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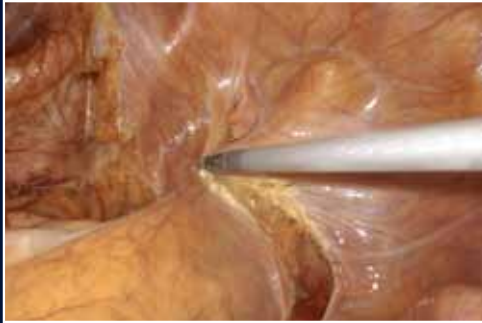
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Hearing Restoration Surgery in Action

The Hear Talk Foundation (耳聽心言基金) is a charity organisation established in 2003 by a group of ENT specialists, audiologists, speech therapists and educational professionals in Hong Kong. The Foundation is dedicated to help the underprivileged and to educate professionals in tackling hearing and communicative disorders in greater China Mainland. This photograph was taken by our professional reporter-photographer during one of the annual China Mainland Mission (耳聽工程) while the surgeon (Dr Michael Tong) was performing a bionic ear (cochlear implant) surgery to restore hearing in a 3-year-old child. The left lower circular insert shows the inside of the cochlear spiral turns where the electrode is to be placed on a cadaveric model, taken with the latest high definition endoscopic camera system by Dr Chang. To-date, about half a million people worldwide have been benefited from the miraculous surgery to regain their hearing.

Further information can be found in <http://www.heartalk.org> or
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Everyday ENT Practice

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Prof Michael Chi-fai TONG

Editor

Otorhinolaryngology, Head and Neck Surgery or simply ENT is a specialty characterised by the incorporation of all the human senses, the coverage of an anatomical area with comprehensive pathologies, the provision of services from birth to the end of life and the application of sophisticated medical technologies. Yet it is one of the oldest medical specialty with both dedicated physicians and surgeons in the discipline, as illustrated by the unique establishment of the Central London Throat and Ear Hospital by both physicians and surgeons in 1874.

With this background and the close connection of our discipline within medical and non-medical practitioners, education across all sectors has always been the priority of otorhinolaryngology-head and neck or ENT specialists in Hong Kong. In this respect, we have come up with this special knowledge-transfer 'Everyday ENT practice' issue to the lay public, health care practitioners, family physicians and specialists.

The Department of Otorhinolaryngology, Head and Neck Surgery has established eight divisions incorporating six clinical subspecialties: otology and neurotology, rhinology, laryngology, head and neck surgery, paediatric otorhinolaryngology, facial plastic surgery and two communicative science units: audiology, and speech therapy. These are the spectra of ENT practices in Hong Kong and beyond. Last year, The Hong Kong Society of Otorhinolaryngology, Head and Neck Surgery and the Federation of Medical Societies of Hong Kong had organised an ENT Update course and one young specialist from each of the six clinical subspecialties had given the well-subscribed course. They now jointly present the course materials in this special issue. Dr Waitz CHANG shows how we hear and what are the current concepts of rehabilitation of deafness. It has to be a proud area of Hong Kong where we are global leaders in this discipline over the past 2 decades in terms of hearing rehabilitation in medical, social and educational sectors. Dr Birgitta WONG writes a brief account of paediatric ENT work and the importance of recognising children not as a miniature adult but someone we always treasure at home or as a health care professional. Dr Peter KWAN gives an overall need to the importance of maintaining a healthy voice to speak, the other indisputably important organ for communication. Pathologies are to be recognised and their proper management shall be understood. Dr Dennis LEE catches our eyes on some of the most common complaints in general practice, allergic rhinitis, rhinosinusitis and epistaxis. The use of minimally invasive approaches has changed a lot of patients' acceptance and satisfaction in medical and surgical treatments. Common head and neck pathologies often present as lumps and bumps but some may appear subtly and Dr Joseph CHUNG guides us through the process of how we make our diagnosis towards an effective management. His article is also chosen as the CME question paper. Dr Winnie KAN describes how we deal with the complex reanimation of sufferers of the paralysed face, updating the knowledge of how we can functionally and aesthetically improve a patient's quality of life.

Last but not least, we have a senior but still young member of the Hong Kong ENT community, Dr Cheuk-lun SHAM, narrating how a music master and an eminent specialist can be the same person.

We sincerely hope that the readers, like we ourselves, will gain and treasure this issue as a continuing process of learning in everyday ENT practice.

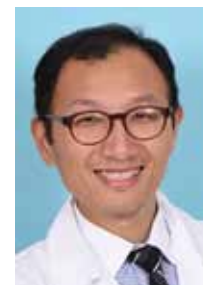


Diagnostic Approaches to Common Head & Neck Masses

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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 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 August 2017.

Introduction

Head & neck masses are commonly encountered in daily clinical practice. Due to the complexity of their anatomy, they have infinite possible pathologies as well as differential diagnoses. Thorough history taking and systematic physical examination are mandatory to distinguishing rare malignant conditions from the common benign lesions and to refer them promptly to ear, nose and throat (ENT) specialists.

Anatomy

Mouth

A mass can be originated from either the oral cavity or the oropharynx. The two are separated by a vertical plane between the hard and soft palate junction that divides the tongue into the anterior two-third tongue (oral tongue) and the posterior one-third tongue (tongue base).

The oral cavity comprises the lips, buccal mucosa, the gingival sulcus, teeth, the floor of mouth, the oral tongue and the hard palate. The oropharynx is comprised of the tonsils, the soft palate, the tongue base, lateral and posterior oropharyngeal mucosa. (Fig. 1)

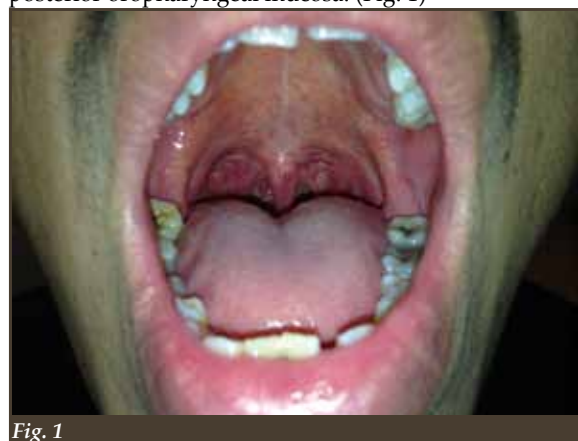


Fig. 1

Neck

There are several major structures that can give rise to a neck mass, including bones (hyoid, cricoid, clavicle), muscles (sternocleidomastoid, trapezius, digastric), vessels (carotid artery and jugular vein), glands (parotid, submandibular, thyroid) and lymph nodes. The neck

is divided into the anterior and posterior triangles to guide us as to the possible origin of the neck mass.

The anterior triangle is bounded by the anterior border of the sternocleidomastoid muscle, the inferior border of the mandible and the midline. The submandibular gland, the hyoid bone, the thyroid cartilage, the cricoid cartilage, the trachea and the thyroid gland are situated within the anterior triangle. The posterior triangle is bounded by the posterior border of the sternocleidomastoid muscle, the trapezius muscle and the clavicle. The great vessels, namely the carotid artery and internal jugular vein are protected by the sternocleidomastoid muscle.

According to the location of the cervical mass, the neck is divided into six levels (Fig. 2). This helps to predict its underlying origin. Level I includes the submandibular and submental regions of the anterior triangle, while level VI includes the rest of the anterior triangle. Level II, III and IV are deep to the sternocleidomastoid muscle, along the internal jugular vein in the upper, middle and lower thirds of the muscle respectively. Level V contains the posterior triangle of the neck.

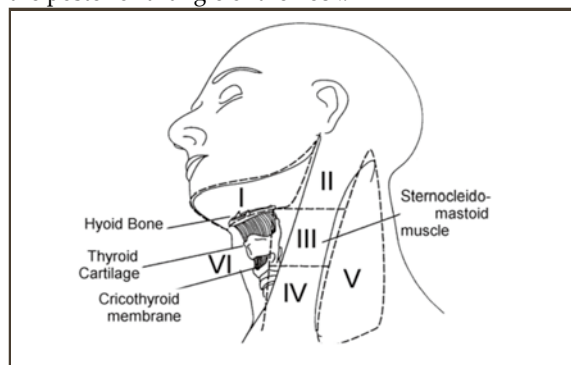


Fig. 2

History

A simple, but careful history taking provides important clues to the diagnosis of the mass. The duration of symptoms is of prime significance in the history. Inflammatory conditions usually give a short and acute onset of symptoms, whereas congenital and malignant conditions may give an indolent, extended duration of the mass except when they are secondarily infected.

Factors such as age, associated symptoms and social habits are also essential in the history. Young adults who do not consume tobacco or alcohol are likely to have congenital, developmental or non-malignant neoplastic conditions, whereas malignant tumours usually occur in middle aged men associated with tobacco and/or alcohol consumption. Other associated symptoms of lesions of the upper aerodigestive tract include blood-stained nasal discharge or saliva, hoarseness, dysphagia and constitutional upset.

A family history of nasopharyngeal carcinoma is important in patients with unilateral tinnitus, hearing impairment and cervical swelling because it is prevalent in Hong Kong and the southern China Mainland.

Physical Examination

A systemic examination should include the mass itself, the oral cavity and the neck, the scalp and skin of the head & neck region, a complete ENT assessment and relevant neurological examinations. If the symptoms point to an area that is difficult to examine without specialised instruments, such as the nasopharynx, larynx and hypopharynx, patients should be referred to ENT specialists for an assessment.

The oral cavity and oropharynx should be examined carefully to assess the location of the mass and its size, consistency, extent and involvement to the surrounding structures. If the intraoral mass is suspected to be malignant, the neck should be examined to search for any secondary cervical lymph node metastases.

For a neck mass, the site of the mass provides essential diagnostic clues as different pathologies originate from different neck levels. The size, consistency, mobility, number and associated signs of inflammation also give important information to possible differential diagnoses. Congenital causes tend to be soft, mobile and non-tender; acute inflammatory masses are mobile, tender with erythema; vascular masses are pulsatile.

Malignant cervical lymph nodes are usually hard, fixed and non-tender. When it is suspected, a comprehensive ENT, head & neck examination should be performed to search for any possible primary site of the malignancy. An otoscopy may reveal otitis media with effusion which may be associated with nasopharyngeal carcinoma. Nasal examination may show a unilateral mass with blood-stained discharge suspicious of a neoplasm. Examination of the oral cavity and oropharynx mucosa may show an intraoral primary malignancy. An asymmetrically unilateral enlarged tonsil or a medially displaced normal size tonsil may suggest an underlying neoplasm. One should not forget to examine the scalp and the skin of the head and neck region to search for primary cutaneous tumours.

Common Pathologies

Oral Cavity

Benign

Infective masses and swellings are usually of rapid onset and associated with pain, odynophagia and

systemic symptoms of infection. Clinical diagnosis of sepsis is usually apparent but delineating the extent of the infection requires a cross sectional imaging like CT scan to delineate before surgical incision and drainage.

A bony swelling over the palate is a common condition that patients would seek for medical advice. 'Torus' is a Latin word which means 'to stand out'. Torus palatinus (Fig. 3) is a sessile bone outgrowth occurring commonly in the midline of the hard palate. Torus mandibularis, a less common condition, is a bony protuberance located on the lingual aspect of the mandible. Surgical removal of the torus is not always necessary unless the patients suffer from repeated ulceration of the mucosal surface, interference of denture placement and periodontal disorders due to trapping of food debris.



Fig. 3



Fig. 4

An impacted salivary ductal stone (Fig. 4) presents as a hard swelling on the floor of the mouth or cheek mucosa. It is usually associated with colicky postprandial glandular painful swellings. Bimanual palpation of the salivary duct will often reveal the diagnosis.

Bluish cystic swelling the floor of the mouth is called ranula (belly of a frog), which is a mucus retention cyst arising from the blocked sublingual gland (Fig. 5). It is lateral to the submandibular duct opening. If the cyst extends beyond the mylohyoid muscle, it is called a plunging or diving ranula.



Fig. 5

Malignant

Squamous cell carcinoma is the commonest malignant tumour in the oral cavity. It commonly originates from the lateral border of the oral tongue. It can also arise from the rest of the oral cavity, like the buccal mucosa, the floor of mouth and the mucosa around



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the alveolar bone (Fig. 6). Apart from presenting as a mass, it can present as an ulcer, invasive growth or verrucous warty growth. These lesions bleed easily and patients may complain of blood stained saliva. With pain and surrounding infiltration, patients may have ankyloglossia, swallowing and speech difficulties. If the carcinoma arises from the alveolar mucosa, it can invade into the dental sockets and present as loosen teeth. Any non-healing dental socket should raise the suspicion of an underlying malignancy and biopsy of the affected mucosa is indicated. One should examine the neck to detect any metastatic neck lymph nodes, commonly in the submandibular or upper jugular region.

