

Union Connection

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Message from the Chief Hospital Manager

Dear Colleagues,

The term ESG stands for Environmental, Social, and Governance, a framework used to measure an institution or a company's sustainability, ethical impact, and operational risk beyond financial metrics. I am very pleased that Union Hospital in the latter part of year 2025 had received the Ming Pao ESG Award 2025 – Excellence in Decarbonization Award. As far as this award is concerned, the honour should go to our Chief Estate Manager Mr Harry Har. He and his team had formulated an action plan based on the recommendations of carbon audit report and energy audit report by the electricity supplier China Light and Power CLPe. With the installation of energy efficient chiller water pumps and fan coils in our air-conditioning system, the projected energy saving annually comes to 111,260 kWh and CO₂ emission cut down by 43,391 kgCO₂e. These are significant in dollar terms in addition to provision of cleaner air for our living environment. There will be more initiatives in the year 2026, both medium and long term in time scale. Some of these will be sponsored by the other energy supplier Hong Kong and China Gas Company Limited, including new hot water boilers with heat recovery functionality. Another item will be the installation of Brushless DC Motors to all fan-coil units of our hospital's air-conditioning system. This latter change can achieve 30% to 58% energy savings.

I shall not miss to mention the social impact on the well-being of the local community in Shatin with our efforts in delivering health talks and free health-checks for the elderly and financially disadvantaged. Next I would like to draw your attention to 'Governance' which is what the third letter 'G' of ESG represents. As far as Corporate Governance is concerned, I can reassure our readers that we are second to none, I mean other private hospitals. Union Hospital's Management Board is chaired by Professor Fok Tai Fai, formerly the Pro-Vice-Chancellor of The Chinese University of Hong Kong, and members include three senior executives of the Henderson Land Group (HLD). I do not need to remind our readers HLD is a listed company and is one of the largest land developers in Hong Kong. Thus we will not be seen to be whimsical when we claim to have good or even excellent corporate governance in our daily operations.

As the chief executive of a healthcare provider, we took the initiative to champion Clinical Governance in Union Hospital more than two decades ago. It involves a strict process of credentialing whereby doctors are awarded clinical privileges according to their training and experience so that the right patient is being treated by the right doctor at the right time and right clinical setting. This cannot be recognized to be effective without performing clinical audits from time to time. In actual fact, audits have been carried out for a number of specialties, viz obstetrics, surgery, paediatrics etc. Professor Sydney Chung has played an important role in supervising these audits. In addition 'Morbidity and Mortality' meetings are being held regularly every six months to ensure that complications in treatment procedures for patients are being scrutinized and being regarded as learning material to improve the quality and outcome of such procedures.

The Medical Protection Society (MPS) has been providing medico-legal coverage for doctors against malpractice allegations for years. Union Hospital has been invited by the MPS to be a strategic partner because of our excellent 'clinical governance'. With such collaboration, teams members of our various clinical departments will enjoy favourable terms when it comes to their annual subscription rates according to preset performance indices. Moreover, they will also enjoy various activities organized by the MPS to safe-guard their well-being and resilience in clinical practice.

I would like to end here with my Best Wishes for your having a well balanced work-life equilibrium.

Yours most sincerely,

Dr Anthony KY Lee

Chief Hospital Manager & Medical Director

Sentinel lymph node mapping in surgical treatment of endometrial cancer



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Introduction

Endometrial cancer is the most common gynaecological cancer in Hong Kong. According to the Hong Kong Cancer Registry, the incidence increased from 15/100 000 in 2015 to 17/100 000 in 2023¹. Surgical treatment involves open, laparoscopic or robotic total hysterectomy and bilateral salpingoophorectomy. Lymphadenectomy is also an integral part because accurate assessment of lymph node status guides the use of adjuvant therapy. Chemotherapy and/or radiotherapy improves the 5-year overall survival (OS) of endometrial cancer with lymph node metastasis from 69.8% to 78.7%^{2,3}. However, complete pelvic and para-aortic lymphadenectomy lacks a therapeutic effect and is associated with morbidities such as lymphedema. The need to perform lymphadenectomy has to be balanced with its morbidity and likelihood of lymph node metastasis. Sentinel lymph node mapping (SLNM) may decrease morbidity by removing less lymph nodes and increase detection rate of lymph node metastasis with application of ultrastaging.

