New Clinical Sessions

Specialty Clinic - Obstetrics & Gynaecology

Booking & Enquiry: 2608 3222	Time Schedule
Dr. Chan Yuen Mei	Mon 15:00-18:00 Thu 15:00-18:00 Sat 09:30-12:30 14:30-17:00

Specialty Clinic - Paediatrics

Booking & Enquiry: 2608 3366	Time Schedule
Dr. Li Nga Wai	Tue 09:30-13:00 Thu 09:30-13:00 Sat 15:00-18:00

Specialty Clinic - Ophthalmology

Booking & Enquiry: 2608 3366	Time Schedule
Dr. Chan Chi Wang, Jeffrey	Mon 10:00-14:00 Tue 15:00-18:00 Wed 16:00-18:00 Thu 10:00-14:00 Fri 16:00-18:00 Sat 13:00-16:00

Plastic and Aesthetic Multidisciplinary Centre

Booking & Enquiry: 2608 3211	Time Schedule
Rheumatology **Dr. Ng Sin Ngai, Ray**	Thu 15:30-19:00 Sat 15:30-18:00

Union Hospital Polyclinic (Tseung Kwan O)

Booking & Enquiry: 2721 0100	Time Schedule
Paediatrics **Dr. Li Nga Wai**	Mon 10:00-13:00 15:00-18:00 Thu 15:00-18:00

Union Hospital Polyclinic (Tsim Sha Tsui)

Booking & Enquiry: 2375 3323	Time Schedule
Gastroenterology & Hepatology **Dr. Pang Hing Yan, Sandy**	Mon 14:00-16:00 Thu 10:00-13:00
Obstetrics & Gynaecology **Dr. Chan Yuen Mei**	Tue 10:00-13:00 Wed 10:00-13:00 14:30-17:30 Fri 14:30-17:30
Internal Medicine/Endocrinology **Dr. Ting Zhao We**	Mon 10:30-12:30

Union Hospital Polyclinic (Ma On Shan)

Booking & Enquiry: 2608 3377	Time Schedule
Obstetrics & Gynaecology **Dr. Chan Yuen Mei**	Tue 15:00-18:00 Thu 10:00-13:00

Union Hospital Polyclinic (Tsuen Wan)

Booking & Enquiry: 2608 3399	Time Schedule
Otorhinolaryngology **Dr. Ho Wai Ki, Ricky**	Tue 13:00-14:30 Thu 13:00-14:30 Sat 14:30-16:00
Paediatrics **Dr. Li Nga Wai**	Tue 15:00-18:00

Regular Meeting

Meeting : X Ray Meeting

Date :	13 December 2023 (Wednesday)
Time :	8:30 a.m. – 9:30 a.m.
Co-ordinator:	**Dr. HUI Ping Kuen, John** **Consultant in Radiology, Union Hospital**
Venue:	Training Room, 8/F MIC Hospital Building, Union Hospital
Booking & Enquiry:	2608 3151 (Quality Assurance and Training Dept)

New Doctors

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

Dr Chan Yuen Mei
Consultant in
Obstetrics & Gynaecology

Dr Li Nga Wai
Consultant in
Paediatrics

Union Hospital Charity Program 仁心仁術慈善計劃

Join our Charity Program and help the Needy!

Founded in 2006, Union Hospital Charity Program was established with an aim of offering quality surgeries and treatments to those patients with financial difficulties. In August, the program provided radiotherapy treatment to Mr Eddie Chau Jr., father of Chau Tin-yu (天瑜爸爸) who diagnosed with malignant muscle tumors. We encourage doctors or any individuals to support the charity program and help the needy!

To learn more about our Program, please scan here:

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Feedback to Union Connection: ccm@union.org

UNION connection

VOL 206
October 2023

Message from the Chief Hospital Manager

Dear Colleagues,

Recently I was invited to be the guest of honour at the Opening Ceremony of Class EN23 of our School of Nursing which occupied the top floor of an upmarket office building in Shatin. While standing in the well-appointed and spacious lecture room overlooking the luscious green scenery outside, I cannot help but reminisce over the humble school campus when it was established. It was in the year 2007 when Union Hospital began to take in nursing students from University of Hong Kong and the Open University (now named Metropolitan University) for clinical placement. School campus was situated in Union Court, gradually expanding from two adjacent units to six units spread out on two floors with one atop the other over the course of four years. The total floor area occupied by the school was about 11,000 sq. ft. In November 2011, the Union Hospital School of Nursing launched its own Diploma in General Nursing (Enrolled Nurse) Programme, after being accredited by the Nursing Council of Hong Kong as a Gazetted Nursing Training School for Enrolled Nurse.

The first principal of the school was a long time loyal staff of the hospital who joined us in March 1995 as Locum Planning Officer. She was none other than Mrs Fan Wong to whom I must give credit for the successful task of working with me together to have attained whole hospital ISO 9001 accreditation. What I would claim this having been an amazing feat was that Fan and I worked together with advice and guidance from Havering Radcliffe as ISO accreditation consultant to write up all the documents required by the accrediting institution simply describing what we were doing in Union Hospital in providing a quality healthcare service to the community. In other words, we documented the organization and hierarchy of the Hospital and her various departments as well as their job responsibilities, departmental procedures and standard working guidelines of every rank and file. We achieved ISO accreditation in 1999 with perfect scores.

