Anniversary Celebration
仁安醫院三十周年

UNION Connection

VOL 214 | March 2025

Message from the Chief Hospital Manager

Dear Colleagues,

The first two months of Year 2025 passed away with the blink of our eyes. Union Hospital will be celebrating her 30th Anniversary with a Grand Opening Ceremony on the 28th March 2025. We are very pleased that Professor Lo Chung Mau, Secretary for Health, has kindly given consent to grace this occasion as the most prominent officiating guest of honour. He will be joined by a number of government officials such as regional district officers who collaborate with us in various community services.

On looking back, I could still remember how I came to join Union Hospital as the Medical Director in 1996. About twelve months before the appointment, I came back to Hong Kong from Melbourne to pay homage to my motherland. Activities included visiting old acquaintances and sampling street foods like wonton noodles and 茶餐廳. My classmate Dr Benedict Chung who was also an Australian migrant told me that a new private hospital in Tai Wai might need the help of a senior clinician to upgrade its services. So I hailed a taxi and asked the driver to take me to Union Hospital. At that time even the taxi driver did not know where it was. Eventually we, i.e., my wife and I found our way to one of the wards which was open for business. We were lucky enough to be greeted by a young and pretty nurse Ms Ho who volunteered to show us around. The most impressive hospital equipment was a spiral CT scanner which was placed on the ground floor of the Medical Centre in an area now occupied by our main pharmacy. The other important piece of information I learned from Ms Ho was that the hospital had a thriving maternity service. Apparently, there was a service contract offered by the British Army whereby Union Hospital was obliged to look after all the female members in the garrison of Gurkhas stationed at Shek Kong. Hence the two full-time lady obstetricians of the hospital were kept busy by the very productive Gurkha families! This not exactly sight-seeing tour did stir up a bit of turbulence when I returned to my tranquil life in Melbourne: Being stricken with the double-whammy of mid-life crisis and empty nest syndrome with my elder daughter Fiona being placed in various country towns, or even out of state for her surgical training, and her sister Denise settling in New York for good, I decided to give it a try to return to Hong Kong. My good friend Benedict arranged a phone interview with Dr Yuen Chung Lau who was chairman of the Management Board of Union Hospital. Subsequently I made a short trip back to Hong Kong to meet with Dr Colin Lam of the Henderson Land Group who represented ownership of the hospital. Colin was very generous with the terms of my appointment as Medical Director of Union Hospital. They were too good to refuse and the rest was history!

When I first took up the helm of the hospital, life was certainly not easy at all. Business was bad for all the private hospitals in Hong Kong when the Government injected huge fundings into the coffers of the Hospital Authority. I had to ask Henderson Land a monthly handout of $3 million to pay salary for the hospital staff. In the newly established HK Private Hospitals Association (HKPHA), I was elected to chair the Quality Assurance or Accreditation Committee. I championed the idea of hospital accreditation and Union Hospital achieved whole hospital ISO:9001 accreditation by the authoritative Lloyd's Registered Quality Assurance (LRQA). Subsequently through the help and connection of Dr Harry Fang of St. Paul's Hospital, the HKPHA engaged the Trent Accreditation Scheme (TAS) to survey and accredit all the local private hospitals in year 2000. The results were excellent and they showed the local community that we were providing quality services to our clients. Pari-passu with these happenings, business performance of the hospital improved. We were able to break even on our ledger account.

The real turning point came in year 2003 with the SARS outbreak. The multiple fatalities of healthcare workers, mostly in public hospitals, revealed the weaknesses in their services and infra-structure. Citizens in Hong Kong would rather spend their savings in private hospitals for serious health problems because life was precious! Our hospital churned in profits since then — what an encouragement indeed.

On looking back, I dare say that other than the excellent caring services provided by our staff 'innovation' contributed much to our success. We have received numerous awards for innovation but the one I treasured most is that from HIMSS (Health Information Management Systems Society) for our Mobile Clinical Solution which enables our staff, doctors and nurses alike, instant access to all the real time changes in their patients' vital statistics, laboratory & imaging reports etc. This was indeed developed with patient's safety as first priority.

I would like to end this message by pledging to continue with our strive for continuous quality improvement and pursuit of innovative ideas to serve our local community and mainland visitors.