Sentinel lymph node mapping theory

Sentinel lymph node refers to the first lymph node that receives lymphatic drainage from the primary malignant tumour. SLNM is based on the presumption that lymphatic drainage occurs stepwise from the most proximal lymph node to the tumour site to more distal lymph nodes. Theoretically, SLN is the first to metastasize in a regional lymphatic drainage area. With a negative SLN, the whole lymphatic drainage area is considered negative for metastasis. The detection rate (percentage of patients with at least one SLN being detected), bilateral detection rate (percentage of patients with SLN being detected at bilateral pelvis), sensitivity (proportion of positive SLN to the total number of patients with lymph node metastasis), negative predictive value (NPV), and false negative rate of SLNM are key parameters for its performance.

Sentinel lymph node technique

ICG is now the most recommended tracer, owing to its high detection rate, consistency, and ease of administration. ICG emits fluorescent signal in near-infrared light range (830 nm wavelength). An equipment (Figure 1) for near-infrared light range imaging is required to identify the SLN, which can be performed via laparoscopy, robotic or open route (Figure 2). The ICG solution injected involves mixing 25 mg of ICG powder with 10 to 20 mL of sterile water^{4,5}(Figure 3). Deep (1-2cm) and superficial (1-3mm) injection of 1-2ml of ICG solution each at 3 and 9 o'clock or 3, 6, 9, and 12 o'clock of the cervix are the most common routes⁵ (Figure 4).

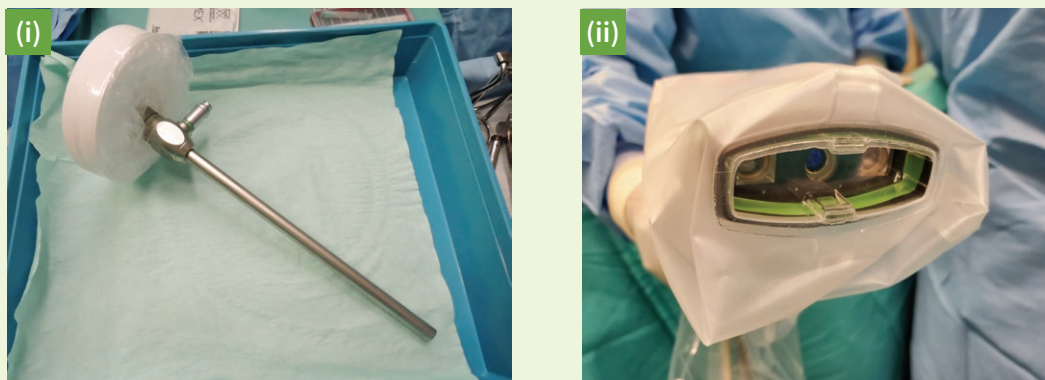


Figure 1. Equipment for sentinel lymph node mapping (i) laparoscopic (ii) laparotomy

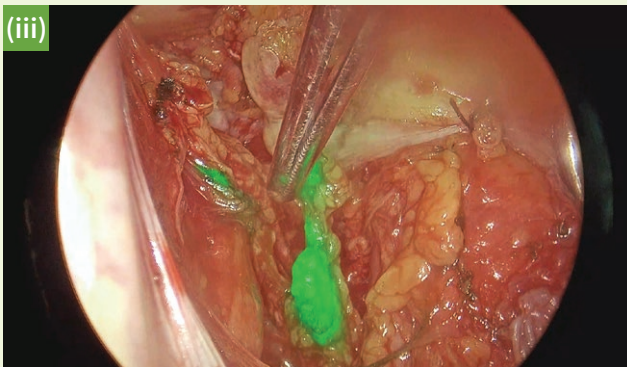
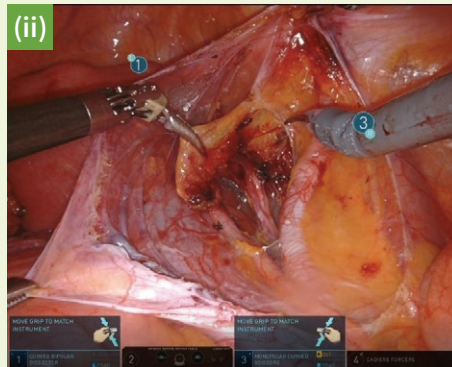


Figure 2. Sentinel lymph node identification in endometrial cancer with cervical injection of indocyanine green (i) laparoscopic (ii) robotic (iii) laparotomy