In the year 2013, the School churned out her first batch of EN (Enrolled Nurse) graduates, numbering 29 in total. Eight of them are still working in Union Hospital. In the following and subsequent years, the EN programme was accredited by the Hong Kong Nursing Council and the HK Council for Accreditation of Academic and Vocational Qualifications (HKCAAVQ). Since 2018, the school has been granted permission by these legislated bodies to adopt English as teaching medium. In order to provide an illustrious career pathway for the student nurses, the school established the Professional Diploma in Nursing (Enrolled Nurse to Registered Nurse Conversion Programme) since 2020.

Over these years, a total of 414 nurses graduated from the EN programme and the school also recorded her first batch of home grown PDN conversion course graduates which consisted of 27 registered nurses. Most of them had been employed by Union Hospital. Up to the present moment, amongst our work force 109 nurses (72 EN and 37 RN) were graduates from the School.

Other than being the breeding ground for our nurses, the School also helps to train assistants for the nurses to partly relieve their workload. These latter are Care Related Service Workers (CRSW). The training course lasts for six weeks and pupils will be instructed along two streams - one for in-patient service and the other being geared toward out-patient care. The curriculum was planned according to procedures and practises currently adopted in Union Hospital. Thus candidates who have completed CRSW training will be very helpful to assist daily chores and somewhat share out the workload of our nurses.

Yours most sincerely,

Dr Anthony K Y Lee
Chief Hospital Manager & Medical Director

UNION HOSPITAL union@union.org www.union.org
18 Fu Kin Street, Tai Wai, Shatin, N.T. Tel: 2608 3388
仁心、安心、貼您心
Caring • Reliable • Empathetic

Spotlight on Male Breast Diseases

Dr Li Birgitta Yan Wing
Specialist in Radiology
Union Hospital

Introduction

The male breast is susceptible to a variety of benign and malignant processes, many of which present clinically as a palpable finding, focal pain, or breast enlargement. Gynecomastia is the most common abnormality in the male breast and needs to be distinguished from malignancy. Diagnostic mammography is the initial imaging modality for the symptomatic male breast. A palpable mass that is occult or incompletely imaged at mammography mandates targeted ultrasound. After a complete diagnostic evaluation, suspicious findings require biopsy because of overlap in clinical and imaging features of benign and malignant pathologies.

Healthy men typically have predominantly fatty tissue with few ducts and stroma, which is distinctly different from women's breasts where ducts, stroma, and glandular tissue predominate. Approximately 57% of the male population over 44 years old have palpable breast tissue. The development of lobular breast is stimulated by estrogen and progesterone. Therefore, lobular proliferation related breast diseases such as fibroadenoma, phyllodes tumor, invasive lobular carcinoma and lobular carcinoma in situ are rare in men. However, ductal and stromal proliferation-related diseases such as gynecomastia, invasive ductal carcinoma and papillary neoplasm are more common in men than diseases related to lobular proliferation.

Unlike female breast imaging, there are no standardized protocols for male breast imaging. In male patients, routine mammographic examination usually includes compressed mediolateral oblique and craniocaudal images. Sometimes advanced imaging methods such as obtaining magnified images with focal compression may be required. Well-developed pectoral muscles in men may mask the breast tissue. In these patients, pectoralis-displaced views can be obtained to better visualize the breast tissue. These views can be accomplished by displacing the pectoralis major muscle posteriorly and asking the patient to contract the muscle while the technologist pulls the breast tissue forward onto the detector.

This article reviews various benign and malignant breast diseases in men in terms of their clinical and imaging findings on mammography and ultrasound.

Figure 1. Normal male mammogram. MLO view demonstrates normal fat and lack of fibroglandular tissue in male patient.

Gynecomastia

Gynecomastia is the most common cause of male breast enlargement. It presents as a unilateral or bilateral palpable mass, with a disk-like tissue at the subareolar region. Men with gynecomastia may complain of palpable swelling, focal tenderness and burning sensation. The adult male breast normally contains a minimal amount of adipose and glandular tissue, which may proliferate if estrogen and progesterone levels are increased. Gynecomastia can be physiological or non-physiological. Physiological gynecomastia is related to an imbalance in estrogen-testosterone ratio, with consequent glandular breast tissue proliferation. There are three peaks in physiological gynecomastia formation: the first peak is in the neonatal period (transient gynecomastia occurs in 60-90% of infants due to transplacental maternal estrogen exposure), the second peak is seen in adolescents in puberty, and the third peak occurs late in life (50 - 80 year old males). Non-physiological gynecomastia can occur in any age group due to underlying health problems such as endocrine and hormonal disorders, Klinefelter's syndrome, systemic diseases, neoplasms, medications, and obesity. There are three types of gynecomastia: nodular, dendritic and diffuse glandular. These types vary according to the degree of ductal and stromal proliferation. The nodular pattern typifies the early florid phase of less than 1 year's duration. At mammography, it appears as a fan-shaped subareolar density that blends into the surrounding subcutaneous fat, resulting in indistinct borders. It corresponds to the classic clinical symptom of a painful breast mass or enlargement. Dendritic gynecomastia represents the quiescent, fibrotic phase and is seen as a 'flame-shaped' subareolar density with marked radial extension into deeper adipose tissues. It may be symmetrical or prominent in the upper outer quadrant. Diffuse glandular gynecomastia is typically seen in patients receiving high-dose estrogen therapy. At mammography, this pattern is similar to the heterogeneously dense female breast consisting of both dendritic and nodular components.

