fat pads in the sitting position help to prevent muscle injury and excessive removal of the orbital fat.

The lid tone can be examined by the distraction test and snap test. In the distraction test, the lower eyelid is pulled away from the globe; 7-8 mm or less is the normal distance. The snap test is the second part of the distraction test. With normal tone, the lower eyelid should return to the globe immediately. Any increase in the distraction distance or delay in snap test indicates laxity in the tarsus or horizontal laxity. Canthopexy or canthoplasty should be considered during blepharoplasty.



Distraction test

Snap test

## Good Surgical Technique

To prevent corneal irritation and injury, the patient's cornea should be protected with corneal shields or antibiotic eye ointment. Handling of instruments should be gentle. Patients with poor lid tone are prone to develop ectropion or sclera show. Lid tightening procedure is indicated. Moreover, excision of skin should be conservative. To prevent sunken eyelids, fat should be excised flush with the orbital rim. In case of doubt, less fat should be excised.

Adequate knowledge of lower eyelid anatomy and meticulous haemostasis are essential to prevent muscle injury or reactional haemorrhage.

## Post-operative Care

Patients are advised not to wear contact lens for 3 weeks. Cold compression should be used for the first 48 hours, 4 to 5 times a day, each for 15-20 minutes. Warm compression is then followed for 5 days. Patients should rest in bed with two pillows. These measures can reduce swelling and post-operative discomfort. In order to decrease the chance of reactional haemorrhage, patients should avoid lifting heavy objects, bending down or doing exercise for one week.

An emergency contact number should be given to patients before discharge. They should seek medical advice immediately if there is any symptom of retrobulbar haematoma like, sudden increase in lower eyelid bruising and swelling, severe retrobulbar pain or blurring of vision.

Stitches can be removed after 5 to 7 days. More vigorous exercises can be resumed after 3 weeks.

## Conclusion

The goal of lower blepharoplasty is to restore the lower eyelid to its former beauty. To achieve this goal, we must have a working knowledge of the aesthetics of the eyes and adjacent tissues. We must know how to analyse the eyes through proper history and physical examination. Good selection of patients, meticulous operation technique and proper post-operative care are essential to avoid complications.

### References

1. Aesthetic Blepharoplasty. Francis G. Wolford, William R. Kanter. Little, Brown and Company. 1995.
2. Aesthetic Plastic Surgery. Sherrill J. Aston, Douglas S. Steinbrech, Jennifer L. Walden. Saunders. 2009.
3. Pearls and Pitfalls in Cosmetic Oculoplastic Surgery. Morri E, John B. Holds, Guy G. Massry. Springer. 2008.
4. Color Atlas of Cosmetic Oculofacial Surgery. William PD Chen, Jemshed A Kan, Clinton D McCord Jr. Butterworth & Heinemann. 2004.
5. Grabb & Smith's Plastic Surgery. Charles H. Thorne. Lippincott, Williams & Wilkins. 2007.
6. Finn JC, Cox. Fillers in their peri-orbital complex. Facial Plastic Surgery Clin North Am 2007;15(1):123-132.
7. Jelks GW, Jelks EB. Pre-operative evaluation of the blepharoplasty patient. Bypassing the pitfalls. Clin Plast Surg 1993;20(2):213-223.
8. Glat PM, Jelks GW, Jelks EB, et al. Evolution of the lateral canthoplasty: Techniques and indications. Plast Reconstr Surg 1997;100(6):1396-1405s.

# Certificate Course on Renal Medicine 2011

Jointly organised by



The Federation of  
Medical Societies of  
Hong Kong



Hong Kong Society  
of Nephrology

CME/CNE Course

Course No. C181

## Objectives:

To update the participants on new advances in renal medicine and clinical practice of common renal problems, and to help the participants to interpret results of common renal investigations.

