Union Connection

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Message from the
Chief Hospital Manager

Dear Colleagues,

In early June I took two weeks off to travel with my wife Roseanna to Melbourne and Launceston in Australia. There were multiple purposes for this trip. In Melbourne we still owned a two bed-room apartment in Parkville next to the Melbourne University campus. We were there for three days with the purpose of renewing our driver's licence and closing our safe deposit account with the bank. There is no such official document as the HKID in Australia. For personal identification, the driver's licence is accepted everywhere because the individual's personal particulars such as age and address plus a photograph & signature are all there. I must commend on the efficiency of the staff of the Victoria Roads Department because we completed all the red tape routine processes within two hours. The new licences would be mailed to us after five working days. This prompt handling of our applications was in sharp contrast with our experience the next day.

Our second errand in Melbourne was to terminate the safe deposit box service of the Commonwealth Bank of Australia. We cleared out the contents of the box before lunch-time. Then it took about four hours for the staff of that particular department to prepare the invoice of the final service for us to settle, to have the matter over and done with. From what we observed there were only five customers including us patronizing the safe deposit department! There were about seven staff who were there and I must say that they constituted a very inefficient bunch of office workers I encountered down under.

Another purpose for our sojourn in Melbourne was to meet an old time friend of ours for over fifty years. He is none other than the legend in restaurant business in Australia – Mr Gilbert Lau, AM (Member of the Order of Australia), the previous owner of the top Chinese restaurant, the Flower Drum, in the Chinatown. The restaurant was renowned for being a fine dining Michelin-starred eatery. When Gilbert retired, he generously handed over the ownership to his loyal staff. However, without Gilbert being in charge, the service and quality of the dishes of the Flower Drum became a bit lack-lustre. Meanwhile Gilbert established a bistro-styled Chinese restaurant in the suburb of St Kilda and named it Lau's Kitchen. Business flourished for about ten years but it finally succumbed to the curse of greedy landlord. Because of his contribution to the community and tourism of the city of Melbourne, the federal government awarded him the Order of Australia (AO) at around the year 2010. In recent years he had retired completely from the restaurant business and resorted to staying home to look after his beloved but frail and ageing wife. Roseanna and I were very pleased to find both of them in good order and shape, bright and graceful as ever!

Our daughter Fiona met us at the Melbourne Airport and accompanied us to Launceston, Tasmania, her home-town where she works as a surgeon. There were two important reasons for visiting this lovely city of about 100,000 population. The first was it being named a UNESCO City of Gastronomy in 2021. Other than its famous restaurants like the Stillwater and the Mee Wah (the equivalent of Flower Drum in Melbourne) offering upmarket dishes and service, there are plenty of small restaurants with an international variety of owner-chefs showcasing their delicious products. In addition there is a market fair every Saturday being held at the vicinity of the Town Hall. There are stalls selling fresh farm produce and also a cosmopolitan range of 'street foods' which I enjoyed sampling. There were two items which have always been my favourite as a weekend brunch whenever we visited Fiona. One of these is the Korean pancake stuffed with spicy bits of pork and the other is a burger of toasted bun sandwiching a freshly fried egg and multiple pieces of bacon and condiments. These go well with a cold beer even in winter! Strangely enough there were no beef burger available, probably because of the Golden Arch McDonald eatery in the vicinity.

The other important reason was to see our son-in-law Damian who had an episode of proximal muscle weakness about three months ago. After consulting a rheumatologist and an orthopaedic surgeon and undergoing a battery of sophisticated investigations, the cause of his muscle weakness remained a mystery until one fine day when a renal physician found out that he had been taking a wrong preparation of Vitamin D for a few weeks. Because of chronic renal failure of long standing which required regular home haemodialysis, he had to take a special form of the vitamin with both 25-hydroxylation and 1-hydroxylation. His severe proximal muscle weakness was entirely due to Vitamin D deficiency. I was no expert in metabolic clinical problems and the above information was Greek to me! Thus Damian gradually recovered after he was put back onto the special Vitamin D concoction. This is another example of 「學無止境」 in clinical medicine.

It is in a happy state of mind that I end this message with my best wishes to you and your loved ones for an enjoyable summer.

Yours most sincerely,

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Migraine in children and adolescents

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The most common disabling primary headache disorder that occurs in children and adolescents. It is characterized by headache that is often throbbing in character and accompanied by symptoms such as photophobia, phonophobia, nausea, vomiting, and movement sensitivity. It is thought to have a polygenetic and multifactorial etiology. Despite the strong genetic underpinnings of migraine, the specific genes underlying migraine have not been fully delineated, with the exception of the rare subform of familial hemiplegic migraine.

Pathogenesis — The mechanism appears to be a primary neuronal dysfunction that leads to an increased sensitivity to a broad range of stimuli.

