Anniversary Celebration
仁安醫院三十周年

UNION Connection

VOL 217 | September 2025

Message from the Chief Hospital Manager

Dear Colleagues,

Union Hospital first achieved whole hospital ISO accreditation in 1999. Around that time private hospitals in Hong Kong were facing a grim situation in their operations because of reforms and improvements in public hospitals after establishment of the Hospital Authority with injection of huge funding by the HK Government. Thus all the private hospitals came together and incorporated the Hong Kong Private Hospitals Association (HKPHA) whose major tasks included upgrading the quality of services of member hospitals together with accreditation by external third parties. This would help to gain the trust of the local community. Through the connections of Professor Harry Fang, then medical superintendent of St. Paul's Hospital, the Trent Accreditation Scheme (TAS) from the United Kingdom was engaged to carry out surveys and accreditation for all members of the HKPHA in the year 2000. TAS surveyors from the UK would visit all the hospitals in a 2 year cycle, correcting bad practices and non-conformities and introducing good practices as known by the surveyors.

With the press release after the first cycle of TAS accreditation, citizens of Hong Kong came to realize that they did have an alternative or choice when they came to require tertiary healthcare or hospitalization because of illness. Then came the first SARS epidemic in 2003 in Hong Kong with quite a number of healthcare workers infected or victimized, mostly amongst those working in public hospitals. It made headline news when an outbreak occurred in the Prince of Wales Hospital with the index patient coming from the Amoy Garden residential estate. This short-lasting epidemic exposed the shortcomings in the infrastructure as well as service practices of public hospitals. A few years later the Department of Health embarked on a pilot study to gauge the performance of private and public hospitals with the same platform of accreditation standards and criteria by the same third party institution – the Australian Council of Healthcare Standards (ACHS). Three private hospitals volunteered and Union Hospital was one of them. Queen Elizabeth Hospital and Pamela Youde Nethersole Eastern Hospital represented the public sector. ACHS audit teams completed the 'Organization Wide Surveys' or OWS according to the set of standards and criteria known as EQuIP 6 modified and adapted to Hong Kong regulations and laws. The survey reports were mostly satisfactory with various grades given. However, it was found impossible to compare one with another because the patient populations were not the same with different levels of expectation between the private and public sector. Since the spirit of ACHS accreditation was 'continuous quality improvement' of healthcare services, the EQuIP 7 edition of standards no longer advised assessors to rank their findings in grades and accreditation results were simply 'pass', 'fail', or 'conditional pass with recommendations'. There would not be a league table! Those recommendations in the last category were to be completed within a specified period and if it were a significant 'non-compliance' it might have to be verified by an appointed assessor, specifically for the purpose.

My personal opinion is that the ACHS accreditation process is more systematised and formalised. There is a sort of syllabus in the form of EQuIP standards for the auditee institution to align its attention to areas for improvement. In other words, it is the 'self awareness' that counts. One should have insight with one's performance in various services and spare no effort in having them upgraded continually. According to Mr John Lee, the Chief Executive of the Hong Kong Government – there is no 'best' but 'better' should be the watch-word.

Good-bye for now and wishing you and your family the Best in the Mid-Autumn Festival.

Yours most sincerely,

Dr Anthony K Y Lee
Chief Hospital Manager & Medical Director

An update on the Surgical Managements of Snoring and Obstructive Sleep Apnea

Dr To Wing Hei Zion
Consultant in Otorhinolaryngology
Union Hospital

Introduction

We spend around 1/3 of our lives sleeping, an US population statistic reveals that for a person with around 78 years of life expectancy, they spend around 28 years on sleeping. **(Figure 1)** Therefore, sleeping is an important aspect of our lives. Regarding obstructive sleep apnea (OSA), there is an obstruction continuum ranging from snoring to upper airway resistant syndrome (UARS) to eventually OSA. Snoring is a symptom of hoarse sound caused by vibration of relaxed respiratory structures of the upper airway which cause obstruction of breathing while asleep. It is more prevalent in male and postmenopausal women.[i] Obstructive sleep apnea is the end result of multilevel obstruction. It is the most common sleep related breathing disorder. It is characterized by repeated episodes of partial or complete obstruction of the upper airway during sleep. For the prevalence it accounts for 4% in middle aged men and 2% in middle aged women.[ii] Symptoms of OSA include fragmented sleep and snoring. Without a good quality sleep, patients can develop excessive daytime sleepiness, morning headache and even poor concentration at work. Risk factors of OSA include obesity, narrowed airway, hypertension and diabetes. OSA could also lead to adverse complications such as cardiovascular, endocrinology and neurocognitive diseases.[iii]