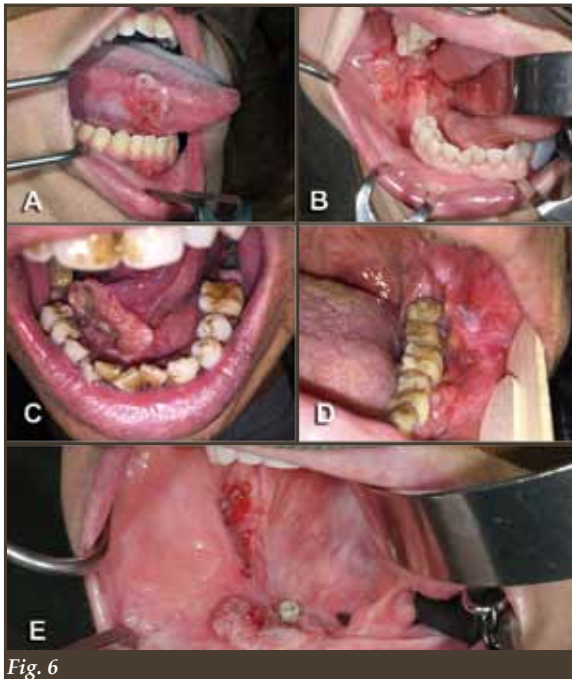


Fig. 6

Tumours arising from the minor salivary glands in the oral cavity usually present as a smooth firm swelling with intact overlying mucosa (Fig. 7). More than 50% of minor salivary gland neoplasms are malignant in nature and they may grow rapidly presenting as an ulcerative swelling. Clinically it is difficult to differentiate benign tumours from malignant ones as they can present as an intraoral mass with intact overlying mucosa. Incisional biopsies of these growths are mandatory before making a definitive treatment plan. Adenoid cystic carcinoma is a special malignant salivary gland tumour that has a high propensity for nerve invasion. It can present as an isolated nerve palsy like hypoglossal nerve palsy, lingual nerve palsy or inferior alveolar nerve palsy.



Fig. 7

Fig. 8

Mucosal melanoma (Fig. 8) is a rare form of malignant melanoma. In the oral cavity, the lesion usually presents as a pigmented nodule that is indurated on palpation. It can ulcerate and bleed. Any pigmented nodule in the oral cavity should be biopsied.

Oropharynx

Infective

Acute tonsillitis is commonly seen in daily practice presenting with bilateral erythematous tonsils enlargement (Fig. 9). It is usually accompanied with fever, exudates on the tonsils and tender cervical lymphadenopathies. In contrast, peritonsillar abscess (quinsy) is the collection of pus between the tonsillar capsule and the superior constrictor (Fig. 10). It presents with unilateral tonsillar swelling pushing the ipsilateral tonsil medially and the uvula to the contralateral side. One pathognomonic sign for quinsy is trismus due to pain and inflammatory irritation to the masticator muscles.



Fig. 9

Fig. 10

Neoplastic

Any unresolved unilateral tonsillar swelling should raise the suspicion of a neoplastic growth. Patients would not have sepsis and trismus unless there is infiltration to the surrounding muscles. The tumour may develop from the parapharyngeal space pushing the tonsil medially and inferiorly (Fig. 11) or from the tonsil itself (Fig. 12). Eighty percent of parapharyngeal space tumours are benign in nature. Apart from squamous cell carcinoma, the tonsil can give rise to a lymphoma because it is a lymphoid rich structure.



Fig. 11

Fig. 12

Neck

Normal structure

Several normal structures in the neck may be confused as an abnormal neck mass (Fig. 13), especially in thin bodily built patients. The hyoid bone; the lateral process of the C1 vertebra which is palpable between the mastoid process and the angle of the mandible; the carotid bulb,

particularly the atherosclerotic ones; and the prominent parotid and submandibular glands may also be palpable. With experience, normal variations in anatomy can be distinguished from true pathology by palpation alone.

Salivary glands

The parotid gland is situated in the preauricular and angle of jaw region. About 80% of parotid gland tumours are benign in nature and 80% of these benign tumours are pleomorphic adenoma (Fig. 14). One should raise the suspicion of malignancy when it grows rapidly with pain, infiltrates to skin or surrounding structures, and when it is associated with facial nerve palsy and cervical lymphadenopathy.

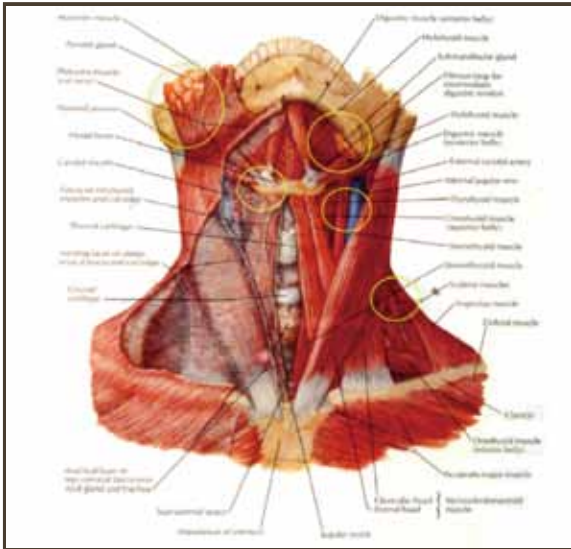


Fig. 13



Fig. 14



Fig. 15



Fig. 16

Half of the submandibular neoplasms (Fig. 15) are benign. They are distinguished from submandibular lymph nodes by bimanual palpation. Similar to parotid tumours, they may be malignant when associated with a

rapid increase in size, surrounding cranial nerve palsies and palpable cervical lymphadenopathies.

Ludwig's angina (Fig. 16) is an odontogenic infection with abscess formation in the floor of mouth. Patients present with submental/ submandibular swelling, pain, odynophagia and systemic upset. It is a life threatening condition because oedema of the floor of mouth will progress to airway obstruction. It requires urgent medical attention to secure the airway and surgical drainage.

Anterior neck

Thyroglossal cyst (Fig. 17) is the commonest upper anterior neck mass. It is usually located at the midline around the hyoid bone level. It moves upwards with swallowing and tongue protrusion during physical examination. It rarely has malignant potential, but surgery is suggested as it may get infected.



Fig. 17

A thyroid mass presents as a lower anterior neck mass that elevates upon swallowing. It typically presents as an incidental mass or a painless swelling alone. When it grows, it causes local compressive symptoms like shortness of breath or dysphagia. When there is a functional thyroid nodule, patients may present with dysfunctional symptoms, for example proptosis, appetite change, weight change, tremor and palpitation.

Lateral neck

The branchial cyst (Fig. 18) is a congenital mass presenting as an upper lateral neck mass in adolescence or early adulthood. It may be situated anywhere along the anterior border of the sternocleidomastoid muscle, most commonly at the junction of the upper and middle thirds. The lymphangioma presents in early infancy or childhood as a soft transilluminated swelling. A neck abscess presents as an acute, erythematous, tender mass in a febrile, systemically septic patient. Other lateral neck masses include the carotid body tumour, paraganglioma, lipoma and neuroma.

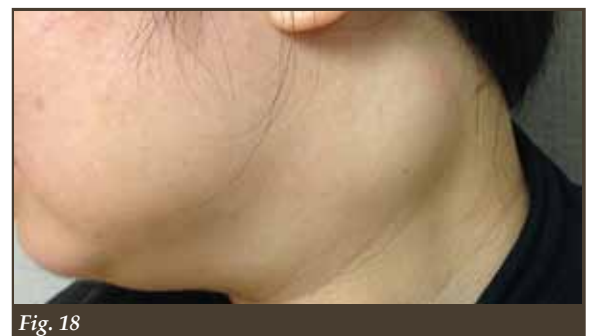


Fig. 18

Lymph node

An important group of neck masses is palpable cervical



lymph nodes. Acute inflammatory lymph nodes may be the result of acute infections in the upper aerodigestive tract, pharynx or tonsils. Chronic inflammatory neck masses may be a result of mycobacterial infection (TB) or actinomycosis. Tuberculous lymphadenopathy (Fig. 19) is the commonest form of extrapulmonary TB. It is not uncommon as TB is still prevalent in our locality. It usually presents as a 'cold abscess' and a discharging sinus if ruptured.

tract and ultrasound examination of the neck with fine needle aspiration to yield tissues for a histological examination.

Management

Many inflammatory causes resolve with conservative management. A course of a broad-spectrum antibiotic and reassessment in 1-2 weeks is a reasonable approach. Benign congenital and developmental masses can be observed and surgical removal is indicated when they are symptomatic or develop complications, like bleeding and infection.

In patients who fail to improve or persist within 2-4 weeks following an initial antibiotic trial, or when clinical features of a malignant tumour are present: (1) rapid growth, (2) hard in consistency, (3) fixed to surrounding structures, (4) >2cm, (5) cranial nerve palsies and (6) associated ENT symptoms, immediate referral to a specialist is indicated for investigations and further management.

Conclusion

A Head & neck mass is a common clinical problem. With knowledge in normal anatomy, common pathologies, together with a good history taking and a systematic physical examination, a provisional diagnosis can be made to guide further investigations and to devise a management plan. All inflammatory masses which are not responsive to antibiotics within 2-4 weeks and all suspected malignant masses should be referred to ENT specialists for further workup and management.



Neoplastic lymph nodes (Fig. 20) may be of lymphoid origin (primary) or mucosal origin (secondary). Lymphomas arising from cervical lymph nodes are usually well defined and rubbery. Accompanying symptoms of a head and neck primary usually reveal the cause of a secondary neck nodal metastasis. As mentioned before, this necessitates a comprehensive ENT, head and neck examination in search for the primary tumour. Nasopharyngeal carcinoma, occult oropharyngeal carcinoma from the tonsil or tongue base and hypopharyngeal carcinoma may present with nodal metastases without localising symptoms and signs. A referral to ENT surgeons is recommended for early panendoscopy to assess the whole upper aerodigestive



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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Diagnostic Approaches to Common Head & Neck Masses" by Dr Joseph Chun-kit CHUNG 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 2017. 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. Submandibular gland is situated in level I
2. Torus palatini has malignant potential and is recommended for excision
3. The commonest histology of carcinoma of oral cavity is adenocarcinoma
4. Minor salivary gland tumours are rarely malignant in nature
5. Trismus is a pathognomonic sign for peritonsillar abscess (Quinsy)
6. Lymphomas can present as tonsillar swellings
7. Antibiotics are the mainstay management of Ludwig's angina
8. Cervical tuberculosis commonly presents as a non-tender 'cold abscess'
9. Nasopharyngeal carcinomas can present with cervical lymph node enlargement only
10. Cervical lymph nodes that do not response to antibiotic trial should proceed for excisional/incisional biopsy

ANSWER SHEET FOR AUGUST 2017

Please return the completed answer sheet to the Federation Secretariat on or before 31 August 2017 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Diagnostic Approaches to Common Head & Neck Masses

Dr Joseph Chun-kit CHUNG

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Honorary Clinical Assistant Professor, The University of Hong Kong*

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Answers to July 2017 Issue

Minimally Invasive Foot and Ankle Surgery

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

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References:

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Encountering Facial Nerve Palsy in the Clinic

Dr Winnie KAN

MBChB (CUHK), MRCS Edin, FRCS(Edin), FHKCORL, FHKAM(Otorhinolaryngology)
 Specialist in Otorhinolaryngology
 Honorary Clinical Associate Professor, The Chinese University of Hong Kong



Dr Winnie KAN

Introduction

Facial palsy is a devastating condition with functional, aesthetic and psychosocial impacts. Facial asymmetry, defective emotion facial expression, lagophthalmos, exposure keratopathy, nasal valve collapse, impaired oral competence and articulation deficits may compromise the quality of life of the sufferers significantly.