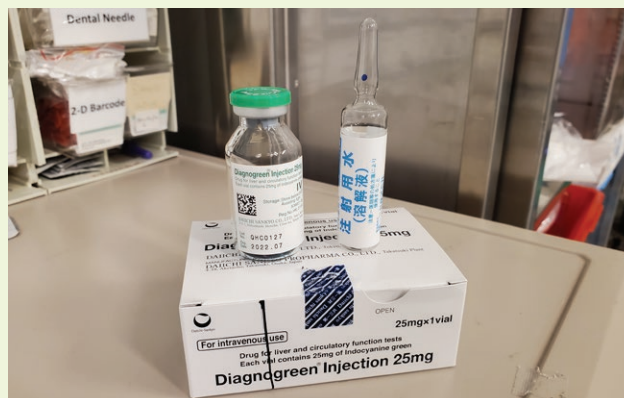


Figure 3. ICG solution for sentinel lymph node detection

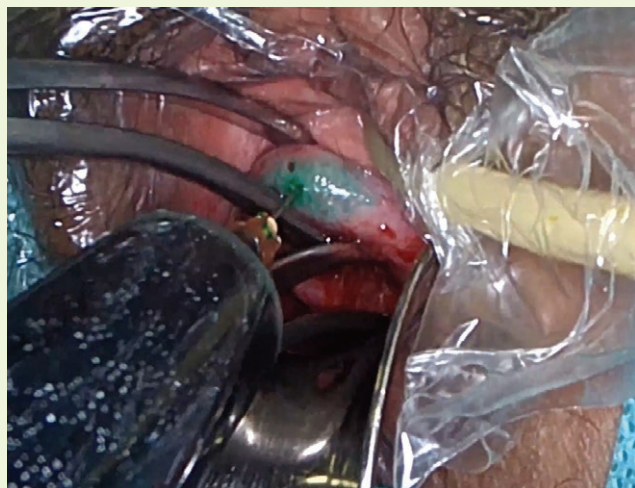
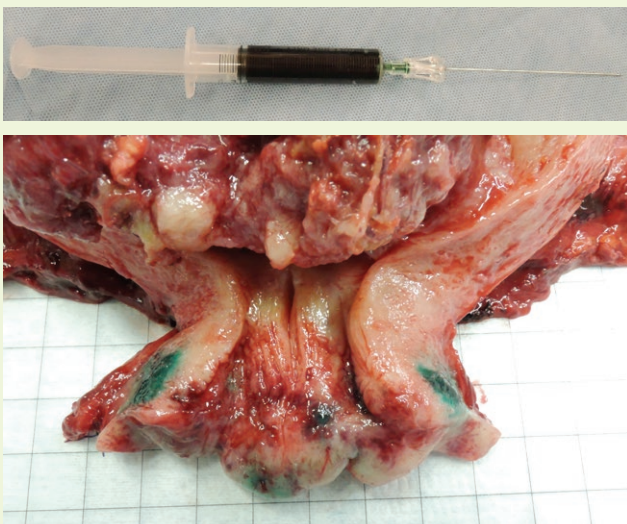


Figure 4. Cervical injection of ICG solution

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Sentinel lymph node algorithm

The National Comprehensive Cancer Network recommends adoption of the SLN algorithm to ensure a low false negative rate⁶. The algorithm involves removal of all SLNs and any suspicious nodes, and a side-specific complete pelvic lymph node dissection if there is no mapping in a hemipelvis⁷. This approach results in approximately 40% of patients requiring unilateral and 10% requiring bilateral complete lymphadenectomy⁸. The implementation of the algorithm decreases the false negative rate of SLNM from 14.9% to 1.9% and increases the sensitivity from 85.1% to 98.1%, and NPV from 98.1% to 99.8%⁷.

Frozen section of the SLN is generally not performed, owing to its cost, low sensitivity in diagnosing low volume metastasis, and potential alteration to ultrastaging of the SLN⁹. Intra-operative frozen section has a low sensitivity of 50% to 83% in identifying lymph node metastasis^{10,11}. The aim of SLN removal is to guide post-operative adjuvant therapy, rather than to determine whether complete lymphadenectomy should be performed intra-operatively.

Performance of SLNM

SLNM in endometrial cancer has a high detection rate, high sensitivity, high NPV, and low false negative rate. A meta-analysis involving 4915 patients reported an overall detection rate of SLN of 81% (range, 75.4%-90.4%), bilateral pelvic node detection rate of 50% (range, 33%-74.6%) and sensitivity of 96%¹². In early-stage low-risk endometrial cancer, SLNM is accurate for lymph node assessment and is widely accepted as a routine procedure for staging.

In early-stage high-risk (deep myometrial invasion, grade 3, non-endometrioid histology) endometrial cancer, the evidence is not as strong. The higher risk of lymph node metastasis in high-risk cases also increases the concern of missing a metastatic case, leading to understaging and inappropriate adjuvant treatment, thereby compromising survival. A meta-analysis including 16 studies targeting high-grade endometrial cancer reported a detection rate of 91% per patient, a bilateral detection rate of 64%, with a sensitivity of 92%, NPV of 97%, and false negative rate of 8%¹³.