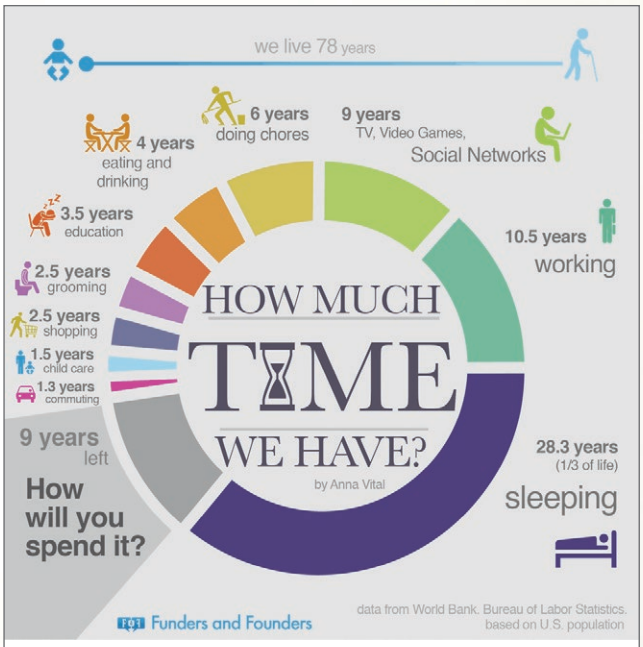

Figure 1. How Much Time We Have?
World Bank Bureau of Labor Statistics based on U.S. population

To evaluate a patient whether they have snoring alone or having sleep apnea, sleep study is conduced either in-laboratory polysomnography (PSG) or home sleep apnea test (HSAT) which become much more popular after the era of COVID-19.[iv] After establishing the diagnosis of obstructive sleep apnea, various treatment options can be offered to patients. Treatments of OSA include conservative and surgical options. Conservative treatments include weight reduction, myofunctional therapy, positional therapy, mandibular advancing device (MAD)[v] and positive airway pressure (PAP). Surgical options depend on the site of obstruction in drug induced sleep endoscopy (DISE)[vi]. Drug induced sleep endoscopy is a dynamic evaluation of the upper airway during sleep. It is useful to identify the pattern and site of obstruction before planning for surgery.

Surgical Treatments

Focusing on the surgical treatments of OSA, it can be divided according to the surgical sites. It can either be soft tissue or bone work surgeries. Sleep surgery is indicated in patients who cannot tolerate or poorly adherence to conservative treatments such as PAP or Oral appliance.[vii] Patients who have surgically correctible abnormalities are beneficial to sleep surgery. It is also important to take into consideration of patient's preference. There are various factors to determine which specific operation to perform on patients. First of all, it depends on the severity of OSA of the patient and also the level of obstruction identified in DISE. Surgical success is defined by the Sher criteria[viii] in which patients achieved 50% reduction in AHI and AHI <20/ hour postoperatively. Surgical options of OSA include nasal surgery, palatal surgery, hypopharyngeal tongue base surgery, bone work open box surgery and the latest hypoglossal nerve stimulation (HGNS).

Nasal surgery

The nose is the gateway to our upper airway thus it is important to establish a patent nasal passage for OSA patients. Common contributing factors of nasal obstruction include nasal septal deviation, inferior tubinates hypertrophy, sinusitis, nasal polyposis and nasal tumors. The prevalence of nasal diseases in OSA patients is reported for more than 30%. [ix] Patients with deviated nasal septum would present with unilateral nasal obstruction. Septoplasty can be performed to reshape the septum and straighten it to provide a patent nasal passage for the patient. Inferior turbinates hypertrophy is commonly observed in patients with rhinitis. For those who failed medical treatments, turbinate reduction can be performed. Rhinosinusitis refers to the inflammation of the nasal cavity and paranasal sinuses. Other causes of nasal obstruction include mass lesion such as presence of nasal polyps and nasal tumor such as sinonasal inverted papilloma which is the most common benign tumor of the sinonasal tract. Functional endoscopic sinus surgery (FESS) is a minimal invasive procedure aims to clear the disease for sinusitis, nasal polyp and nasal tumor to establish a patent nasal airway. Nasal surgery does have a role to increase PAP compliance, improve sleep quality and reduce subjective sleepiness.