Yours most sincerely,

Dr Anthony K Y Lee
Chief Hospital Manager & Medical Director

Increase patient's safety in laparoscopy cholecystectomy

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Laparoscopic cholecystectomy (LC) is one of the commonest procedures performed in gastrointestinal surgery. It is the standard procedure for acute cholecystitis (AC). While LC has a lower complication rate, shorter hospital stay, and lesser pain when compared with open cholecystectomy, conversion to the latter remains common, with a rate ranging from 4 to 30% as reported in a number of studies on AC[1, 2]. One important risk factor for conversion is AC itself. The presence of inflammation can lead to improper assessment of the anatomy and make dissection difficult, and this may necessitate conversion. Furthermore, misidentification of structures during LC can be fatal. Strasberg et al[3] have advocated "critical view of safety" for proper identification of the biliary anatomy to avoid biliary injury and reduce the need of conversion.

Meanwhile, intraoperative cholangiogram (IOC) has been an effective way in demonstrating biliary anatomy; however, it has certain limitations that are not ideal in some conditions. It is often time-consuming, as it requires the setup of fluoroscopy equipment, contrast and X-ray during surgery, which can further extend operative time. Furthermore, IOC requires a certain level of technical skill, and sometimes it may be too late to perform an IOC, as bile duct injury might have already occurred.

Indocyanine green (ICG) has been commonly used in medicine as an indicator substance, and ICG fluorescence cholangiography (ICG-FC) is coming on the scene. ICG is a water-soluble, tricarbocyanine dye with peak spectral absorption at 805nm. It is metabolized exclusively by hepatic parenchymal cells and secreted entirely into the bile. After intravenous injection of ICG, the vascular and biliary structure can be visualized under polarized light. ICG-FC provides high-resolution, near-infrared images of blood flow, organ perfusion, and the biliary structure[4]. This technique makes real-time assessment of the biliary system possible. ICG fluorescence integrates directly with laparoscopic systems, providing continuous real-time visualization without additional handling or workflow disruption, making it particularly valuable in cases where a stable view of biliary anatomy is essential.

The overall incidence of bile duct injury was low, and there were some statistically insignificant differences in outcomes between the ICG and conventional cholecystectomy. Larger-scale studies or pooled analyses would be needed to demonstrate the real differences[5].

In straightforward cases with clear anatomical landmarks, the effect of ICG on reducing operative time was minimal. This suggests that ICG may not offer substantial time-saving advantages when the anatomy is uncomplicated and easily identifiable. However, in more challenging scenarios, such as those involving inflammation, obesity, or anatomical variance, ICG fluorescence demonstrated a greater impact on reducing operative time by clarifying anatomy and allowing for more efficient dissection.

A systematic review showed that ICG has benefits in complex LC, including reducing operative time and improving visualization of critical structures. These advantages have the potential to reduce complications, such as bile duct injury. Additionally, ICG has been shown to be non-inferior to IOC in visualizing critical biliary junctions, particularly in challenging cases[6].

Despite the widespread use and evaluation of ICG in recent years, significant differences persist including dosage, concentration, and timing of administration of ICG. Two approaches to the timing of drug injection have been proposed: one involves administering ICG about 15 hours before surgery to minimize liver background fluorescence interference, while the other suggests administration approximately 45 minutes prior to surgery for practical clinical application[7, 8]. Given that most emergency LC patients undergo surgery upon admission, the 15-hour administering timeframe is often impractical. The concentration of ICG injection should be reduced if it was given 45 minutes prior to the surgery[9]. Furthermore, the patient's BMI would affect the concentration; therefore, tailoring the dosage of ICG based on patients BMI may yield superior intraoperative outcomes compared to administering a fixed dose[10]. In previous study at Queen Mary Hospital, a bolus dose of 3.5mg ICG was administered 30 minutes before general anesthesia, resulting in variable visualization of the bile duct and liver background was obtained[11]. Hence, a dose of 0.02mg/BMI of ICG was suggested[12].

Widespread implementation of ICG may not be universally cost-effective; however, in case of complicated cholecystectomy, the demonstrated time savings – through shorter operative times and a lower conversion rate to open surgery – suggest that ICG could be a potential financial asset. Morever, there is a growing consensus on the use of this technique in the treatment of gallstone disease, as indicated by various surveys and international consensus meetings[7, 13].

This article highlights the latest operative option in managing difficult cholecystectomy, which could reduce the chance of bile duct injury, as well as lower the conversion rate, so to maximize the advantages of the LC.