There are numerous causes of facial palsy, Bell's Palsy is the commonest and makes up 70% of all cases.^{1,2} Other causes include neoplasms, iatrogenic injury, herpes zoster oticus, trauma and congenital palsy.⁴

Due to the complexity of the course of the facial nerve, its intricate relation to the facial muscles and the variabilities in neural regeneration, long term outcomes after facial nerve insults are heterogeneous. They range from complete flaccid facial paralysis to full return of facial motions. The disease spectrum is scattered into varying degrees of hypertonicity, hypotonicity and synkinesis. Therefore, the management of facial palsy is individualised and widely diversified.

Assessment and Improvements in Grading system

Faulty re-routing and re-innervation of facial muscles may result in spastic activity and synkinesis around six months after the insult. Synkinesis is unwanted involuntary movements of the face triggered by voluntary movement of another part of the face. To accurately identify the problem, an analysis of the face as separate zones with respect to the various complications is important. The face can be stratified vertically into the brow, periocular region, midface, oral commissure area, lower lip, chin and neck. Both sides of the face are also observed for symmetry and abnormal movements.

The House-Brackmann grading was devised for facial palsy related to acoustic neuroma surgeries. It is simple and widely applied. However, it does not address some important features in facial palsy patients: the various degrees and mixtures of hypercontracture, hypotonia, mass movement and synkinesis in individualised patients and variable compensatory hyperactivity on the healthy side. The Sunnybrook scales³ and the revised Facial Nerve Grading System 2.0 take facial nerve palsy complications into account. They allow better documentation and more sophisticated grading. To synchronise with the international standard, we can use the House-Brackmann system together with one or more of these grading systems in our daily practice.

The image shows the Sunnybrook Facial Grading System form. It is a detailed assessment tool for facial nerve palsy, divided into three main sections: Resting Symmetry, Symmetry of Voluntary Movement, and Synkinesis. Each section contains a grid for grading different facial expressions and movements, with checkboxes for 'Total' scores and a legend for 'Voluntary movement score', 'Resting symmetry score', and 'Synkinesis score'. The form also includes fields for patient name, date, and a 'Total' score calculation.

Fig. 1. Sunnybrook Facial Grading System³

Updates on Medical Treatment of Acute Facial Palsies

In acute facial palsy with an anatomically intact nerve, early recovery is critical to preserve facial functions. Guidelines from the American Academy of Otolaryngology–Head and Neck Surgery Foundation and the American Academy of Neurology both reached a consensus that steroids should be offered to new-onset Bell's palsy.¹

American Academy of Otolaryngology–Head and Neck Surgery Foundation (issued in November 2013) supported the use of corticosteroids within 72 hours of symptom onset in patients aged 16 or older. Three common regimens of oral prednisone are 1 mg per kg daily, 25 mg two times a day or 60 mg per day for 5 days, then tapered over 5 days, for a total of 10 days.^{1,2}

Only marginal benefits are observed if antivirals are given in Bell's Palsy² and therefore they should not be routinely given. The effects could be explained by the correlation of Bell's and herpes virus. Another possible reason can be zoster sine herpette which is the Ramsay Hunt Syndrome without manifestation of vesicles. It makes up 12 % of Herpes Zoster Oticus and patients may present with a higher grade of facial palsy and delayed recovery. Therefore, antivirals can be considered in patients presented with high grade facial palsy even without manifestation of vesicles.

If the patient has herpes zoster oticus, antiviral medications are indicated, and they are most effective when started within 72 hours after the onset of the rash.

Co-organisers:



Care for Advanced Diseases: Joint CME Seminar with HKMA

Dates : 9 Sept 2017 (Saturday)

Time : 1:30-3:30pm

Venue : 5/F, Duke of Windsor Social Service Building,
15 Hennessy Road., Wanchai, Hong Kong

Language Media : English

Rundown

12:30pm Registration

1:00pm Lunch

1:30pm Palliative care for advanced diseases: from principles to practice

Dr Raymond S.K. LO

Convenor, Care for Advanced Diseases Consortium; Immediate Past President, Federation of Medical Societies of Hong Kong; Clinical Professor (Hon) Dept of Medicine and Therapeutics, Chinese University of Hong Kong

Q & A

Update on oncological palliation for advanced cancers

Dr LAW Chun-kay

Specialist in Clinical Oncology, Comprehensive Oncology Centre, HKSH Healthcare (Central)

Q & A

3:30pm End of Programme

Remarks

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- iii RSVP by faxing the reply form to 2865 0943 or cme@hkma.org on or before 1 September 2017 (Fri) as seats are limited.

CME/CNE has been applied and pending confirmation

Sponsor





Acyclovir (800mg 5 times/day for 7 to 10 days), famciclovir (500mg three times/day for 7 days), valacyclovir (1000mg three times/day for 7 days) are proven to decrease the duration of herpes zoster rash and the severity of pain associated with the rash⁵. Valacyclovir and famciclovir are preferred as they have better bioavailability and require less frequent dosing⁶.

Steroids and antivirals should only be prescribed after the contraindications are ruled out because the spontaneous recovery rate of Bell's palsy is 80%.²

Non-invasive modalities in management of facial palsy

Firstly, the eyes must be protected with adequate lubrication, taping and even moisture chamber. Gas-permeable scleral lenses worn up to 12 hours a day may be used to treat and prevent exposure keratopathy⁷. Upper lid stretching exercises can reduce lagophthalmos. It is easy to teach patients to perform home physiotherapy for the eyes.



Fig. 2. Upper lid stretching exercise

Neuromuscular retraining exercises, usually by physiotherapists, are essential in the initial management of non-flaccid facial paralysis and they produce a better long-term outcome. The patient is asked to practise minimal, precisely coordinated movement patterns in conjunction with modalities such as surface electromyographic, proprioceptive and mirror feedback.

It must be stressed that certain activities in physiotherapy e.g. maximum effort exercises and electrical stimulation are contraindicated in facial paralysis.⁸ This is because they will increase the risk of complications e.g. hypertonia, worsen facial asymmetry.

If a group of muscular movements does not respond well to physiotherapy, chemodenervation can be considered. Botulinum toxin has been shown to restore normal facial features and symmetry. When chemodenervation is used concurrently with neuromuscular training, the result was confirmed to be longer lasting⁹. Botulinum toxin can be injected in the affected synkinetic hemiface to relax hyperactive

muscles and the normal hemiface for balance to restore facial symmetry. The most common injection sites include the orbicularis oculi, corrugator, platysma and mentalis muscles. Be cautious at injecting at the midface and lip depressors to avoid drooping of oral commissure and lip asymmetry.

Below shows a patient complaining of right periorbital spasm, asymmetry and limited visual field on the right eye when she eats. She reports improvement of all symptoms after Botox injection.



Fig. 3. Reduction of synkinesis and hypertonia on right periorbital region with botox injection (left side –pre-injection, right side - one week post-injection) Note the wider palpebral fissure

Filler injection can improve resting asymmetry by fading out the facial folds and rhytids on the hyperactive normal face or the hypertonic palsy face. The patient's facial contour can also be improved with filler augmentation above the atrophied muscles.

Patient Counselling- Important concepts about Reanimation Surgeries

Facial palsy surgeries can be categorised into static procedures and dynamic reanimation. (Table 1)

Static procedures	Dynamic Reanimation
brow lift	neurorrhaphy
lid chain	cranial nerve substitution
Canthoplasty	free muscle graft
Rhytidectomy	local muscle transfer e.g. masseter, digastric muscle
static slings to nasolabial fold, oral commissure	
filler injection	

They should be discussed separately with reference to the facial zones. The choice of appropriate procedures for individualised patients is also determined by the viability of neuromuscular units, degree of weakness, presence of complications, medical co-morbidity and the patient's expectations.

With regard to dynamic reanimation when the nerve is transected, the earliest primary nerve repair delivers the best functional outcome¹⁰. An interposition graft is indicated if the stumps cannot be anastomosed without tension. The greater auricular nerve and sural nerve are the common donor nerves. They mainly work as neural conduits to guide regeneration of axons. One to two years' delay in repair will result in significantly worse mimetic outcomes. Age has also been shown to correlate with decreased neuron survival, regeneration and muscle receptivity to reinnervation following injuries in animal models.¹¹

When a proximal facial nerve stump is not available and the motor units are still viable, cranial nerve substitution can be offered. Studies have compared different cranial nerves as donor nerve for reanimation¹². The major considerations are listed in Table 2.

Table 2 - The major considerations in choosing suitable neural substitution

Functional deficit produced by sacrificing the donor nerve (i.e., speech, swallowing)
Need for interposition nerve grafts
Synergism between the donor nerve and facial nerve and its influence on motor reeducation
Nerve topography (diameter, axon count, fibre type)
Donor nerve's ability to provide adequate power
Without inducing mass movement

The hypoglossal nerve with or without a jump graft is well established and the masseteric nerve has increased importance¹⁰ with multiple advantages in reanimation of the face: proximity to the facial nerve, ability of central adaptation to control the face, minimal morbidity and less mass movement. Alternative methods are the use of cross facial nerve grafts and the accessory nerve.

Often, after two years of facial palsy with inadequate neural supply, the muscle or the motor end-plates become non-receptive. Free muscle transfer or local muscle transfer can be offered. Gracilis, latissimus dorsi, pectorals minor, extensor digitorum brevis are common muscles for facial reanimations. They are also studied by different surgeons showing satisfactory results¹³⁻¹⁵. The outcomes of free muscle grafts vary with the surgical expertise.

If the patient is medically unfit or prefers a simpler procedure, local muscle transfer e.g. temporalis tendon transfer, may deliver acceptable results, too. It is still the gold standard for the older population and for those who have failed free muscle transfer. There are studies to investigate on how to optimise the outcome of temporalis transfer^{16,17}. One commonly performed procedure is orthodromic temporalis tendon transfer via the nasolabial fold. Below shows a case of temporalis tendon transfer with successful outcome. The patient was also taught to smile with her mouth closed and to control smiling motion with clenching teeth motions. Her intradermal nevus on the corner of mouth was also removed to reduce attention to the asymmetrical oral commissure.



**Fig. 4. Left: pre-temporalis tendon transfer to oral commissure
Right: post-operation, temporalis tendon transferred**

Summary

The goal in facial palsy treatment is to re-establish facial symmetry and movement. Static techniques and non-invasive procedures may help a lot of patients but they are only useful for the resting appearance. Identifying the best dynamic reanimation option warrants a thorough analysis of the extent of the facial nerve injury, the duration of palsy and viability of the facial musculature.

Patient factors, age, overall health, motivation and goals for rehabilitation all play equally important roles. Attention to both the paralysed and non-paralysed sides of the face is essential to yield effective results.

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21 Aug	Drugs or poisons, two faces of a coin 藥物與中毒(藥物的毒性)	Dr Herman Ka-hing LEE & Dr Wing-hong TSANG Associate Consultants A&E UCH
28 Aug	Toxicities of Chinese medicine 中藥的毒性	Dr Hon-wah NG Senior Medical Officer A&E UCH
4 Sep	Venomous and poisonous animals in Hong Kong 毒蛇與其他有毒動物	Dr William Cheung-lun WONG Associate Consultant A&E PMH
11 Sep	Poisons in the household 家居有毒物品	Dr Odin Ming-yin CHAN Associate Consultant A&E PYNEH
18 Sep	Poisons in food and water 食物與水中的有毒物質	Dr Kai-kee LAU Associate Consultant Hong Kong Poison Information centre HA

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08:30 – 09:00	Registration	
09:00 – 09:05	Welcome	Mr. Wyman LI Manager (Administration) Hong Kong Sanatorium & Hospital
09:05 – 09:10	Welcome	Mr. Josh LEVINE President and CEO, Accuray
09:10 – 09:45	Early Experience with Multileaf Technology in CyberKnife – a Clinician’s Perspectives	Dr. Chun Key LAW Specialist in Clinical Oncology Hong Kong Sanatorium & Hospital
09:45 – 10:10	A Decade of Dosimetric Transition: from Coplanar Beams with Margins to Non-coplanar Realtime Tracking Dosimetry	Mr. Alan MUI Senior Dosimetrist Department of Radiotherapy Hong Kong Sanatorium & Hospital
10:10 – 10:35	Evaluation of CyberKnife in real-time target tracking during treatment delivery	Mr. Kimi YANG Medical Physicist Medical Physics and Research Department Hong Kong Sanatorium & Hospital
10:35 – 10:50	Coffee Break	
10:50 – 11:35	SBRT in Lung Cancer Treatment	Dr. YUAN Zhi Yong Chief of Radiotherapy Department Tianjin Medical University Cancer Institute and Hospital, China
11:35 – 12:20	Cutting Edge Technology of CyberKnife	Mr. Robert HILL Senior Vice President Research and Development, Accuray
12:20 – 13:30	Lunch	
13:30 – 14:15	SBRT for HCC: Multicenter Phase II Prospective Study Results in Korea	Dr. Mi Sook KIM Chief in Department III of Radiation Oncology Korea Institute of Radiological & Medical Sciences, South Korea
14:15 – 15:00	CyberKnife: The Ideal Radiosurgery Device for Lung and Liver Tumours	Dr. Brian COLLINS Clinical Director Department of Radiation Medicine Georgetown University Hospital, USA
15:00 – 15:15	Coffee Break	
15:15 – 16:00	Overview of Cranial and Extracranial SBRT	Dr. Jonathan HAAS Chief, Division of Radiation Oncology Winthrop-University Hospital, USA

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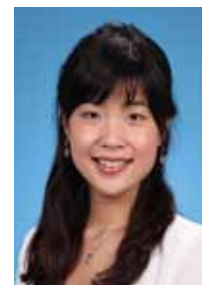


Hearing loss and hearing rehabilitation

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Dr Waitsz CHANG

Hearing Loss

Hearing loss is a common chronic impairment, particularly in late adulthood. An estimate from the World Health Organization has shown that hearing losses are affecting 538 million people globally. The prevalence in newborns is around 1 in 1,000. Significant hearing loss is the most common disorder at birth leading to delayed language development, behavioural problems, deprivation in psychosocial interactions and poor academic achievement. Besides, approximately 1% of the population are suffering from single sided hearing loss (SSD), the impact of which is increasingly aware in the society.