Palatal surgery

Tonsils and adenoid hypertrophy are one of the main causes for pediatric OSA patients. The first line surgical treatment is to remove the lymphoid tissue which causes mechanical obstruction to the upper airway. Tonsillectomy is commonly performed for patients with enlarged tonsils in both adult and pediatric group using cold steel instruments or energy devices. Uvulopalatopharyngoplasty (UVPPP) is performed in adult patients to remove the soft tissue in the pharynx including the uvula and part of the soft palate. Relocation pharyngoplasty is performed to apply suspension absorbable suture over the ptergomandibular raphe in order to sling up the lateral wall. Minimal invasive radiofrequency ablation to the soft palate can cause tissue fibrosis and expand the oropharyngeal airway. It is indicated for mild to moderate OSA patients. It can be performed under local anesthesia as an office base procedure.

Tongue base surgery

Minimal invasive radiofrequency can also be applied to the tongue base region in retrolingual collapse patients. For patients with lingual tonsil hypertrophy leading to mechanical obstruction to the tongue base region, lingual tonsillectomy either by endoscopic or even robotic assisted means can be conducted. Midline glossectomy is another option for tongue base collapse patients using robot with better visualization and instrument handling in tight space within oropharynx known as Transoral Robotic Surgery (TORS)[x].

Bone work surgery

Distraction osteogenesis maxillary expansion (DOME) is indicated with patients with high-arch palate phenotype. The lack of intraoral volume for tongue may lead to tongue falls back. An expander is anchored to the roof of the maxilla intraorally to expand the palate. Orthodontic treatment is necessary to restore the occlusion. Sliding genioplasty is indicated in retrolingual predominant tongue base obstruction patient. This surgery can not only improve function but also aesthetics as well. The ultimate open box surgery is maxillomandibular advancement (MMA). It is maxillofacial surgery to expand the upper airway by moving forward the maxilla and mandible bone.

Hypoglossal nerve stimulation

An innovative new surgical option for patients with retrolingual obstruction would be Hypoglossal nerve stimulation (HGNS) **(Figure 2)**. It consists of a device like a pacemaker to stimulate the hypoglossal nerve for tongue protrusion in order to open up the upper airway during sleep. Components of Inspire system HGNS include an electrode with a cuff enclosing the hypoglossal nerve with another impulse generated with a sensing lead to synchronize the impulse with patient's breathing. The landmark paper published in New England Journal of Medicine 2014 known as the STAR trial- stimulation therapy for apnea reduction.[xi] It is a multicenter, prospective, single-group, cohort design. Surgically implanted upper-airway stimulation device is indicated for patients with moderate to severe OSA who had difficulty either accepting or adhering to CPAP therapy. The study consists of 126 participants and the median AHI score at 12 months decreased 68%, from 29.3 to 9 ($P<0.001$).

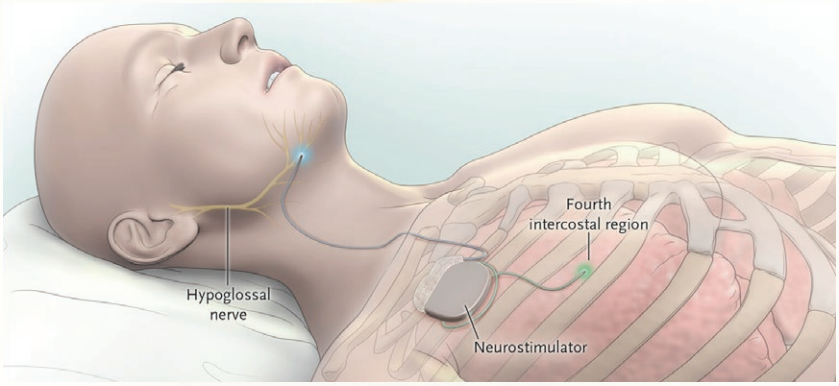

Figure 2. Hypoglossal nerve stimulation
Patrick J. Strollo, et al. Upper-Airway Stimulation for Obstructive Sleep Apnea. N Engl J Med 370:2.

