Union Connection

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Message from the
Chief Hospital Manager

Dear Colleagues,

'爆竹一聲除舊' — this is an old Chinese saying when the Chinese New Year (CNY) was traditionally being 'rung in' by the noise of firecrackers. However, letting off firecrackers had been banned quite some years ago because of fire hazard and potential blast injury of the eyes for by-standers. So it brought back memories of my childhood years when I came across the noise of firecrackers being let off during my stay in Zhuhai in the Greater Bay area for a couple of nights at the Renaissance Hotel there. There were also mini-fireworks here and there after night-fall but they were nothing compared with the grand fireworks in Hong Kong on the second night of CNY (年初二).

During my sojourn in Zhuhai, I had the opportunity of having a number of meals there. The dishes were tasty, services were average, probably because of the large crowd in new year, but the price was much cheaper than what I would expect to pay in Hong Kong. My naive thinking is that the costs to run a restaurant 'up north' is much lower, because both rent and staff wages will probably be just a fraction of what a restaurateur in Hong Kong will have to bear. The trend of going up north to spend or consume one's pocket money will never be stopped or even diminished until these two adverse factors come under control.

After the week-long holiday I came back to my office and made a tally of some recent key performance indices, comparing those of year 2025 with those of the previous year. Overall speaking, the numbers showed a few percentage points of deficit but the total hospital income remained unscathed. In my opinion, the world's economy including that of China and Hong Kong suffered quite significantly after US President Donald Trump's tariff policy introduced in April 2025. The downturn affected consumers' confidence or desire in spending their hard-earned income or savings. Most people in the community would rather join the long queue of public hospitals when they do need tertiary care for their body ailments. They will not go to private hospitals for help until it became absolutely necessary or when services provided by the public hospital of their own choice did not live up to their expectations. This may explain why attendances were down but yet the total hospital income remained robust. One of the major engines driving admission in Union Hospital is our accredited Emergency Medicine Centre (EMC). Attendance dropped 7% in 2025 and admissions via EMC was down 17%. Fortunately, attendance at our Specialist Clinics did not disappoint us and take over the leading position in terms of hospital admissions. The best performer in this area is our maternity service. We welcomed the arrival of our 100,000th baby in late September 2025. Throughout that year a total of 3852 babies were delivered in our hospital and I believe that this could possibly be the highest number amongst both private and public hospitals in Hong Kong.

It is with a happy mood brought about by childbirth that I would like to end this communication and I would like to wish you and your family a Happy and Pleasant Easter holiday!

Yours most sincerely,
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Review on Management of Metastatic Triple Negative Breast Cancer

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Introduction

Triple-negative breast cancer (TNBC) represents approximately 15% of all breast cancers and is characterized by the absence of estrogen receptor (ER), progesterone receptor (PR), and human epidermal growth factor receptor 2 (HER2) expression.[1] This aggressive subtype disproportionately affects younger women and is associated with a 5-year relative survival of only 15% in the metastatic setting.[2] Until recently, cytotoxic chemotherapy remained the sole treatment option, resulting in suboptimal response rates and short overall survival. However, over the past five years, the approval of multiple targeted therapies has transformed TNBC from a single entity into a molecularly stratified disease with biomarker-driven treatment options.[3][4]

Biomarker Testing and Patient Stratification

Contemporary management of metastatic TNBC requires comprehensive biomarker assessment to guide therapeutic decision-making. This includes routine testing for germline BRCA1/2 mutations in all patients with recurrent or metastatic breast cancer to identify candidates for PARP inhibitor therapy.[5] PD-L1 expression should be assessed using the 22C3 antibody, with a combined positive score (CPS) ≥ 10 defining positivity for immunotherapy selection.[5] Additionally, HER2 testing should distinguish between IHC 0 (with and without membrane staining), IHC 1+, and IHC 2+/ISH-negative categories, as these distinctions are clinically relevant for antibody-drug conjugate selection in HER2-low and HER2-ultralow disease.[5][6]

First-Line Treatment Strategies

PD-L1-Positive Disease (CPS ≥ 10)

For patients with metastatic TNBC and PD-L1 CPS ≥ 10, immunotherapy pembrolizumab combined with chemotherapy is the preferred first-line approach, regardless of germline BRCA mutation status.[5] The KEYNOTE-355 trial demonstrated that pembrolizumab plus chemotherapy (albumin-bound paclitaxel, paclitaxel, or gemcitabine/carboplatin) resulted in significantly longer progression-free survival (9.7 vs 5.6 months) and overall survival (23.0 vs 16.1 months) compared to chemotherapy alone in patients with PD-L1 CPS ≥ 10.[1] Despite this, only 38% of patients with advanced TNBC meet this PD-L1 threshold.[1]

Sacituzumab govitecan (SG) is a first-in-class antibody–drug conjugate targeting trophoblast cell-surface antigen 2 (TROP2), a protein highly expressed in 90% of breast cancer tumours. Recent data from the ASCENT-04/KEYNOTE-D19 trial suggest that sacituzumab govitecan plus pembrolizumab may offer superior outcomes compared to chemotherapy plus pembrolizumab PD-L1–positive metastatic TNBC, with median progression-free survival of 11.2 versus 7.8 months (HR 0.65).[2] This antibody-drug conjugate and immunotherapy combination represents a promising potential first-line strategy, although additional confirmatory data and mature overall survival analyses are needed.[2]

PD-L1-Negative Disease Without BRCA Mutations

For patients with PD-L1 CPS < 10 and no germline BRCA1/2 mutation, single-agent chemotherapy remains the standard first-line approach.[5] Sequential single agents are preferred over combination regimens except in patients with high tumor burden, rapidly progressing disease, or visceral crisis.[5] Preferred regimens include anthracyclines (doxorubicin, liposomal doxorubicin), taxanes (paclitaxel), antimetabolites (capecitabine, gemcitabine), and microtubule inhibitors (vinorelbine, eribulin).[5]