Surgeon experience affects the detection rate of SLNM^{14,15,16,17}. A study reported that at least 27 cases were required to achieve proficiency in SLNM¹⁸. After the first 30 cases, the rate of successful mapping significantly increased from 77% to 94%¹⁶. Before competence in SLNM is achieved, an add-on completion pelvic lymphadenectomy is recommended to avoid missing any lymph node metastasis⁹.

Benefit of SLNM

SLNM offers an appropriate balance between morbidity of a complete lymphadenectomy and the risk of missing lymph node metastasis. SLNM is a relatively safe procedure with no adverse events¹⁹. SLNM reduces the number of lymph nodes removed, thus reducing the risk of complications (Table 1).

Table 1. Comparison between SLNM only and complete lymphadenectomy^{20, 21, 22, 23}

	SLNM only	Complete lymphadenectomy	P value
Pelvic nodes removed	4	15	<0.0001
Operative time	137min	181min	<0.0001
Blood loss	56ml	80ml	0.004
Post-operative complications	5.2%	13%	0.04
Leg lymphedema	1.3%	18.1%	0.0003
Lymphocele	3.4%	14.1%	0.009

SLNM increases the identification of lymph node metastasis, with a lower number of lymph nodes removed when compared with complete lymphadenectomy, providing better guidance to adjuvant therapy^{24,25}. In the FIRES trial, 17% of the positive SLN were found in regions outside the routine lymphadenectomy area (eg pre-sacral area) and would have been missed if SLNM was not performed⁸. Comparing 661 endometrial cancer cases with pelvic +/- para-aortic lymphadenectomy with 119 endometrial cancer cases with SLNM + pelvic +/- para-aortic lymphadenectomy, the SLNM group had more lymph node metastasis detected (30.3% vs. 14.7%, $p < 0.001$), and received more chemotherapy + radiation (28.6% vs 16.3%, $p < 0.003$)²⁴. Patients staged with SLNM were more likely to receive adjuvant treatment^{12,24}, because of the higher detection rate of metastatic disease. The higher detection rate is partly due to ultrastaging. SLNM can identify lymph nodes at particular high risk of metastasis, allowing pathologist to concentrate on these smaller number of more relevant lymph nodes with ultrastaging.

Ultrastaging and low volume metastasis

Ultrastaging is a pathological technique to increase the accuracy of lymph node assessment^{26,8}. It involves performing more serial sections and the use of IHC for cytokeratin rather than only haematoxylin and eosin (H&E) staining. Ultrastaging picks up low volume metastasis, which is not detected by routine histology. Low volume metastasis includes micrometastasis, defined as metastasis of 0.2-2 mm and isolated tumour cells (ITC), defined as foci of metastasis < 0.2 mm or cells stained positive for cytokeratins⁸. In the FIRES trial, 54% of positive lymph nodes are micrometastasis or ITC⁸. Among the low volume metastasis cases, 47% were micrometastases and 53% were ITCs. Survival rate was worse for those with micrometastasis without adjuvant therapy²⁷, supporting the need of adjuvant therapy for micrometastasis. However, the benefit of adjuvant therapy for ITC is not proven.

Oncological safety of SLNM

The decrease in radicality of surgery with SLNM does not compromise oncological safety in terms of OS and PFS^{26,28,29}. In 802 patients with preoperative stage 1 endometrial cancer, undergoing surgical staging by SLNM +/- complete lymphadenectomy or complete lymphadenectomy ($p = 0.002$)²⁶, the three-year disease-free survival was 90.4% in the SLNM group and 89.6% in the complete lymphadenectomy group. In a multi-institutional retrospective study evaluating long-term outcomes (≥ 3 years) of endometrial cancer patients who underwent (1) complete lymphadenectomy, (2) SLNM followed by lymphadenectomy, or (3) SLNM alone, the three groups were comparable in terms of DFS and OS³⁰.

In addition, the recurrence rate was comparable after SLNM or complete lymphadenectomy. In a meta-analysis including 1249 (35.3%) patients with SLNM and 2287 (64.7%) patients with lymphadenectomy, the overall recurrence rate was 4.3% and 7.3%, and the nodal recurrence rate was 1.2% and 1.7%, respectively³¹.

Some studies reported an improvement in survival with SLNM. This improvement in survival may be due to the more accurate lymph node assessment by SLNM and ultrastaging, thus allowing more accurate provision of adjuvant therapy.

Conclusion

SLNM with adherence to the SLN algorithm provides an effective option for lymph node assessment in endometrial cancer, balancing the morbidity of complete lymphadenectomy with the risk of missing lymph node involvement. SLNM is considered a routine practice in low-risk early-stage endometrial cancer, allowing accurate staging while decreasing morbidity. Recent evidence suggests similar staging performance in high-risk early-stage endometrial cancer, making SLNM a reasonable alternative in high-risk endometrial cancer.