Conclusion

Snoring and obstructive sleep apnea affects not only patients but also the community. Polysomnography (PSG) is the gold standard of sleep diagnostic test and Drug induced sleep endoscopy (DISE) can be used to evaluate the site of obstruction to guide surgical treatment options. Various surgical options can be offered to patients with anatomical mechanical obstruction. Nasal surgery can help improve compliance of positive airway pressure (PAP) and facilitate subsequent surgery. Palatal surgeries with different pharyngoplasty techniques and tonsillectomy benefits patient with large tonsils. Open box bone work surgery combined with pharyngeal surgery can achieve a significant improvement. Hypoglossal nerve stimulation shows promising results particularly for retrolingual obstructing patients. Choosing the appropriate surgical options for sleep apnea patients will certainly improve both the function and quality of life of patients who cannot tolerate conservative options.

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X. Claudia Vicini, et al. Transoral robotic surgery for obstructive sleep apnea syndrome: Principles and technique. World J Otorhinolaryngol Head Neck Surg. 2017 Jun 13;3(2):97–100.
XI. Patrick J. Strollo, et al. Upper-Airway Stimulation for Obstructive Sleep Apnea. N Engl J Med 370:2.

Can Photon-Counting CT (PCCT) Truly Deliver on Its Pronounced Advancements & Benefits?

Mr Brightson Li
Senior Radiographer
Union Hospital

Preface

In the realm of cutting-edge medical imaging, relying solely on manufacturers' claims is insufficient—rigorous scientific validation through real-world data and clinical experience remains paramount.

Therefore, I have conducted a research that focuses on evaluating the technical performance and clinical efficacy of **PCCT** and the **advanced contrast medium injection system with automated personalized injection protocol** during their early-phase implementation in medical practice, verifying their purported benefits. Beyond validation, this work seeks to identify opportunities for system optimization, with the ultimate goal of contributing actionable insights to the field.

With the genuine support from Hospital Administration and Dr James Chan (Head of MEI), I am grateful to represent Union Hospital to deliver an Oral Presentation of this study at the **18th Asian Society of Cardiovascular Imaging Congress (ASCI 2025)**. And I was honored to receive the **"Best Scientific Presentation Award"** especially as a representative from Hong Kong. This demonstrates the high level of recognition on this topic among global professionals.

Accepting congratulation from Dr Stephen Cheung (Former President of ASCI; COS of Radiology, QMH) & Dr Carmen Chan (Vice President of ASCI; Consultant Cardiologist, QMH), and sharing our perspectives.

SHARING CORNER

Below is a key excerpt from the study:

Patient Safety with the Application of SMART Protocols for Contrast Injection in Coronary Computed Tomography Angiography (cCTA) with Energy Integrated Detector CT (EIDCT) & Photon-counting CT (PCCT) Scanners

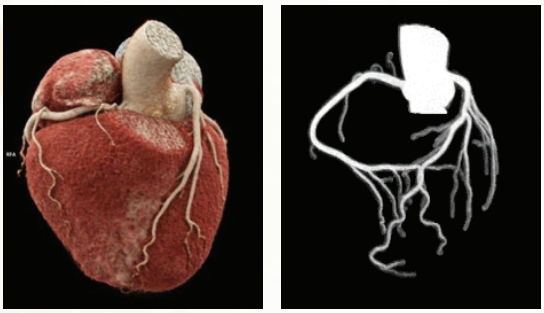
1. INTRODUCTION

Nowadays, the role of coronary CT angiography (cCTA) is so important in non-invasive cardiac imaging. While contrast injection remains the major risk of examination. Personalized contrast injection targets to reduce the risks while maintaining diagnostic excellence. This study evaluates how these injection protocols impact cCTA examination, with both conventional EIDCT and cutting-edge PCCT scanner. This study bridges innovation with real clinical practice, revealing the potential for personalized injection protocol to become standard practice, representing a major advancement in non-invasive coronary imaging.