The ASCENT-03 trial recently demonstrated that first-line sacituzumab govitecan (SG) monotherapy significantly improved progression-free survival compared to chemotherapy (9.7 vs 6.9 months; HR 0.62) in patients not eligible for PD-1/PD-L1 inhibitors.[7] Sacituzumab govitecan achieved a similar objective response rate to chemotherapy but provided a substantially longer duration of response, marking an important advance for patients with PD-L1–negative metastatic TNBC.[7]

The phase III TROPION-Breast02 trial is evaluating datopotamab deruxtecan (Dato-DXd) versus investigator's choice of chemotherapy in patients with previously untreated metastatic TNBC who are not candidates for PD-1/PD-L1 inhibitors.[8] Datopotamab deruxtecan is another Trop-2-directed antibody-drug conjugate. With the recent 2025 ESMO update, datopotamab deruxtecan significantly improved median progression-free survival compared with chemotherapy (10.8 vs 5.6 months; HR 0.57) and overall survival (23.7 vs 18.7 months; HR 0.79). The objective response rate with datopotamab deruxtecan was approximately doubled compared with chemotherapy (62.3% vs 29.3%), and the median duration of response was prolonged (12.3 vs 7.1 months).[9]

Both Dato-DXd and SG are therefore likely to become future standards of care for the treatment of metastatic TNBC lacking PD-L1 expression.

BRCA-Mutated Disease

Patients with germline BRCA1/2 mutations and PD-L1 CPS<10 should receive PARP inhibitors (olaparib or talazoparib) or platinum-based chemotherapy (cisplatin or carboplatin) as preferred first-line options.[5] The OlympiAD trial demonstrated that olaparib improved progression-free survival compared to chemotherapy (7.0 vs 4.2 months; HR 0.58), with particularly pronounced benefit in the TNBC subset (HR 0.39).[10][11] Similarly, the EMBRACA trial showed talazoparib extended progression-free survival to 8.6 versus 5.6 months compared to chemotherapy (HR 0.54).[10][12] Both agents demonstrated superior quality of life and lower rates of grade 3+ adverse events compared to chemotherapy.[10][12]

Platinum agents also demonstrate substantial activity in BRCA-mutated TNBC by exploiting defects in homologous recombination repair. The choice between a PARP inhibitor and a platinum-based regimen in the first-line setting should consider prior treatments, patient comorbidities, toxicity profiles, and access to oral therapy. In PD-L1–positive, BRCA-mutated disease, immunotherapy-chemotherapy combinations remain preferred, and PARP inhibitors or platinum can be integrated at subsequent lines of therapy.

Second-Line and Beyond

Antibody-Drug Conjugates

Sacituzumab govitecan, a Trop-2-directed antibody-drug conjugate, is the preferred second-line option for all patients regardless of biomarker status.[5] The ASCENT trial established its superiority over chemotherapy, demonstrating improved progression-free survival (5.6 vs 1.7 months) and overall survival (12.1 vs 6.7 months) in heavily pretreated patients.[13]

For patients with HER2-low TNBC (IHC 1+ or 2+/ISH-negative) without germline BRCA mutations, trastuzumab deruxtecan represents an additional second-line option.[5] The DESTINY-Breast04 trial demonstrated that trastuzumab deruxtecan improved progression-free survival (8.5 vs 2.9 months) and overall survival (18.2 vs 8.3 months) compared to chemotherapy in the hormone receptor-negative HER2-low population.[6][14] Approximately 60% of TNBC tumors express HER2-low levels, making this a relevant option for a substantial proportion of patients.[4] Importantly, trastuzumab deruxtecan has shown activity even in HER2-ultralow tumors (IHC 0 with membrane staining), challenging traditional HER2 categorization.[15]

In the phase I TROPION-PanTumor01 study, datopotamab deruxtecan demonstrated an objective response rate of 31.8% in heavily pretreated TNBC patients, with a median duration of response of 16.8 months and median progression-free survival of 4.4 months.[16] The most common adverse events were stomatitis (72.7%, with 11.4% grade ≥ 3) and nausea, both generally manageable.[16][18] Datopotamab deruxtecan differs from sacituzumab govitecan in its construct, featuring a cleavable tetrapeptide linker and a more potent topoisomerase I inhibitor payload (deruxtecan), with higher stability in circulation and a longer half-life.[17] While datopotamab deruxtecan received FDA approval for HR+/HER2- breast cancer based on the TROPION-Breast01 trial, it is not currently FDA-approved for second-line TNBC.

PARP Inhibitors in Later Lines

For patients with germline BRCA1/2 mutations who did not receive PARP inhibitors in first-line, olaparib or talazoparib remain preferred second-line options.[5] However, available evidence suggests PARP inhibitors are more effective when used earlier in the treatment sequence.[5][10]

Chemotherapy Options

Standard chemotherapy regimens remain important options throughout the treatment course. After progression on taxanes and anthracyclines, alternatives include capecitabine, eribulin, gemcitabine, platinum agents, and vinorelbine.[5][19] The choice should be individualized based on prior exposures, toxicity profiles, and patient preferences.