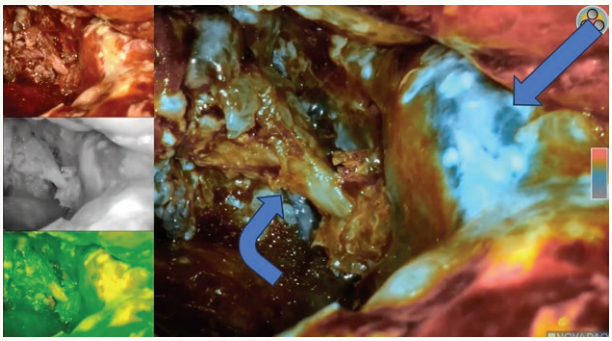

Figure Intraoperative photo of cystic duct and common bile duct under the visualisation of ICG florescence imaging. The straight arrow points at the common bile duct; while the curve arrow points at the cystic duct.

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Epiretinal membrane

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Macula is the central region of the retina, which is responsible for central vision. Epiretinal membrane (ERM) is one of the commonest macular diseases.

In a multicentric meta-analysis of population-based studies involving 40,000 participants[1], it was shown that 9% had some form of ERM. In a multi-ethnic study of the United States population which involved 5960 participants aged 45 to 84 years[2], it was shown that ERM was present in 39% of Chinese. 35% of the cases had bilateral eye involvement[2].

Epiretinal membrane is a thin sheet of fibrotic membrane developing on the surface of the macula. The pathogenesis involves proliferation of cells on the retina's surface, which usually occurs after posterior vitreous detachment (PVD). Aging vitreous liquefies and detaches from its posterior attachments leading to PVD. This causes dehiscence in the internal limiting membrane (ILM), which allows the microglial cells to migrate to the preretinal surface where they interact with the hyalocytes and laminocytes of the vitreous cellular membrane. These cells later transdifferentiate into fibroblast-like cells to form a cellophane thin ERM[3].

The other synonyms for ERM are macular pucker, preretinal macular fibrosis, surface wrinkling retinopathy, epimacular proliferations, epiretinal fibrosis or gliosis, and cellophane maculopathy.

Risk factors

- Greater age[2]: most common in people over 50 years old
- Gender: female[2]
- Diabetes mellitus[2]
- Hypercholeteraemia[2]
- High myopia
- Uveitis
- Retinal vascular diseases e.g. retinal venous occlusion
- Intraocular tumors
- History of retinal argon laser photocoagulation (e.g. for retinal breaks or retinal detachment)
- Previous eye surgeries or trauma

Symptoms

In mild cases, patients can be asymptomatic and are diagnosed during routine clinical examination. If the ERM progresses, patients may experience increased blurring of vision, usually over weeks or months. Another common symptom is metamorphopsia, which means seeing distorted images or straight lines become curved or wavy. As the membrane affects mainly the macula region, it interferes with patients' quality of life especially during reading and writing.

Diagnosis

Epiretinal membrane can be diagnosed clinically during dilated fundal examination using binocular indirect ophthalmoscope (Figure 1). It appears as glistening watery silky light reflex over the macula, with retinal folds and vascular tortuosity as the membrane contracts. In severe cases, there can be retinal haemorrhages, exudates, macular hole or pseudohole.

Optical coherence tomography (OCT) is a highly sensitive investigation and is routinely done for cases with ERM. On OCT, an ERM appears as a hyperreflective layer over the inner surface of the retina (Figure 2). It appears irregular and corrugated causing the inner retinal layer to wrinkle. There is often loss or even elevation of the foveal depression due to traction from the ERM. In severe cases, the macula thickens with cystoid spaces.

Epiretinal membrane can be classified into difference stages based on their OCT finding[4]:

- Stage 1: ERMs were mild and thin. Foveal depression is present.
- Stage 2: ERMs with a widening of the outer nuclear layer and loss of the foveal depression.
- Stage 3: ERMs with continuous ectopic inner foveal layers crossing the entire foveal area.
- Stage 4: ERMs were thick with continuous ectopic inner foveal layers and disrupted retinal layers.

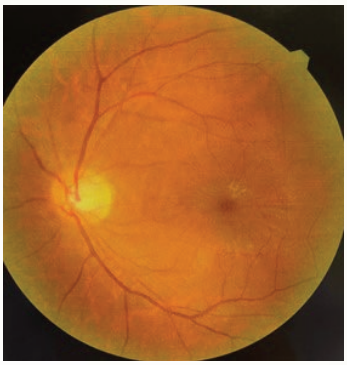

Figure 1a: Fundus photo of a patient's left eye showing ERM, which appears as glistening reflex, assembling a piece of cellophane over macula.