2. OBJECTIVES

To demonstrate the effectiveness of personalized contrast injection in cCTA, in relation to:

- Reduction of unnecessary contrast volume and injection rates without sacrificing image quality.
- Achieving the above while keeping radiation dose unaffected.



3. METHODOLOGY

CT Scanners

- Siemens SOMATOM Force (EIDCT)
- Siemens NAEOTOM Alpha Peak (PCCT) Scanners

Power Injector

Bayer MEDRAD® Centargo CT Injection System

Contrast Injection Protocol

- Standard Fixed CT Protocol (STD)
- Personalized Patient Protocol Technology (P3T)*
- Smart Iodine Delivery Rate (IDR)*

** SMART injection protocol*

Study Population

30 cases per each injection protocol.

Patient Selection

Inclusion criteria

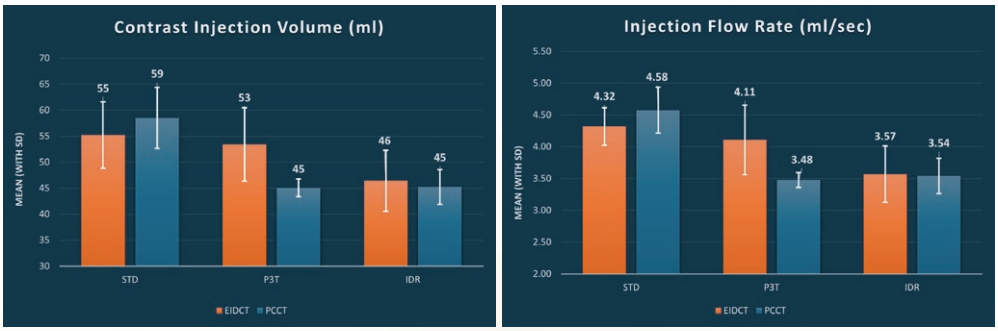
- ✓ ≥ 18 years old
- ✓ 55-70 kg
- ✓ Heart rate ≤ 80 bpm

Exclusion criteria

- × Serious coronary stenosis or stent case
- × heart rate > 80 bpm

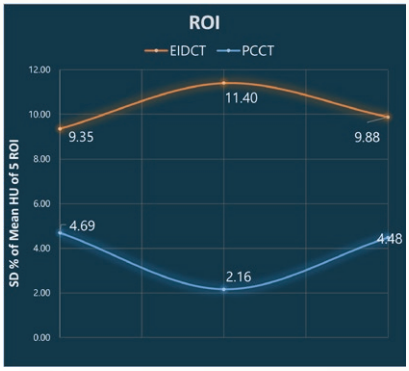
4. RESULTS

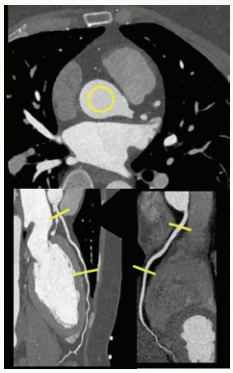
Comparison of contrast injection volume (ml) & injection rate (ml/sec) among 3 injection protocols on 2 scanners



Comparing standard injection protocol, SMART injection protocol achieves a remarkable reduction of both contrast injection volume and injection rate with either EIDCT or PCCT.

Image consistency measured in SD% of Mean Hounsfield Unit (HU) at 5 different Regions of Interest (ROI) (Aorta, pLAD, mLAD, pRCA, mRCA) on cCTA images





- The homogeneity of vessel opacification was evaluated by measuring the HU of identified ROI along the major coronary arteries.
- For EIDCT, image consistency with the use of SMART injection protocol is slightly lower when compared to fixed injection protocol (STD).
- **For PCCT**, results show that SMART injection protocol **improves the image consistency** when compared to fixed injection protocol.
- Overall image consistency was found significantly higher on PCCT over EIDCT.

PATIENT SAFETY - Radiation Dose & Extravasation Rate

- Effective dose of all the selected samples were calculated and compared, results showing lower effective dose for the scans with SMART injection protocol.
- It is proved that **no additional radiation dose is required** to compensate for reduction in contrast injection volume and rate, while maintaining image quality/ consistency. There is **no extravasation incident with the use of Smart Protocol** (P3T & IDR). This improvement is likely due to the optimization of injection rates tailored to individual patients, avoiding unnecessary high injection rate.