Emerging Biomarker-Directed Therapies

For patients with specific molecular alterations, targeted therapies may be considered in third-line and beyond. These include agents for MSI-H, NTRK fusions, RET alterations, and TMB-H tumors.[5]

Safety Considerations

Each therapeutic class carries distinct toxicity profiles requiring specific monitoring. Immunotherapy combinations necessitate surveillance for immune-related adverse events, though pembrolizumab generally demonstrates acceptable tolerability.[20] Sacituzumab govitecan commonly causes neutropenia and diarrhea, both manageable with standard supportive care.[13][17] Trastuzumab deruxtecan requires regular monitoring for interstitial lung disease/pneumonitis, occurring in approximately 12% of patients, with 0.8% experiencing deaths.[14] PARP inhibitors are associated with myelosuppression but generally have more favorable toxicity profiles than chemotherapy.[10][21]

Datopotamab deruxtecan demonstrates a distinct safety profile characterized by stomatitis, nausea, and ocular surface events including dry eye and keratitis.[18][22] Interstitial lung disease/pneumonitis occurs in approximately 5% of patients (all grades) and 1.7% (grade ≥ 3), requiring regular monitoring.[23] Prophylactic measures for stomatitis and early intervention strategies can help manage these adverse events effectively.[18]

Treatment Sequencing and Clinical Decision-Making

Optimal treatment sequencing remains an evolving area. For PD-L1-positive patients, immunotherapy-based regimens should be prioritized in first-line given that approximately half of patients with metastatic TNBC do not receive treatment beyond first-line therapy.[2] For BRCA-mutated patients, the choice between PARP inhibitors and platinum chemotherapy in first-line depends on PD-L1 status, with immunotherapy-chemotherapy combinations preferred for PD-L1 CPS ≥ 10.[5] The emergence of multiple antibody-drug conjugates raises questions about optimal sequencing. Both datopotamab deruxtecan and sacituzumab govitecan are likely to become future first-line standards of care for the treatment of metastatic TNBC lacking PD-L1 expression.[9]

Current evidence supports sacituzumab govitecan as the preferred second-line option given its demonstrated overall survival benefit in TNBC.[13] Trastuzumab deruxtecan represents an important option for HER2-low disease, though its optimal positioning relative to sacituzumab govitecan requires further study, and the future integration of datopotamab deruxtecan will further refine treatment pathways.[9][16]

Figure 1 illustrates the biomarker-driven treatment algorithm for metastatic TNBC, demonstrating the sequential decision-making process based on PD-L1 expression, BRCA mutation status, and HER2-low expression.

Line of Therapy	PD-L1 CPS ≥ 10	PD-L1 CPS<10, BRCA wild-type	PD-L1 CPS<10 BRCA mutated
First-Line	Pembrolizumab + chemotherapy (preferred) SG + pembrolizumab (investigational)	Chemotherapy (preferred) SG monotherapy (emerging) Datopotamab deruxtecan (Dato-DXd) (emerging)	PARP inhibitor (preferred) Platinum chemotherapy (preferred)
Second Line	SG (preferred) T-DXd if HER2-low Chemotherapy	SG (preferred) T-DXd if HER2-low Chemotherapy	PARP inhibitor if not used 1L (preferred) SG (preferred) T-DXd if HER2-low
Third Line	Chemotherapy Biomarker-directed therapy if applicable	Chemotherapy Biomarker-directed therapy if applicable	Chemotherapy Biomarker-directed therapy if applicable

Conclusion

The management of metastatic TNBC has evolved dramatically from a chemotherapy-only paradigm to a biomarker-driven approach incorporating immunotherapy, PARP inhibitors, and multiple antibody-drug conjugates. Comprehensive molecular profiling including PD-L1 expression, germline BRCA1/2 status, and HER2-low assessment is essential for optimal treatment selection. The expanding arsenal of Trop-2-directed antibody-drug conjugates, including sacituzumab govitecan and datopotamab deruxtecan, provides additional therapeutic options with distinct mechanisms and toxicity profiles. Despite these advances, median survival remains substantially shorter than other breast cancer subtypes, highlighting the continued need for novel therapeutic strategies, predictive biomarkers, and clinical trials to define optimal treatment sequencing and further improve outcomes in this challenging disease.

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Expanded Carrier Screening: Integrating Genetic Counselling into Modern Reproductive Care

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Introduction

Autosomal recessive and X-linked disorders number in the thousands, with carrier prevalence varying widely across ethnic groups, creating distinct population burdens. Locally, thalassaemia is prevalent (~5% α-thalassaemia, ~3% β-thalassaemia carriers), while cystic fibrosis (~1:25 carriers) predominates among Caucasians but is rare in Chinese populations. Ashkenazi Jewish communities face elevated risks for conditions like Tay-Sachs disease, a severe early-onset neurodegenerative disorder.

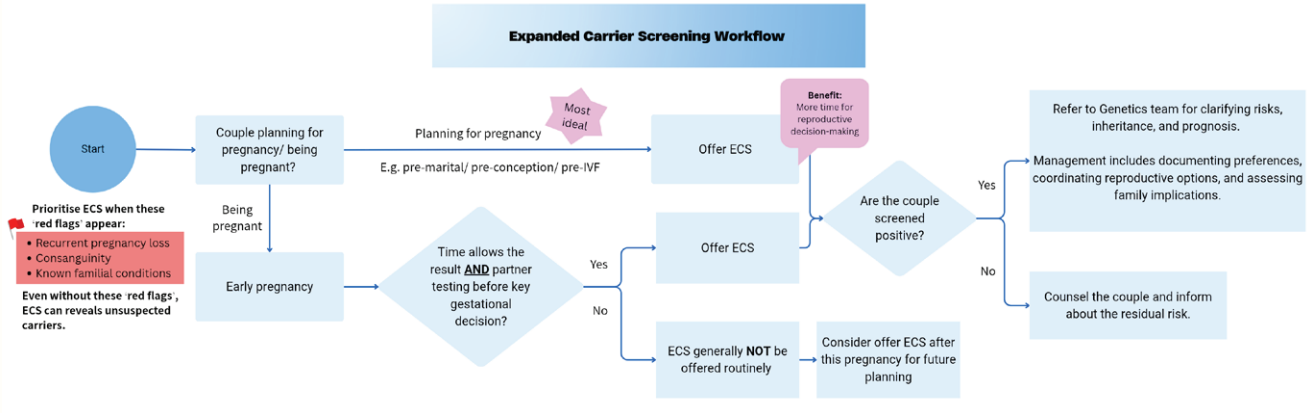
Carrier screening began in the 1970s, targeting high-prevalence, serious conditions in specific populations. In Hong Kong, thalassaemia—a major healthcare burden—prompted universal antenatal screening by the Hospital Authority since 2000. Screen-positive couples receive prenatal diagnosis or preimplantation genetic testing (PGT), dramatically reducing thalassaemia major births requiring lifelong transfusions.