A primary event may occur in the hypothalamus and/or brainstem to initiate a migraine attack. In one study, increased blood flow was found in the cerebral hemispheres in the cingulate, auditory, and visual association cortices and in the brainstem. In another study of adults with migraine attacks triggered by nitroglycerin infusion, the hypothalamus and brainstem regions activated during the premonitory phase. Antidromic stimulation of the trigeminal nerve results in the release of substance P, calcitonin gene-related peptide (CGRP), and other vasoactive peptides that cause pain and vasodilatation in experimental models and lead to the sequence of events labeled as "neurogenic inflammation". Locus ceruleus projections to the cerebral cortex may initiate cortical hypoperfusion and spreading depression, which can explain the aura of migraine.

- **Epidemiology** — Migraine is the most common disabling headache disorder in children. The prevalence of migraine increases throughout childhood with a prevalence by age 10 years of approximately 5 percent. Prior to puberty, females and males are affected equally; during puberty, migraine starts to affect females more than males (figure 1).
- **Clinical features** — A migraine attack may be classified by distinct clinical phases:
  - **Premonitory phase** — The premonitory phase of migraine consists of affective, vegetative, and sensitivity symptoms that appear hours to even a day prior to the onset of the headache.
  - **Migraine aura** — Aura may occur with some migraine attacks. Key clinical features of the aura are the spread and progression of positive neurologic symptoms (eg, scintillations or tingling) followed by negative symptoms (scotoma or numbness), typically over at least five minutes. Symptoms most commonly consist of visual symptoms; sensory or language symptoms may also occur.
  - **Headache** — The headache of migraine tends to have a throbbing or pulsatile quality and is most often bifrontal, bitemporal, or generalized rather than unilateral. The migraine attack is often accompanied by nausea and sensitivity to light and noise. Cranial autonomic symptoms occur with headache.
  - **Postdrome phase** — During the transient postdrome phase following cessation of the headache children often feel drained or exhausted, although some report a feeling of mild elation or euphoria.

TERMINOLOGY AND CLASSIFICATION

Migraine subtypes — In 1988, the International Headache Society (IHS) replaced the terms "classic" and "common" for migraine with "with" and "without aura". The "complicated migraine" was replaced by "complications of migraine".

Associated episodic syndromes — These include cyclical vomiting, abdominal migraine, benign paroxysmal vertigo of childhood, and benign paroxysmal torticollis.

Related conditions — Alice in Wonderland syndrome and confusional migraine, are not addressed in the ICHD system. "Ophthalmoplegic migraine" has been replaced by "recurrent painful ophthalmoplegic neuropathy" because symptoms are due to cranial neuralgia, rather than migraine.

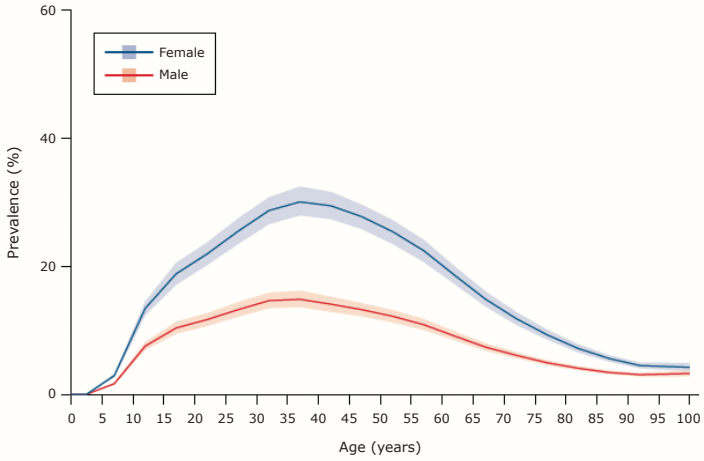
Diagnostic criteria for migraine with and without aura

Migraine without aura
A. At least five attacks fulfilling criteria B through D
B. Headache attacks lasting 4 to 72 hours (untreated or unsuccessfully treated)
C. Headache has at least two of the following characteristics: • Unilateral location • Pulsating quality • Moderate or severe pain intensity • Aggravation by or causing avoidance of routine physical activity (eg, walking or climbing stairs)
D. During headache at least one of the following: • Nausea, vomiting, or both • Photophobia and phonophobia
E. Not better accounted for by another ICHD-3 diagnosis

Migraine with aura
A. At least two attacks fulfilling criteria B and C **B.** One or more of the following fully reversible aura symptoms: • Visual • Sensory • Speech and/or language • Motor • Brainstem • Retinal
C. At least three of the following six characteristics: • At least one aura symptom spreads gradually over ≥ 5 minutes • Two or more symptoms occur in succession • Each individual aura symptom lasts 5 to 60 minutes • At least one aura symptom is unilateral • At least one aura symptom is positive • The aura is accompanied or followed within 60 minutes by headache
D. Not better accounted for by another ICHD-3 diagnosis