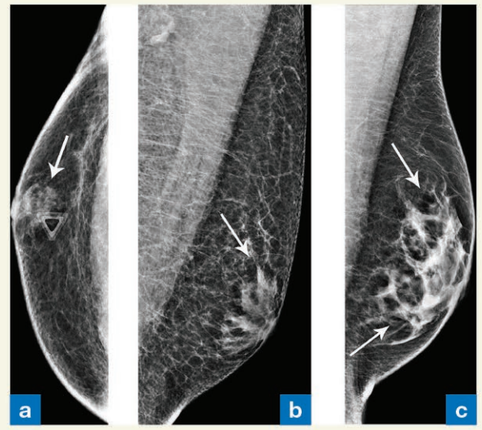


Figure 2. Types of gynecomastia. (a) Right CC view shows fan-shaped retroareolar density (arrow) in male patient with focal pain (triangle marker) and nodular gynecomastia. (b) Left MLO view shows flame-shaped retroareolar density (arrow) in male patient with dendritic gynecomastia. (c) Left MLO view shows heterogeneously dense parenchyma (arrows) and unilateral breast enlargement (contralateral breast not shown) in a 27-year-old male with diffuse idiopathic gynecomastia.

Pseudo-gynecomastia

This is enlargement of the male breast due to actual loss of breast tissue and deposition of excessive fat tissue instead. It usually occurs in older men and overweight young men. The diagnosis is based on clinical findings. The enlarged breast tissue contains radiolucent fat, and is easily differentiated from true gynecomastia by this feature.

Lipoma

Lipomas are the most common type of soft tissue tumor, with a prevalence of 2.1 per 1,000, and the second most frequent benign breast lesion in males. They typically present as soft, palpable, nontender masses. Lipomas may be numerous and/or show bilateral distribution. At mammography, it has a characteristic appearance of a well encapsulated, radiolucent, fat-density lesion, which corresponds to a mildly hyperechoic, relatively avascular, oval mass at ultrasound. However, lipomas may also be hypoechoic or isoechoic relative to subcutaneous fat.

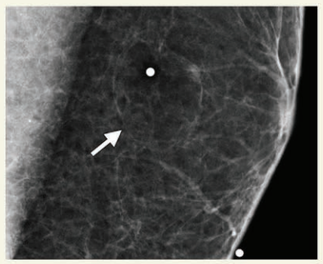


Figure 3. Lipoma in a 49-year-old man with a palpable breast mass. Left MLO mammogram (coned-down view) shows an encapsulated radiolucent lesion of fat density (arrow), an appearance diagnostic of a lipoma.

Fat necrosis

This is a benign process usually related to trauma or surgery. It may present as a tender mass. Depending on chronicity, it may be seen as large calcifications with a radiolucent center or a radiolucent well-defined lesion on mammography. However, the mammographic image of a lipoma may be mistaken for breast cancer or breast abscess due to its variable mammographic appearance, which can include persistent round, oval, or lobulated masses; foci of architectural distortion, which reflect fibrosis and desmoplastic change; and dystrophic calcifications.

Inflammatory diseases of the breast

Mastitis refers to breast infection that is relatively less common in men as compared to women and that can develop into an abscess. Microorganisms enter via the nipple and progress into the gland following trauma (e.g. nipple piercing). Typical symptoms of mastitis are local inflammation, pain, erythema, fever, skin thickening and edema. Mastitis is generally seen as unilateral breast growth accompanied by skin thickening on mammography. Subareolar abscesses are the most common inflammatory lesions of the male breast. It is a localized infection associated with ductal ectasia. They have a tendency to recur even after treatment with excision of the abscess and duct. General clinical signs include fever, swelling of the nipple and nipple discharge. Differentiation from malignancy can be difficult by mammography.

Intra-mammary lymph node

Intramammary lymph nodes can be detected anywhere in the breast, mostly in the upper outer quadrant. Normal lymph nodes can be seen as oval or reniform structures with dense peripheral edge corresponding to the cortex and more radiolucent center corresponding to hilar fat tissue on mammography. They usually have a typical appearance on ultrasound.