Expanded carrier screening (ECS) now assesses hundreds of recessive conditions simultaneously using next-generation sequencing. Professional guidelines endorse offering ECS preconception or early pregnancy to all couples, regardless of ethnicity or family history, empowering informed reproductive choices. Our genetics service integrates ECS with expert counselling, supporting referring clinicians in delivering comprehensive reproductive care.

How and When to Offer ECS

Professional bodies including the American College of Obstetricians and Gynecologists (ACOG) and European Society of Human Genetics (ESHG) recommend offering ECS preconception or early pregnancy to all couples, regardless of ethnicity, to inform reproductive risk.

Figure 1. ECS Workflow



ACOG advises screening disorders with carrier frequency ≥ 1:100, well-defined childhood-onset phenotypes requiring intervention, excluding adult-onset conditions. American College of Medical Genetics (ACMG) recommends Tier 3 panels (>1:200 carrier frequency; 113 core genes). Commercial ECS panels (300–600 genes) yield ~10% screen-positive couples, with limited gain from adding rarer genes. Customisation by ethnicity enhances relevance.

The Genetics Team: Who Does What?

The genetics team typically comprises clinical geneticists and genetic counsellors. Clinical geneticists are medical specialists who diagnose, evaluate, and manage genetic disorders while integrating genomic results with clinical findings. Genetic counsellors are health professionals trained in medical genetics and psychosocial support who interpret complex results and deliver evidence-based, patient-centred guidance. Working with referring clinicians, they clarify test indications, streamline follow-up, and ensure at-risk couples receive timely specialised counselling.

Genetic counselling facilitates understanding of genetic risks' medical, psychological, and familial implications while supporting values-based reproductive decisions. This process usually includes both pre-test and post-test counselling. Pre-test counselling sets expectations by explaining ECS scope and limitations. Post-test counselling reviews combined risks and options without directing choices, empowering couples to align decisions with their beliefs and circumstances. These reproductive options are natural conception with/without prenatal diagnosis, IVF with PGT, donor gametes, or no further intervention.

Ethical and Psychosocial Aspects

ECS identifies at-risk couples but raises ethical and psychosocial challenges, including informed consent, result interpretation, and emotional impacts.

Table 1. Common ethical and psychosocial challenges in ECS counselling

Common Challenges	Example	Typical Address in Counselling
Fear of discrimination	"Will insurance/ employers know about this result?"	Explain potential implications, normalising carrier prevalence, and clarifying that carriers remain healthy.
Guilt or self-blame	"My partner/ I have the defective gene!"	Reframe everyone carries multiple recessive variants, shifting focus from fault to proactive family planning.
Milder conditions or with variable expressivity	GJB2-related hearing loss (More examples in Table 2)	Clarify severity ranges, residual uncertainties, and proportionality, supporting couples who opt for postnatal monitoring over intensive interventions.

ECS Case Scenarios

Table 2. Illustrate how genetic counselling tailors advice to condition severity, supporting informed, proportionate reproductive choices.

Scenario	Condition Examples	Severity & Key Features	ypical Counselling Focus & Reproductive Decisions
Severe childhood-onset AR disorder	Thalassaemia Spinal muscular atrophy (SMA)	High morbidity/ mortality. Significant lifelong impact	Most couples opt for prenatal diagnosis or PGT. Discuss treatments (e.g., in-utero transfusion/stem cell transplant for thalassaemia; gene therapy for SMA).
Common/mild childhood-onset disorder	G6PD deficiency (X-linked) GJB2-related hearing loss	Mild-moderate and manageable (G6PD: ~4% male prevalence locally; GJB2 c.109G>A: ~17% penetrance, variable hearing loss)	Few pursue invasive testing. Educate on inheritance, precautions, postnatal screening (e.g., hearing tests). Emphasise proportionality.
Severe AR in child; mild risk to parents	LDLR-related hypercholesterolaemia	Child: severe early coronary risk (25% chance). Parents: heterozygous carriers with the risk of hypercholesterolaemia	Discuss PGT/prenatal diagnosis + parental lipid screening, lifestyle advice. Balance child/parental health management.

TRENDS OF CULTURED PATHOGENS

The Most Frequently Isolated Pathogens from Urine Cultures during September to December 2025

Most Common Pathogens Isolated	***Escherichia coli***	
Period	**Sep to Dec**	May to Aug
Number of Isolates per Admission (Total number of Urine Cultures)	**242 (2200) Including 34 ESBL & 0 CPE**	264 (2228) Including 53 ESBL & 1 CPE
Isolation Rate	**14%↑**	11.8%
Antibiotics	**Non-susceptible Rate**	
Amoxicillin/Clavulanic Acid	**25.2%↓**	28%
Ampicillin	**73.1%↓**	74%
Ceftriaxone/Cephalosporins 3G	14.9%↓	21%
Cefuroxime (Oral)	25.2%↓	34%
Cefuroxime (Parenteral)	18.2%↓	27%
Ciprofloxacin	64.9%↑	47%
Ertapenem	0.0%↓	0.8%
Gentamicin	16.7%↑	15%
Imipenem	0.0%↓	0.8%
Levofloxacin	62.4%↑	62%
Nitrofurantoin	2.9%↓	4%
Trimethoprim/Sulfamethoxazole	39.8%↑	34%

CPE = Carbapenemase Producing Enterobacteraceae – E.coli

The Most Frequently Isolated Pathogens from Respiratory Secretion Cultures during September to December 2025