Features of migraine in children and adolescents
Attacks may last 2 to 72 hours
Headache is more often bilateral than in adults; an adult pattern of unilateral pain usually emerges in late adolescence or early adulthood
Photophobia and phonophobia may be inferred by behavior in young children

Migraine prevalence by age (figure 1)



Clinical evaluation — Headache drawings may be a useful adjunct to the history and physical examination in differentiating migraine from nonmigraine headaches. Drawings with features consistent with migraine (eg, pounding pain, nausea/vomiting, photophobia) had a sensitivity and specificity of 93.1 and 82.7 percent, respectively, and a positive predictive value of 87.1 percent for migraine. The child should have no abnormalities on general physical and neurologic examinations related to migraine.

Indications for diagnostic testing — Children with an established history (at least three months) of typical intermittent headaches and a normal examination usually do not need neuroimaging. Imaging should be performed if there are abnormal neurologic examination findings or features of the history concerning for elevated intracranial pressure such as diplopia, ataxia, or worsening of headache when supine.

The ICHD-3 states that occipital headache in children is rare and calls for diagnostic caution.

Neuroimaging — A consortium to evaluate the need for brain imaging in patients with headache:

- Rapidly increasing headache frequency
- History of lack of coordination
- History of localized neurologic signs or subjective numbness or tingling
- History of headache causing awakening from sleep (although this can occur with migraine headache)

Laboratory evaluation and other testing — Laboratory testing rarely is helpful in the evaluation of childhood headache.

Lumbar puncture (LP) may be necessary to diagnose an intracranial infection or abnormal cerebrospinal fluid pressure. Children with episodic syndromes that may be associated with migraine, such as cyclic vomiting syndrome or abdominal migraine, may require more testing to be able to come to a diagnosis.

Electroencephalography (EEG) is not indicated in the routine evaluation of headache.

An EEG is performed if seizures are suspected.

DIFFERENTIAL DIAGNOSIS

- Transient ischemic attack (TIA)
- Seizure
- Syncope
- Electrolyte disturbances
- Vestibular disorders

CHRONIC MIGRAINE

Chronic migraine is defined by headache that occurs on ≥ 15 days per month for more than three months, with features of migraine headache on at least 8 days per month.

OTHER PEDIATRIC MIGRAINE VARIANTS

Confusional migraine — Is described in patients with a headache with migrainous features associated with symptoms of agitation, disorientation, and aphasia that last longer than the headache. Children ranged in age from 6 to 15 years, and males predominated. The duration of confusion was 2 to 24 hours.

Estrogen-associated migraine — Menstrual migraine (also called catamenial migraine) occurs in close temporal relationship to the onset of menstruation; this time period usually encompasses two days before through three days after the onset of menses. Females with migraine that also occurs at other times during the month are classified as having menstrually related migraine. Menstrual migraine is usually not associated with aura, even in those who have migraine with aura at other times. Menstrual migraine is common, occurring in up to 70 percent of adolescent females with a history of headache.

COMPLICATIONS OF MIGRAINE

- **Status migrainosus** — A debilitating migraine attack lasting more than 72 hours
- **Migrainous infarction** — Ischemic infarction on neuroimaging in a territory that correlates with one or more migraine aura symptoms
- **Persistent aura without infarction** — Aura symptoms persisting for one week or more without neuroimaging evidence of infarction
- **Migraine aura–triggered seizure** — Seizure triggered by an attack of migraine with aura

Comparison of overlapping symptoms in cyclic vomiting syndrome, abdominal migraine, and migraine headaches in children and adolescents

	Percentage of patients with symptom		
	Cyclic vomiting syndrome	Abdominal migraine	Migraine headache
Core symptoms			
Vomiting	100	39 to 72	40 to 69
Abdominal pain	3 to 81	100	10 to 55
Headache	38 to 59	31 to 50	100
Associated symptoms			
Lethargy	91	-	-
Pallor	87	90 to 100	23 to 88
Anorexia	74	91 to 98	13 to 93
Nausea	72	73 to 91	46 to 100
Photophobia	32	1 to 42	27 to 81
Mean age			
	5 years	9 years	11 years

Acute treatment of migraine in children

General measures for all patients — When migraine symptoms develop, the child should rest or sleep in a dark, quiet room with a cool cloth applied to the forehead.

Step-wise selection of medications

1. **First-tier (analgesics)**
   Either acetaminophen or ibuprofen. Naproxen is an alternative.

