Union Connection

Vol. 224 | November 2026

Message from the
Chief Hospital Manager

Dear Colleagues,

In recent months, the topic of 'price transparency' has come up in debates on legislation to clamp down on extreme fluctuation in fees for services rendered by private hospitals — the so-called 'seafood prices' (海 鮮 價 !). Actually this is a misnomer coined out of misunderstanding of fees charged by doctors in private practice and their estimates of hospital charges. Taking the example of Union Hospital, we do have a comprehensive list of the fees charged for individual items of drugs, medical consumables, and fees charged for various services, including those for pathology tests, medical imaging and nursing procedures. Such information will become useful for our staff to explain to patients when the latter have questions about their bills on discharge. Moreover, the vast volume of information has been digitalised and individual patients will be charged for every item consumed and service rendered at the point of care. However, the above 'encyclopaedia' does nothing to prevent controversies when the hospital bills are being presented to patients!

In order to prevent or to minimise the incidence of controversies with patients not being happy with the hospital bill, we have been sparing no effort to help our doctors, resident and/or visiting, prepare a reasonably accurate quotation for their patients. For a physician in internal medicine, it may not be satisfactory. At most, we can do is for our staff to give patients the fees charged for costly examinations such as molecular blood tests for pathogens and medical imaging investigations like CT scans and magnetic resonance imaging (MRI). Pricey medications like big-gun antibiotics, biologics and anti-cancer drugs are items which will require their costs to be revealed to the patient when prescribed by the attending doctor.

When it comes to a surgical procedure, we shall have to leave it to the surgeon, because it is only he or she who is familiar with the history and physical findings of the patient, thus having knowledge of the complexity of the operation and the appropriate peri- and post-operative medications to be administered. Surgeons and anaesthetists do have their preferred drug formularies and the items they favour may be much more expensive than those commonly prescribed by their colleagues! How could we help? Over the years, the Accounts Department of Union Hospital has been mailing, electronically in recent years, detailed accounts to our doctors of their patients. The details include room charges, doctors' fees, drug costs, and charges for miscellaneous investigations as well as for use of the operating theatre in time slots of 15 minutes! This sort of detailed 'financial history' will certainly help the doctor to give a fairly reliable quotation for future patients undergoing a similar operation in our hospital.

At the end of the day, the purpose of ensuring price transparency is to help the patient to budget for an intended operation or treatment procedure of a similar nature. The best solution is the provision of an all-inclusive 'package' by the hospital or day procedure centre. Union Hospital is one of the first private hospitals to have 'packages' for child-birth delivery — by natural birth or elective Caesarean Section. Presently we are offering packages for joint replacement of the lower limbs, i.e., hips and knees. Nowadays these previously complicated Orthopaedic operations have been rendered simple and standardised with computer-scan image-guided navigation systems in the operating theatre. Thus the choice of the size of the prosthesis and the amount and shape of the receptive bone to be cut away will be meticulously accurate through computerisation of the whole process. Deviations and complications are rare, and these are sound bases for making 'packages' possible. This is an example of the kind of price transparency which will certainly be welcome and successful, with a win-win situation. We are closely watchful of the response and feedback after a number of these packages have been taken up, in order to look for room for improvement. I hope that they will be successful to a similar extent as our maternity packages.

Wishing you and your family a most pleasant summer-like autumn.

Yours most sincerely,

Dr Anthony K Y Lee
Chief Hospital Manager & Medical Director

Management of Chronic Coronary Syndromes (CCS): A Comprehensive Clinical Overview for General Clinicians



Dr Chan Kam Tim (MBBS, MRCP, FRCP, FACC)
Consultant in Cardiology
Union Hospital

Introduction and Definition

Chronic Coronary Syndromes (CCS) represent the different evolutionary stages of coronary artery disease (CAD) outside of acute, unstable presentations. Officially introduced by the European Society of Cardiology (ESC)[1] to replace the older concept of "chronic stable ischemic heart disease", CCS emphasizes that CAD is a dynamic, continuous, and progressive disease spectrum rather than a static condition.