EIDCT

Injection Protocol	Relative Radiation Dose
STD	*As reference for comparison*
P3T	78%
IDR	73%

PCCT

Injection Protocol	Relative Radiation Dose
STD	*As reference for comparison*
P3T	91%
IDR	93%

Extravasation case % of cCTA cases in 1 year period (27 May 2024 - 26 May 2025)		
STD	P3T	IDR
0.0015%	0%	0%

5. DISCUSSION & CONCLUSION

In this study, **personalized contrast injection is shown to be effective** in non-invasive coronary computed tomography angiography (cCTA) for typical body size population in Hong Kong. The **advancements and benefits** of personalized contrast injection on **patient safety and image quality** are demonstrated with the combination of both EIDCT & PCCT Scanners, and **more remarkable with PCCT**, probably related to the better contrast to noise ratio offered by photon-counting technology. The optimized contrast dosage and reduced injection rate enhanced patient safety by **minimizing the risk of contrast-induced side effects or reactions, renal impairment, and extravasation without any radiation penalty**. Effective utilization of state-of-the-art technologies is crucial to **provide substantial benefits to patients** in the radiology domain.

Outcome and future direction through this scientific study

Real world data speaks

Scientific and evidence-based data is compelling and garners widespread attention, substantially enhancing our service's credibility and acceptance.

Positive impact to the field

I am also encouraged that the validated results of this study have influenced local institutions who have subsequently installed PCCT systems, many of whom have now emulated the personalized injection protocol advocated in this study. It is gratifying to see this contribution to elevating standards within our field.

Continuous refining for excellence

Based on the study findings, we collaborated with CT scanner application specialists to further refine the PCCT system settings. This optimization successfully achieved a further reduction in radiation dose while also enabling a marked decrease in both the volume and rate of contrast injection.

Leading with insight

Leveraging the latest dataset acquired with this refined technique, a comprehensive & multi-faceted analysis is in progress for publish. I hope the coming work will provide new insights and stimulate further innovation within the global medical community regarding the application of PCCT and personalized contrast injection. Ultimately, aiming to pioneer a new chapter in CT imaging and advance the delivery of patient-centered care.

NEWS & EVENTS

The 100,000th Union Baby Is On the Way! Three Decades of Care: Piecing Together Every Family's Cherished Moments

For over 30 years, we have accompanied families on the journey of bringing new lives into the world, witnessing countless 'Union Baby Stories'. Today, we are about to celebrate the birth of our 100,000th baby—a precious milestone that reflects the trust and confidence each family has placed in us.

'Union Baby Stories' are precious. Visit our milestone website to watch the heartwarming video 'Where 100,000 Lives Begin', guiding you through the touching journeys of Union Babies. You can also experience 'Union Babies Story Hub', where families and healthcare team share their cherished memories, and we warmly invite you to share your thoughts as part of the wonderful caring team to this mosaic memories.

Explore our milestone website

Share your thoughts

Awards Recognition

HONG KONG INNO:dus Recognition Program 2025 – Distinguished Award: Social Impact (25 August 2025)

Union Hospital is thrilled to receive the 'Hong Kong INNO:dus Distinguished Award: Social Impact', in recognition of our UH30 charity initiatives. This award acknowledges our dedicated efforts in promoting health education and supporting primary health screenings for the community.

Headline No.1 Award: Editor's Choice – Excellence in Private Hospital Maternity Services Award (29 August 2025)

Union Hospital is proud to once again be recognised with the Headline Daily's No.1 Award. This year, we received the 'Editor's Choice - Excellence in Private Hospital Maternity Services Award' (編輯之選 – 卓越私院分娩服務大獎), highlighting the trust and support our quality maternity services have earned from countless families. This award is dedicated to our professional healthcare team for their 30 years of effort. As we approach a significant milestone–the 100,000th baby to be delivered at Union Hospital–our team remains committed to providing the best care to mothers for a safe and comfortable childbirth experience.