2. **Second-tier (triptans)**
   - **Older children and adolescents** — Children >12 years of age and weigh more than 40 kg include:
     - Sumatriptan 50 mg tablet or Sumatriptan 20 mg nasal spray
     - Zolmitriptan 5 mg tablet, melt, or nasal spray
   - **Younger children** — Children 6- 11 years of age and who weigh < 40 kg:
     - Sumatriptan 25 mg oral tablet or Sumatriptan 5 mg nasal spray
     - Zolmitriptan 2.5 mg tablet, melt, or nasal spray

3. **Third-tier (combination)** — For children (age ≥ 6 years) and adolescents, triptan taken with naproxen 5 mg/kg per dose, or the proprietary combination drug sumatriptan-naproxen. Or promethazine 0.25 to 0.5 mg/kg per dose, used as adjunct therapy with a triptan.

Indications for preventive therapy

- Frequent or long-lasting migraine headaches
- Migraine attacks that cause significant disability or diminished quality of life
- Contraindication to, failure of, or adverse effects of acute therapies
- Medication overuse headache
- Menstrual migraine

Initial treatment options

- **Lifestyle measure** — Should receive patient education and counseling about lifestyle measures that can be helpful for preventing attacks. These include good sleep hygiene, regular exercise, consistent meal schedules, adequate fluid intake, and migraine trigger management.
- **Pharmacotherapy and behavioral treatment options** — Cognitive-behavioral therapy - includes education, relaxation exercises, coping skills training, and stress management; cognitive therapy focuses on helping the patient identify and correct distorted, maladaptive beliefs.
  - Amitriptyline, topiramate, or propranolol.
  - Calcitonin gene-related peptide (CGRP) antagonists may also be offered to school-aged children. Fremanezumab may be given to children aged 6 to 17 years who weigh ≥ 45 kilograms. The monthly dose of fremanezumab in children is 225 mg by subcutaneous injection.
  - For young children who cannot swallow tablets, cyproheptadine can be given as an oral syrup.
  - For children and their families or caregivers who prefer treatment with supplements rather than prescription medications, nutraceuticals including riboflavin (vitamin B2), melatonin, or magnesium.

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Understanding the Connection: How Early Hearing Support Benefits Cognitive Health in Older Adults

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Introduction

Presbycusis, or age-related hearing loss (ARHL), is more than just a natural change in how we hear; it is a critical, modifiable factor in maintaining cognitive wellness as we age (Livingston et al., 2020). Evidence suggests that untreated hearing loss is linked to an increased risk of cognitive decline, potentially doubling the risk in mild cases and increasing it further as the loss becomes more severe (Thomson et al., 2017). A common yet often distressing accompaniment to this decline is tinnitus—the perception of sound without an external source. Research indicates that approximately 70% to 85% of older adults with hearing loss also experience tinnitus, as the brain attempts to compensate for a lack of external auditory input by increasing internal neural activity. For healthcare providers in Hong Kong, this connection is particularly meaningful given the tonal nature of Cantonese and Putonghua, where clear hearing and a "quiet" auditory background are essential for understanding the nuances of daily conversation. Local studies suggest that the combination of hearing loss and persistent tinnitus can further increase the risk of depression and social isolation (Chang et al., 2022). It appears that when the brain has to work harder to process sound, it uses energy that would otherwise be spent on memory and thinking (Degeest et al., 2015).

Hearing Aids Help Reducing Listening Effort

Recognizing hearing as a key part of overall health highlights the value of early support. Providing hearing aids does more than simply make sounds louder; it helps maintain the steady stream of information the brain needs to stay active. By refining how sound is processed, modern hearing aids can reduce "listening effort", allowing older adults to engage in social life without feeling mentally exhausted (Appleton, 2020). The Aging and Cognitive Health Evaluation in Elders (ACHIEVE) study has shown that consistent use of hearing aids can help slow the rate of cognitive decline for those at risk (Reed et al., 2024). Furthermore, early amplification support has been linked to better outcomes regarding general mental well-being and a reduced risk of falls, suggesting that a small device can make a large difference in daily safety (Mahmoudi et al., 2019).

SHARING CORNER

Modern Hearing Aid Technologies

Modern hearing aid technology has evolved significantly to address lifestyle and cosmetic concerns. Today's devices offer discreet options like "completely-in-canal" (CIC) and sleek "receiver-in-canal" (RIC) designs. A new generation of devices now mimics the design of popular wireless earbuds with stylish black finishes, shifting the perception of hearing support from a medical necessity to a sophisticated wearable. Crucially, these innovations are no longer exclusive to high-end, expensive models. Advanced features have "trickled down" to essential and mid-range tiers, providing high-tech support at more acceptable price points. Even basic modern models now come equipped with AI-driven noise reduction to filter background chatter, Bluetooth connectivity for direct phone streaming and app-based adjustments, advanced tinnitus sound masking as a standard feature, and lithium-ion rechargeability which eliminates the cost and hassle of tiny disposable batteries.