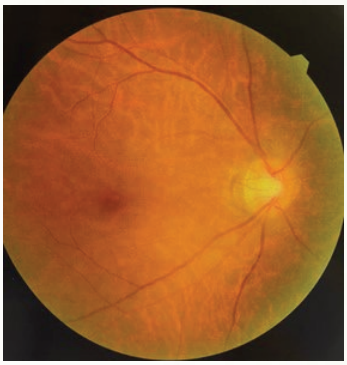

Figure 1b: fundus photo of the right eye of the same patient with no ERM.

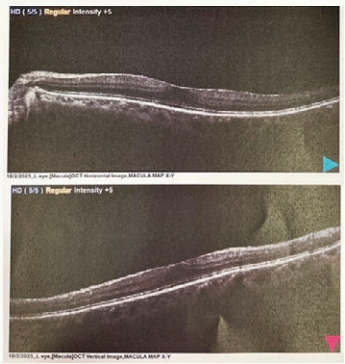

Figure 2a: OCT macula of the patient's left eye showing a hyperreflective membrane overlying the macula with loss of foveal depression.

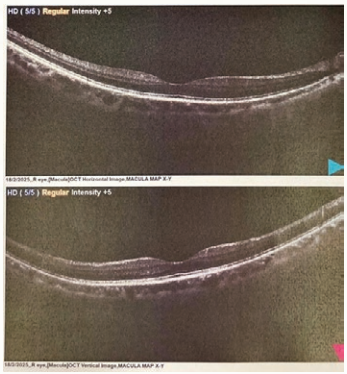

Figure 2b: OCT macula of the right eye of the same patient with no ERM and normal foveal depression.

Treatment

For mild asymptomatic cases, patients can be managed conservatively with regular monitoring by an ophthalmologist. Patients are also advised for self-monitoring periodically with Amsler grid (Figure 3).

Figure 3: Amsler grid for self-monitoring.

1. Wear any glasses you normally use to read, hold the grid 12 to 15 inches away from your face in good light.
2. Cover one eye.
3. Look directly at the center dot with your uncovered eye and keep your eye focused on it.
4. While looking directly at the center dot, notice in your side vision if all grid lines look straight or if any lines or areas look blurry, wavy, dark or blank.
5. Follow the same steps with the other eye.

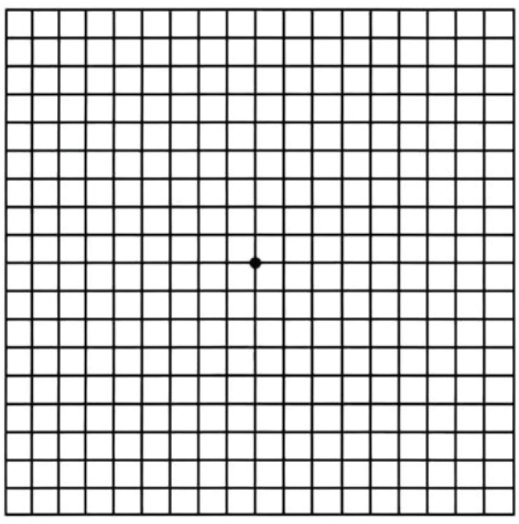

Figure 3

In more severe cases or if the patients are symptomatic, surgery is indicated.

Surgical management involves pars-plana vitrectomy (PPV) with ERM and ILM peeling. Internal limiting membrane is thought to provide a platform for the proliferation of fibroblasts, glial cells, and astrocytes for the retina to form ERM[5]. During the operation, three 0.4-0.6mm wounds are created at sclera. Instruments are passed through these sclerotomies for vitrectomy and membrane peeling. If cataract is present, the procedure should be combined with cataract removal to ensure better visualization of the surgical procedure and to prevent a subsequent second cataract surgery. The operation can be performed under local anaesthesia and patient can be discharged after the operation.

Factors that affect the visual outcome include the duration of the condition, the degree of vitreomacular traction, and the cause for ERM. Idiopathic ERM has a better prognosis than ERM secondary to ocular pathology[6].

Long standing ERM has poorer potential for visual recovery compared with new onset ERM. Therefore, when indicated, early operation is advised for better outcomes. The recurrence of ERM ranges from 1%[7] to 21%[8].