Key messages:

1. SLNM is accepted as routine in low risk early stage endometrial cancer and can be considered in high risk endometrial cancer cases
2. SLNM has high detection rate, sensitivity, NPV, low false negative rate
3. SLNM decrease morbidity with less lymph nodes removed
4. SLNM increase detection of lymph node metastasis
5. Ultrastaging allows detection of low volume metastasis: isolated tumour cells and micrometastasis
6. SLNM guides adjuvant therapy provision more accurately

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Physiotherapy Treatment for Urinary Incontinence

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Stress urinary incontinence (SUI) is defined as the involuntary leakage of urine with multiple causes, including physical effort or exertion. Although SUI is not a life-threatening disease, it presents a significant social burden and leads to negative impacts on quality of life.

Treatment of SUI is divided into surgery or nonsurgical options depending on the severity of symptoms. Nonsurgical methods included pelvic floor muscles exercise, which could strengthen muscles surrounding the urethra or vagina.

How physiotherapy supports pelvic floor muscles exercise training?

Professional pelvic floor rehabilitation, combined with independent, regular exercise, can often successfully treat the condition. Patients first learn how to take pressure off the pelvic floor in everyday activities, such as lifting and carrying. After a thorough medical history assessment, the physiotherapist introduces **targeted exercises to help identify, strengthen, and relax the pelvic floor muscles.**

1. Active pelvic floor muscle training by physiotherapists

Many patients may not be able to feel the pelvic floor muscles properly and are therefore unable to train the muscles by contracting and relaxing them. It is difficult to judge from the outside whether pelvic floor exercises are being done correctly and effectively.

Previous physiotherapy pelvic muscle training including Kegel exercises and biofeedback exercises. The biofeedback pelvic floor muscles exercises used a vaginal sensor for female patients to train the target muscles which may cause discomfort and embarrassment:

Peritron Precision Perineometer Kit with Vaginal Sensor



PfX Pelvic floor exercises kit with Vaginal Sensor



New device is now used for active pelvic floor muscles training for both male and female which patients can wear clothes during exercises to avoid embarrassment:

Biofeedback training devices offer an effective method of strengthening and training the pelvic floor muscles by providing precise and immediate feedback on muscle activity^{(1),(2),(3)&(4)}.

The Alonea PelvicTool, which works with biofeedback, consists of an ergonomically shaped **seat cushion with a soft sensor tube and the “Training App”**.

Training with the PelvicTool: the seat cushion with the tube is placed on a flat stool and the patient sits on with light training clothes. The “PelvicTool App” is then started on the tablet and the desired exercise is selected.

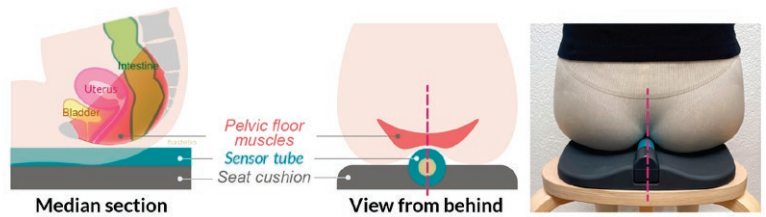
The sensor tube sends the contraction values via Bluetooth to the tablet, where they are displayed graphically. The App displays these pressure changes in real time, allowing the physiotherapist to **monitor the contraction and relaxation of the pelvic floor muscles live on screen**. Individual training program settings are possible as well as guided⁽⁵⁾.

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Alonea Pelvic Tool



PelvicTool App



Training progress is documented by automatically storing training data in the PelvicTool-App on the tablet. The results are clearly displayed both graphically and numerically. The training results can be tracked.

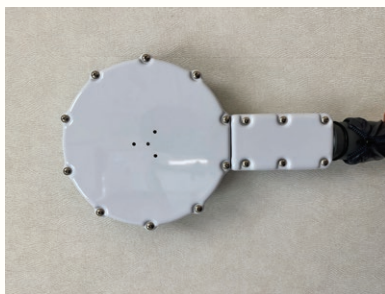
2. Passive Stimulation of Pelvic Floor Muscles by High Intensity Focus Electromagnetic (HIFEM) Therapy:

High-intensity focused electromagnetic (HIFEM) therapy (TESLA-3000) is a non-invasive treatment uses high-intensity electromagnetic fields to stimulate thousands of supramaximal pelvic floor muscle contractions in a single session, strengthening the muscles that support bladder control.