The extent of hearing loss is defined by measuring the hearing threshold in decibels (dB) at various frequencies. Normal hearing people have a hearing threshold of 0 to 25 dB. The degree of hearing loss ranges from mild to profound. Hearing loss may also be classified into three types: conductive, involving the external ear canal to the middle ear, sensorineural, involving the inner ear, cochlear or the auditory nerve and mixed loss being the combination of both conductive and sensorineural hearing losses. Various abnormalities may lead to these types of hearing losses. Examples are ear wax, infection of the external ear, perforation of the tympanic membrane, fluid or space-occupying lesions in the middle ear, discontinuation or fixation of the ossicular chain, age-related cochlear degeneration, ototoxicity, specific infection, tumours and injuries affecting the cochlear and the auditory nerves.

Hearing screening

Screening newborns for the not uncommon congenital hearing loss is important as early detection and intervention can improve speech and language development and educational achievement in affected children.

The screening programme in Hong Kong is categorised into universal screening and targeted screening. All babies born in public hospitals in Hong Kong receive universal hearing screening before they are discharged from the hospital. Two electrophysiologic techniques are used in hearing screening: Automated auditory brainstem responses (AABR) and otoacoustic emissions (OAE). Both AABR and OAE techniques are inexpensive, portable, reproducible and automated. They evaluate the peripheral auditory system and the

cochlea, but cannot assess activities in the highest levels of the central auditory system. They will be followed by diagnostic tests and referrals to otorhinolaryngologists if any of the tests fails. Screening for target groups including neonates suffering from meningitis, admission to ICU with intubation, extremely low birthweight etc. Their hearing will be screened again at 1 year of age.

Hearing Tests

All patients with hearing losses shall undergo formal audiological assessments to identify the cause and severity of their hearing losses. After an otoscopic examination for obvious external ear obstruction and simple pathologies of the middle ear, a formal audiologic assessment is performed by an audiologist in a hearing test booth. This evaluation provides an accurate and detailed assessment of a patient's hearing ability. The most common tests are pure tone audiometry and tympanometry (impedance audiometry). In pure tone audiometry, the patient sits in a soundproof booth and the audiologist assesses the ability of him or her to hear the pure tone stimuli at the frequencies of 250, 500, 1,000, 2,000, 4,000, and 8,000 Hz. The threshold for each stimulus is determined by finding the sound level in dB at which the patient can detect the tone in more than 50 percent of the time. The hearing ability is assessed for both air and bone conduction of sound. In air conduction tests, the ability to hear with earphones via the normal mechanism of hearing is measured: sound through the ear canal, tympanic membrane and the middle ear. In bone conduction evaluation, the hearing threshold is tested with a bone oscillator. The oscillator is placed on the mastoid prominence. The stimulating sounds go into the skull, bypassing the middle ear directly into the cochlea. Any difference between air and bone conduction thresholds is known as the air-bone gap. It indicates a conductive type of hearing loss. Tympanometry or impedance audiometry is usually used in combination with the pure tone audiogram. It is an examination used to test the middle ear condition and the tympanic membrane/ear ossicle mobility by creating a variation of air pressure in the ear canal. It is an objective test of the middle ear function measuring energy transmission through the middle ear.

There are specific audiological tests for paediatric patients according to the mental age. Some other more specific tests are only employed when diagnosis is in doubt or when further surgical interventions are required.

Hearing rehabilitation

Hearing rehabilitation depends on the individual's rehabilitation needs. All paediatric patients with bilateral hearing losses of any type of more than 40dB are advised for aiding, as evidence has shown that their speech development will surely be affected. For adults, in general, mild grade hearing losses can be put on either observation or usage of hearing aids depending on the patients' preferences. For moderate to profound hearing losses, some form of hearing rehabilitation would be required for a normal life.

Hearing rehabilitation prostheses are classified into environmental assistive listening devices, hearing aids or auditory implants.

Environmental assistive listening devices — these devices enhance hearing by environmental hints through other senses including vibration, vision and amplification. These include smoke alarms, alarm clocks and vibration pagers. They are particularly useful in elders with severe to profound hearing loss.

Hearing aids — these are customised wearable devices prescribed by ENT specialists or audiologists for everyday hearing. Modern digital hearing aids contain one or more microphones to pick up sound, a computer chip that amplifies and processes sound and a speaker that sends the signal to the ear and a battery for power. Hearing aids can be classified by its style of fitting: completely-in-the-canal (CIC); in-the-canal (ITC); in-the-ear (ITE); behind-the-ear (BTE) and body-worn-hearing aids(BWHA). Its choice depends on the hearing threshold and the patient's choice, abilities and affordability. In general, a sizable device may offer more amplification, more durability and less feedback. Smaller devices are more cosmetic but not suitable for patients suffering from more severe hearing losses. Most importantly is whether the patient is using it rather than owning it. With professional support, it is important to achieve device accustomisation within a few weeks of its first dispensary.

Auditory implants — these are surgically implanted devices for hearing improvement. For the selected individuals who cannot be benefited from the use of hearing aids, auditory implants may be helpful. Auditory implants are categorised into bone conduction implants, middle ear implants, cochlear implants and auditory brainstem implants.

When problems in the outer or middle ear prevent or restrict the flow of sound waves, or when conditions do not allow the use of traditional hearing aids, either the wearable or the implantable bone conduction device is indicated. A bone conduction implant (Fig. 1) bypasses the external ear and middle ear transferring sounds directly to the cochlea via bone conduction pathways. These implantable devices provide an alternative treatment option for people with conductive or mixed hearing loss or even single sided hearing loss.

Middle ear implants (MEI) use a sophisticated attachment (coupler) to one of the bones of the middle ear or directly onto the round window for mechanical transmission. Rather than amplifying the sound

travelling to the eardrum, an MEI vibrates the ear ossicles directly. They are therefore also known as active hearing devices. These implantable devices are suitable for patients with outer or middle ear problems. They may work in patients with some decreased bone conduction thresholds without damaging their inner ears.

A cochlear implant (Fig. 2) is an electronic medical device that replaces the function of the damaged cochlea to provide electrical stimulation to the cochlear nerve. This is particularly useful for patients who have severe to profound sensorineural hearing losses in both ears while the most powerful hearing aids cannot adequately help. Indications now are extended to patients with single sided deafness. The cochlear implant consists of the internal and external components. The internal component is surgically inserted under the skin behind the pinna, and a wire is threaded into the inner ear. The external component is connected to the internal one through the skin via electromagnetic induction. Incoming sounds are thus converted to electrical currents and transmitted to the cochlear nerve. The cochlear implant has become widely recognised as the treatment for profound hearing loss in the past two decades.

An auditory Brainstem Implant (ABI) is a solution for individuals with hearing loss due to a non-functioning auditory nerve like bilateral acoustic neuromas/ vestibular schwannomas (Neurofibromatosis Type 2). Bypassing both the inner ear and the auditory nerve, the ABI stimulates the cochlear nucleus (CN) and provides users with a variety of hearing sensations to assist them with sound awareness and enhance the ability to communicate.



Fig. 1: The external appearance of a bone-anchored hearing aid; the internal component is attached to the skull bone.

Fig. 2: The external appearance of a child wearing the speech processor of a cochlear implant, the internal component of which is placed inside the cochlea and the skull underneath the external magnet.

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Flexible microsensor technology for real-time navigation tracking in balloon sinus ostial dilation

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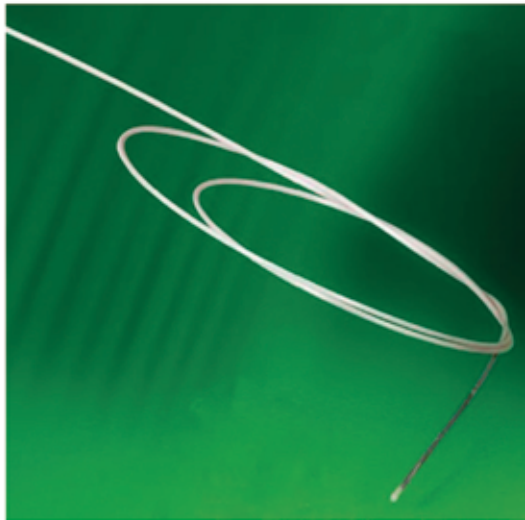
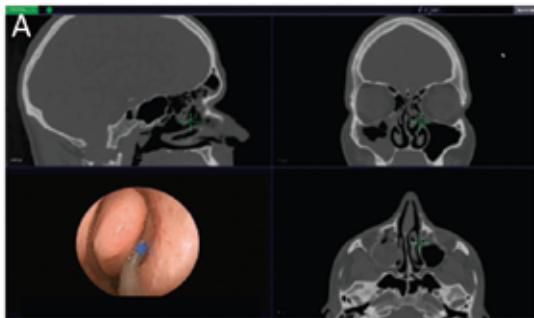


Figure 1. GuideWire navigation device (image provided by Fiagon).



Figure 2. The location of GuideWire is shown at the tip of balloonsinus ostial dilation device; navigational tracking of the catheter tips unique in demonstrating the path needed to deliver the balloon device from the external nares to the target sinuses.



ABSTRACT

Background: Microsensor navigation has the potential to aid balloon sinus ostial dilation by providing real-time tracking of balloon devices within the complex anatomy of the sinonasal cavities.

Objective: This feasibility study evaluated the incorporation of a new microsensor technology into a flexible guidewire for use with current instruments in balloon sinus ostial dilation.

Methods: A retrospective study was conducted to include seven men and one woman (age range, 33–68 years), who underwent balloon sinus ostial dilation with flexible microsensor navigation in the operating room setting. All the procedures were performed at target sinuses with the patient under general anesthesia, in conjunction with subsequent endoscopic sinus surgery.

Results: Balloon dilation was attempted at the maxillary (n = 3), frontal (n = 14), and sphenoid (n = 1) sinuses. In all the cases, the surgical navigation system displayed the flexible wire tip as it was advanced to the target sinus ostia; this visual feedback for wire position guided the balloon placement. Successful balloon dilation with assistance of flexible microsensor navigation was performed on most sinuses, except a single frontal sinus with adjacent type 2 frontal cells.