Case sharing

A 55-year-old lady presented with left metamorphosia and blurring of vision for 3 months. On presentation, her visual acuity was 0.9 in right eye and 0.5 in left eye. Fundal examination showed bilateral early cataract and left ERM. OCT macula of the left eye showed ERM with wrinkling of the inner retinal layers, loss of foveal depression and increased macular thickness (figure 4). Combined left cataract and ERM operation with vitrectomy and membrane peeling was performed. Patient opted for operation under general anaesthesia due to anxiety. One month after the operation, her left eye visual acuity had improved to 1.0 with significant reduction in metamorphopsia. Six weeks after the operation, OCT macula showed absence of ERM and reduction in inner retinal wrinkling (Figure 5).

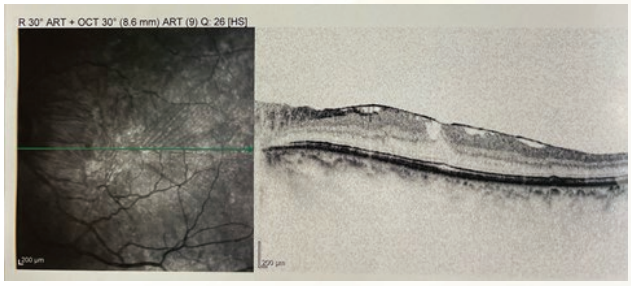

Figure 4: OCT macula before operation showed ERM with inner retinal wrinkling.

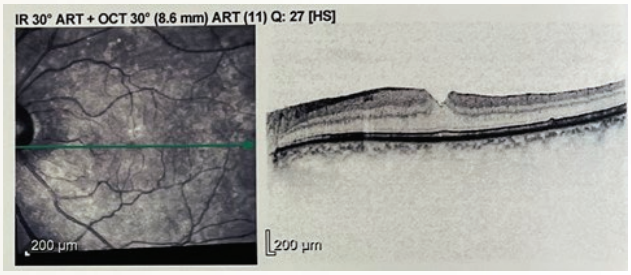

Figure 5: OCT macula after operation showed smoothening of the inner retinal layers.

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NEWS & EVENTS

Post-Event Highlights

Union Hospital Celebrates Arrival of the First Baby of the Year of the Snake (29 January 2025, the First Day of the Lunar New Year)

Union Hospital delightedly welcomed its first baby of the Year of the Snake, born at midnight on the first day of the Lunar New Year. Union Hospital extends its warmest congratulations to the Lee family, wishing the newborn a lifetime filled with health and happiness.

CME Programme – Pearls of Anticoagulation Management in Patients with Upcoming Procedures or Active Bleed (28 February 2025)

Dr Lau Ho Shing Louis, Assistant Professor (Clinical), Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, shared his insights on anticoagulation management in patients facing invasive procedures or active bleeding. He addressed the complexities of adjusting anticoagulation therapy in these challenging situations, highlighting current guidelines, emerging therapies, and practical clinical pearls. The session concluded with a lively discussion.

Exclusive Promotional Offer for the Siemens NAEOTOM Alpha Photon-counting CT Scanner at Union Hospital

We are excited to announce the extension of our exclusive promotional offer for the Siemens NAEOTOM Alpha photon-counting CT scanner at Union Hospital.

In June 2024, we had the pleasure of introducing this cutting-edge technology to you, our valued colleagues, and offered a special promotional price of HK$4,150.00 (50% off the regular price) for CT Coronary Angiogram, Calcium Score, and Extracardiac Screening examinations. This offer was initially set to expire on December 31, 2024.

Given the overwhelming positive response and feedback from our VMS doctors, we are delighted to extend this exclusive promotional period until June 30, 2025. This means that you, our trusted partners, will continue to have access to the exceptional diagnostic capabilities of the Siemens NAEOTOM Alpha at the special discounted rate.

We understand the importance of providing our VMS doctors with the latest advancements in medical technology, and the NAEOTOM Alpha delivers unparalleled image quality, enhanced diagnostic accuracy, and improved patient safety. This exclusive offer is our way of demonstrating our commitment to supporting you and your practice.

We encourage you to take advantage of this extended promotional period and experience the benefits of the Siemens NAEOTOM Alpha for your patients. To schedule your appointment or learn more about this cutting-edge technology, please don't hesitate to contact us at 2608 6888 / 2608 3260.

Thank you for your continued trust and support. We look forward to continuing our partnership and providing you with the best possible diagnostic services.