Post-Event Highlights

CME Programme – Potential Liabilities from the Use of AI in Healthcare: Views of a Medical Defence Lawyer (1 August 2025)

An insightful CME lecture titled 'Potential Liabilities from the Use of AI in Healthcare: Views of a Medical Defence Lawyer' was expertly delivered by Dr David Kan and Ms Maureen Liu from Howse Williams. They shared their valuable perspectives on the implications of AI in the healthcare sector and provided essential knowledge on potential legal liabilities, helping attendees navigate the complexities of AI in healthcare.

Chaired by Dr Clara Wu, Deputy Medical Director at Union Hospital, the session featured meaningful discussions that enhanced participant engagement and understanding of the topic. The lecture attracted over 100 participants, both onsite and online, fostering a rich exchange of ideas.

New Clinical Sessions

Minimally Invasive Centre	
Booking & Enquiry: 2608 3383	Time Schedule
Gastroenterology & Hepatology **Dr Fan Tam Ting, Tina**	Mon 11:00 – 13:00 15:00 – 18:00 Thu 10:00 – 13:00 Fri 15:00 – 18:00 Sat 10:00 – 13:00

Specialty Clinic	
Booking & Enquiry: 2608 3366	Time Schedule
Speech Therapy **Ms Kwong Ka Yi**	Thu 10:00 – 13:00

Plastic and Aesthetic Multidisciplinary Centre	
Booking & Enquiry: 2608 3211	Time Schedule
Dermatology **(Aesthetic and Laser Surgery)** **Dr Chan Kai Ming**	Mon 09:00 – 13:00 Fri 08:00 – 10:00

Union Oncology Centre	
Booking & Enquiry: 2159 6100	Time Schedule
Oncology **Dr Chan Man Hong, Helen**	Mon 14:00 – 17:00 Wed 14:00 – 17:00 Fri 10:00 – 13:00
Oncology **Dr Lee Wai Chung, Kirsty**	Thu 09:00 – 12:30

Union Healthcheck Centre	
Booking & Enquiry: 2682 2313	Time Schedule
General Practice **Dr Feng Longyin**	Mon to Fri 09:00 – 17:00 Sat 09:00 – 13:00 (Please call 2682 2313 to confirm the duty doctors for the day.)

Union Hospital Polyclinic (Tsim Sha Tsui)	
Booking & Enquiry: 2375 3323	Time Schedule
Dermatology **Dr Chiu Lai Shan, Mona**	Mon 13:00 – 14:30 Wed 09:00 – 10:30
Gastroenterology & Hepatology **Dr Fan Tam Ting, Tina**	Tue 11:00 – 13:00 15:00 – 18:00 Wed 15:00 – 18:00 Thu 15:00 – 18:00 Fri 10:00 – 13:00

Union Hospital Polyclinic (Ma On Shan)	
Booking & Enquiry: 2375 3323	Time Schedule
Psychiatry **Dr Tung Ka Yee, Carrie**	Tue 10:00 – 12:30 Thu 10:00 – 12:30

Regular Meetings

Meeting :	X-Ray Meeting	Mortality and Morbidity Meeting
Date : Time :	8 October 2025 (Wednesday) 8:30am – 9:30am	12 November 2025 (Wednesday) 8:30am – 9:30am
Co-ordinator:	**Dr CHAN Chi Sang, James** **Head, Department of Medical Imaging, Union Hospital**	**Dr YIU Ying Chang, Raymond** **Consultant in General Surgery, Union Hospital**
Venue:	Training Room, 8/F MIC, Hospital Building, Union Hospital	
Booking & Enquiry:	2608 3160 (Quality Assurance and Training Department)	

CME Programme

Common Haematological Conditions and Haematological Emergencies in Hospitals

Date : 10 October 2025 (Friday)

Time : 2:00pm-3:00pm
(Lunch Buffet will be served at 1:15pm)

Venue : 2/F Seminar Room, Union Hospital

Speaker : **Prof. Leung Yu Hung, Anskar**

Chair of Haematology,
Li Shu Fan Medical Foundation
Professor in Haematology
Department of Medicine,
School of Clinical Medicine,
LKS Faculty of Medicine, HKU

Chairperson : **Prof. Chan Lik Yuen, Henry**
Deputy Chief Hospital Manager
Union Hospital

On-site Registration
2608 3180

Online Registration (Zoom)
cme@union.org

New Clinical Member

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

Dr Chan Kai Ming
Specialist in
Dermatology and Venereology

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