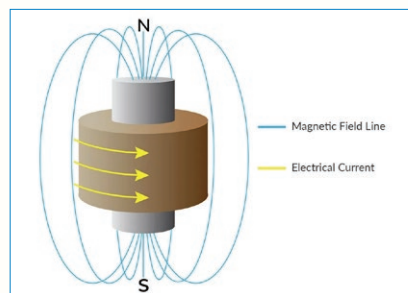
HIFEM is particularly helpful for stress incontinence (leakage during coughing, laughing, or activity) and mixed types, as stronger pelvic floor muscles provide better urethral support improving urethral sphincter tone and bladder control. It's FDA-cleared for urinary incontinence treatment in both men and women.^{(6),(7),(8),(9)(10),(11)(12)}

Magnetic therapy generating a current induced in a non- contact manner instead of directly conducting current to and through the human body. The magnetic field safely stimulates the nervous system without the interference of fat and bones⁽¹³⁾.

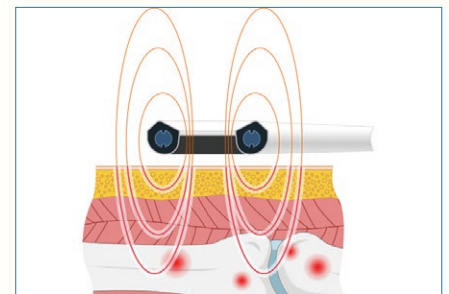
3-Point Diode



Induced magnetic field generated by a coil of wire



Stimulation of induced electromagnetic field generated in the human body



When a magnetic field that changes rapidly in time is applied around an electrical conductor, an eddy current is formed in the conductor according to Faraday's Law (the human body has a lower electrical conductivity compared to metal). The eddy current formed and stimulates the nerve cell and muscles⁽¹³⁾.

An electromagnetic field of 15 to 30 V/m is generated at 100 mm deep inside the body safely stimulates the deeper part. It enables the treatment parts of the body where it is difficult to attach electrodes for electric therapy, while the magnetic therapy significantly reduces tissue damage and other risks. In addition, a magnetic field has the property of passing through a specific medium without significant energy attenuation⁽¹³⁾. Pelvic floor muscles simulation treatment can be delivered with the patient wearing clothes and sitting on a chair⁽¹³⁾.



High Intensity Focus Electromagnetic Stimulation for incontinence (Magnetic Therapy Device Tesla-3000)

Contraindications / Precaution for High Intensity Focus Electromagnetic (HIFEM) Therapy

- Patient with cardiac pacemaker / implanted defibrillators / implanted neurostimulators / cranial implant / cochlear implants / other ferromagnetic or electronically operated devices
- Acute DVT (over site) / DVT post anticoagulation
- Stimulation over carotid sinus
- Peripheral vascular disease
- Malignant tumor
- On anticoagulation drug, e.g. warfarin
- Uncontrolled hyper / hypotension
- Active infection
- Poor skin condition / external wounds / hemorrhage conditions
- Abnormal tissue swelling
- History of epilepsy / seizure
- Stimulation on implanted devices
- Pregnancy
- Intrauterine device, application over adjacent area
- Menstruation / premenstruation,
- Artificial joints / metal screws / plates / haemostatic clips

Suggested parameters for HIFEM therapy

- At least 8 sessions
- Twice weekly
- 20-30 mins

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12. Katarzyna S., Agnieszka S., Agnieszka R., Magdalena W., 2023. The Effects of Extracorporeal Magnetic Innervation in the Treatment of Women with Urinary Incontinence: A Systematic Review. *J Clin Med* 12(17):5455
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Awards Recognition

ET Net Health Partnership Award 2025

Union Hospital is proud to receive the Outstanding Achievement and Excellence in Medical Services and Outstanding Sustainable Private Hospital awards, recognising our strong hospital governance, effective service management, and long-term commitment to quality improvement and sustainable healthcare development across clinical operations. Moving forward, we will continue to work collaboratively to deliver high-quality services and support the hospital's responsible and sustainable growth.