TRENDS OF CULTURED PATHOGENS

The Most Frequently Isolated Pathogens from Urine Cultures during September to December 2024

Most Common Pathogens Isolated	***Escherichia coli***	
Period	**Sep to Dec**	May to Aug
Number of Isolates per Admission (Total number of Urine Cultures)	**268 (2198) Including 59 ESBL & 1 CPE**	267 (2261) Including 52 ESBL & 1 CPE
Isolation Rate	**12.2%↑**	11.8%
Antibiotics	**Non-susceptible Rate**	
Amoxicillin/Clavulanic Acid	**22%↑**	20%
Ampicillin	**70.%↓**	73%
Ampicillin/Sulbactam	**55%↓**	64%
Cefazolin (Oral)	**29%↑**	23%
Ceftriaxone/Cephalosporins 3G	**23%↑**	21%
Cefuroxime (Oral)	**30%↑**	26%
Cefuroxime (Parenteral)	**27%↑**	23%
Ciprofloxacin*	**53%↓**	54%
Ertapenem	**0.4%**	0.4%
Gentamicin	**16%↓**	25%
Imipenem	**0.4%↓**	0.4%
Levofloxacin*	**66%↑**	64%
Nitrofurantoin	**1%↓**	2%
Trimethoprim/Sulfamethoxazole	**33%↓**	37%

* 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.

CPE = Carbapenemase Producing Enterobacteraceae – E.coli

The Most Frequently Isolated Pathogens from Respiratory Secretion Cultures during September to December 2024

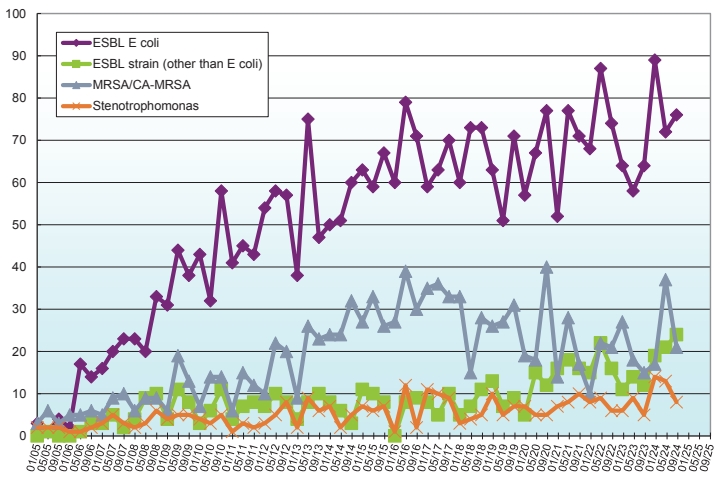
Period	**Sep to Dec 2024**		May to Aug 2024	
No of Request	**850**		953	
Pathogens	**Number of Isolates**	**Isolation Rate**	**Number of Isolates**	**Isolation Rate**
Pseudomonas aeruginosa	**74**	**8.7%↑**	75	7.9%
Streptococcus pyogenes (GAS)	**53**	**6.2%↑**	43	4.5%
H. Influenzae	**49**	**5.8%↓**	78	8.2%
Staphylococcus aureus	**45 (include 7 MRSA)**	**5.3%↑**	40 (include 10 MRSA)	4.2%

The Most Frequently Isolated Pathogens From Genital Cultures During September to December 2024

Most Common Pathogens Isolated	*Group B Streptococci*		*Candida albicans*		*Yeast (Candida albicans excluded)*	
Period	**Sep to Dec 2024**	May to Aug 2024	**Sep to Dec 2024**	May to Aug 2024	**Sep to Dec 2024**	May to Aug 2024
Number of Isolates per Admission (Total number of Genital Cultures)	**161 (893)**	185 (895)	**148 (893)**	150 (895)	**40 (893)**	46 (895)
Isolation Rate	**18.0%↓**	20.6%	**16.6%↓**	16.8%	**4.5%↓**	5.1%
Antibiotics	**Non-susceptible Rate**					
Cefotaxime	**0.0%**	0.5%				
Clindamycin	**66.7%↑**	55.6%				
Levofloxacin	**17.6%↑**	11.2%				
Penicillin	**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 & Stenotrophomonasisolated from all specimentypes by quarter since 2005



	ESBL *E coli*	ESBL strain (other than *E coli*)	MRSA/ CA-MRSA	*Stenotrophomonas*
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
Sep-Dec 23	64	12	15	5
Jan-Apr 24	89	19	17	14
May-Aug 24	72	21	37	13
Sep-Dec 24	76	24	21	8

Antibiotics non-susceptible profile of commonly isolated bacterial pathogen at Union Hospital 2024