Conclusion: Flexible navigation technology may be combined with balloon sinus technology to facilitate localization of instruments in the sinus anatomy. Additional optimization of both the device and software technology is warranted. (Allergy Rhinol 8:e20–e24, 2017; doi: 10.2500/ar.2017.8.0193)



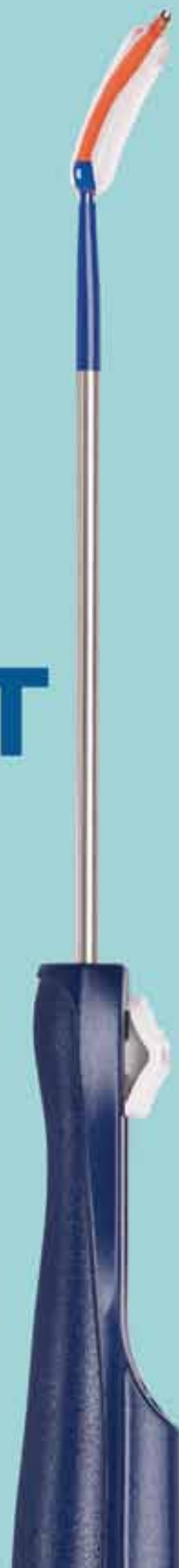
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Evaluation and management of hoarseness

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Introduction

Hoarseness is a common ENT symptom which refers to an abnormal change in the voice. There are various causes of hoarseness, including upper respiratory tract infection which will usually resolve when the infection subsides and benign voice disorders including lesions of the vocal folds, abnormal mobility of the vocal folds and neurological conditions. Hoarseness can also be a presenting symptom of cancer, with the malignant tumour locating in the larynx or along the course of the recurrent laryngeal nerve. Most cases of hoarseness can be treated successfully by surgery or speech therapy. Unexplained or persistent hoarseness should be evaluated carefully to identify its cause and be managed accordingly. The first part of this article highlights the essentials in the evaluation of hoarseness. It will be followed by an update on the management of vocal fold lesions and glottal insufficiency. The last part will talk about spasmodic dysphonia, a diagnosis frequently missed.

Evaluation of hoarseness

The assessment of hoarseness should begin by listening to the abnormal voice, which may be rough, raspy, breathy, strained, or sounds abnormal in tone or volume. A rough voice usually signifies the presence of abnormalities over the free edges of the vocal folds. A breathy voice is caused by glottal insufficiency, while a strained voice generally suggests hyper-functional glottal closure. Some voice pathologies, including adductor type spasmodic dysphonia which causes the characteristic strangled and strained voice during connected speech, rely mainly on the perceptual evaluation by an experienced clinician to make the accurate diagnosis.

Direct visualisation of the larynx with assistance of an endoscope/stroboscope can help to establish the diagnosis of most voice disorders including vocal fold lesions and glottal insufficiency. If vocal fold paralysis is found, further workup with a CT scan and/or MRI is needed to rule out structural lesions along the course of the recurrent laryngeal nerve. Depending on clinical suspicion, direct laryngoscopy under anaesthesia and assessment of the cricoarytenoid joint mobility may have to be considered. Laryngeal electromyography (EMG) can provide useful clinical information for accurate diagnosis and better treatment plan in cases of vocal fold paralysis¹.

Assessing the impact of the voice disorder on the individual patient is equally important. The same degree of hoarseness may affect patients differently because of the difference in social and occupation voice demand. Jacobson et al.² developed the Voice handicap Index (VHI) in 1997. In 2004, Rosen et al.³ designed a simplified version, VHI-10 (Fig. 1), which comprises only 10 questions from the original 30 questions. VHI-10 is used widely over the world and a validated Chinese version is also available⁴.

聲線障礙測量表-10 (Voice Handicap Index - 10)	
下列句子是很多人形容聲音以及聲音之問題對日常生活之影響。請圈出你通常的答覆。	
These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you had the same experience.	
0 = 完全沒有	0 = Never
1 = 很少	1 = Almost Never
2 = 間中有	2 = Sometimes
3 = 經常	3 = Almost always
4 = 從無間斷	4 = Always
1 別人難以聽到我的聲音。	0 1 2 3 4
My voice makes it difficult for people to hear me.	
2 在嘈吵環境裏，別人難以明白我的說話。	0 1 2 3 4
People have difficulty understanding me in a noisy room.	
3 我聲音的問題限制我的個人和社交生活。	0 1 2 3 4
My voice difficulties restrict personal and social life.	
4 我的聲音使我感到在交談中跟不上。	0 1 2 3 4
I feel left out of conversations because of my voice.	
5 我聲音的問題使我減少收入。	0 1 2 3 4
My voice problem causes me to lose income.	
6 別人問我：「你的聲音出了什麼問題？」	0 1 2 3 4
People ask "What's wrong with your voice?"	
7 我感到好像要用力才可發出聲音。	0 1 2 3 4
I feel as though I have to strain to produce voice.	
8 我聲音的清晰度反覆無常。	0 1 2 3 4
The clarity of my voice is unpredictable.	
9 我聲音的問題使我感到苦惱。	0 1 2 3 4
My voice problem upsets me.	
10 我的聲音使我感到身體有缺陷。	0 1 2 3 4
My voice makes me feel handicapped.	

Fig. 1 - Validated Chinese version of VHI-10 (from Lam PKY et al. *Laryngoscope*2006; 116:1192-1198)

Vocal fold lesions

Benign vocal fold lesions over the mid-membranous vocal fold include vocal fold nodules, polyps (Fig. 2), cysts, fibrous masses, pseudocysts, reactive lesions and non-specific lesions. These lesions are either treated conservatively by speech therapy and

laryngopharyngeal reflux treatment or surgically by microlaryngoscopic surgery⁵.



Fig. 2 - Videolaryngoscopic view of a left vocal fold polyp

Laser is a useful tool in the surgical management of laryngeal lesions. Carbon dioxide (CO₂) laser is frequently used to treat different lesions including laryngeal papilloma and early laryngeal carcinoma. Excellent haemostasis, precise tissue dissection and minimal trauma to adjacent normal tissues are the benefits of CO₂ laser. Recent intervention of the flexible CO₂ laser delivery system improves surgical access to certain difficult area.

Another commonly used laser is potassium titanyl phosphate (KTP) laser. KTP laser ablation can reduce the size of the vocal fold lesion significantly without worsening of the mucosal wave and glottic closure⁶. The laser energy can be delivered through thin glass fibres through the working channel of a flexible laryngoscope. It has been gaining popularity in the treatment of laryngeal lesions including small vocal fold lesions since early 2000. It was proved to be safe to perform as an office procedure⁷.

Glottal insufficiency and injection augmentation

Glottal insufficiency can be due to vocal fold paralysis, paresis and atrophy. Additional causes include vocal fold scars and sulcus vocalis. Surgery is the mainstay of treatment and the two common surgical options are medialisation thyroplasty and injection augmentation. Recent studies suggested that medical treatment with nimodipine, a calcium channel blocker, can be effective in promoting nerve recovery in selected cases of acute vocal fold paralysis due to recurrent laryngeal nerve injury without transection⁸.

Injection augmentation can be done while the patient remains awake in the office setting or under general anaesthesia in the operating theatre. Injection can be done by either the transoral or per-cutaneous method⁹. The filling substance can be injected through the cricothyroid membrane, thyroid cartilage or thyrohyoid membrane.

Hyaluronic acid (Restylane™; Q-MED AB, Uppsala, Sweden) and calcium hydroxylapatite (Radiess™

Voice; Merz Aesthetics Inc., San Mateo, California, US) are the two commonly used materials for injection in Hong Kong. The effect of hyaluronic acid can last for about 12 weeks¹⁰, while that of calcium hydroxylapatite can persist up to about 19 months in average¹¹. For patients suffering from acute recurrent laryngeal nerve injury with potential to a spontaneous recovery of nerve function, a temporary improvement of voice while awaiting possible recovery can be achieved by injection of short-acting materials such as hyaluronic acid.

Potential complications of injection augmentation include airway obstruction, airway bleeding, aspiration or injury to nearby structures. The overall incidence of these complications is low. Recently a new complication of injection augmentation, inflammatory reaction, was described by Dominguez et al.¹². They reported an inflammatory reaction rate of 3.8% after injection augmentation with hyaluronic acid. The degree of reaction ranges from minor mucosal erythema to oedematous swelling of the supraglottis ipsilateral to the injection site. The most common complaints from patients are odynophagia, dysphonia and dyspnoea, normally presented within 24-48 hours after the injection.

Spasmodic dysphonia

Spasmodic dysphonia is a voice disorder caused by focal dystonia affecting the intrinsic muscles of the larynx. There are two main phenotypes. In the more common adductor type (ADSD), the patient's speech would sound strangled and strained. This is caused by involuntary spasmodic closure of the vocal folds. In abductor spasmodic dysphonia (ABSD), the patient's voice would be interrupted by intermittent breathiness as a result of involuntary spasmodic opening of the vocal folds. There is a third least common type, the mixed type, characterised by equivalent phonatory features of both ADSD and ABSD.

Diagnosis of spasmodic dysphonia is challenging. It can take an average of about 4.4 years to have the condition accurately diagnosed¹³. The diagnosis of this condition depends mainly on perceptual evaluation of voice quality by an experienced assessor. Laryngoscopy mainly helps to rule out other voice pathology. It may show some features of spasmodic movement but study show that it may not provide extra diagnostic benefits when compared to hearing the voice alone¹⁴.

Botulinum toxin (BOTOX) injection is the mainstay of treatment. It can be done in clinic settings with laryngoscopy and /or electromyography (EMG) guidance¹⁵. In ADSD, BOTOX is injected into the thyroarytenoid and lateral cricoarytenoid muscle complex. In ABSD, the injection is targeted at the posterior cricoarytenoid muscle, the only abductor of the intrinsic laryngeal muscles. The dosage of injection has to be titrated for individual patients. Potential complications in BOTOX injection for ADSD include swallowing problem and voice breathiness. Airway obstruction is the major concern in cases of BOTOX injection for ABSD, especially when the injection is done bilaterally at the same time. The main drawbacks of BOTOX injection are high treatment cost and the necessity to repeat every few months.



Surgical treatment for ADSD reported in the literature includes Isshiki type 2 thyroplasty¹⁶, recurrent laryngeal nerve avulsion¹⁷ and selective adductor denervation surgery (SLAD-R)¹⁸ but they are rarely indicated.

Conclusions

A comprehensive evaluation to look for the causes as well as a thorough assessment of the resulting disabilities are essential for patients presented with unexplained hoarseness. Most of the causes of hoarseness are treatable. Recent advances in laryngology shift the management of some common voice disorders to office-based settings. However, the diagnosis and treatment of some neurological voice disorders including spasmodic dysphonia, is still suboptimal, which requires further improvement.

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Radiology Quiz



Radiology Quiz

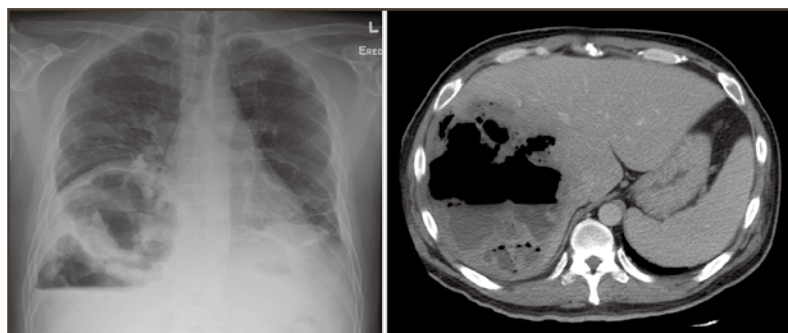
Dr Andrew CHENG

MBBS (HK)

Resident, Department of Radiology, Queen Mary Hospital



Dr Andrew CHENG



Questions

1. What is the CXR finding?
2. What is the CT finding?
3. What is the diagnosis?
4. What are the common causes?
5. What is the treatment?