Period	**Sep to Dec 2025**		May to Aug 2025	
No of Request	**705**		693	
Pathogens	**Number of Isolates**	**Isolation Rate**	**Number of Isolates**	**Isolation Rate**
Pseudomonas aeruginosa	**41**	**5.8%↓**	48	6.9%
Staphylococcus aureus (include 5 MRSA)	**44**	**6.2%↓**	48	6.9%
Klebsiella pneumonia	**33**	**4.7%↑**	27	3.9%
Hemophilus influenzae	**28**	**4.0%↓**	43	6.2%

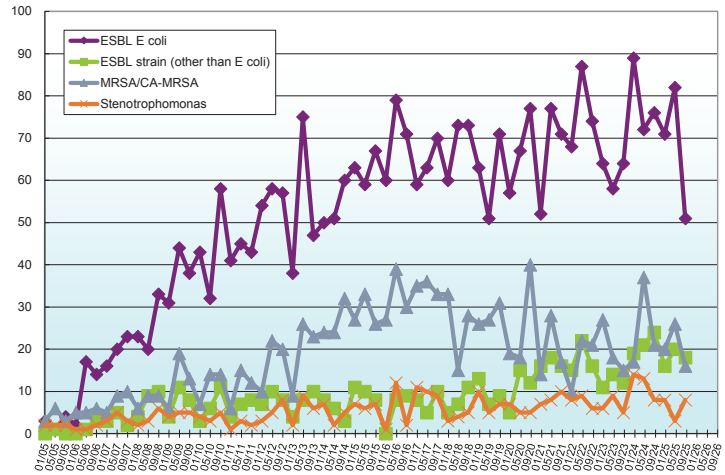
Most common pathogen isolated	Antibiotics	Non-susceptible rate	Most common pathogen isolated	Antibiotics	Non-susceptible rate
Pseudomonas aeruginosa	Cefepime	9.8%	Staphylococcus aureus (include 5 MRSA)	Erythromycin	15.9%
	Ceftazidime	9.8%		Levofloxacin	9.1%
	Ciprofloxacin	17.1%		Oxacillin	11.4%
	Levofloxacin	17.1%		Penicillin	84.1%
	Meropenem	12.2%		Tetracycline	32.6%
	Piperacillin/ Tazobactam	14.6%		Trimethoprim/ Sulfamethoxazole	4.5%
				Vancomycin	0.0%

The Most Frequently Isolated Pathogens From Genital Cultures During September to December 2025

Most Common Pathogens Isolated	*Group B Streptococci*		*Candida albicans*		*Yeast (Candida albicans excluded)*	
Period	**Sep to Dec 2025**	May to Aug 2025	**Sep to Dec 2025**	May to Aug 2025	**Sep to Dec 2025**	May to Aug 2025
Number of Isolates per Admission (Total number of Genital Cultures)	**135 (840)**	168 (962)	**117 (840)**	148 (962)	**23 (840)**	38 (962)
Isolation Rate	**16.1%↓**	17.5%	**13.9%↓**	15.3%	**2.7%↓**	4.0%
Antibiotics	Non-susceptible Rate					
Cefotaxime	**0.0%**	0.0%				
Clindamycin	**56.3%↓**	61.9%				
Levofloxacin	**14.1%↓**	16.7%				
Penicillin	**0.0%**	0.0%				
Vancomycin	**0.0%**	0.0%				

[1] Suspectible to penicillin can be considered susceptible to ampicillin, amoxicillin, amoxicillin-clavulanate, ampicillin-sulbactam, cefazolin, cefepime, ceftaroline, cefotaxime, ceftriaxone, imipenem, ertapenem, 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 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
Jan-Apr 25	71	16	20	8
May-Aug 25	82	20	26	3
Sep-Dec 25	51	18	16	8

Antibiotics non-susceptible profile of commonly isolated bacterial pathogen at Union Hospital 2025

Pathogens	Acinetobacter sp.	Enterobacter sp.	Escherichia coli	Enterococcus sp. (1)	Haemophilus influenzae	Klebsiella sp.	Proteus sp.	Pseudomonas aeruginosa	Staphylococcus aureus	Salmonella sp.	Strep pneumoniae
Count / Antibiotics	39	55	1097 (206 ESBL + 7CPE)	278	151	364 (42 ESBL)	126 (12 ESBL)	215	626 (134 MRSA + 37 CA-MRSA)	324	56
Amoxicillin/Clavulanic Acid		100.00%	24.70%		16.60%	30.80%	36.50%				
Ampicillin			72.60%	5.80%	60.70%	100.00%	49.20%			70.90%	
Ampicillin/Sulbactam	2.90%		62.30%			29.9	36.50%				
Cefazolin/Cephalosporins 1G			36.40%				38.00%				
Cefepime	2.8%							10.20%			
Cefotaxime					1.30%						
Ceftriaxone/Cephalosporins 3G		16.40%	20.10%		0.00%	14.80%	11.10%			9.30%	
Ceftriaxone (meningitis)											7.1%
Ceftriaxone (non-meningitis)											5.4%
Ceftazidime/Cephalosporins 3G	2.60%				0.70%			10.20%			
Cefuroxime (Oral)			30.00%		26.50%	24.00%	29.40%				
Cefuroxime (Parenteral)			24.00%			22.10%	29.40%				
Ciprofloxacin	7.70%	13.00%	54.10%			20.40%	32.50%	16.30%			
Clarithromycin					25.80%						
Clindamycin											
Erythromycin				90.30%					23.50%		80.0%
Ertapenem		3.80%	0.70%			0.80%	0.00%				
Gentamicin	5.10%	2.60%	17.80%			4.70%	37.60%		5.60%		
Gentamicin (High Conc)											
Imipenem		2.60%	1.00%			1.20%	9.00%				
Levofloxacin		14.80%	63.00%	20.90%	0.00%	22.90%	29.60%	22.30%	16.80%	61.80%	1.80%
Meropenem	2.60%	0.0%				0.0%		14.40%			
Nitrofurantoin			4.10%	9.20%		86.80%	100.00%				
Oxacillin									27.30%		
Penicillin				5.80%					81.90%		
Penicillin Oral											39.30%
Penicillin parenteral (Men)											39.30%
Penicillin parenteral (NonMen)											0.0%
Piperacillin	6.30%							17.90%			
Tetracycline				86.90%					24.20%		76.8%
Trimethoprim/Sulfamethoxazole	2.9%	6.50%	36.00%		45.00%	17.50%	50.00%		9.50%	30.20%	32.10%
Vancomycin				0.00%					0.00%		0.00%