Pathogens	Acinetobacter sp.	Enterobacter sp.	Escherichia coli	Enterococcus sp. (1)	Haemophilus influenzae	Klebsiella sp.	Proteus sp.	Pseudomonas aeruginosa	Staphylococcus aureus	Salmonella sp.	Group B Streptococci
Antibiotics \ Count	55	55	1127 (248 ESBL + 6CPE)	235	271	401 (50 ESBL)	132	224	644 (140 MRSA + 48 CA-MRSA)	261	628
Amikacin								2.1%			
Amoxicillin											
Amoxicillin/Clavulanic Acid		100.0%	20.2%		20.3%	29.9%	22.0%				
Ampicillin			73.3%	3.8%	62.0%	100.0%	35.6%			80.5%	
Ampicillin/Sulbactam	0.0%		61.7%			26.7%	23.5%				
Cefazolin/Cephalosporins 1G		100.0%	33.6%			49.0%	20.6%				
Cefepime	8.5%							0.9%			
Cefotaxime					0.4%						0.0%
Ceftriaxone/Cephalosporins 3G		14.6%	23.1%		0.0%	17.7%	1.5%			7.7%	
Ceftriaxone (meningitis)											
Ceftriaxone (non-meningitis)											
Ceftazidime/Cephalosporins 3G	10.9%				1.1%%			0.9%			
Cefuroxime (Oral)			29.7%		40.6%	21.9%	21.2%				
Cefuroxime (Parenteral)			26.4%			20.2%	21.2%				
Ciprofloxacin	9.1%	8.2%	53.0%			22.8%	12.9%	8.5%			
Clarithromycin					38.4%						
Clindamycin											56.3%
Erythromycin				81.0%					24.9%		
Ertapenem		2.0%	0.6%			0.8%	0.0%				
Gentamicin	1.8%	4.2%	20.1%			7.3%	12.9%	2.7%	7.2%		
Gentamicin (High Conc)											
Imipenem		4.1%	0.6%			0.3%	9.8%				
Levofloxacin		12.2%	65.6%	19.9%	2.6%	24.4%	13.6%	11.6%	17.8%	66.8%	13.7%
Meropenem	0.0%							2.7%			
Nitrofurantoin			1.8%	3.6%		84.3%	100.0%				
Oxacillin									29.2%		
Penicillin				4.7%					80.1%		0.0%
Penicillin Oral											
Penicillin parenteral (Men)											
Penicillin parenteral (NonMen)											
Piperacillin	4.0%							5.5%			
Tetracycline				87.0%					27.7%		
Trimethoprim/Sulfamethoxazole	4.3%	8.6%	35.4%		48.3%	18.2%	26.8%		8.5%	22.6%	
Vancomycin				0.0%					0.0%		0.0%

100% The highlighted non-susceptible antibiotics are due to intrinically resistant to particular bacterial pathogen.
CPE Carbapenemase producing *enterobacteriaceae*
ESBL Extended-spectrum β-lactamases
MRSA/CA-MRSA Methicillin-resistant *Staphylococcus aureus* / Community associated MRSA
(1) Include *Enterococcus faecalis & Enterococcus faecium*

Union Hospital Surgical Site Infection (SSI) Surveillance Feb – Dec 2024

Surgical site infections (SSIs) are unexpected infections that occur at the incision site, organ, or surgical area following a procedure. Managing SSIs in surgical patients with complex comorbidities, alongside the rise of antimicrobial-resistant pathogens, is particularly challenging and costly. As the number of surgical procedures performed worldwide continues to increase, the prevention of SSIs has become increasingly important[1].

Implementing a Surgical Site Infection Surveillance Program enables hospitals to monitor SSI rates for internal and surgical team reference, while also identifying potential risks in clinical areas at an early stage. This, in turn, helps reduce the incidence of SSIs. For example, based on data collected from Union Hospital over the past two years, the risk of SSIs remained low from 2022 to 2023 – with a rate of 0.06% for general surgeries in 2022 and 0% for gynecological transabdominal and obstetric surgeries in 2023.

In 2024, Union Hospital's Hospital Infection Control team continued the surveillance program, focusing on all patients undergoing orthopedic procedures, including both open wound and minimally invasive approaches. The collected data were analyzed, and during the surveillance period from February to December 2024, a total of 1,685 orthopedic cases met the surveillance criteria and were reviewed. Among these cases, only one infection was identified, resulting in an SSI rate of 0.06%.