Date	Topics	Speakers
8 Sep 2011	<ul style="list-style-type: none"> <li>• Screening tests for renal disease including approaches to proteinuria &amp; haematuria</li> <li>• How to interpret common investigation tests for renal disease</li> </ul>	Dr. Bonnie Ching-ha KWAN Dr. Chik-cheung CHOW
15 Sep 2011	<ul style="list-style-type: none"> <li>• Drug prescribing in renal failure</li> <li>• Update and management of diabetic nephropathy</li> </ul>	Dr. Kay-tai LEUNG Dr. Kin-ye LO
22 Sep 2011	<ul style="list-style-type: none"> <li>• Approach to patient presenting with elevated blood pressure</li> <li>• Update and management of primary glomerulonephritis</li> </ul>	Dr. Kai-chung TSE Dr. Kai-ming CHOW
29 Sep 2011	<ul style="list-style-type: none"> <li>• Update and management of acute kidney injury</li> <li>• Renal protective strategy for chronic kidney disease</li> </ul>	Dr. Terence Pok-siu YIP Dr. Sze-kit YUEN
6 Oct 2011	<ul style="list-style-type: none"> <li>• ABC of peritoneal dialysis</li> <li>• ABC of haemodialysis</li> </ul>	Dr. Man-fai LAM Dr. Hon-lok TANG
13 Oct 2011	<ul style="list-style-type: none"> <li>• ABC of renal transplantation - Part I</li> <li>• ABC of renal transplantation - Part II</li> </ul>	Dr. William LEE Dr. Yiu-han CHAN

**Time :** 7:00 pm – 8:30 pm

**Venue :** Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong

**Language Media :** English (Supplemented with Cantonese)

**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

## 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>





## News from Member Societies

Name of member societies	President	Hon. Secretary	Hon. Treasurer
Hong Kong Society of Nephrology	Dr. Chi-bon LEUNG	Dr. Samuel Ka-shun FUNG	Dr. Andrew Koon-shing CHOI
Hong Kong Society of Orthodontists Ltd.	Dr. Vincent Fun-shing LEUNG	Dr. Don C.D. TRAN	Dr. Lily Mei-yan SHUM
Hong Kong Surgical Laser Association	Dr. Wai-man CHAN	Dr. Mon-ching WONG	Dr. Chi-kong OR
Hong Kong Thoracic Society	Dr. Chung-man HO	Dr. Fanny Wai-san KO	Dr. Pok-yiu TSE
Institute of Biomedical Science (HK Branch)	Mr. Wing-kwong CHAN	Mr. Kin-kun CHAN	No such position
Medical Society, The Chinese University of Hong Kong	Ms. Jessica Nga-man HUNG	Ms. Pui-shan NG	Ms. Ka-ki HUNG
The College of Dental Surgeons of Hong Kong	Dr. Roch K.H. LEE	Dr. Edmond H.N. POW	Dr. Alfred chee-ching TSANG
The Hong Kong Association of Oral & Maxillofacial Surgeons Ltd.	Dr. Kwok-fai CHOW	Dr. Anthony Siu-kwong TSE	Dr. Alfred Sze-lok LAU
The Hong Kong Association of Speech Therapists	Mr. Raymond FONG	Mr. Chun-ho WONG	Ms. Natalie Hing-yea AU
The Hong Kong Association of the Pharmaceutical Industry	Dr. Sian NG	No such position	Mr. Andrew HEXTER
The Hong Kong College of Anaesthesiologists	Prof. Michael IRWIN	Dr. Simon Kin-cheong CHAN	Dr. Chi-hung KOO
The Hong Kong College of Paediatricians	Prof. Pak-cheung NG	Dr. Winnie Wing-yea TSE	Dr. Chi-sik CHAN
The Hong Kong College of Psychiatrists	Prof. Linda Chiu-wa LAM	Dr. Wai-him CHEUNG	Dr. Victoria Wing-kay TANG
The Hong Kong Institute of Allergy	Dr. Jane Chun-kwong CHAN	Dr. Helen Hei-ling CHAN	Dr. William Po-tin YIP
The Hong Kong Medical Association	Dr. CHOI Kin	Dr. Fook-kay LEE	Dr. Chi-chiu LEUNG
Hong Kong Paediatric Haematology and Oncology Study Group	Dr. Ping-wa YAU	Dr. Frankie Wai-tsoi CHENG	Dr. Daniel Ka-leung CHEUK
Hong Kong Society for Coloproctology	Dr. Cliff Chi-chiu CHUNG	Dr. William Chia-shing MENG	Dr. Chi-man LEUNG
Hong Kong Society of Paediatric Dentistry	Prof. Stephen Hon-yin WEI	Dr. KI Yung	Dr. Kitty Mei-yin HSE
International College of Surgeons (Hong Kong Section)	Dr. Paul Yue-hung YUNG	Dr. Clement Leung-kwok CHAN	Dr. Siu-yeung CHUN
The Hong Kong Society of Child Neurology and Developmental Paediatrics	Dr. Chok-wan CHAN	Dr. Stephenie Ka-yea LIU	Dr. Theresa Yee-ling WONG
The Guild of St. Luke, St. Cosmas and St. Damian Hong Kong Limited	Dr. Chi-ming POON	Dr. Pui-yan WONG	Dr. Anthony Kwun-to LEUNG
The Pharmaceutical Society of Hong Kong	Mr. Benjamin Yiu-sum KWONG	Mr. Peter Kai-lok LEUNG	Ms. Candy Yee-man TAI
The Hong Kong Nutrition Association	Mr. Chi-leung CHEUNG	Mr. Frankie Pui-lam SIU	Ms. Carmela LEE
The Hong Kong Paediatric Society	Dr. Kelvin Kam-wing LIU	Dr. Lilian Hiu-lei WONG	Dr. Patrick Pak-keung IP
The Hong Kong Radiological Technologists' Association	Mr. Apollo Pak-leung WONG	Mr. Thomas Tai-yin CHEUNG	Ms. Wenny Yuet-kuen CHAN
The Hong Kong Society for Colposcopy and Cervical Pathology	Dr. Siu-keung LAM	Dr. So-fan YIM	Dr. Alice Ngot-htain CHAN
The Hong Kong Society for Immunology	Prof. Allan Sik-yin LAU	Dr. James Chun-bong LI	Dr. Danny Tze-ming LEUNG
The Hong Kong Society of Gastroenterology	Prof. Benjamin WONG	Dr. Judy Wai-chu HO	Dr. Wai-cheung LAO
The New Medico-legal Society of Hong Kong	Ms. Diane M. CREBBIN	Mr. Patrick M. BURKE	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.