Pathophysiologically, CCS involves structural or functional changes of the epicardial coronary arteries or microcirculation. These alterations result in a transient myocardial demand-supply mismatch, culminating in inducible myocardial ischemia. Clinically, CCS manifests as episodes of typical angina pectoris, dyspnea (ischemic equivalent), or it may remain entirely asymptomatic.

International Guidelines[1,2]

The 2023 American Heart Association/ American College of Cardiology and 2024 ESC guidelines on management of CCS have laid down the foundations for understanding of the prognosis and contemporary management of CCS. Management has transitioned from an invasive-first approach toward robust optimal medical therapy (OMT), precise non-invasive diagnostics, and specialized management of microvascular dysfunction. For practicing clinicians, we need to have a comprehensive understanding of contemporary risk stratification, advanced pharmacology, and the specific indications for revascularization.

The 2024 ESC Guidelines – Clinical Entities of CCS

- Patients with suspected CAD and stable anginal symptoms or dyspnea
- Patients with new-onset heart failure or left ventricular systolic dysfunction of suspected ischemic origin
- Asymptomatic or symptomatic patients stabilized after an Acute Coronary Syndrome (ACS) or a recent revascularization procedure
- Asymptomatic patients in whom CAD is detected during routine screening
- Vasospastic or microvascular angina (such as Angina/Ischemia with Non-Obstructive Coronary Arteries, or ANOCA/INOCA)

Clinical Diagnosis and Initial Assessment

The diagnostic pathway for patients with suspected CCS relies on a 4-step systematic, structured clinical evaluation.

Step 1: Clinical History and Symptom Classification

A detailed clinical history and physical examination are the mandatory first step to approach patients with CCS. We should establish the details of the symptom characteristics, prior ACS or PCI/CABG, left ventricular function or heart failure symptoms, comorbidities like DM, chronic kidney diseases, metabolic syndromes and high bleeding risk factors.

Step 2: Basic Investigations and Clinical Likelihood

Initial diagnostic tests include:

Resting 12-lead ECG: for prior myocardial infarction, left ventricular hypertrophy, conduction abnormalities, or arrhythmias.

Laboratory Biomarkers: Complete blood count, fasting glucose, HbA1c, renal function, lipid profiles, and high-sensitivity troponin if acute destabilization (ACS) is suspected.

Resting Transthoracic Echocardiography: to assess regional wall motion abnormalities, global left ventricular ejection fraction (LVEF), and exclude concurrent valvular pathologies.

Step 3: Risk Assessment and Diagnostic Pathways

Following these baseline evaluations, clinicians often apply the Risk Factor-Weighted Clinical Likelihood (RF-CL) model, which integrates traditional pre-test probabilities (age, sex, and symptoms profile) with cardiovascular risk factors (smoking, hypertension, dyslipidemia, diabetes, and family history) to estimate the likelihood of underlying obstructive CAD. (Defined as ≥ 50% lesions in the major epicardial coronary arteries.)

- Very Low Likelihood: ≤ 5%
  - ➢ Further diagnostic testing can generally be deferred unless symptoms persist and non-cardiac causes have been ruled out.
- Low Likelihood: >5% to 15%
- Moderate Likelihood: >15% to 50%
- High Likelihood: >50% to 85%
  - ➢ For low to moderate risk (>5%-50%) - Coronary computed tomography angiography (CCTA) is preferred as the primary non-invasive diagnostic test to rule out or evaluate obstructive CAD and assess non-obstructive plaque.
  - ➢ For moderate to high risk (>15-85%) - Non-invasive functional imaging (such as stress echocardiography, CMR perfusion, or nuclear/PET imaging) is recommended to confirm/ quantify ischemia and guide revascularization plan, or when CTCA is not suitable or result is inconclusive.
- Very High Likelihood: >85%
  - ➢ Direct invasive coronary angiography (ICA) is recommended (especially if symptoms are refractory to medical therapy, angina at low levels of exercise, or high events risk is present), often paired with invasive functional assessment (FFR/iFR).

* Traditional exercise ECG (treadmill testing) is no longer favored as the primary standalone diagnostic test due to its lower diagnostic accuracy; it is primarily reserved when assessing for exercise tolerance and prognostic purposes.

Step 4: Therapeutic Management

The ultimate goals of managing CCS are twofold: to alleviate symptoms (angina and ischemia) and to prevent future cardiovascular events (such as myocardial infarction or cardiac death).