(See P.44 for answers)

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Date	Topics	Speakers
6 Sep	New advances in interventional pulmonology	Dr Johnny CHAN COS (Med), QEH
20 Sep	Chronic pulmonary infection (TB/Non-tuberculosis mycobacterium)	Dr Ida WONG AC (Med), HHH
27 Sep	Non-invasive ventilation, Acute vs Chronic	Dr PS CHEUNG AC (Med), UCH
11 Oct	Palliative care for patients with advanced Respiratory disease	Dr Jeff NG AC (Med), HHH Ms TC NG (APN), HHH
18 Oct	Multidisciplinary approach to Pulmonary rehabilitation	Dr Thomas MOK COS (RMD), KH Mr Eddy CHEUNG PT, KH
25 Oct	Diagnostic investigations and Pharmacotherapy for chronic airway disease	Dr Maureen WONG COS (MG/ICU), CMC

Date : 6, 20, 27 September, 2017 & 11, 18, 25, October 2017 (Every Wednesday, skip 13 Sep & 4 Oct, 2017)

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

Course Fee : HK\$750 (6 sessions)

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

Tel.: 2527 8898 Fax: 2865 0345 Email: info@fmskhk.org

Certificate Course for Medical and Healthcare Professionals • Course No. C304 • CME/CNE Course

Certificate Course on Renal Medicine 2017

Jointly organised by



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Societies of Hong Kong



Hong Kong Society of
Nephrology

Date	Topics	Speakers
7 Sep	Common investigation tests for renal disease including approach to proteinuria and haematuria	Dr Sze-kit YUEN Associate Consultant Department of Medicine & Geriatrics Caritas Medical Centre
	Update and management of glomerular disease	Dr Tsz-ling HO Associate Consultant Department of Medicine Tung Kwun O Hospital
14 Sep	Update and management of acute kidney injury	Dr Chun-hay TAM Associate Consultant Department of Medicine & Geriatrics United Christian Hospital
	Nutritional Management in Kidney Diseases	Ms Cherry Pui-yeet LAW Dietitian Hong Kong Dietitians Association
21 Sep	Update and management of hypertension	Dr Siu-man WONG Associate Consultant Department of Medicine Alice Ho Miu Ling Nethersole Hospital
	Drug prescribing in renal failure	Dr Kai-ching HAU Associate Consultant Department of Medicine & Geriatrics Yuen Mun Hospital
28 Sep	Kidney Involvement in Multi-System Disorders	Dr Desmond Yat-hin YAP Clinical Assistant Professor Department of Medicine, Queen Mary Hospital University of Hong Kong
	Update on diabetic nephropathy	Dr Terence Pok-siu YIP Consultant Department of Medicine Tung Wah Hospital
12 Oct	ABC of peritoneal dialysis therapy	Dr Joseph Ho-sing WONG Associate Consultant Department of Medicine Queen Elizabeth Hospital
	ABC of hemodialysis therapy	Dr Gensy Mei-wa TONG Private Nephrologist
19 Oct	Update and management of chronic kidney disease	Dr Wing-fai PANG Associate Consultant Department of Medicine & Therapeutics Prince of Wales Hospital
	ABC of renal transplantation	Dr Ka-fai YIM Associate Consultant Department of Medicine & Geriatrics Princess Margaret Hospital

Dates : 7, 14, 21, 28 September 2017 & 12, 19 October, 2017 (Every Thursday, skip 5 October 2017)

Time : 7:00 pm – 8:30 pm

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

Course Fee : HK\$750 (6 sessions)

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Paediatric Otorhinology

Dr Birgitta Yee-hang WONG

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Consultant, Department of ENT, Queen Mary Hospital
Honorary Associate Professor, University of Hong Kong
Vice-President of the Hong Kong Society of Otorhinolaryngology, Head and Neck Surgery



Dr Birgitta Yee-hang WONG

Paediatric Otorhinology

Paediatric otorhinology includes common problems such as the obstructive sleep apnoea syndrome, hearing loss and allergic rhinitis. With the advances in paediatric specialties, we are also managing complicated paediatric ENT pathologies such as congenital laryngeal diseases, head and neck tumours and foetal neck masses.

Paediatric Obstructive sleep apnoea

Snoring was reported in 10-34% of children. Among those with snoring, approximately 10% (1-4% of children) were associated with the obstructive sleep apnoea syndrome (OSAS). Many studies have demonstrated the co-morbidities of OSAS in children including neurocognitive deficits, hyperactivity attention deficits, concentration difficulties, metabolic dysfunction, cardiovascular morbidity and nocturnal enuresis. Apart from taking a careful history and a thorough physical examination, polysomnography (PSG) remains the gold standard for diagnosis and is highly recommended for children with obesity, syndromic phenotypes, craniofacial abnormalities and neuromuscular disorders. For very young children who cannot cooperate for a formal polysomnography, nocturnal saturation monitoring can be used for screening. Adenotonsillar hypertrophy is the commonest cause of snoring and OSAS in toddlers and older children. However, as a tertiary referral centre, we are also managing special groups of children with OSAS with our paediatric respirologists in a combined airway clinic. They include infants with sleep-dependent laryngomalacia, craniofacial abnormalities, craniosynostosis and the Prada-Willi syndrome. We have shown that adenotonsillectomy is a safe operation¹, while supraglottoplasty or laser aryepiglottoplasty can reduce the apnoea-hypnoea index in sleep-dependent laryngomalacia². Mandibular distraction has been performed for patients with the Pierre Robin and Treacher Collin Syndromes.

Congenital laryngeal diseases

Neonates and infants suspected to have congenital airway problems are often referred to us by paediatricians and family physicians. The main presenting symptom is stridor which can be inspiratory suggestive of obstruction at the supraglottic and glottic levels, biphasic indicating obstruction at the glottis and subglottic levels and expiratory implying obstruction at the tracheal level. Other obstructive symptoms

include feeding difficulties, choking or aspiration on swallowing, failure to thrive and weak cries. A history of intubation or recurrent croup may also be obtained. In general, causes of congenital laryngeal diseases include laryngomalacia, vallecular cyst, vocal cord palsy, subglottic stenosis, tracheal anomaly, laryngeal cleft, vascular and lymphatic malformation, laryngeal papillomas & head and neck tumours (Fig 1-4). We had evaluated our patients with stridor at Queen Mary Hospital between 2005 and 2011³. There were a total of 138 infants presenting with stridor. The gold standard of diagnosis for paediatric airway problems is endoscopy in terms of both flexible laryngoscopy which is good for assessing the dynamic function of the larynx and rigid laryngotracheobronchoscopy for anatomical abnormalities. Surgical treatments include laser aryepiglottoplasty for laryngomalacia, laser surgery and balloon dilatation for subglottic stenosis, laser ablation and oral propranolol treatment for subglottic haemangioma, endoscopic repair for laryngeal cleft, excision of laryngeal cyst and resection of papillomas with laryngeal debrider and laser. Open surgery like laryngotracheal reconstruction is indicated for severe subglottic stenosis. All these infantile surgeries and laser procedures can be performed nowadays with the multidisciplinary team work of paediatric anaesthetists, paediatric respirologists and paediatric intensivists. Besides, tracheostomy is still performed for children with airway obstruction and those requiring long-term ventilation. A well-structured tracheostomy care plan is established with our paediatric rehabilitation team and active participation of parents.



Fig 1. Subglottic haemangioma

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Fig 2. Subglottic stenosis



Fig 3. Vallecular cyst



Fig 4. Recurrent respiratory papillomatosis

Congenital head and neck tumours and foetal neck masses

In recent years, we have an upsurge in referrals for foetal neck masses by obstetricians with better antenatal ultrasonographic examination. The foetal neck mass could be a cystic hygroma, teratoma, haemangioma or neuroglial heterotopia. A well-planned delivery requires joint care by obstetricians, radiologists, anaesthetists, neonatologists and paediatric ENT surgeons. Nowadays foetal MRI can be performed at late gestation to predict the airway condition during delivery (Fig 5). EXIT (Ex-utero intrapartum treatment) has been carried out in Queen Mary Hospital in a patient with anticipated airway obstruction. This involved an extension of standard caesarean section with the baby partially delivered while the maternal-foetal circulation was maintained to allow time for intubation and to secure the airway⁴. In our centre, we have demonstrated early

resection of head and neck tumours and reconstruction with locoregional flaps in infants to avoid prolonged intubation and tracheostomy for a series of teratomas⁴.

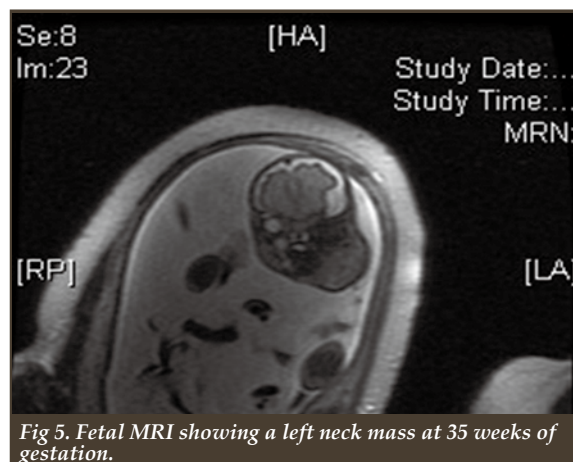


Fig 5. Fetal MRI showing a left neck mass at 35 weeks of gestation.

Head and neck tumours in older children include rhabdomyosarcoma in nasal cavities, paranasal sinuses, middle ear and temporal bone; angiofibroma, nasopharyngeal carcinoma, craniopharyngioma and neurothekeoma⁵.

Paediatric hearing loss

Paediatric hearing losses can be congenital and acquired. Nowadays we have a structured neonatal hearing screening programme for early detection of hearing loss. Newborns will undergo hearing screening with automated auditory brainstem response (AABR) on day 1 or day 2 after birth. Those babies who failed the screening will have a full brainstem evoked response audiometry (BERA) for assessing the hearing threshold. Children with bilateral profound sensorineural hearing losses are indicated for cochlear implants for normal speech development and future learning. Often we work closely with our speech therapists for training of post-implant patients and for children with other levels of hearing impairment.

Conclusions

Paediatric otorhinolaryngology ranges from simple ENT diseases to acute airway emergencies. Often multidisciplinary care by various teams including anaesthetists, paediatricians, radiologists, paediatric surgeons, obstetricians, speech therapists and audiologists are needed. Parental understanding and involvement in decision making are of utmost importance.

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Certificate Course on Common Geriatric Problems 2017



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The Hong Kong
Geriatrics Society

Objectives:

To update on practical approach to common problems in older people

Date	Topics	Speakers
4 Aug	Clinical Pearls in Geriatric Medicine	Dr LUM Chor Ming, Christopher Consultant Geriatrician Shatin Hospital
11 Aug	Chronic Obstructive Pulmonary Disease in Older People	Dr KO Chi Fai Consultant Geriatrician North Lantau Hospital
18 Aug	Cognitive Impairment	Dr CHAN Chun Chung, Ray Private Geriatrician
25 Aug	Urinary Incontinence: A Geriatrician's Perspective	Dr TONG Bing Chung Consultant Geriatrician Princess Margaret Hospital
1 Sep	Atrial Fibrillation & Oral Anticoagulant Therapy in Older People	Dr Joseph KWAN Clinical Associate Professor, HKU Honorary Consultant Queen Mary Hospital
8 Sep	Falls and Injuries in Older People	Dr YIM Ting Kwan Associate Consultant Specialist in Geriatric Medicine United Christian Hospital

Date : 4, 11, 18, 25 August, 2017 and 1, 8 September, 2017 (Every Friday)

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
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Allergic Rhinitis, Rhinosinusitis and Epistaxis

Dr Dennis Lip-yen LEE

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Dr Dennis Lip-yen LEE

Allergy rhinitis, sinusitis and epistaxis are the three most common rhinologic conditions managed by otorhinolaryngologists and general practitioners. Updates on the classification and management of these diseases will be discussed in this article.

Allergic Rhinitis

Classification of allergic rhinitis

Rhinitis is defined as inflammation of the nasal mucosa with two or more of the following symptoms in most of the days (nasal obstruction, rhinorrhoea, sneezing and nose itchiness).¹ Rhinitis can be allergic or non-allergic based on whether the symptoms are IgE-mediated hypersensitivity response to aeroallergens or not. Allergic rhinitis was traditionally classified as seasonal or perennial depending on the timing and duration of symptoms after allergen exposure. The commonest allergen for causing seasonal rhinitis is pollen of trees and flowers, and that of perennial rhinitis is the house dust mite. However, confusion in clinical diagnosis arises when the environment concentration of perennial allergens fluctuates throughout the year, causing intermittent symptoms mimicking a seasonal disease; or when allergy to multiple seasonal pollens may cause nasal symptoms throughout the year mimicking a perennial disease. Furthermore, the differentiation between seasonal and perennial rhinitis does not help much in the treatment of allergic rhinitis except for allergen avoidance. A new international classification by ARIA (Allergic Rhinitis and its Impact on Asthma) has then evolved. The ARIA guideline classifies allergic rhinitis based on the duration and severity of symptoms.² Intermittent disease is defined as nasal symptoms that last for less than 4 weeks or less than 4 days per week. Persistent disease is defined as nasal symptoms that last for more than 4 weeks and for more than 4 days per week. In terms of the severity of rhinitis, moderate to severe disease is defined if one of the following symptoms is present: troublesome symptoms, problems in work and school, abnormal sleep or impaired daily activities, sport or leisure (Table 1). This classification will then generate four degrees of allergic rhinitis: intermittent mild disease, intermittent moderate to severe disease, persistent mild disease and persistent moderate to severe disease. The important issue of this new classification is that different patients become comparable in terms of severity and stepwise management with difficult management methods according to different severity is made feasible (Fig. 1).