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*

Diagnostic Performance of the FilmArray Multiplex PCR System in Bloodstream Infections

Patrick Tsoi, Senior Medical Technologist
Irene Cheung, Medical Technologist
Dr PL Ho, MBBS, MD, MRCP, FRCPath, FRCPA, FIDSA, FHKCPath, FHKAM
Department of Pathology, Union Hospital

Background — The FilmArray Blood Culture Identification 2 (BCID2; bioMérieux) is a fully automated, one-hour PCR assay that identifies bacteria, fungi, and key bacterial resistance markers directly from positive blood cultures.

Objective — This study evaluated the diagnostic performance of the BCID2 panel as part of the laboratory's quality assessment.

Method — A retrospective analysis was performed to assess the concordance between blood culture (reference method) and BCID2 results at Union Hospital Laboratory from January 2024 to December 2025.

Results — We included 200 positive blood cultures, comprising 190 monomicrobial and 10 polymicrobial cultures. A total of 210 isolates were detected, including 149 Gram-negative bacteria, 60 Gram-positive bacteria, and one yeast (Table 1). These include 14 samples with organisms that were common contaminants.

The putative culture contamination rates in children and adults were 0.33% (95% CI, 0.17-0.58) and 0.06% (95% CI, 0.008-0.23), respectively.

In monomicrobial cultures, the BCID2 correctly identified all 184 on-panel organisms at the species or genus level. In polymicrobial cultures, three isolates (*Bacteroides fragilis, Staphylococcus hominis, Citrobacter freundii*) from three samples were missed by the BCID2 assay (Table 2). Eight isolates (one *Actinomyces*, one *Bacillus*, one *Vibrio vulnificus*, four *Micrococcus* species, and one *Pseudomonas oryzihabitans*) were off-panel organisms.

The resistance genes detected by BCID2 included 29 $bla_{\text{CTX-M}}$, 4 bla_{NDM}, 1 $bla_{\text{OXA-48}}$, 2 *mecA/C*, and 1 sample positive for both *mecA/C* and MREJ (indicating MRSA). All detected $bla_{\text{CTX-M}}$ results correlated with the recovery of ESBL-producing Enterobacterales (*Escherichia coli, Klebsiella pneumoniae,* or *Salmonella* spp.). The bla_{NDM} and $bla_{\text{OXA-48}}$ detections correlated with the recovery of carbapenemase-producing Enterobacterales in the cultures. The three *mecA/C* signals correctly correlated with a methicillin-resistant phenotype in two coagulase-negative staphylococci and one *Staphylococcus aureus*.

Implications

The results obtained by BCID2 exhibited excellent concordance with culture results, confirming the assay's clinical utility. However, BCID2 results should always be interpreted in conjunction with clinical findings. False-negative results may occur due to low organism burden, target sequence variation, assay inhibition, or infection by off-panel pathogens. Conversely, a "Detected" result does not confirm microbial viability, as the assay detects both live organisms and residual DNA; consequently, false-positive signals may arise from non-viable organisms or exogenous nucleic acid introduced during sample collection or present in the blood culture media.

Table 1. Organisms detected in blood cultures		
Organisms	**Adults (n=169)**	**Children (n=31)**
Escherichia coli	46%	3%
Klebsiella spp.	13%	3%
Other Enterobacterales	6%	0%
Other Gram-negative bacteria	4%	0%
Salmonella spp.	3%	29%
Staphylococcus aureus	7%	10%
Staphylococcus lugdunensis	1%	0%
Streptococcus spp.	14%	13%
Anaerobes	1%	3%
Candida	1%	0%
Polymicrobial	5%	3%
Others^	1%	35%
Total	100%	100%

^ Including Bacillus, coagulase-negative staphylococcus and Micrococcus which are common blood culture contaminants

Table 2. Discrepancy of pathogen identification between the BCID2 panel and culture		
Sample no.	**Culture results**	**BCID results**
263	*Micrococcus* spp.*, *Pseudomonas oryzihabitans**	None
707	*Citrobacter braakii*^, *Bacteroides fragilis*@	Enterobacterales
616	*Staphylococcus hominis*^, *Staphylococcus epidermidis*	*Staphylococcus epidermidis*
64	*Escherichia coli*, *Citrobacter freundii*^	*Escherichia coli*
633	*Actinomyces**	None
726	*Vibrio vulnificus**	None
349	*Bacillus* spp.*	None
24	*Micrococcus* spp.*	None
881	*Micrococcus* spp.*	None
374	*Micrococcus* spp.*	None

@ On-panel organism; ^ Organism detected at genus level; * Off panel organism

References

1. Aygar İS, Hoşbul T. Diagnostic accuracy and clinical impact of filmarray multiplex PCR system in bloodstream infections: A comparative study with conventional methods in a tertiary health care setting. Medicine (Baltimore). 2025 Jul 18;104(29):e43263. doi: 10.1097/MD.0000000000043263. PMID: 40696646; PMCID: PMC12282700.
2. Imataki O, Masumoto R, Hamano M, Ishimatsu M, Suemori SI, Tsujioka T, Tamura M, Kitanaka A. Fungal false positive in BioFire® FilmArray® analysis for bloodstream infection. J Microbiol Methods. 2026 Feb;241:107380. doi: 10.1016/j.mimet.2025.107380. Epub 2025 Dec 25. PMID: 41455529.

Union Hospital Surgical Site Infection (SSI) Surveillance February – December 2025

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, SSI prevention has become increasingly important.