## Annual Scientific Meeting 2011

The Federation's Annual Scientific Meeting 2011 was successfully held on June 18, 2011 at the Hospital Authority Building, Mongkok. The theme of the Meeting was "The Era of the Superbugs".

During the Meeting, five topics were discussed: "Control of MRSA in the Hospital – An Old Problem with New Challenges" by Dr. Vincent CHENG, "The Emergence of Ultimate Superbug – Carbapenem-resistant Enterobacteriaceae" by Dr. KY TSANG, "The Emergence of Multidrug and Extensively Drug-resistant Tuberculosis in Hong Kong" by Dr. KC CHANG, "Multiple Drug-resistant Gram-negative Organisms – from ESBL to Carbapenem-resistant Acinetobacter Species" by Dr. TC WU and "An Update on Pandemic Influenza (H1N1)" by Dr. Kelvin TO.

We would like to thank the Meeting Chairman, Dr. Gilberto LEUNG and all the above guest speakers, the sponsors – MSD, Pfizer and Johnson & Johnson and the participants for the support to the Meeting.



## Public Talk on Cancer Nutrition

On June 26, 2011, the Federation's Lecture Hall was filled with friends and joyful sharing during the Cancer Nutrition Public Talk.

We were very glad to have 2 guest speakers – Ms. Carmela LEE and Ms. Rhoda NG from the Hong Kong Nutrition Association joined us to deliver the Talk to the audience. The Talk was a practical yet relaxing one which gave the public audience many useful suggestions on cancer patients' diet and helped them to make better diet choices by mastering the information on nutrition labels. Meanwhile, we have to thank Fresenius Kabi for being the sponsor of the Talk.





Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>
<ul style="list-style-type: none"> <li>* HKMA Joint Professional Bowling Tournament 2011</li> <li>* HKMA Certificate Course on Family Medicine 2011</li> </ul>	<ul style="list-style-type: none"> <li>* 2011 Inter Professional Teams Bridge Tournament</li> </ul>	<ul style="list-style-type: none"> <li>* FMSHK Officers' Meeting</li> <li>* HKMA Council Meeting</li> </ul>	<ul style="list-style-type: none"> <li>* Hong Kong Neurosurgical Society Monthly Academic Meeting – Treatment Options of Trigeminal Neuralgia: Which One is Better?</li> <li>* HKMA Central, Western &amp; Southern Community Network – Certificate Course on Urology (Session 1)</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA Kln East Community Network - Noble Treatment in Hypertension</li> <li>* HKMA NTW Community Network-Overview of Convulsions and Epilepsy</li> <li>* HKMA YTM Community Network - Overview of Type 2 DM from OAD to Insulin</li> <li>* HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2011 – What should we know about Chest and Lung Intervention in 2011?</li> </ul>	<ul style="list-style-type: none"> <li>* Joint Surgical Symposium – Advances in Breast Surgery</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA Dragon Boat Team Celebration Dinner</li> </ul>
<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>
<ul style="list-style-type: none"> <li>* HKMAPS 3rd Photo Competition &amp; Sharing Session 2011</li> <li>* HKMAPS Subcommittee Meeting</li> <li>* HKMA Joint Professional Singing Concert 2011</li> </ul>	<ul style="list-style-type: none"> <li>* FMSHK Executive Committee Meeting &amp; Council Meeting</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA Hong Kong East Community Network - Tinnitus Patient Management</li> <li>* HKMA Kln West Community Network – Dealing with Medically Unexplained Symptoms - from Neurologist's Perspective</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA Central, Western &amp; Southern Community Network –Certificate Course on Urology (Session 2)</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA NTW Community Network – Recent Advance &amp; Practical Management on Allergic Rhinitis &amp; Sinusitis for General Practice</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA YTMCN and Kowloon Central Cluster – Certificate Course on Bringing Better Health to Our Community (Lecture 3)</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA – KLN East Community Network; HA – UCH; HKCFP – CME Course for Health Personnel 2011</li> </ul>
<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>
<ul style="list-style-type: none"> <li>* HKMA Joint Professional Badminton Tournament 2011</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA Kln West Community Network – New Updates on Cervical Cancer Prevention and Vaccination</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA Kln West Community Network – Treatment Options of Trigeminal Neuralgia: Which One is Better?</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA Central, Western &amp; Southern Community Network –Certificate Course on Urology (Session 2)</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA NTW Community Network – Recent Advance &amp; Practical Management on Allergic Rhinitis &amp; Sinusitis for General Practice</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA YTMCN and Kowloon Central Cluster – Certificate Course on Bringing Better Health to Our Community (Lecture 3)</li> </ul>	<ul style="list-style-type: none"> <li>* HKMA YTMCN and Kowloon Central Cluster – Certificate Course on Bringing Better Health to Our Community (Lecture 3)</li> </ul>
<b>28</b>	<b>29</b>	<b>30</b>	<b>31</b>			