1. Medical Management for Symptoms Relief (Anti-anginal Therapy)

Anti-ischemic medications must be tailored to the individual's heart rate, blood pressure, and left ventricular function.

First-line Therapy: Beta-blockers or Calcium Channel Blockers (CCBs) are established as first-line agents to control heart rate and reduce myocardial oxygen demand. They can be titrated as monotherapy or used in combination if symptoms persist.

Second-line / Add-on Therapy: For patients with refractory symptoms or specific contraindications, long-acting nitrates, ivabradine, nicorandil, trimetazidine, or ranolazine may be introduced. Ranolazine is particularly effective as an add-on therapy without significantly altering systemic hemodynamics.

2. Pharmacological Secondary Prevention (Future Events Prevention)

A. Antiplatelet Therapy

Most patients with established obstructive CAD without another indication for anticoagulation, single antiplatelet therapy, usually low-dose aspirin, is appropriate for secondary prevention. Clopidogrel is now regarded as an effective alternative therapy (Class IA), not only for those with aspirin-intolerance or contraindications. After elective PCI, dual antiplatelet therapy (DAPT) with aspirin and P2Y12 inhibitors is generally used for a defined duration determined by ischemic and bleeding risks, lesion characteristics and clinical presentation. Patients with AF or other indications for oral anticoagulation will require a careful detailed planning for the optimal duration and regimen of the antiplatelet and anticoagulant.

In selected CCS patients with high ischemic but low bleeding risks, low-dose rivaroxaban (2.5mg/bid) plus aspirin may be considered, this is not a routine substitute for individualized risk assessment.

B. Lipids Management

Lipid lowering targets have been intensified. The ESC guideline establishes an LDL-C goal of ≤ 1.4mmol/L (≤ 55mg/dL) and ≥ 50% baseline reduction as a Class I recommendation for patients with clinically manifest atherosclerotic cardiovascular disease, including high risk CCS patients. It even uses LDL-C goal of ≤ 1.0 mmol/L (≤ 40mg/dL) for those very high-risk cases (recurrent vascular events within 2 years despite maximal tolerated therapy). Statins remain the first line therapy and for those not reaching target on statin monotherapy, addition of Ezetimibe or PCSK9 inhibitors is recommended. Bempedoic acid now has a Class I recommendation for statin-intolerant patients who fail Ezetimibe. Inclisiran, a small interfering RNA (siRNA), administered twice yearly, can offer sustained LDL-C reduction while improving compliance. It is important to note that definitive clinical outcomes data are still pending for Inclisiran. Lp(a) should be measured at least once in CCS patients to further refine their risk assessment.

C. Cardio-metabolic Modifiers

Cardio-metabolic therapies can provide CVS benefit beyond glycemic control. SGLT2 inhibitors and GLP-1 receptor agonists carry Class I, level A recommendation for CCS patients with type 2 DM to reduce CVS events, independent of baseline HbA1c. GLP-1 agonist, Semaglutide, now has a Class IIa recommendation for non-DM patients with BMI >27kg/m^2, based on the SELECT trial[3] demonstrating reduced CVS mortality, MI and stroke.

D. Anti-inflammatory Therapy

The 2024 ESC guidelines gave low-dose colchicine (0.5mg daily) a Class IIa Level A recommendation for reducing MI, stroke and revascularization in atherosclerotic CAD.

The randomized EKSTROM trial (2026)[4] demonstrated that colchicine significantly reduced total plaque burden and dense calcified plaque over 12 months in stable CAD, though it did not significantly reduce low-attenuation plaque volume. These support colchicine's role in slowing overall plaque progression, particularly in patients with residual inflammatory risk.

E. Lifestyle Modification and Cardiac Rehabilitation

Comprehensive risk-factor modification includes smoking cessation, adopting a nutrient-dense Mediterranean diet, limiting alcohol, and participating in regular, tailored physical activity (at least 150 minutes of moderate aerobic exercise per week). Formal cardiac rehabilitation programs are highly effective at promoting long-term behavioral changes and improving functional capacity.