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 SSI incidence. For example, data collected from Union Hospital over the past two years show that SSI risk remained low from 2023 to 2024—with a rate of 0% for gynecological transabdominal and obstetric surgeries in 2023 and 0.06% for orthopedic surgeries in 2024.

In 2025, Union Hospital's Hospital Infection Control team continued the surveillance program, focusing on all patients undergoing general surgical procedures, including both open-wound and minimally invasive approaches. The collected data were analyzed, and during the surveillance period from February to December 2025, a total of 1,813 general surgical procedures 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 2025. 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

Hospital Update

Union Hospital partners with Medical Protection Society in tireless pursuit of clinical excellence

Since the 4th quarter of 2025, Union Hospital (UH) has entered into collaboration with Medical Protection Society (MPS) seeking to achieve shared goals of robust clinical governance that prioritise patient safety, quality healthcare and continuous improvement through a multifaceted approach.

Collaboration terms mutually agreed upon by Dr Anthony Lee and Chief Executive Officer of MPS, Ms Karen Miller

The collaboration agreement is the first of its kind signed between the two sides on the grounds of UH's clinical governance framework being effectively implemented that is highly regarded by MPS. While accelerating efforts to support doctors and dentists practising at UH, MPS will provide education, ethics and risk management training that help sustain a culture of safe clinical practice in the hospital.

Meeting attended by (from left to right) Dr Law Sze Man, Dr Danny Lee (MPS Senior Medical Advisor), Dr Yu Kai Man, Dr Clara Wu, Dr Nirven Maharaj (MPS Chief Commercial Officer, International), Dr Louis Cheung, Dr Steve Lau and Ms Joeky Leung (MPS Regional Development Director, Asia)

Doctors and dentists, who meet specific criteria set out by the hospital management, may as well be offered subscription relief subject to MPS's underwriting approval and annual review. Eligible individuals would be notified and must submit mandatory documents to initiate the underwriting process, given that the relief shall not be automatically granted.

For enquiries, please contact Deputy Medical Director's Office by email (dmdteam@union.org).

NEWS & EVENTS

Post-Event Highlights

Union Hospital Press Conference on Hepatitis B Study and New 'Reflex HBV DNA Testing' in Health Check Packages

We held a press conference on 19 March 2026 to present the findings of a retrospective study from 2014 to 2023 on hepatitis B linkage to care. The press conference featured presentations by Prof. Henry Chan Lik-yuen, Deputy Chief Hospital Manager; Ms Christie Cheng Fung-yin, Senior Nursing Officer; and Ms Judy Lee Man-lee, Senior Registered Nurse, followed by a testing demonstration at the pathology lab.

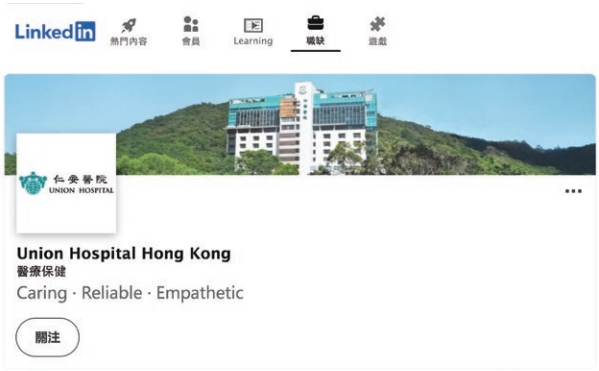
The study revealed that only 48% of individuals who tested positive for HBsAg during health checks were referred to hepatologists, highlighting a significant gap in the care cascade. Critically, patients with high viral load (HBV DNA ≥ 2000 IU/mL) had a 21 times higher referral rate compared to those not tested, confirming that HBV DNA is the most critical factor influencing referral decisions.

In response to these findings, Union Health Maintenance Centre and Union Healthcheck Centre have introduced 'reflex HBV DNA testing' since January 2026. This new protocol automatically performs HBV DNA tests for all HBsAg-positive individuals without requiring additional blood draws or incurring extra charges.

Union Hospital Welcomes Two Horse-Year Babies

On the first day of the Chinese New Year (17 February 2026), Union Hospital joyfully welcomed two newborns at the stroke of midnight (00:00)! A baby boy weighing 2.94 kg and a baby girl weighing 2.90 kg were delivered, marking a meaningful beginning to the Year of the Horse.

We extend our heartfelt congratulations to the families and express our deepest gratitude for entrusting Union Hospital with this precious occasion. May these Horse-Year babies grow up surrounded by love, laughter, and happiness.



Connect with Union Hospital on *LinkedIn*

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

CME Programme – Healing Under Fire: Stories from Gaza and Beyond Borders (30 January 2026)

The CME lecture 'Healing Under Fire: Stories from Gaza and Beyond Borders' featured Dr Ng Siu Pan, Specialist in Anaesthesiology. He provided compelling insights into anaesthesia techniques developed through his extensive fieldwork with Médecins Sans Frontières (MSF) across various countries. The talk, highlighting Dr Ng's humanitarian journey, attracted over 270 onsite and online participants. Dr Yannie O.Y. Soo, Assistant Chief Hospital Manager at Union Hospital, encouraged active discussion on Dr Ng's frontline experiences and the work behind the scenes.

CME Programme – 病 從 口 入 Illness Enters Through the Mouth (6 March 2026)

Dr Ho Pak Leung, Consultant in Clinical Microbiology and Infection at Union Hospital, delivered the CME lecture ' 病 從 口 入 Illness Enters Through the Mouth', with reviews on clinical case studies, evidence-based recommendations on dietary practices and medication timing for patients and clinical staff. The lecture drew over 300 onsite and online participants. A dynamic Q&A session was led by Dr Wu Wing Yee, Clara, Deputy Medical Director, Dr Wong Tin Yau, Andrew, Consultant in Infectious Disease and Honorary Consultant of Infection Control, and Dr Lam Wilson, Consultant in Infection Control, all from Union Hospital, reinforcing the discussion of best practices in infection prevention.