EJ Health Awards of Excellence 2026

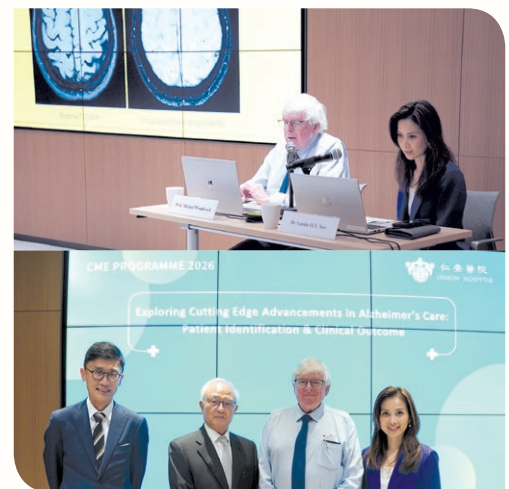
Union Hospital is honoured to receive the Excellence in Caring Medical Services Award. This accolade highlights our continued focus on providing compassionate care and thoughtful service delivery across the patient journey. It stands as a meaningful recognition of our healthcare teams, whose professionalism and empathy continue to strengthen patient trust and deliver a supportive care experience.



Post-Event Highlights

CME Programme – Exploring Cutting Edge Advancements in Alzheimer's Care: Patient Identification & Clinical Outcome (27 March 2026)

Union Hospital hosted a CME lecture titled 'Exploring Cutting Edge Advancements in Alzheimer's Care: Patient Identification & Clinical Outcome', delivered by Prof. Michael Woodward, Director of Dementia Research and Senior Clinician of Memory Clinic at Austin Health. Prof. Michael Woodward shared practical, research-informed insights into recent advancements in Alzheimer's identification and clinical outcomes, highlighting the latest breakthroughs in Alzheimer's care. The lecture was chaired by Dr Soo Oi Yan, Yannie, Assistant Chief Hospital Manager at Union Hospital, and attracted over 350 onsite and online participants.



CME Programme – Innovations in Early Stage Lung Cancer Management (15 May 2026)

We hosted a CME lecture titled 'Innovations in Early Stage Lung Cancer Management'. Prof. Ng Sze Hang, Calvin, Environmental Foundation Professor of Thoracic Surgery at CUHK and Honorary Consultant Surgeon at Prince of Wales Hospital, shared important clinical data, updates to clinical guidelines, and the latest technologies and procedural approaches for lung cancer treatment. He also emphasized the increasing global focus on robotic surgery. The lecture was chaired by Dr Soo Oi Yan, Yannie, Assistant Chief Hospital Manager at Union Hospital, and attracted over 350 participants across both onsite and online platforms.



Upcoming CME

CME
Programme

Mandatory Reporting of Child Abuse Ordinance

Date : 12 June 2026 (Friday)
Time : 2:00pm-3:00pm
(Lunch Buffet will be served at 1:15pm)
Venue : 2/F Seminar Room, Union Hospital
Speakers :



Mr David Kan
Partner,
Solicitor Advocate,
Howse Williams



Ms Maureen Liu
Partner,
Howse Williams

Chairperson : **Dr Joseph Ho**
Head of Quality Assurance & Training Department
Consultant in Emergency Medicine
Union Hospital



On-site Registration



Online Registration (Zoom)

2608 3180

cme@union.org

Regular Meetings

Meeting :	Clinical Pathologic Conference	X-Ray Meeting
Date :	10 June 2026 (Wednesday)	8 July 2026 (Wednesday)
Time :	8:30am – 9:30am	8:30am – 9:30am
Co-ordinator:	Dr FUNG Ming Kit, Terence Deputy Head, Department of Surgery, Union Hospital Dr LUI Chi Wai, Philip Consultant in Pathology, Union Hospital	Dr CHAN Chi Sang, James Head, Department of Medical Imaging, Union Hospital
Venue:	Training Room, 8/F MIC, Hospital Building, Union Hospital	
Booking & Enquiry:	2608 3160 (Quality Assurance and Training Department)	

New Clinical Members

Please extend a warm welcome to the following health professionals for joining our clinical team!



Dr Law Yuk
Consultant in
Vascular Surgery



Dr Tse Wing Lim
Consultant in
Orthopaedics &
Traumatology



Dr Lau Ka Ying
Specialist in
Dermatology & Venereology



Dr Ma Hon Sum
Consultant in
Cardiology

New Clinical Sessions

Minimally Invasive Centre		
Booking & Enquiry: 2608 3383	Time Schedule	
General Surgery Dr Li Chak Man, Jimmy	Mon	13:00 – 18:00
	Tue	15:00 – 18:00
	Wed	10:00 – 14:00
	Thu	10:00 – 13:00
	Fri	09:00 – 11:00
	Sat	09:00 – 10:00
Orthopaedics & Traumatology Dr Cheng Hi Shan	Mon	11:30 – 14:00
	Thu	12:30 – 18:00
Orthopaedics & Traumatology Dr Lau Yip Kwong, Francis	Tue	13:00 – 14:30
Orthopaedics & Traumatology Dr Tse Wing Lim	Mon	10:00 – 13:00
	Tue	15:00 – 18:00
	Thu	15:00 – 18:00
	Fri	15:00 – 18:00
Vascular Surgery Dr Law Yuk	Mon	14:30 – 17:00