Sebaceous cyst

A sebaceous cyst is a benign intradermal lesion secondary to an obstructed sebaceous gland. It is typically smaller than an epidermal inclusion cyst; however, these two entities are often indistinguishable at imaging. They are typically seen as relatively small, well-defined, superficial lesions on mammography. At ultrasound, it appears as a round or oval, well-circumscribed, hypoechoic mass in the subcutaneous tissue immediately adjacent to the skin. If the cysts rupture, the cyst contents initiate an inflammatory reaction. It is difficult to distinguish ruptured cysts from malignant lesions on mammography because of their irregular boundaries.

Diabetic mastopathy

Diabetic mastopathy is a rare fibroinflammatory breast disease in men. It is characteristically seen in patients with long-standing type 1 diabetes. Findings at mammography and ultrasound are often non-specific and may appear suspicious, mimicking malignancy. Biopsy is often required for definitive diagnosis. Once the diagnosis is established, surgical excision is typically not indicated, as there is no associated increased risk of malignancy.

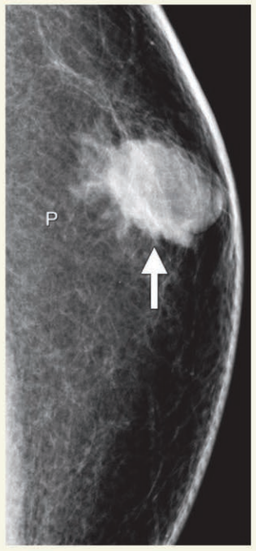


Figure 4. Diabetic mastopathy in a 36-year-old diabetic man with a palpable breast mass. Left CC mammogram shows an irregular subareolar mass.

Malignant diseases of the breast

Approximately 0.7% of all breast cancers occur in men; it constitutes less than 1% of all newly diagnosed cancer in men and is responsible for 0.2% of cancer-related deaths. Male patients with Klinefelter's syndrome, a history of orchitis or testicular tumor, liver disease, thoracic radiotherapy, and genetic predisposition (BRCA 2 gene mutation, presence of breast cancer in female relatives, p53 mutation) are at risk for developing breast cancer. The average age on diagnosis of male breast cancer is 67, which is 5-10 years more than the average age of women on diagnosis. In addition, men usually present at a more advanced stage of cancer than do women owing to a delay in diagnosis. It has been reported that approximately 50% of men have axillary nodal metastasis at initial evaluation. Male breast cancer is usually unilateral, occurring bilaterally in less than 1% of cases. The most common clinical sign is a painless, palpable retro-areolar mass. The most common forms are invasive ductal carcinoma (85% of cases), ductal carcinoma in situ and papillary carcinoma. Lymphoma and metastases can rarely occur. Breast cancer usually occurs in a subareolar location or a site that causes alteration of the nipple, and they are rarely located peripherally. Secondary signs such as skin thickening, nipple retraction, axillary lymphadenopathy and microcalcifications may be observed on mammography.

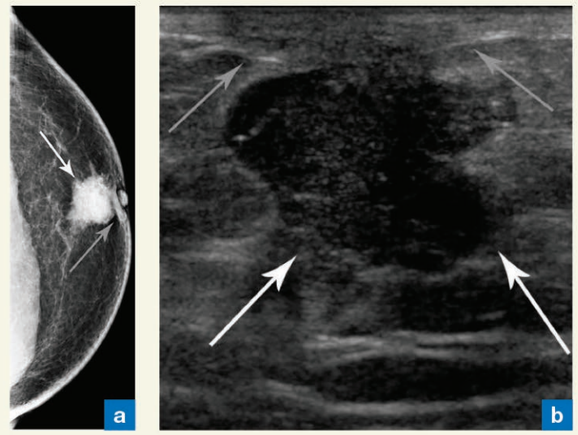


Figure 5. Nipple retraction and discrete mass in a 59-year-old male with breast cancer. (a) Left MLO view shows an irregular, high density mass in the retroareolar breast (white arrow) with associated nipple retraction (gray arrow). (b) Ultrasound shows an irregular, hypoechoic mass (white arrow) with associated nipple retraction and skin thickening (gray arrow). US-guided core biopsy demonstrated invasive ductal carcinoma.

Conclusion

Most breast conditions in men are benign conditions, many of which have characteristic imaging features that allow differentiation from malignancy. Appropriate use of mammography, US, and, when appropriate, MR imaging in the workup of male breast lesions can help us identify the small subset of patients who require biopsy to confirm or exclude malignancy. Although gynecomastia is the most common condition involving the male breast, a variety of other benign and malignant disease entities have been reported in the literature and have been described. Differentiation between benign and malignant male breast disease on mammography and ultrasound can be difficult on occasion, thus necessitating further investigations such as biopsy. Familiarity with the typical clinical and imaging features of the classic benign male breast conditions can allow us to accurately reach a diagnosis and avoid unnecessary and often invasive treatments.

References

1. Şafak KY. Mammography of the Male Breast. J Breast Health 2015; 11: 106-10.
2. Iuanow E. Spectrum of Disease in the Male Breast. AJR 201; 196:W247–W259.
3. Nguyen C. Male Breast Disease: Pictorial Review with Radiologic-Pathologic Correlation. RadioGraphics 2013; 33:763–779.
4. Chesebro AL. Male breast disease: what the radiologist needs to know. Curr Probl Diagn Radiol 2019 Sep-Oct; 48(5):482-493.