Table 1. ARIA Classification of allergic rhinitis

Intermittent	Persistent
<4week or <4days/week	>4week and >4 days/week
Mild	Moderate / severe (one of the below)
No troublesome symptoms Normal work and school Normal sleep Normal daily activities, sport, leisure	Troublesome symptoms Problems in work and school Abnormal sleep Impaired daily activities, sport, leisure

Guided Treatment by ARIA Classification 基於ARIA分類的治療指南



Fig. 1. Stepwise treatment guideline by ARIA (Allergic Rhinitis and its Impact on Asthma).

Uncommon symptoms of allergic rhinitis

Nasal obstruction, clear watery rhinorrhoea, sneezing and nose itchiness are the usual symptoms of allergic rhinitis. Patients may present atypically with persistent cough due to post nasal drip without being noticed. They may even present as repeated asthmatic attacks. Some patients will present to ophthalmologists for the symptoms of eye itchiness and epiphora. Others may present as snoring and a poor sleep quality with increasing nocturnal nasal blockage secondary to venous congestion in the supine position. Uncommon symptoms may delay the patients from the presentation to seek medical help.

Management of allergic rhinitis

Allergen avoidance remains the first line prevention method but it is impractical or sometimes impossible for complete allergen avoidance in an active lifestyle.



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Oral anti-histamine is the simplest way to control nasal symptoms in allergic rhinitis. Disadvantages of first generation anti-histamines such as chlorpheniramine are: the necessity to be taken more than once per day because of the short acting time and their sedative and anti-cholinergic side effects like dry mouth. Second generation anti-histamines such as fexofenadine, loratadine and cetirizine are taken once per day. They are relatively non-sedative with less anti-cholinergic effects. Recently, bilastine 20mg was shown to have truly non-sedative effects as evidenced by the absence of drug passing through the blood-brain barrier as demonstrated in positron emission tomography (PET) scan.³ The effect of antihistamine is mainly for the symptoms of rhinorrhoea, sneezing and nose itchiness but its effect on nasal blockage is minimal. Some preparations of antihistamine would include decongestants intending to improve the symptom of nasal obstruction. However, side effects such as palpitation and insomnia have to be aware.

Intranasal corticosteroids (INS) have a stronger and wider spectrum of effects on the symptoms of nasal obstruction, rhinorrhoea, sneezing and itchiness of the nose in comparison with oral antihistamines. The systemic bioavailability of the new generation INS (mometasone and fluticasone) has been shown to be lower than 1% and the side effect of growth retardation is not a major concern.⁴ Recently, combined steroid and antihistamine as an intranasal spray is available in the market and they claim to have a better clinical response when compared with conventional INS.⁵

Intranasal decongestants cause immediate vasoconstriction thus having a fast and strong effect on the symptom of nasal obstruction. There are minimal effects on rhinorrhoea and nasal itchiness. Their prolonged usage will induce rebound swollen effect on the mucosa or rhinitis medicamentosa, which is a potentially irreversible condition. The role of intranasal decongestants is to relieve nasal obstruction in the acute flare up stage of disease.

Leukotriene receptor antagonists have been shown to have significant effects in treating asthmatic symptoms. However, the effect on allergic rhinitis is not that promising. Monotherapy has been shown to be less effective than oral antihistamines. Nevertheless, the combination of leukotriene receptor antagonists with oral antihistamine was shown to have a synergistic effect on rhinitis symptoms particularly in nasal blockage because of vasodilation inhibition of the nasal mucosa by the leukotriene.⁶

Normal saline douching has been shown to be an effective adjunctive therapy for allergic rhinitis. Nasal douching not only cleans the nasal discharge and allergic cytokines mechanically, but also the sodium chloride may help recovery of the normal mucociliary clearance pattern. This simple therapy is a very effective treatment to patients with post nasal drip symptoms.

The role of surgery in allergic rhinitis is mainly on the relief of nasal obstruction. Inferior turbinate reduction surgery by various methods (cold steel, radiofrequency and laser) can help to relieve the symptom of nasal obstruction (Fig. 2). As nasal septal deviation is a

common coexisting condition, correction of the septum (septoplasty) together with turbinate reduction surgery for allergic rhinitis is a popular procedure to help patients who do not respond to medication treatment.

Immunotherapy is a second line medical treatment for patients with refractory allergic rhinitis. The principle is to reduce the specific clinical immunological reactions after a repeated low dose exposure of the corresponding allergen. Sublingual immunotherapy (SLIT) and subcutaneous immunotherapy (SCIT) are the two main methods of immunotherapy being used worldwide. Reviews have shown that it is effective in reducing nasal symptoms and medication consumption in patients with intractable allergic rhinitis. The response after a 36-month therapeutic regimen may sustain for a few years thereafter. Immunotherapy may also be able to prevent patients from developing new allergic reactions and asthma.⁷⁻⁹ However, the commitment and the relative high costs of an approximately 3 years' treatment are prerequisites, leaving its limited applications in the refractory cases.



Fig. 2. Endoscopic view showing swollen turbinate before (left) and after (right) turbinate reduction operation to improve the nasal patency.

Sinusitis

Sinusitis is a group of disorders characterised by inflammation of the mucosa of the nasal cavity and paranasal sinuses. And it is uncommon to have inflammation of the sinus without nasal cavity involvement, in that the term sinusitis is gradually being replaced by rhinosinusitis nowadays.

Definition and classification of rhinosinusitis

In the past, the diagnosis of sinusitis was made by symptom based criteria including nasal obstruction, purulent nasal discharge, halitosis, smell loss and headache. However, false positive and false negative rates were quite high. Not until EPOS (European Position Paper on Rhinosinusitis and Nasal Polyps) 2007 and other relevant papers requesting the recruitment of endoscopic finding of mucopus or nasal polyp and/or CT confirmed mucosal changes within sinuses and osteomeatal complex as diagnostic criteria, the accuracies of diagnosis remain high and consistent (Fig. 3).¹⁰

Rhinosinusitis is arbitrarily divided into acute and chronic based on the duration of symptoms at the time of presentation. A duration of 3 months of symptoms is the consensus cut-off between acute and chronic rhinosinusitis. In reality, acute and chronic rhinosinusitis

are different spectra of diseases with different aetiologies, presentation, treatment and prognosis.



Fig. 3. Endoscopic view showing mucopus from right middle meatus to confirm the diagnosis of sinusitis.

Management of acute rhinosinusitis

Acute rhinosinusitis is a bacterial infection of the paranasal sinuses after an episode of viral upper respiratory tract infection. Occasionally, it is related to dental caries of the upper alveolar or anatomical nasal compression post sinus surgeries. The management is mainly by broad spectrum antibiotics, nasal decongestant, normal saline nasal douching and pain control.

The majority of patients will respond to medical treatment. Surgery should be considered in the non-responsive cases. First-line surgery can be accomplished with antral sinus washout. A catheter is inserted into the diseased maxillary sinus through a small puncture to the inferior meatus of the medial maxillary wall. The maxillary sinus will then be irrigated with saline solution until the washout is clean and the procedure is done without resistance by a blocked natural sinus ostium. This is a minor procedure which can be performed under local anaesthesia in the ambulatory setting. If this procedure fails or the main infected sinus is not the maxillary sinus, a proper functional endoscopic sinus surgery (FESS) should be considered. The principle of this endoscopic surgery is to open wide the diseased sinus ostium enhancing a recovery of the mucociliary clearance pattern of the diseased sinus.¹¹ In recent years, balloon sinuplasty has been widely applied to enlarge the diseased and narrowed maxillary, sphenoid and frontal sinus openings aiming at a shorter recover rate.¹² Prognosis of treating acute rhinosinusitis is usually good.

Management of chronic rhinosinusitis

Unfortunately, the pathophysiology of chronic rhinosinusitis is not fully understood. Local allergic responses with normal levels of systemic IgE and eosinophiles are the agreed pathophysiology to-date, with the presence of bilateral nasal polyposis being sub-classified as a type of chronic sinusitis.¹⁰

The management of chronic rhinosinusitis is aimed at allergy control with reference to its pathophysiology. Intranasal corticosteroid (INS), oral antihistamine and nasal douching become the mainstay of treatment.¹³

Medical treatment for chronic rhinosinusitis is effective usually at the level of symptomatic control and its long term usage prevents deterioration or recurrences.

If symptomatic control is inadequate to relieve symptoms, surgery (Functional endoscopic sinus surgery or FESS) to clear up all the diseased sinuses is indicated.¹⁴ The prognosis of chronic rhinosinusitis is not as good as active rhinosinusitis in general because of the chronic background of allergic conditions.

In the last decade, long term macrolide treatment was found to have potential effects on chronic rhinosinusitis due to the mechanism of immunomodulation and biofilm breakdown in the diseased sinuses. Further studies are necessary to support this treatment.¹⁵

Epistaxis

Causes of epistaxis

The commonest cause of epistaxis is idiopathic which is the bleeding of small arteries on the Little's area at the anterior part of the nasal septum (Figure 4). Other aetiologies of epistaxis can be classified into local and systemic causes. Local causes are traumatic, sinusitis, granulation disease and nasal tumour, and systemic causes being bleeding disorder, on anticoagulant or a specific condition called hereditary haemorrhagic telangiectasia (HHT).

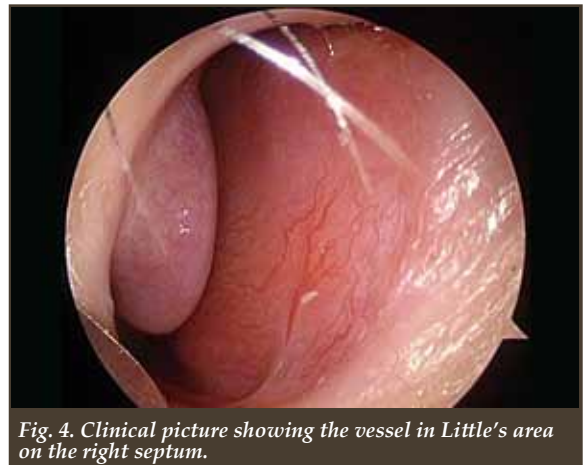


Fig. 4. Clinical picture showing the vessel in Little's area on the right septum.

Presentation of Nasopharyngeal carcinoma

Uncontrolled epistaxis is not a common presentation of nasopharyngeal carcinoma. Approximately, one-third of nasopharyngeal carcinoma patients present as nasal symptoms such as blood stained nasal discharge and blood stained post nasal drip for a few weeks to a few months. One-third of patients will present as hearing loss and tinnitus, usually unilateral, because of Eustachian tube dysfunction. Another one-third of patients will present as neck masses due to cervical metastases. It can be presented as uncommon symptoms such as diplopia due to skull base involvement and VIth cranial nerve palsy.



Control of epistaxis

A simple measure of nose bleeding is to pinch on either side of the nostrils with a head down position. This will help to compress on the Little's area and decrease the chance of aspiration of blood. If the bleeder is identified in the Little's area and it is not severe, repeated antibiotic (neomycin or mupirocin) cream applied can help the bleeder to heal well. If the bleeding is repeated or uncontrolled, cauterisation by either silver nitrate AgNO₃ (chemical) or bipolar diathermy (electrical) has to be considered.

If the bleeder cannot be identified or the active bleeding cannot be controlled by cauterisation, anterior and posterior nasal packaging with different materials can be used to control the epistaxis. Usually the materials will be kept until removed in 2 days. Then the nose will be re-examined for any bleeder and special pathologies.

Occasionally, bleeding is so severe that surgical ligation of the nasal artery (endoscopic ligation of the sphenopalatine artery or open/endoscopic ligation of anterior ethmoid artery) or angiogram with embolisation of nasal artery has to be considered.¹⁶

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ERHU (二胡)

Dr Cheuk-lun SHAM

Specialist in Otorhinolaryngology
'Erhu Master'



Dr Cheuk-lun SHAM

The erhu's history in China dates back to at least 1,000 years, probably in the Tang Dynasty. The origin of the instrument is controversial. Some believe it is an instrument used by small tribes in the Northern areas of China, while some say it is introduced to China from the Westerners. These speculations arise from the word "胡" which may imply people or tribes geographically "external" to the centrally inhabited Chinese.

Structurally, it is a string instrument with two strings, a resonance box mounted with python skin and a bow. The setup is similar to a violin except that the later has four strings, a finger board and a bigger resonance box without any skin mounting. The bow of the erhu is also different because the bow stick is made of bamboo instead of wood and the bow hair is placed between the two strings.