F. Role of Myocardial Revascularization[5]

Myocardial revascularization via Percutaneous Coronary Intervention (PCI) or Coronary Artery Bypass Grafting (CABG) is indicated under two major clinical scenarios:

i. Prognostic Indications: Severe anatomical diseases, such as left main stem stenosis (≥ 50%), proximal left anterior descending (LAD) artery disease (≥ 70%), or multi-vessel disease with impaired LV function.

ii. Symptomatic Indications: Persistent, limiting angina or documented significant ischemia that remains refractory to optimal medical therapy (OMT).

As demonstrated by landmark clinical data, including the COURAGE/ISCHEMIA Trials[5], initial revascularization does not significantly reduce overall mortality compared to optimal medical therapy alone in stable patients without high-risk anatomy. Concerning the revascularization modes, a multidisciplinary Heart Team discussion remains essential to weigh anatomical complexity against procedural risks for choosing PCI or CABG.

Management of INOCA or ANOCA

For patients with persistent angina symptoms but non-obstructive diseases on CCTA or ICA, guidelines strongly mandate an invasive functional assessment of the coronary vasomotor function during coronary angiogram (measure coronary flow reserve (CFR), index of microvascular resistance (IMR) and provocative acetylcholine testing for vasospasm) to distinguish between microvascular angina and vasospastic endotypes. Current treatment focuses mainly on risk factor control and medical therapy is tailored directly to the specific endotypes identified during functional testing.

Endotypes-Specific (Mechanisms Based) Management:

Patient Profile / Endotype	Primary Medical Recommendations
Endothelial Dysfunction	Consider an **ACE inhibitor (ACEi)** and a **statin** if co-existing atherosclerosis is present.
Abnormal Microvascular Vasodilation	Consider **Beta-blockers**, Calcium Channel Blockers **(CCBs)**, **ranolazine**, trimetazidine, or ivabradine.
Abnormal Microvascular Vasoconstriction	Consider **CCBs** (combining two when necessary) and **nitrates**.
Abnormal Epicardial Vasoconstriction ***(Vasospastic Angina)***	**CCBs are first-line therapy**; nitrates or nicorandil may be added. **Note: Avoid beta-blockers in isolated vasospastic angina as they can worsen spasms.**
Microvascular Angina with reduced CFR	Consider antianginal medication to prevent demand myocardial infarction (MI).

Summary of Core Clinical Targets

Overall, the 2024 ESC guidelines move CCS care toward precision medicine: identify the mechanism of ischemia, quantify risk, tailor prevention and symptom therapy, and reserve invasive procedures for patients who are most likely to benefit.

Metric / Parameter	Current Guideline-Directed Target	Primary Therapeutic Options
LDL-Cholesterol	**<1.4 mmol/L (<55 mg/dL)** and ≥ 50% reduction	High-intensity statins, Ezetimibe, PCSK9 inhibitors, Inclisiran
First-Line Diagnostic	**CCTA** for low/moderate likelihood	Anatomical imaging vs functional stress imaging
Antithrombotic Standard	Long-term monotherapy	Clopidogrel 75 mg QD (Class IA) or Aspirin 75–100 mg QD
Comorbid T2DM/ Obesity	Cardiovascular and metabolic protection	SGLT2 inhibitors and GLP-1 receptor agonists
Residual Inflammatory Risk	Cardiovascular event reduction	Low-dose Colchicine (0.5 mg/day)

List of References:

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SHARING CORNER

Congenital Upper Limb Differences



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Congenital upper limb difference (formerly called anomalies) is a variation in how a baby's hand or arm has formed. It includes a wide spectrum of presentations: from a slightly smaller thumb that does not affect function to the absence of a whole limb that affects function and cosmetic appearance significantly. Traditionally Swanson's morphological classification (1960s)[1] was most widely used, which groups the variations into:

I. Failure of formation,
II. Failure of differentiation,
III. Duplication,
IV. Overgrowth,
V. Undergrowth,
VI. Constriction band syndrome, and
VII. Generalized skeletal dysplasia.

It was adopted by IFSSH in 1983, but in 2013 the Federation adopted the OMT (Oberg, Manske, Tonkin) classification[2] which tried to consider the etiology, molecular genetics, and developmental biology, and classifies into Malformation, Deformations, and Dysplasias and Syndromes.