Date / Time	Function	Enquiry / Remarks
<b>1 MON</b> 6:00 pm	<b>2011 Inter Professional Teams Bridge Tournament</b> Organiser: The Hong Kong Medical Association, Venue: Victoria Room I & II, Regal Hong Kong Hotel	Miss Alice TANG; Miss Sharon HUNG Tel: 2527 8285
<b>2 TUE</b> 8:00 pm – 10:00 pm	<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. Sonia CHEUNG Tel: 2527 8898 Fax: 2865 0345
8:00 pm	<b>HKMA Council Meeting</b> Organiser: The Hong Kong Medical Association, Chairman: Dr. Kin CHOI, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road,	Ms. Christine WONG Tel: 2527 8285
<b>4 THU</b> 1:45pm	<b>HKMA NTW Community Network - Lecture on PR-Bleeding &amp; Visiting Tour to CancerLink Support Centre</b> Organiser: HKMA NTW Community Network, Chairman: Dr. Alvin Kwok-wai CHEUNG, Speaker: Dr. Chun-sing WONG, Venue: CancerLink Tin Shui Wai Support Centre, Shop No. 201C, 2/F., Phase 2, Kingswood Ginza, 12-18 Tin Yan Rd, Tin Shui Wai, N.T.	Mr. Alan LAW Tel: 25278285 0.5 CME Point
<b>5 FRI</b> 8:00 am – 9:00 am	<b>Joint Surgical Symposium – Advances in Breast Surgery</b> Organisers: Department of Surgery, The University of Hong Kong & Hong Kong Sanatorium & Hospital, Chairman: Dr. Ting-Ting WONG, Speakers: Dr. Ava KWONG & Dr. Clement CHEN, Venue: Hong Kong Sanatorium & Hospital, Hong Kong	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 Fax: 2892 7511 1 CME Point (Active)
<b>6 SAT</b> 7:00 pm	<b>HKMA Dragon Boat Team Celebration Dinner</b> Organiser: The Hong Kong Medical Association, Venue: The Hong Kong Medical Association Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Alice TANG; Miss Sharon HUNG Tel: 2527 8285
<b>9 TUE</b> 1:00 pm	<b>HKMA Hong Kong East Community Network - Tinnitus Patient Management</b> Organiser: HKMA Hong Kong East Community Network, Chairman: Dr. Joseph See-yui LAM, Speakers: Dr. Han-qian WONG & Ms. Celine Sin-yue LAI, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Miss Candice TONG Tel: 2527 8285 1 CME Point
1:00 pm	<b>HKMA Kln West Community Network – Dealing with Medically Unexplained Symptoms - from Neurologist's Perspective</b> Organiser: HKMA Kln West Community Network, Chairman: Dr. Bernard Siu-man CHAN, Speaker: Dr. Lawrence Man-wai LO, Venue: Crystal Room I-III, 30/F., Panda Hotel, Tsuen Wan, N.T.	Miss Candice TONG Tel: 2527 8285 1 CME Point
<b>10 WED</b> 7:30 pm	<b>Hong Kong Neurosurgical Society Monthly Academic Meeting – Treatment Options of Trigeminal Neuralgia: Which One is Better?</b> Organiser: Hong Kong Neurosurgical Society, Chairman: Dr. Shing-chau YUEN, Speaker: Dr. Kevin King-fai CHENG, Venue: Seminar Room, G/F, Block A, Queen Elizabeth Hospital, Kowloon	Dr. Gilberto LEUNG Tel: 2255 3368 Fax: 2818 4350 1.5 CME Points (College of Surgeons of Hong Kong)
1:00 pm (24)	<b>HKMA Central, Western &amp; Southern Community Network –Certificate Course on Urology (Session 1 &amp; 2)</b> Organiser: HKMA Central, Western & Southern Community Network, Chairmen: Dr. Kenneth Kam-fung FU & Dr. Sabrina Lai-ching HO, Speakers: Dr. Francis Chan-wing LEE & Dr. Sammy Kwok-keung CHAN, Venue: The Hong Kong Medical Association Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Mr. Alan LAW Tel: 2527 8285 1 CME Point
<b>11 THU</b> 1:00 pm	<b>HKMA Kln East Community Network - Noble Treatment in Hypertension</b> Organiser: HKMA Kln East Community Network, Chairman: Dr. Gary Ka-kui AU, Speaker: Dr. Warren Wai-lun WONG, Venue: Lei Garden Restaurant, Kwun Tong	Mr. Alan LAW Tel: 25278285 1 CME Point
1:00 pm	<b>HKMA NTW Community Network-Overview of Convulsions and Epilepsy</b> Organiser: HKMA NTW Community Network, Chairman: Dr. Aaron Fook-kay LEE, Speaker: Dr. Alvin Yee-shing CHAN, Venue: Maxim's Palace Tuen Mun	Mr. Alan LAW Tel: 25278285 1 CME Point
1:00 pm	<b>HKMA YTM Community Network – Management of Type 2 DM from OAD to Insulin</b> Organiser: HKMA YTM Community Network, Speaker: Dr. Fu-keung CHEUNG, Venue: 5/F., Diamond Room, The City View, 23 Waterloo Road, Yaumatei, Kowloon	Miss Candice TONG Tel: 2527 8285 1 CME Point
2:00 pm	<b>HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2011 – What Should we Know about Cardiac Intervention in 2011?</b> Organiser: The Hong Kong Medical Association, Chairman: Dr. Kin-lun TSANG, Speaker: Dr. Duncan H.K. HO, Venue: The Hong Kong Medical Association Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	HKMA CME Department Tel: 2527 8452 1 CME Point
<b>14 SUN</b> 12:00 pm	<b>HKMA Joint Professional Bowling Tournament 2011</b> Organiser: The Hong Kong Medical Association, Venue: Mei Foo Bowling World	Ms. Dorothy KWOK Tel: 25278285
2:00 pm	<b>HKMA Certificate Course on Family Medicine 2011</b> Organiser: The Hong Kong Medical Association, Speakers: Dr. Andy Kit-ying CHEUNG & Dr. Anisha ABRAHAM, Venue: Queen Elizabeth Hospital, Kowloon	HKMA CME Department Tel: 2527 8452 3 CME Points
<b>16 TUE</b> 7:00 pm – 10:00 pm	<b>FMSHK Executive Committee Meeting &amp; Council 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. Sonia CHEUNG Tel: 2527 8898 Fax: 2865 0345
<b>20 SAT</b> 1:30 pm	<b>HKMA – KLN East Community Network; HA – UCH; HKCFP - CME Course for Health Personnel 2011</b> Organiser: HKMA – KLN East Community Network, Chairman: Dr. Gary Ka-kui AU, Speaker: Dr. Clement Yick-wang LAM, Venue: UCH	Mr. Alan LAW Tel: 2527 8285 1.5 CME Points
<b>21 SUN</b> 2:00 pm	<b>HKMAPS 3rd Photo Competition &amp; Sharing Session 2011</b> Organiser: HKMA Photographic Society, Chairman: Dr. Amy Lai-man PANG, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Dorothy KWOK Tel: 2527 8285