This outcome represents another satisfactory achievement in 2024. The success can be attributed to good practices in patient education, pre-operative MRSA screening, adherence to aseptic techniques, high standards of clinical care, and rigorous environmental hygiene maintenance. Nevertheless, we remain committed to upholding and further improving the highest standards of hospital care for our patients, as we have always done.

References

1. Centers for Disease Control and Prevention (CDC). Surgical Site Infection (SSI) Event. Available from: https://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf

UNION HOSPITAL 30th ANNIVERSARY CELEBRATION

Anniversary Celebration
仁安醫院三十周年

The Community Chest New Territories Walk for Millions 2025 (16 February 2025)

Symbolizing the kick-off of Union Hospital's 30th Anniversary Celebration (UH30) community engagement, around 50 members of the Union Hospital Volunteer Team, along with their family members, participated in the Community Chest Walk for Millions 2025 at GO PARK, Sai Sha on 16 February 2025.

Union Hospital 30th Anniversary Medical Symposium: Marching into the Future (22 June 2025)

Join us as we celebrate a remarkable milestone—Union Hospital's 30th Anniversary Medical Symposium, one of the signature events commemorating our hospital's three decades of distinguished healthcare services.

Under the inspiring theme 'Marching into the Future', this one-day symposium will open doors to groundbreaking innovation, visionary insights, and meaningful collaboration. We are honoured to welcome a distinguished panel of prestigious keynote speakers, comprising eminent medical leaders and industry experts, to share their invaluable perspectives on the evolving healthcare landscape.

Through thought-provoking keynote addresses, interactive panel discussions, and dynamic sessions, designed to encourage knowledge sharing and professional collaboration.

Let's march into tomorrow together!

Date : 22 June 2025 (Sunday)

Venue : Ballroom – Cloud 39, The Henderson, 2 Murray Road, Central

Event Website & Registration:

Keynote speakers:

Prof. Chan Tak Cheung, Anthony
The Chinese University of Hong Kong

Prof. Lau Yun Wong, James
The Chinese University of Hong Kong

Prof. Lo Yuk Ming, Dennis
The Chinese University of Hong Kong

Prof. Leung Ka Kit, Gilberto
The University of Hong Kong

Prof. Lau Chak Sing
The University of Hong Kong

Prof. Mok Chung Tong, Vincent
The Chinese University of Hong Kong

Prof. Chiu Wai Yan, Philip
The Chinese University of Hong Kong

Prof. Ng Siew Chien
The Chinese University of Hong Kong

Prof. Hung Fan Ngai, Ivan
The University of Hong Kong

Regular Meetings

Meeting :	X-Ray Meeting	Clinical Pathologic Conference
Date : Time :	9 Apr 2025 (Wednesday) 8:30am – 9:30am	14 May 2025 (Wednesday) 8:30am – 9:30am
Co-ordinator:	-	**Dr FUNG Ming Kit, Terence** **Deputy Head, Department of Surgery, Union Hospital** **Dr LUI Chi Wai, Philip** **Consultant in Pathology, Union Hospital**
Venue:	Training Room, 8/F MIC, Hospital Building, Union Hospital	
Booking & Enquiry:	2608 3160 (Quality Assurance and Training Department)	

New Clinical Member

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

Dr Chan Chi Sang, James
Deputy Head,
Department of Radiology

New Clinical Sessions

Specialty Clinic - Obstetrics & Gynaecology	
Booking & Enquiry: 2608 3222	Time Schedule
Dr Mak Ho Leung, Jimmy	Mon 15:00 – 18:00

Union Hospital Polyclinic (Tsuen Wan)	
Booking & Enquiry: 2608 3399	Time Schedule
Obstetrics & Gynaecology **Dr Choi Sze Ngar, Sylvia**	Wed 14:00 – 17:00 Thu 10:00 – 13:00

Union Hospital Polyclinic (Ma On Shan)	
Booking & Enquiry: 2608 3377	Time Schedule
Dermatology **Dr Tang Yuk Ming, William**	Wed 10:30 – 12:00

Union Hospital Polyclinic (Tseung Kwan O)	
Booking & Enquiry: 2721 0100	Time Schedule
Otorhinolaryngology **Dr To Wing Hei, Zion**	Mon 14:00 – 16:00 Wed 14:00 – 16:00

Union Hospital Polyclinic (Science Park)	
Booking & Enquiry: 2662 6388	Time Schedule
Dermatology **Dr Tang Yuk Ming, William**	Wed 09:00 – 10:00