CME Programme – Medico-legal Risks and Well-being of Doctors in Private Practice (10 March 2026)

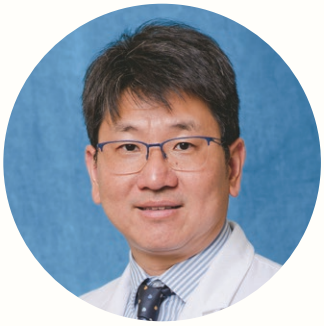
In partnership with Medical Protection Society (MPS) to strengthen clinical governance, patient safety, and quality of care, Union Hospital delivered the CME lecture titled 'Medico-legal Risks and Well-being of Doctors in Private Practice' via Zoom.

Dr Pallavi Bradshaw, Medical Director at MPS, presented data and trends on the current landscape of medico-legal risks and challenges in private sector. Dr Rob Hendry, Chief Member Officer at MPS, spoke on doctors' well-being and resilience. With over 210 participants, the lecture concluded with a robust discussion session led by Dr Lee Kai Yiu, Anthony, Chief Hospital Manager and Medical Director, Dr Wu Wing Yee, Clara, Deputy Medical Director, and Dr Cheung Chin Pang, Louis, Assistant Medical Director, from Union Hospital.

Upcoming CME

CME Programme

Innovations in Early Stage Lung Cancer Management



Date : 15 May 2026 (Friday)

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

Venue : 2/F Seminar Room, Union Hospital

Speaker : Prof. Ng Sze Hang Calvin
Environmental Foundation Professor of Thoracic Surgery, The Chinese University of Hong Kong
Honorary Consultant Surgeon, Prince of Wales Hospital

Chairperson : Dr Yannie O.Y. Soo
Assistant Chief Hospital Manager, Union Hospital

On-site Registration

Online Registration (Zoom)

2608 3180

cme@union.org

New Clinical Sessions

Specialty Clinic		
Booking & Enquiry: 2608 3315	Time Schedule	
Internal Medicine / Infectious Disease Dr Lam Wilson	By Appointment	
Internal Medicine / Nephrology Dr Tsang Kwong Yuen	Tue	09:00 – 10:30

Specialty Clinic		
Booking & Enquiry: 2608 3222	Time Schedule	
Obstetrics & Gynaecology Dr Lee Ho Sze, Jacqueline	Mon Wed	10:00 – 13:00 10:00 – 13:00 14:00 – 17:00
Obstetrics & Gynaecology Dr Mak Ho Leung, Jimmy	Mon Thu Sat	15:00 – 18:00 15:00 – 18:00 15:30 – 17:30

Specialty Clinic		
Booking & Enquiry: 2608 3366	Time Schedule	
Paediatrics Dr Lau Shing Chi, Steve	Tue Wed Thu	09:00 – 11:00 15:00 – 18:00 09:00 – 11:00
Paediatrics Dr Pang Lap Ian	Mon Thu	10:00 – 13:00 15:00 – 18:00
Paediatrics Dr Yu Wai Ling	Tue Thu Sat	15:00 – 18:00 14:30 – 17:00 14:30 – 17:00
Paediatrics Dr Yim Sau Wing	Mon Tue Wed	15:00 – 18:00 15:00 – 18:00 10:00 – 13:00
Paediatric Neurology Dr Ng Sui Fun, Grace	By Appointment	
Genetic Counsellor Ms Chu Wing Yiu	By Appointment	

Specialty Clinic		
Booking & Enquiry: 2608 3222	Time Schedule	
Psychiatry Dr Tung Ka Yee, Carrie	Mon Tue Wed Fri Sat	09:30 – 12:30 14:30 – 17:30 09:30 – 12:30 09:30 – 12:30 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 Thu Fri	09:00 – 13:00 14:00 – 16:00 08:00 – 10:00
Podiatry Ms Heidi S. Corcoran	Fri	10:00 – 13:00

Union Heart Centre		
Booking & Enquiry: 2608 6777	Time Schedule	
Cardiology Dr Chan Kam Tim	Thu	15:00 – 18:00

Union Hospital Polyclinic (Tsim Sha Tsui)		
Booking & Enquiry: 2375 3323	Time Schedule	
Obstetrics & Gynaecology Dr Chan Yuen Mei	Tue Wed Fri	10:00 – 13:00 15:00 – 18:00 10:00 – 13:00 14:30 – 17:30 14:30 – 17:30
Otorhinolaryngology Dr Yu Hip Cho	Mon Tue Wed Thu Fri Sat	14:00 – 17:30 09:30 – 13:30 09:30 – 13:30 09:30 – 13:30 09:30 – 13:30 09:30 – 13:00

Union Hospital Polyclinic (Tsuen Wan)		
Booking & Enquiry: 2608 3399	Time Schedule	
Orthopaedics & Traumatology Dr Chan Shiu Wai	Mon Thu	14:00 – 17:00 15:00 – 18:00

Union Hospital Polyclinic (Ma On Shan)		
Booking & Enquiry: 2608 3377	Time Schedule	
Obstetrics & Gynaecology Dr Chan Yuen Mei	Thu	10:00 – 13:00
Obstetrics & Gynaecology Dr Lee Ho Sze, Jacqueline	Mon	15:00 – 18:00
Psychiatry Dr Tung Ka Yee, Carrie	Thu	10:00 – 12:30

Regular Meetings

Meeting :	X-Ray Meeting	Mortality and Morbidity Meeting
Date : Time :	8 April 2026 (Wednesday) 8:30am – 9:30am	13 May 2026 (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)	

New Clinical Members

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

Dr Ng Sui Fun, Grace
Consultant in
Paediatric Neurology

Dr Wong Wai Sheung
Consultant in
Endocrinology,
Diabetes & Metabolism

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