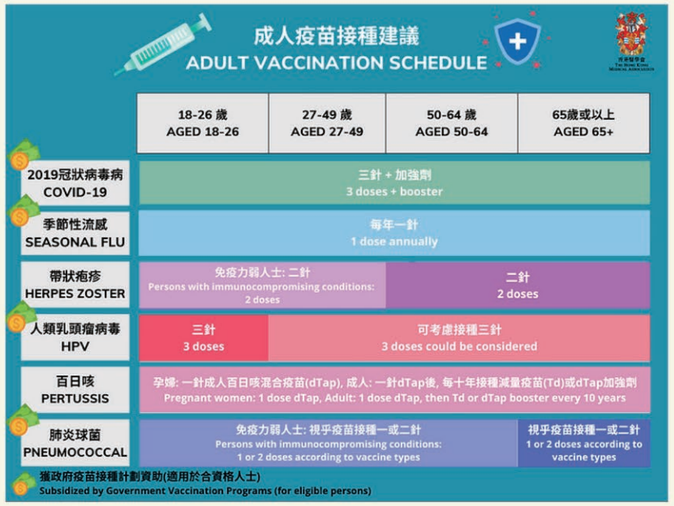
Doctor, do I need a jab?

Dr Ho Shu Wan
Specialist in Family Medicine
Union Hospital

Vaccines are one of the best preventive health tools we have. While immunization is one of the most successful public health interventions, coverage plateaued in the decade prior to COVID-19. The COVID-19 pandemic, associated disruptions, and vaccination efforts strained health systems in 2020 and 2021, resulting in dramatic setbacks. [1]

While Seasonal Influenza vaccines and COVID vaccines were vigorously discussed in the past few years, in this sharing I am going to focus on the following vaccines which are commonly enquired in primary care:

- Measles Vaccine
- Human Papillomavirus Vaccine (HPV)
- Zoster vaccine



Measles Vaccine

Measles is an acute viral respiratory illness. It is characterized by a prodrome of fever (as high as 105 ° F) and malaise, cough, coryza, and conjunctivitis -the three "C"s -, a pathognomonic enanthema (Koplik spots) followed by a maculopapular rash. Measles is highly contagious, it can be transmitted via droplets and airborne spread.

In 2000, measles was declared eliminated from the United States. However, there was a surge of confirmed cases of measles in HK in 2019.

It can cause complications such as otitis media, bronchopneumonia, Croup (laryngotracheobronchitis), and diarrhea especially in high risk groups. Subacute sclerosing panencephalitis (SSPE) is a rare, but fatal degenerative disease of the central nervous system characterized by behavioral and intellectual deterioration and seizures that generally develop 7 to 10 years after measles infection.

Koplik spots
(Source Center for Disease Control and Prevention)

For the general public, the following groups can be considered to be non-immune to measles in general:

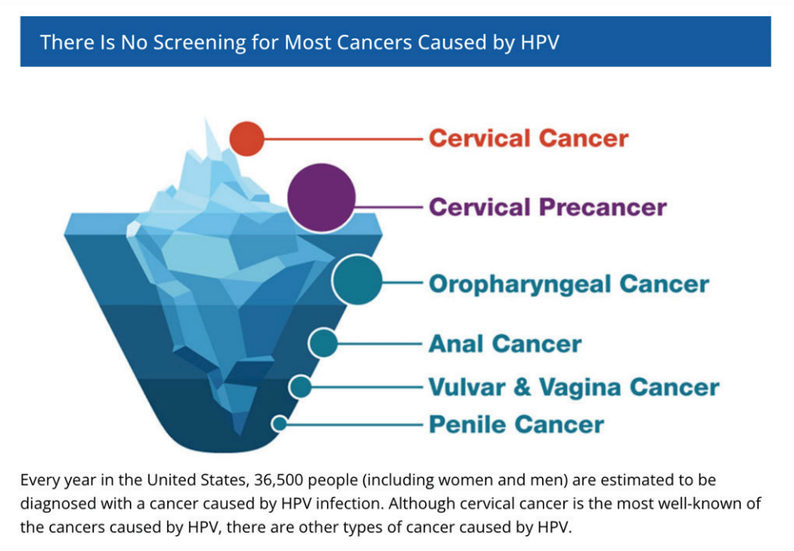
1. not having received two doses of measles-containing vaccine; or
2. not confirmed to have measles infection in the past.

The Hong Kong Childhood Immunisation Programme offers routine immunization of 1st dose MMR at 12 month and 2nd dose of MMRV at 18 month. MMR vaccine should be offered to persons who are non-immune to measles without the need of testing for measles antibody. A **two doses** regimen should be given at least four weeks apart. Those who had received one dose in the past only require one additional dose.