Specialty Clinic		
Booking & Enquiry: 2608 3228	Time Schedule	
Union Breast Centre Dr Cheng Tsz Ling	Mon	15:00 – 18:00
	Wed	15:00 – 16:00

Specialty Clinic		
Booking & Enquiry: 2608 3222	Time Schedule	
Obstetrics & Gynaecology Dr Ng Pui Shan, Doris	Tue	10:00 – 12:30
	Thu	10:00 – 12:30
	Sat	10:00 – 12:00

Specialty Clinic		
Booking & Enquiry: 2608 3366	Time Schedule	
Paediatrics Dr Lee Shuk Han	Tue	16:00 – 18:00
Paediatric Endocrinology Dr But Wai Man, Betty	Tue	14:00 – 16:00
	Fri	15:00 – 18:00
Paediatric Immunology, Allergy and Infections Diseases Dr Chua Gilbert T.	Mon	15:00 – 18:00
	Wed	09:30 – 13:00
		15:00 – 18:00
	Fri	09:30 – 13:00
		15:00 – 18:00
	Sat	14:00 – 18:00

Plastic and Aesthetic Multidisciplinary Centre		
Booking & Enquiry: 2608 3211	Time Schedule	
Dermatology (Aesthetic and Laser Surgery) Dr Chiu Lai Shan, Mona	Tue	09:00 – 12:00
	Wed	14:00 – 17:00
	Thu	09:00 – 12:00
	Fri	14:30 – 18:00
	Sat	10:00 – 14:00
Dermatology (Aesthetic and Laser Surgery) Dr Lau Ka Ying	Mon	14:00 – 18:00
	Tue	08:00 – 10:00
		14:00 – 18:00
	Wed	09:00 – 13:00
	Thu	08:00 – 10:00
	Fri	10:00 – 13:00
Sat	09:00 – 14:00	

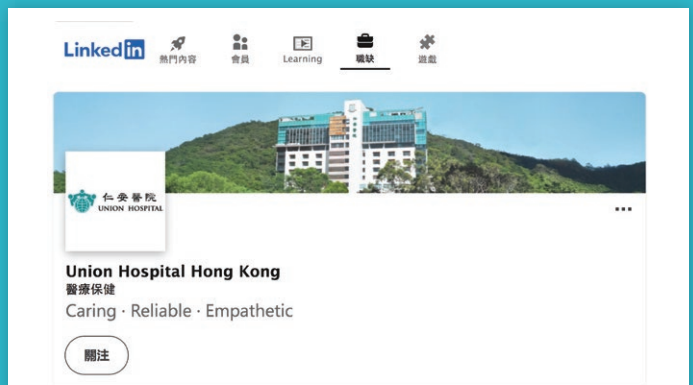
Union Heart Centre		
Booking & Enquiry: 2608 6777	Time Schedule	
Cardiology Dr Ma Hon Sum	Tue	10:00 – 13:00

Union Hospital Polyclinic (Tsim Sha Tsui)		
Booking & Enquiry: 2375 3323	Time Schedule	
Orthopaedics & Traumatology Dr Lau Yip Kwong, Francis	Mon	15:00 – 17:30

Union Hospital Polyclinic (Tsuen Wan)		
Booking & Enquiry: 2608 3399	Time Schedule	
Orthopaedics & Traumatology Dr Tse Wing Lim	Wed	10:00 – 13:00
	Thu	10:00 – 13:00

Union Hospital Polyclinic (Ma On Shan)		
Booking & Enquiry: 2608 3377	Time Schedule	
Orthopaedics & Traumatology Dr Tse Wing Lim	Mon	15:00 – 18:00
	Tue	10:00 – 13:00
	Wed	15:00 – 18:00
	Fri	10:00 – 13:00
	Sat	09:00 – 13:00

Union Hospital Polyclinic (Tseung Kwan O)		
Booking & Enquiry: 2721 0100	Time Schedule	
Internal Medicine / Endocrinology Dr Wong Wai Sheung	Wed	15:00 – 17:30



Connect with Union Hospital on LinkedIn

Union Hospital's official LinkedIn page has been growing steadily, serving as a hub to share updates on our services, events, and achievements. We invite you to follow us to stay connected and support us by liking and sharing our posts. Join us in building a vibrant LinkedIn community that reflects Union Hospital's commitment to providing compassionate and reliable healthcare. Scan the QR code to follow — and don't forget to tag us in your posts!



To unsubscribe from this newsletter, please send your name, contact number and address to unsubscribe@union.org or fax 2605 4499.