Worldwide, the prevalence of congenital upper limb anomalies (CULAs) is generally estimated between 4.9 and 13 per 10,000 live births. The prevalence of different conditions also varies in different regions; however, pre-axial polydactyly, syndactyly and congenital trigger thumbs are the most common conditions, accounting for around 70% of all the cases.

Since the thumb is the most affected part (in pre-axial polydactyly and congenital trigger thumb) I would like to introduce the 3 most common congenital differences that affect the thumb: radial polydactyly, congenital trigger thumb, and thumb hypoplasia.

1. "Too Many" Thumb

Extra thumb (Radial polydactyly or pre-axial polydactyly) is the most common condition, occurring in approximately 1 in 3,000 live births (Fig. 1). It is most prevalent in Caucasian and Asian populations and is usually a sporadic, unilateral event. The etiology is believed to be ectopic over-signalling of Zone of Polarizing Activity (ZPA) and the Sonic Hedgehog (SHH) signalling pathway at the limb bud. Unlike postaxial (pinky-side) duplication, it is less frequently associated with systemic syndromes.

The structures are not truly "extra" but rather a "split" or sharing of bone and joints, tendons, ligaments and neurovascular structures. Wassel's Classification (I to VII) is most used which categorises them according to the level of bone or joint that bifurcates. The Hong Kong group[3] proposed a sub-classification of the most common type IV that guides surgical treatment strategies and is widely accepted locally.



Figure 1.

Surgery is usually performed between 12 and 18 months. (Fig. 2) It is a reconstruction and not just amputation because, besides ablating the more hypoplastic thumb (usually the radial one), its collateral ligaments and intrinsic muscles are transferred to the retained thumb and sometimes a corrective osteotomy may be needed to correct the angular deformity. In some cases, the Bilhaut-Cloquet procedure, or modification of this[4] which is a combination of two thumbs are indicated when both thumbs are too small.

The complications following surgery include residual deviation deformity, stiffness or instability and hypertrophic scar. Secondary surgeries to correct these complications are not common and may be performed during adolescence.



Figure 2.

2. "Too Stiff" Thumb

Congenital trigger thumb (Fig. 3) is rarely present at birth and typically presents between 9 months and 4 years of age. It affects roughly 3 in 1,000 children and is bilateral in nearly 30% of cases. The pathology is a volume mismatch between the flexor pollicis longus tendon and the A1 pulley. A palpable fibrocartilaginous mass, named Notta's Node (Fig. 4), is usually palpable at the palmar aspect of metacarpophalangeal joint. Usually, the thumb is locked at a position of interphalangeal joint flexion, because the node becomes trapped at the proximal edge of the A1 pulley. Unlike the triggering presented in adults, paediatric cases are usually fixed deformities.



Figure 3.



Figure 4.

Long-term prospective studies show that 32% to 75.9% of untreated paediatric trigger thumbs resolve spontaneously over time, and it takes 3 - 4 years to resolve. Patients with bilateral thumb involvement and interphalangeal joint flexion angle >30 degrees are less likely to have spontaneous resolution. Depending on initial severity and follow-up length, roughly 27% to 43% of paediatric trigger thumbs eventually undergo surgical A1 pulley release, typically around a median age of 4.1 years. The surgery is a highly successful, low-risk procedure. If left untreated, permanent flexion contractures and compensatory hyperextension of the metacarpophalangeal joint may compromise the ability to grasp large objects.

3. "Too Small" Thumb

Hypoplastic thumb occurs in 1 in 30,000 births. (Fig. 5) It is a clinical "red flag" as up to 80% of patients are associated with systemic syndromes, most notably VACTERL association and Fanconi Anemia, which may require early or even urgent treatment of the potential life threatening visceral and haematological anomalies. Chromosomal studies are often mandatory for these neonates.

Recently, hypoplastic thumb is believed to be included in a spectrum of "radial longitudinal deficiencies" which various extends of shortening of radius bone and carpal bone aplasia may be present. The elbow may be stiff, and forearm deformed and may need complicated, staged surgeries for forearm, wrist and elbow, besides the thumb.



Figure 5.

The Blauth Classification which reflects the severity of thumb anomalies is most widely adopted.

I: Simply smaller thumb with normal function.