Healthy people in general can enjoy long term, even lifelong protection after receiving measles vaccination as recommended. One dose of MMR vaccine is 93% effective against measles while two doses are 97% effective. **Foreign domestic helpers** who are non-immune to measles should receive Measles, Mumps and Rubella (MMR) vaccine, preferably before they arrive in Hong Kong.

HPV Vaccine:

- Human papillomavirus is a double-stranded DNA viruses that infect the epithelium, which can infect the genital areas of men and women mainly through sexual contact. Majority, around 90%, of HPV infections are cleared or become suppressed within 1 to 2 years of infection by the host's own immunity.
- **Persistent infection** of high risk HPV is a prerequisite for the increased risk of pre-malignant lesions and progression to malignant cervical cancer. 2 high risk HPV types (HPV-16 and HPV-18) account for **about 70% of cervical cancer**.
- In 2020, cervical cancer ranked the **seventh** most common cancer among female and the eighth leading cause of female cancer deaths, accounting for 3.2% of all new cancer cases in females, and 2.6% of female cancer deaths respectively.
- HPV vaccination could **prevent more than 90% of cancers caused by HPV**. It has high vaccine efficacy, more than 98% of recipients develop an antibody response to covered HPV types within one month after completing the series. HPV vaccine is generally well-tolerated and has a good safety profile. It offers long-lasting protection against HPV. Studies of the bivalent and quadrivalent vaccines have followed vaccinated individuals for more than 10 years and have found no evidence of protection decreasing over time



Every year in the United States, 36,500 people (including women and men) are estimated to be diagnosed with a cancer caused by HPV infection. Although cervical cancer is the most well-known of the cancers caused by HPV, there are other types of cancer caused by HPV.

HPV immunization in Hong Kong:

- Starting from the 2019/20 school year, eligible **female** primary school students are provided with HPV vaccine under the Hong Kong Childhood Immunisation Programme (HKCIP)

HPV vaccine and pregnancy:

- Initiation of the vaccine series should be delayed until after completion of pregnancy. But pregnancy test is not required before HPV vaccination.
- If a woman is found to be pregnant after initiating the vaccination series, remaining dose(s) should be delayed until after the pregnancy

For adults age 27 and beyond, a shared clinical decision-making approach shall be adopted in discussion, for example, discussion of pros and cons of vaccine and any factors that put patient at risk for acquiring a new HPV infection eg having a new sex partner.

Zoster vaccines

There are two kinds of zoster vaccines in the market.

1. Zoster Vaccine Live (ZVL) (Zostavax), and
2. Zoster Vaccine Recombinant (RZV), Adjuvanted (Shingrix).

In separate clinical trials, for all age categories, the efficacy of Recombinant Zoster Vaccine was higher than ZVL against herpes zoster and postherpetic neuralgia. Moreover, duration of protection of ZVL wanes substantially during the 4 years following receipt. Therefore there is preferential use of RZV* *Recommendations of the Advisory Committee on Immunization Practices for Use of Herpes Zoster Vaccines*. MMWR. 2018;67:103–108.

Two doses of Shingrix provides more than 90% protection against shingles and postherpetic neuralgia (PHN)

In immunocompetent adults 70 years and older, vaccine efficacy remained high, at or above 84% in all 7 years after vaccination. Shingrix should be given to adults 50 years and older, including those who

- had shingles in the past
- received Zostavax at least 8 weeks prior
- have health conditions, such as chronic renal failure, DM, RA, chronic pulmonary disease
- are receiving other vaccines, such as influenza and PCV, can be given in the same visit

Dosing schedule of Shingrix:

- 2 doses regimen. Give the second dose 2 to 6 months after the first.
- Vaccine recipients should plan to avoid strenuous activities, such as yardwork or swimming, for a few days after vaccination

With Up to date information and patient centered recommendations, optimizing vaccination coverage is one of the priority in preventive care in primary care.

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2. Center for Health Protection, Statistics on Communicable Diseases, Notifiable Infectious Diseases. Available at https://www.chp.gov.hk/en/statistics/data/10/26/43/6994.html
3. CDC vaccines & Preventable Diseases: for Healthcare Professionals
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CME Programme

Upcoming CME

Hallux Valgus: My Approach of Management

Date : 17 November (Friday)

Time : 2:00pm-3:00pm

Venue : 8/F MIC, Union Hospital or Zoom

Speaker : **Prof Lui Tun Hing**
Consultant in Orthopaedics & Traumatology

Chairman : **Dr Tse Lung Fung**
Consultant in Orthopaedics & Traumatology
Union Hospital

On-Site (Premium Lunch served)

Zoom registration

Enquiry: **2608 3180** Email: cme@union.org

Post-Event Highlights

Exoskeleton Robotics for Neuro Rehabilitation - 15 September 2023

Prof Raymond Tong, Department of Biomedical Engineering, The Chinese University of Hong Kong, was invited to deliver a talk on "Exoskeleton Robotics for Neuro Rehabilitation". Prof Tong also demonstrated robotic devices for neuro rehabilitation.

Management of Thoracic Aneurysm and Dissection - 18 August 2023

Prof Randolph Wong gave a CME lecture on "Management of Thoracic Aneurysm and Dissection" on 18 August 2023. The lecture was chaired by Dr. Yannie So and received great response from the participants.