Date / Time	Function	Enquiry / Remarks
<b>21 SUN</b> 4:00 pm 7:00 pm	<b>HKMAPS Subcommittee Meeting</b> Organiser: HKMA Photographic Society, Chairman: Dr. Amy lai-man PANG, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong <b>HKMA Joint Professional Singing Concert 2011</b> Organiser: The Hong Kong Medical Association, Dr. Jeffrey Chiu-fai PONG, Venue: Grappa	Ms. Dorothy KWOK Tel: 2527 8285 Miss Sharon HUNG Tel: 2527 8285
<b>25 THU</b> 1:00 pm	<b>HKMA NTW Community Network - Recent Advance &amp; Practical Management on Allergic Rhinitis &amp; Sinusitis for General Practice</b> Organiser: HKMA NTW Community Network, Speaker: Dr. Chun-kuen CHOW, Venue: Maxim's Palace Tuen Mun	Mr. Alan LAW Tel: 2527 8285 1 CME Point
<b>27 SAT</b> 1:00 pm	<b>HKMA YTMCN and Kowloon Central Cluster - Certificate Course on Bringing Better Health to Our Community (Lecture 3)</b> Organisers: HKMA YTMCN and Kowloon Central Cluster, Speakers: Dr. Kam-tim CHAN & Dr. Cheung-hei CHOI, Venue: Block M, Lecture Theatre, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon, Hong Kong	Miss Candice TONG Tel: 2527 8285
<b>28 SUN</b>	<b>HKMA Joint Professional Badminton Tournament 2011</b> Organiser: The Hong Kong Medical Association, Venue: Western Park Sports Centre	Miss Alice TANG; Miss Sharon HUNG Tel: 2527 8285
<b>30 TUE</b> 1:00 pm	<b>HKMA Kln West Community Network - New Updates on Cervical Cancer Prevention and Vaccination</b> Organiser: HKMA Kln West Community Network, Chairman: Dr. Kai-sing TONG, Speaker: Dr. Helen LIANG, Venue: Crystal Room I-III, 30/F., Panda Hotel, Tsuen Wan, N.T.	Miss Candice TONG Tel: 2527 8285