Receiver-in-canal style

In-the-ear style

Completely-in-canal style

Change of Beliefs

Despite these clear benefits, many older adults wait an average of nearly nine years before seeking help (Simpson et al., 2019). While over 66% of residents aged 70 and above experience hearing loss (Centre for Health Protection, 2016), only a small fraction use hearing aids. This delay is driven by a lack of recognition, where individuals rationalize the change as an inevitable part of aging, or the "one good ear" fallacy, where they believe they can manage if one ear still functions well (Wong & McPherson, 2010). This belief is particularly detrimental as it leads to unilateral auditory deprivation, where the brain's auditory pathway in the neglected ear weakens, making later rehabilitation much more difficult (Wieselberg & Iório, 2012). Furthermore, many are simply not psychologically "ready" to accept a device they still associate with disability, or they are deterred by the perceived high cost of private instruments. Even for those ready to seek help, systemic hurdles such as the public healthcare queue—where wait times for specialist consultations and audiology fitting can exceed two years—often discourage timely intervention (Chang et al., 2026).

Conclusion

In conclusion, helping our elderly population stay connected through better hearing is a simple but profound way to support their cognitive health. By highlighting that contemporary, user-friendly, and technologically advanced devices are available at various price points, we can help patients move past outdated perceptions. Moving toward timely hearing aid fitting is an act of care that protects not just the ability to hear, but the ability to stay connected to loved ones and enjoy a high quality of life throughout the aging process.

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Prevalence and Antibiogram of Urinary Pathogens, 2021-2025

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Background Urinary tract infection (UTI) typically presents with local bladder symptoms, including dysuria, urgency, frequency, and suprapubic pain. Urine cultures are useful for confirming the diagnosis and for providing guidance on the choice of antibiotics.

Objective This study aimed to evaluate the prevalence of uropathogens and identify trends in antimicrobial susceptibility patterns among the most frequently isolated pathogens.

Method Culture results from midstream urine samples and those obtained via in-and-out catheterization ("cath once") collected between 2021 and 2025 were reviewed following CLSI guidelines (1). The prevalence of uropathogens in samples showing significant growth was analyzed. Antimicrobial susceptibility patterns for the three most frequently isolated uropathogens against seven oral antibiotics were assessed using the first isolate per patient per year method. The level of susceptibility was graded as very high (>90%), high (70%-90%), moderate (50%-69%) and low (<50%).

Results

- The most frequently isolated uropathogen is *Escherichia coli* (75%), followed by *Klebsiella pneumoniae* (8%) and Proteus mirabilis (5%) (Figure 1A).
- For *E. coli*, susceptibility was very high for nitrofurantoin (98%), and high for amoxicillin-clavulanate (79%) and cefuroxime (73%) (Figure 1B). Susceptibility levels were moderate or low for the other antibiotics.
- Nitrofurantoin was ineffective against *K. pneumoniae* (only 15% susceptible) and *P. mirabilis* (intrinsic resistance), while susceptibility rates of the other antibiotics ranged 65%-79% and 61%-81%, respectively (Figure 1B).
- Extended-spectrum beta-lactamase (ESBL) rates were 19% for both *E. coli* and *K. pneumoniae*, and 8% for *P. mirabilis*.
- Variations in susceptibility levels were observed between 2021 and 2025 (Table 1). There was a trend toward lower susceptibility rates for *E. coli* to ciprofloxacin, and for *K. pneumoniae* to cefuroxime, ciprofloxacin, and levofloxacin. Susceptibility rates were generally lower among older age groups (61–70 and >70 years) and among inpatients compared to outpatients.

Discussion

- Nitrofurantoin and amoxicillin-clavulanate are suitable antibiotic options for treating lower urinary tract infections (2,3). Additionally, amoxicillin-clavulanate and cefuroxime remain appropriate choices even in cases of intermediate susceptibility, as they reach high concentrations in the urine.
- Fluoroquinolones, including ciprofloxacin and levofloxacin have potential to cause serious adverse effects and should be generally be avoided (2,4).

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Figure 1. Prevalence of uropathogens (A) and susceptibility of top three uropathogens (B) in urine samples, 2021-2025.