Happy Parents Health Event - Momo Party 2023

Momo party was successfully held on 19 August 2023 in Regal Kowloon Hotel. Dr Lam Siu Keung and Dr Chu Wai Po were invited to give talks on maternity and common problems in newborn babies respectively. The event received overwhelming response with over 500 expectant parents attended.

Medical Support to Hong Kong Jockey Club by Chief Medical Officer Team (HKJC CMO team: Dr Clara Wu, Dr Johnson Chu, Dr Ho Man Kam, and Dr Yuen Pak Chuen)

It has come to the commencement of the sixth racing season that the Chief Medical Officer (CMO) Team of Emergency Medicine Centre to provide medical services to Hong Kong Jockey Club (HKJC).

The past few years have been some of the most challenging times for us, but the experience we gained has enabled us to be ready for any challenges ahead in the future with no fear. I want to take this opportunity to express my profound gratitude for CMO team's and all UH team's continued professionalism and hard work during the turbulent times.

I believe that we have been successful in our endeavour of providing prehospital emergency care of international standard to HKJC. On many occasions, CMO Team has been invited to share views and expert options regarding head concussion management and prehospital care with other racing authorities.

We strive to maintain our professionalism and continue to explore new paradigms which will play a major part in our operation for better prehospital emergency care. Thank you again for all your support.

Union Hospital Garnered Outstanding Innovation and Excellence in Health Partnership Award 2023

Organized by "Hong Kong ETnet", the Health Partnership Award Ceremony was held on 21 September 2023 at InterContinental Grand Stanford Hong Kong. Union Hospital is privileged to receive the Outstanding Innovation and Excellence in Medical Service Award for consecutive two years. The award recognizes the hospital's continued commitment for providing high quality healthcare service for the patients. The recognition was received by Professor Henry Chan, Deputy Chief Hospital Manager of Union Hospital.

Union Hospital Garnered Outstanding Gold Award in Privacy-Friendly Awards 2023

Union Hospital is honoured to received the Outstanding Gold award from Office Of The Privacy Commissioner For Personal Data, Hong Kong in 2023. The accolade recognizes the hospital's continued commitment for providing high quality healthcare service for the patients and demonstrated our effort to safeguard and protect patients' privacy.

Activity Highlights

UNION ONCOLOGY CENTRE

Union Hospital Symposium on Oncology Treatment 2023

Advances in Lung Cancer Treatment

4 November 2023 (Saturday)

Time : 2:00pm - 8:00pm
Registration begins at 1:30pm

Venue : Regency Ballroom, Hyatt Regency Hong Kong
18 Hanoi Road, Tsim Sha Tsui, Kowloon, Hong Kong

Afternoon Symposium
2:00pm - 6:00pm

Advances in Radiation Therapy for Lung Cancer

Prof. Feng-Ming KONG
- Tenure Clinical Professor of Clinical Oncology
  Li Ka Shing School of Medicine, The University of Hong Kong
- Director of Thoracic Oncology Center, HKU-SZH
- Leader of the Peacock Project on Innovative Clinical Trial Platform
- Chair of WHOCC-STAR Guideline in Oncology
- President of Global Collaborative Oncology Group (GCOG)

Current Status of Transbronchial Ablation of Lung Tumours

Prof. Calvin Sze Hang NG
- Professor in Thoracic Surgery at Prince of Wales Hospital
  The Chinese University of Hong Kong
- Honorary Consultant Surgeon at New Territory East Cluster (NTEC) hospitals in Hong Kong

Application of SBRT in Patients with Metastatic Lung Cancer

Dr. Oscar Siu Hong CHAN
- Specialist in Clinical Oncology
  Hong Kong Integrated Oncology Centre

Roche Session

Breakthrough of Immunotherapy and Targeted Therapy for Early Stage NSCLC

Dr. Macy TONG
- Specialist in Clinical Oncology
  Union Oncology Centre

Optimizing Treatment Strategies for Metastatic Non-Small Cell Lung Cancer

Prof. Rina HUI
- Clinical Professor and Director
  Centre of Cancer Medicine, School of Clinical Medicine
  The University of Hong Kong

Evening Symposium
7:15pm - 7:45pm

Varian Session

Combining Immunotherapy and Radiotherapy - What we have learnt so far

Dr. Kevin Lee Min CHUA
- Senior Consultant
  Division of Radiation Oncology, National Cancer Centre Singapore
- Clinical Assistant Professor
  SingHealth Duke-NUS Oncology Academic Clinical Programme
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* Content is subject to change without prior notice.