## Course / Meeting

18/9/2011	<b>2011 Paediatric Update No. 3 Clinical Audit</b> Organiser: Hong Kong College of Paediatricians, Chairman: Dr. Better YOUNG & Dr. Chun-fai CHENG, Speakers: Various, Venue: Hospital Authority Head Office, M Floor, Lecture Theatre, 147 Argyle Street, Kowloon, Enquiry: Ms. Vanessa WONG, Tel: 2871 8773, Fax: 2785 1850, CME Accreditation: 3 CME Points
11-14/10/2011	<b>PALS Course 2011</b> Organisers: Hong Kong College of Paediatricians, the Heart Institute for Children, Hope Children's Hospital, Illinois, USA & Hong Kong Paediatric Nurses Association, Speakers: Various, Venue: A & E Training Centre, Tang Shiu Kin Hospital, CME Accreditation: 12 points for provider course (Hong Kong College of Paediatricians), Enquiry: Ms. Kitty HO/Vanessa WONG, Tel No: 2871 8769, Fax No: 2785 1850, Email: enquiry@paediatrician.org.hk, Website: http://www.paediatrician.org.hk/entnews.htm
11/9/2011 - 3/6/2012	<b>Amazing Vaccines Exhibition</b> Organiser: Hong Kong Museum of Medical Sciences, Venue: Hong Kong Museum of Medical Sciences, 2 Caine Lane, Mid-Levels, Hong Kong, Enquiry: Secretariat, Tel: 2549 5123, Fax: 2559 9458, Email: info@hkmmms.org.hk

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

Date	Course No	Course Name	Target Participants	CME/CNE
7/7/2011 - 18/8/2011	C184	Certificate Course on Paediatric Nutrition	Medical, Health and Child-Care Professionals	9 CNE Points; CME/CPD Accreditation in application
12/7/2011 - 16/8/2011	C178	Certificate Course on Occupational Hygiene Practice	Healthcare Workers	9 CNE Points; CME/CPD Accreditation in application
5/8/2011 - 9/9/2011	C183	Certificate Course on Communication and Swallowing Problem in the Elderly Population	Paramedical Professional	9 CNE Points; CME/CPD Accreditation in application
7/9/2011 - 19/10/2011	C177	Certificate Course on Respiratory Medicine 2011	Nurses and Allied Health Professionals	9 CNE Points; CME/CPD Accreditation in application
8/9/2011 - 13/10/2011	C181	Certificate Course on Renal Medicine 2011	Medical and Health Professionals	9 CNE Points; CME/CPD Accreditation in application
3/11/2011 - 15/12/2011	C185	Certificate Course on Wilderness Medicine for Healthcare Professionals 2011	Healthcare Professionals	9 CNE Points; CME/CPD Accreditation in application
7/11/2011 - 12/12/2011	C182	Certificate Course on Sports Medicine and Emergencies	Medical and Health Professionals	9 CNE Points; CME/CPD Accreditation in application



## Answer to Dermatological Quiz

- There are multiple small 2 to 3mm erythematous vascular papules over the right labium majora, perivulval and perianal areas asymmetrically. Some lesions showed central erosions and umbilications. The clinical diagnosis may include molluscum contagiosum, haemangioma, pyogenic granuloma and angiokeratoma. The relatively smooth vascular surface of most of the papules make the diagnoses of viral wart, bowenoid papulosis and prurigo nodularis less likely. Coupled with the histological features of haemangiomatous dermal vascular proliferation with the typical cobblestone or hobnail epithelioid endothelial cell and tissue eosinophilia, a rare diagnosis of angiolymphoid hyperplasia with eosinophilia (ALHE) affecting the vulva and perineum can be made.

ALHE is a rare condition affecting young to middle-aged adults, with a female preponderance. The typical lesion usually presents as red to purplish haemangiomatous dermal or subcutaneous papules, plaques or nodules of 0.1 to 2cm affecting the head and neck, especially in the auricular and peri-auricular areas. The disease less commonly affects the trunk, limbs and mucosal area and only rarely occurs in the genitalia as in this patient.

- Peripheral eosinophilia in blood is found in about 20% of ALHE patients which might aid the clinical diagnosis of this rare disease.
- Surgical removal by excision or cryotherapy is usually required although spontaneous regression has rarely been reported. Carbon dioxide laser therapy and electrocauterisation can be useful especially when intraoperative bleeding can be problematic. About 30% of lesions recur after excision. Other treatment options with anecdotal benefits include intralesional steroids, oral isotretinoin, oral pentoxifylline, oral indomethacin farnesil, intralesional interferon alfa-2b, intravenous anti-interleukin-5 antibody. Most of these treatments probably act through mechanisms of anti-angiogenesis, anti-inflammation or inhibition of eosinophils.

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