Figure 1A

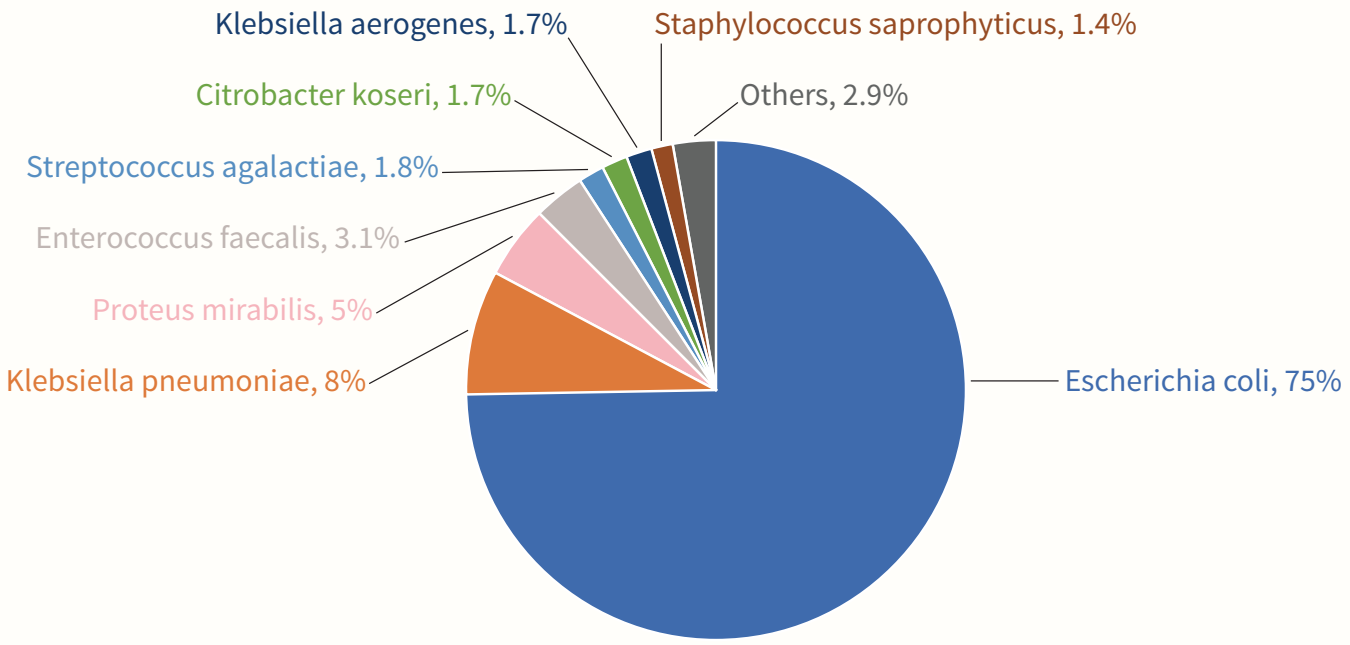


Figure 1B

	Escherichia coli			*Klebsiella pneumoniae*			*Proteus mirabilis*		
	S	I	R	S	I	R	S	I	R
Ampicillin	32%	1%	67%	0%	0%	100%	61%	0%	39%
Amoxicillin-clavulanate	79%	14%	7%	76%	12%	12%	73%	15%	12%
Cefuroxime (Oral)	73%	7%	21%	71%	4%	24%	81%	1%	18%
Ciprofloxacin	52%	13%	35%	67%	5%	28%	74%	2%	24%
Levofloxacin	39%	35%	26%	65%	20%	15%	75%	7%	18%
Cotrimoxazole	67%	0%	33%	79%	0%	21%	64%	0%	36%
Nitrofurantoin	98%	2%	0%	15%	45%	40%	0%	0%	100%

S, susceptible; I, intermediate; R, resistant

No. of isolates tested: *E. coli* (2630), *K. pneumoniae* (336), *P. mirabilis* (282).

Klebsiella pneumoniae and *P. mirabilis* has intrinsic resistance to ampicillin and nitrofurantoin, respectively.

Extended-spectrum beta-lactamase (ESBL) rates were 19% for both *E. coli* and *K. pneumoniae* , and 8% for *P. mirabilis*.

% susceptible
>90%
70%-90%
50%-69%
<50%
Intrinsic resistance

Table 1. Susceptibility of uropathogens by year, age groups and patient location, 2021-2025

Organism and agent	Year, % susceptible					Age group, % susceptible					Location, % susceptible	
Escherichia coli **(n=2630)**	**2021**	**2022**	**2023**	**2024**	**2025**	**0-17y**	**18-50y**	**51-60y**	**61-70y**	**70+y**	**Inpatient**	**Outpatient**
Ampicillin	33%	35%	32%	30%	29%	26%	34%	33%	31%	29%	30%	33%
Amoxicillin-clavulanate	81%	83%	74%	81%	74%	79%	80%	80%	77%	76%	77%	80%
Cefuroxime (Oral)	74%	73%	72%	73%	71%	74%	75%	76%	71%	66%	70%	74%
Ciprofloxacin	57%	52%	54%	49%	48%	63%	57%	53%	46%	42%	52%	52%
Levofloxacin	39%	36%	40%	38%	40%	43%	44%	38%	34%	31%	39%	39%
Cotrimoxazole	69%	65%	68%	67%	65%	58%	71%	66%	65%	64%	66%	67%
Nitrofurantoin	98%	98%	98%	98%	96%	97%	99%	98%	97%	96%	98%	98%