* HKAMP & HKCRRT awards 3CPD points
* HKIPM awards 4CPD points
* HKCMN awards 4.5 CNE points
* CME accreditation: pending

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Trends of Cultured Pathogens

The Most Frequently Isolated Pathogens from Urine Cultures during May to August 2023

Most Common Pathogens Isolated	*Escherichia coli*	
Period	May to Aug 2023	Jan to Apr 2023
Number of Isolates per Admission (Total number of Urine Cultures)	255 (2240) (Including 37 ESBL)	194 (2026) (Including 46 ESBL)
Isolation Rate	11.4%↑	9.57%
Antibiotics	**Non-susceptible Rate**	
Amoxicillin/Clavulanic Acid	24%↓	27%
Ampicillin	69%↓	71%
Ampicillin/Sulbactam	56%↓	58%
Cefazolin (Oral)	20%↓	28%
Ceftriaxone/Cephalosporins 3G	16%↓	24%
Cefuroxime (Oral)	27%↓	31%
Cefuroxime (Parenteral)	18%↓	29%
Ciprofloxacin*	47%	47%
Ertapenem	0%	0%
Gentamicin	18%	18%
Imipenem	0%	0%
Levofloxacin*	59%	59%
Nitrofurantoin	3%	3%
Trimethoprim/Sulfamethoxazole	33%↓	36%

* Non-susceptible Rate of Levofloxacin & Ciprofloxacin is increased as the criteria for the interpretation of Susceptibility on Levofloxacin & Ciprofloxacin were changed on 1st April 2020.

The Most Frequently Isolated Pathogens from Respiratory Secretion Cultures during May to August 2023

Period	May to Aug 2023		Jan to Apr 2023	
No of Request	601		497	
Pathogens	Number of Isolates	Isolation Rate	Number of Isolates	Isolation Rate
Staphylococcus aureus	40 (Including 6 MRSA 15%)	6.7%↑	26 (Including 9 MRSA 34.6%)	5.2%
Haemophilus influenzae	37	6.2%↑	7	1.4
Pseudomonas aeruginosa	37	6.2%↑	21	4.2%
Klebsiella pneumoniae	21	3.5%↓	20	4.0%
Escherichia coli	20	3.3%↑	9	1.8%

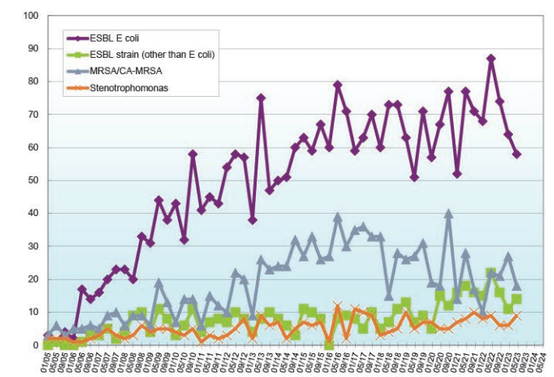
The Most Frequently Isolated Pathogens From Genital Cultures During May to August 2023

Most Common Pathogens Isolated	*Group B Streptococci*		*Candida albicans*		*Yeast (Candida albicans excluded)*	
Period	May to Aug 2023	Jan to Apr 2023	May to Aug 2023	Jan to Apr 2023	May to Aug 2023	Jan to Apr 2023
Number of Isolates per Admission (Total number of Genital Cultures)	132 (784)	125 (735)	93 (784)	111 (735)	42 (784)	27 (735)
Isolation Rate	16.8%↓	17.0%	11.9%↓	15.1%	5.4%↑	3.7%
Antibiotics	**Non-susceptible Rate**					
Cefotaxime	0.0%	0.0%				
Clindamycin	51.1%↓	54.0%				
Levofloxacin	9.8%↓	12.0%				
Penicillin[1]	0.0%	0.0%				
Vancomycin	0.0%	0.0%				

[1] Suspectible to penicillin can be considered susceptible to ampicillin, amoxicillin, amoxicillin/clavulanic acid, ampicillin/sulbactam, cefaclor, cefazolin, cefdinir, cefepime, cefprozil, cefotaxime, ceftriaxone, cefuroxime, cefpodoxime, ceftizoxime, cephalothin, cephapirin, imipenem, loracarbef, and meropenem.

Trend of ESBL, MRSA & Stenotrophomonas isolated from all specimen types by every four months

Trend of ESBL, MRSA & *Stenotrophomonas* isolated from all specimen types by quarter since 2005



	ESBL *E coli*	ESBL strain (other than *E coli*)	MRSA/ CA-MRSA	*Stenotrophomonas*
May-Aug 17	63	5	36	10
Sep-Dec 17	70	10	33	9
Jan-Apr 18	60	5	33	3
May-Aug 18	73	7	15	4
Sep-Dec 18	73	11	28	5
Jan-Apr 19	63	13	26	10
May-Aug 19	51	7	27	5
Sep-Dec 19	71	9	31	7
Jan-Apr 20	57	5	19	7
May-Aug 20	67	15	18	5
Sep-Dec 20	77	12	40	5
Jan-Apr 21	52	16	14	7
May-Aug 21	77	18	28	8
Sep-Dec 21	71	16	17	10
Jan-Apr 22	68	15	10	8
May-Aug 22	87	22	22	9
Sep-Dec 22	74	16	21	6
Jan-Apr 23	64	11	27	6
May-Aug 23	**58**	**14**	**18**	**9**