The presence of the python skin in the resonance box gives erhu a characteristic timbre strikingly different from that of the violin. It is because of this special timbre that the erhu is particularly suitable for playing sorrowful musical pieces simulating weeping voices, exemplified by pieces like "江河水" and "二泉映月". The presence of only two strings, on the other hand, limits its frequency range, which is much wider in the four string instruments. The absence of the finger board also makes learning more demanding as variations of finger pressure on the string can markedly affect stability of the frequency of the notes being played. Having said that, the ability to alter frequency by varying the finger pressure on the string enables the erhu player to produce a much bigger vibrato with larger frequency variations that is unique in erhu as the magnitude of the string depression during vibrato playing is not limited by the finger board as in the case of the violin.

The two most important determinants of the sound quality of an erhu are the materials and craftsmanship of the resonance box. Only wood materials with the right density can give erhu a good timbre. Good wood materials include mahogany and red sandalwood (particularly the species *Pterocarpus indicus* from India). As in the case of the violin, the wood material has to be stable to avoid excessive contraction and expansion from temperature or humidity variations. The best mahogany materials are taken from remnants of old furniture of the Ming and Ching Dynasties. Good craftsmen usually collect these remnants from discarded old furniture or second hand markets. Since pythons are protected animals, recently craftsmen have successfully replaced it by environmental friendly artificial fibres. These new products are sometimes seen in major

orchestras. I personally still find python irreplaceable. Other than making a tight fitting resonance box from pieces of well polished wood, the most demanding part of the craftsmanship is mounting a good piece of python skin with the right thickness and tension. That of course takes years to achieve!

(Editor's notes: Dr Sham has always been known as the first generation of master endoscopic sinus surgeons and a great teacher for rhinology. He had been the chief of Division of Rhinology of the Chinese University of Hong Kong for eight years since 2007, alongside with a busy private practice. His interests and reputation in performing erhu has risen from being an amateur to currently a master holding regular concerts in the past few years.)





Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		<ul style="list-style-type: none"> * FMSHK Officers' Meeting * HKMA Council Meeting 				
<ul style="list-style-type: none"> * HKMACF Charity Concert for SLE Patients 		<ul style="list-style-type: none"> * HKMA Yau Tsim Mong Community Network - Lecture Series on Chronic Hepatitis (Session 1) - Update of Chronic Hepatitis C Infection 	<ul style="list-style-type: none"> * Hong Kong Neurosurgical Society Monthly Academic Meeting * HKMA Central, Western & Southern Community Network - Management on Insomnia - Update and New Approaches 	<ul style="list-style-type: none"> * HKMA Hong Kong East Community Network - Certificate Course on Pain Management (Session 3) - Update in Joint Pain Management 		
<ul style="list-style-type: none"> * HKMA Dragon Boat Fun Day 2017 				<ul style="list-style-type: none"> * HKMA Kowloon East Community Network - Anticoagulation Strategies in Atrial Fibrillation: New Insights, New Approach 		
			<ul style="list-style-type: none"> * HKMA Central, Western & Southern Community Network - Update on Management of Fatty Liver 	<ul style="list-style-type: none"> * HKMA Hong Kong East Community Network - Three non-drug Pillars in Dementia Management * Joint Neurology Conference (HKCNDP and PNAHK) * FMSHK Executive Committee Meeting * FMSHK Council Meeting 	<ul style="list-style-type: none"> * HKMA Yau Tsim Mong Community Network - Lecture Series on Chronic Hepatitis (Session 2) - Update on Chronic Hepatitis B Treatment 	
		<ul style="list-style-type: none"> * HKMA Kowloon West Community Network - How to Help Children Eat Well - Transition to Eating Family Meal 		<ul style="list-style-type: none"> * HKMA Kowloon East Community Network - Latest Strategies to Improve Asthma Care and Management * HKMA New Territories West Community Network - Update in Management in Diabetic Cardiovascular Complications 		



Date / Time	Function	Enquiry / Remarks
1 TUE 8:00 PM	FMSHK Officers' Meeting 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. Nancy CHAN Tel: 2527 8898
	9:00 PM HKMA Council Meeting Organiser: The Hong Kong Medical Association; Chairman: Dr. CHOI Kin; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Christine WONG Tel: 2527 8285
6 SUN 8:00 PM	HKMACF Charity Concert for SLE Patients Organiser: The Hong Kong Medical Association Charitable Foundation; Chairman: Dr. LAM Tzit Yuen, David; Venue: Auditorium, Tsuen Wan Town Hall, 72 Tai Ho Rd., Tsuen Wan, NT	Miss Ellie FU Tel: 2527 8285
8 TUE 1:00 PM	HKMA Yau Tsim Mong Community Network - Lecture Series on Chronic Hepatitis (Session 1) - Update of Chronic Hepatitis C Infection Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. CHOI Kin; Speaker: Dr. KAN Yee Man; Venue: Crystal Ballroom, 2/F, The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
9 WED 7:30 PM	Hong Kong Neurosurgical Society Monthly Academic Meeting Organiser: Hong Kong Neurosurgical Society; Speaker(s) : Dr HO Wing Kiu Joanna; Chairman: To be confirmed; Venue : Conference Room, 2/F, Block F, Queen Elizabeth Hospital	1.5 points College of Surgeons of Hong Kong Dr. LEE Wing Yan, Michael Tel: 2595 6456 Fax. No.: 2965 4061
	1:00 PM HKMA Central, Western & Southern Community Network - Management on Insomnia - Update and New Approaches Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. YIK Ping Yin; Speaker: Dr. CHEUNG Hon Kee; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
10 THU 1:00 PM	HKMA Hong Kong East Community Network - Certificate Course on Pain Management (Session 3) - Update in Joint Pain Management Organiser: HKMA Hong Kong East Community Network; Chairman: Dr. CHAN Hoi Chung, Samuel; Speaker: Dr. CHOW Kai Pun; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Candice TONG Tel: 2527 8285 1 CME Point
13 SUN 2:00 PM	HKMA Dragon Boat Fun Day 2017 Organiser: The Hong Kong Medical Association; Chairman: Dr. CHAN Hau Ngai, Kingsley / Dr. IP Wing Yuk; Venue: Sai Sha Wan, Sai Kung	Miss Ada SIU / Miss Denise KWOK Tel: 2527 8285
17 THU 1:00 PM	HKMA Kowloon East Community Network - Anticoagulation Strategies in Atrial Fibrillation: New Insights, New Approach Organiser: HKMA Kowloon East Community Network; Chairman: Dr. AU Ka Kui, Gary; Speaker: Dr. LAU Chun Leung; Venue: Lei Garden Restaurant (利苑酒家), Shop no. L5-8, apm, Kwun Tong, No. 418 Kwun Tong Road, Kowloon	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
23 WED 1:00 PM	HKMA Central, Western & Southern Community Network - Update on Management of Fatty Liver Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. TSANG Chun Au; Speaker: Dr. CHAN Nor, Norman; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
24 THU 1:00 PM	HKMA Hong Kong East Community Network - Three non-drug Pillars in Dementia Management Organiser: HKMA Hong Kong East Community Network; Chairman: Dr. KONG Wing Ming, Henry; Speaker: Dr. CHAN Chun Chung, Ray; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Candice TONG Tel: 2527 8285 1 CME Point
	7:00PM Joint Neurology Conference (HKCNDP and PNAHK) Venue: M block, Ground Floor, lecture theater, Queen Elizabeth Hospital	www.hkcndp.org





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References: 1. Guidelines on the Management of Non-Neurogenic Male LUTS. European Association of Urology, 2015. 2. DIAGNOSIS AND TREATMENT OF OVERACTIVE BLADDER (non-Neurogenic) IN ADULTS: AUA/SUGO GUIDELINE. American Urological Association, 2014.

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Date / Time	Function	Enquiry / Remarks
24 THU	7:00PM FMSHK Executive Committee Meeting Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
	8:00PM FMSHK Council Meeting Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
25 FRI	1:00 PM HKMA Yau Tsim Mong Community Network - Lecture Series on Chronic Hepatitis (Session 2) - Update on Chronic Hepatitis B Treatment Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. CHOI Kin; Speaker: Dr. LEE Ming Kai, Derek; Venue: Crystal Ballroom, 2/F, The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
29 TUE	1:00 PM HKMA Kowloon West Community Network - How to Help Children Eat Well - Transition to Eating Family Meal Organiser: HKMA Kowloon West Community Network & Primary Care Office of the Department of Health; Chairman: Dr. CHAN Siu Man, Bernard; Speaker: Dr. Vinci MA; Venue: Crystal Room IV-V, 3/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, NT	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
31 THU	1:00 PM HKMA Kowloon East Community Network - Latest Strategies to Improve Asthma Care and Management Organiser: HKMA Kowloon East Community Network; Chairman: Dr. CHU Wen Jing, Jennifer; Speaker: Dr. CHAN Chio Ho, Michael; Venue: V Cuisine, 6/F., Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O, Kowloon	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
	1:00 PM HKMA New Territories West Community Network - Update in Management in Diabetic Cardiovascular Complications Organiser: HKMA New Territories West Community Network; Chairman: Dr. CHEUNG Kwok Wai, Alvin; Speaker: Dr. WONG Lai Sze, Alice; Venue: Function Room B-E, Lobby Floor, Hong Kong Gold Coast Hotel, 1 Castle Peak Road, Gold Coast, Hong Kong	Mr. Ziv WONG Tel: 2527 8285 1 CME Point

Upcoming Meeting

3 Sept 2017 8:50 AM	Li Shu Pui Symposium 2017 – Recent Developments of Medical Practice (Oncology) Organiser: Hong Kong Sanatorium & Hospital; Speakers: Various; Venue: Ballroom, JW Marriott Hotel Hong Kong	Hong Kong Sanatorium & Hospital Tel: 2835 8800 CME Point TBC
9 Sept 2017 1:00 - 3:30 PM	Care for Advanced Diseases: Joint CME Seminar with HKMA Organiser: HKFMS Foundation Care for Advanced Diseases Consortium, HKMA; Chairman: Convenor Dr Raymond SK LO; Speakers: Dr Raymond SK LO, Dr LAW Chun-kay; Venue: 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, HK	Ms. Alison HUI Tel: 2527 8285 Fax: 2865 0943 CME Point TBC
12 Sept 2017 1:00 PM	HKMA Yau Tsim Mong Community Network - The Right ULT to the Right Patients Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. HO Kit Man; Speakers: Dr. SUNG Chi Keung; Venue: The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 CME Point TBC
29 Sept 2017 1:00 PM	HKMA Yau Tsim Mong Community Network - LUTS Management: A New Step after 30 Years Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Pending; Speakers: Dr. CHUNG Yeung, Vera; Venue: The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 CME Point TBC
18-19 Nov 2017	The 7th Joint Scientific Meeting of The Royal College of Radiologists & Hong Kong College of Radiologists and 25th Annual Scientific Meeting of Hong Kong College of Radiologists Venue: Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, HKSAR, China	HKCR Secretariat Tel: 2871 8788 Registration Secretariat Te: 8106 9878

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References: 1. Carr W et al. A novel intranasal therapy of azelastine with fluticasone for the treatment of allergic rhinitis. *J Allergy Clin Immunol.* 2012 May;129(5):1282-1289.
2. Leung DYM et al. MP29-02: A major advancement in the treatment of allergic rhinitis. *J Allergy Clin Immunol.* 2012 May;129(5):1216.

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Answer:

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2. There is a hypodense lesion with internal air fluid level noted at the R liver lobe. Peripheral contrast enhancement is associated.
3. Liver abscess.
4. Bacterial, Parasitic or Fungal.
5. Image guided aspiration or drainage + antimicrobial therapy.

Dr Andrew CHENG

MBBS (HK)

Resident, Department of Radiology, Queen Mary Hospital

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Reference 1: Tempera G. et al. Antibiotic Susceptibility of Respiratory Pathogens Recently Isolated in Italy: Focus on Cefditoren, *J Chemother*, 2010;22(3): 153-159 2: J.Gonzalez-Castillo, et al. Guidelines for the management of community-acquired pneumonia in the elderly patient, *Rev Esp Quimioter* 2014;27(1):69-86 3: Rosario Menendez, Beatriz Montull and Raul Mendez. Antibiotic choice, route and duration: minimizing the harm associated with antibiotics, *Eur Respir Monogr* 2014; 63:155-167 4: Meiact Package Insert, ver. HK Mar 2010

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