Klebsiella pneumoniae **(n=336)**	**2021**	**2022**	**2023**	**2024**	**2025**	**0-17y**	**18-50y**	**51-60y**	**61-70y**	**70+y**	**Inpatient**	**Outpatient**
Ampicillin	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Amoxicillin-clavulanate	83%	81%	75%	67%	73%	71%	84%	61%	71%	77%	80%	73%
Cefuroxime (Oral)	74%	78%	69%	65%	69%	76%	76%	65%	71%	68%	72%	70%
Ciprofloxacin	70%	70%	61%	62%	69%	76%	72%	61%	63%	65%	66%	67%
Levofloxacin	69%	70%	57%	59%	68%	76%	70%	57%	63%	63%	65%	65%
Cotrimoxazole	86%	79%	82%	67%	79%	82%	79%	71%	73%	84%	81%	77%
Nitrofurantoin	17%	18%	10%	16%	15%	24%	9%	20%	14%	18%	17%	14%

Proteus mirabilis **(n=282)**	**2021**	**2022**	**2023**	**2024**	**2025**	**0-17y**	**18-50y**	**51-60y**	**61-70y**	**70+y**	**Inpatient**	**Outpatient**
Ampicillin	69%	57%	64%	66%	51%	68%	62%	66%	70%	45%	57%	63%
Amoxicillin-clavulanate	85%	69%	72%	79%	63%	75%	71%	82%	82%	63%	71%	75%
Cefuroxime (Oral)	83%	80%	83%	82%	78%	85%	84%	87%	84%	70%	79%	82%
Ciprofloxacin	65%	73%	78%	83%	69%	83%	76%	79%	74%	62%	66%	78%
Levofloxacin	67%	73%	75%	84%	72%	86%	76%	82%	74%	62%	69%	78%
Cotrimoxazole	63%	67%	69%	72%	51%	68%	71%	68%	65%	53%	64%	65%
Nitrofurantoin	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

	% ESBL positive					% ESBL positive					% ESBL positive	
Organism	**2021**	**2022**	**2023**	**2024**	**2025**	**0-17y**	**18-50y**	**51-60y**	**61-70y**	**70+y**	**Inpatient**	**Outpatient**
Escherichia coli **(n=2630)**	18%	17%	19%	20%	18%	18%	17%	18%	19%	22%	20%	18%
Klebsiella pneumoniae **(n=336)**	14%	18%	21%	27%	17%	18%	12%	27%	21%	23%	18%	21%
Proteus mirabilis **(n=282)**	0%	12%	14%	5%	10%	8%	7%	5%	5%	11%	8%	8%

NEWS & EVENTS

Award Recognition

Ming Pao ESG Award 2026 (12 June 2026)

Following our success with the 'Excellence in Decarbonization Award' last year, Union Hospital has achieved another significant milestone by receiving the 'Elite of Sustainability Performance Award' at the Ming Pao ESG Award 2026.

This latest honour marks our advancement from targeted carbon reduction to comprehensive sustainability leadership. It recognises the successful integration of ESG principles into our clinical governance and daily operations, reinforcing our commitment to embedding green practices alongside healthcare excellence.

Post-Event Highlights

Union Hospital Polyclinic (Tsuen Wan) Relocates to New Premises

To enhance accessibility and provide a more comfortable healthcare experience for the Tsuen Wan community, Union Hospital Polyclinic (Tsuen Wan) has relocated to its new premises at KOLOUR • Tsuen Wan I. The new clinic commenced service on 26 May 2026 and celebrated its Grand Opening on 17 June 2026.

Located on the 3rd floor of KOLOUR • Tsuen Wan I, the new clinic offers a spacious and modern environment designed to improve patient comfort and service efficiency.

The Grand Opening Ceremony was officiated by Mr Yip Ying Chee, John, Executive Director of Henderson Land Development Company Limited and Member of the Union Hospital Management Board, together with members of the Hospital's senior management and doctors. Colleagues from various departments also joined the celebration and toured the new facilities.

The clinic continues to provide a comprehensive range of healthcare services, including Specialist Outpatient Services, General Practice and Family Medicine, Chronic Disease Management, Health Screening Programmes and Vaccination Services, bringing quality healthcare closer to residents in Tsuen Wan and neighbouring districts.

CME Programme – Mandatory Reporting of Child Abuse Ordinance

On 12 June 2026, Union Hospital organised a CME lecture titled 'Mandatory Reporting of Child Abuse Ordinance'. The session covered the latest ordinance, reporting procedures, and relevant penalties, delivered by Mr David Kan, Partner and Solicitor Advocate at Howse Williams, and Ms Maureen Liu, Partner at Howse Williams. Mr Kan also shared practical strategies to support implementation in clinical practice.

The lecture was chaired by Dr Joseph Ho, Head of Quality Assurance & Training Department at Union Hospital and it facilitated an active discussion with both onsite and online participants. This lecture attracted over 230 doctors, nurses, and other healthcare professionals, making a valuable contribution to continuing medical education.

New Clinical Sessions

Minimally Invasive Centre		
Booking & Enquiry: 2608 3383	Time Schedule	
Neurosurgery Dr Lam Ming Kuen, Joseph	Tue Fri	09:00 – 10:00 09:00 – 10:00
Orthopaedics & Traumatology Dr Tong Sheung Chi	Tue Fri	15:00 – 18:00 13:30 – 16:00

Specialty Clinic		
Booking & Enquiry: 2608 3366	Time Schedule	
Paediatric Immunology, Allergy and Infectious Diseases Dr Chua Gilbert T.	Mon Wed Fri Sat	15:00 – 18:00 09:30 – 13:00 15:00 – 18:00 09:30 – 13:00 15:00 – 18:00 14:30 – 18:00

Specialty Clinic		
Booking & Enquiry: 2608 3222	Time Schedule	
Psychiatry Dr Tam Mo Shing, Paul	Mon Sat	10:00 – 13:00 10:00 – 13:00
Psychiatry Dr Tam Woon Chi, Cindy	Mon Wed	14:00 – 18:00 14:00 – 18:00

Union Heart Centre		
Booking & Enquiry: 2608 6777	Time Schedule	
Cardiology Dr Lam Chiu Wah	Mon Tue Wed Thu Fri Sat	10:00 – 12:30 10:00 – 12:30 16:15 – 18:00 10:00 – 12:30 10:00 – 12:30 10:00 – 12:30 15:30 – 17:30 10:00 – 13:00

Union Hospital Dental Centre		
Booking & Enquiry: 2608 3393	Time Schedule	
Dental Surgeon Dr Cheung Ngai Yu, Iris	Tue Thu *Will be on duty on alternate weeks	14:30 – 18:00* 09:00 – 13:00 14:00 – 17:00
Dental Surgeon Dr Esther Kong	Mon Wed Fri 	09:00 – 13:00 14:00 – 18:00 09:00 – 13:00 14:00 – 17:00 09:00 – 13:00 14:00 – 18:00

Union Hospital Polyclinic (Tsim Sha Tsui)		
Booking & Enquiry: 2375 3323	Time Schedule	
Dermatology Dr Chiu Lai Shan, Mona	Mon Wed Fri	13:00 – 14:30 09:00 – 10:30 09:30 – 11:00

Union Hospital Polyclinic (Tsim Sha Tsui) Dental Centre		
Booking & Enquiry: 2608 3393	Time Schedule	
Dental Surgeon Dr Cheung Ngai Yu, Iris	Mon Sat *Will be on duty on alternate weeks	09:00 – 13:00 14:00 – 17:00 09:00 – 13:00 14:00 – 17:00*
Dental Surgeon Dr Esther Kong	Tue Thu 	09:00 – 13:00 14:00 – 18:00 09:00 – 13:00 14:00 – 18:00

Union Hospital Polyclinic (Tsuen Wan)		
Booking & Enquiry: 2608 3399	Time Schedule	
Internal Medicine / Respiratory Dr Ip Lap Shun, Thomas	Tue Sat	17:15 – 18:30 16:00 – 18:00

Regular Meetings

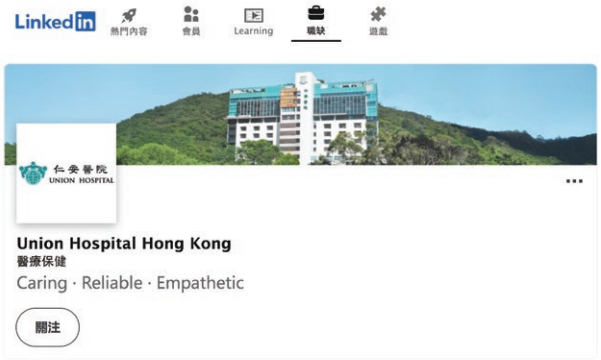
Meeting :	Mortality and Morbidity Meeting	Clinical Pathologic Conference
Date : Time :	12 August 2026 (Wednesday) 8:30am – 9:30am	9 September 2026 (Wednesday) 8:30am – 9:30am
Co-ordinator:	Dr YIU Ying Chang, Raymond Consultant in General Surgery, Union Hospital	Dr FUNG Ming Kit, Terence Deputy Head, Department of Surgery, Union Hospital Dr LUI Chi Wai, Philip Consultant in Pathology, 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 Tong Sheung Chi
Consultant in Orthopaedics and Traumatology

Dr Mok Yin Kwan
Consultant in Obstetrics & Gynaecology



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, reliable healthcare. Scan the QR code to follow — and don't forget to tag us in your posts!

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