II: Small thumb with minor muscular and / or ligamentous deficiencies.

IIIa: Significant skeletal hypoplasia with stable 1st carpometacarpal joint.

IIIb: Unstable carpometacarpal joint.

IV: Floating thumb ("pouce flottant").

V: Complete absent thumb ("aplasia").

Children with Grades I, II and IIIa may be managed surgically with 1st web-space deepening, joint stabilization with collateral ligament plication or reconstruction, and tendon transfers. (Fig. 6 & 7) For Grades IIIb through V, since the unique function of "Thumb opposition" is lost due to the non-functional 1st carpometacarpal joint, or absence of thumb, the standard of care is transposition of index finger to the 1st carpometacarpal position to reanimate the thumb opposition. This "Index Finger Pollicization" is a highly complicated procedure where the index finger is migrated, shortened, and rotated to function as a thumb. The new hand then composed of a new "thumb" and 3 fingers.



Figure 6.



Figure 7.

Even with successful pollicization, the hand has decreased strength compared with a five-digit hand. Besides, cultural beliefs in the Eastern World prefer preservation of all digits if possible. While several surgical reconstruction methods were proposed by Japanese experts utilizing tissue transfer from toes, significant donor site morbidities at the foot resulted.

The Hong Kong group proposed a free hemi-metatarsal transfer procedure for Grade IIIb and IV patients[5], harvesting a longitudinal half of 2nd metatarsal bone and combining with local flap procedures that create a functional 1st web and tendon transfers to reanimate the new thumb. The function of the new thumb is not as functional as that following index pollicization, however, the child preserves a 5-finger hand and minimal foot morbidity.

Patients who undergo any of the above surgeries will require long-term rehabilitation therapy to integrate the "new" thumb into their cortical motor patterns.

Almost no two congenital upper limb differences are identical. Treatment, both operative and conservative, and timing, must be discussed in detail and repeatedly with serial assessment, and individualized to match the changing need of the child during development. A good rapport is mandatory: be empathic, be attentive in listening, be supportive and positive in attitude, focus on the healthy body parts and unique character of the child rather than the "anomalies". As a professional team we may introduce families with children having similar differences and let them learn the future journeys and let the supportive relationship spread. In Hong Kong there is a voluntary organization that provides art, music and sports lessons to children with congenital upper and or lower limb problems[6]. These activities help the children to develop skills and psychological confidence to be integrated into normal school life.

The incidence of congenital upper limb difference is relatively low but the varieties are numerous. A local registry[7] has been established, and this is extremely helpful in studying the prevalence, natural history and treatment outcome so that we can provide a better and more evidence-based treatment for the children in future.

When a child is born, people see the difference. The child sees what she is born with – NOT losing anything that she is supposed to be born with. A child is born to appreciate her uniqueness, but it's the people who make her believe that she has to accept that she is different.

References

1. Swanson A.B., A Classification for congenital limb malformations, Journal of Hand Surgery (Am). 1976 Jul;1(1):8-22
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5. Mak, C.K., HO, P.C., Chow, C.S., Liu, B., Tse, W.L.(2021) Neurovascular Island Flap for Pulp and Nail Augmentation in Thumb Duplication Reconstruction: A Surgical Method With Long-Term Follow-Up. Journal of Hand Surgery Volume 46, Issue 4, April 2021, P.340.e1-340.e8
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7. Cheung, W.H., Ho, P. C., Tse, W. L., Mak, M. C. K., Koo, J. J. S. C., Ting, J.W.C., Chau, W. W. & Wong, M.Y. (2025), Registry for congenital upper limb anomalies in Prince of Wales Hospital, Hong Kong: abridged secondary publication. Hong Kong medical journal 31, 5(Suppl 7), p. 45-47

NEWS & EVENTS

Award Recognition

HK01 ESG & Sustainable Development Forum and Awards Ceremony 2026: Outstanding ESG Enterprise Award and Excellent ESG Enterprise Rating Certificate

We are honoured to receive the Outstanding ESG Enterprise Award and the Excellent ESG Enterprise Rating Certificate at the HK01 ESG & Sustainable Development Forum and Awards Ceremony 2026, recognising our ongoing efforts in environmental stewardship, social responsibility and good governance. The rating certificate was assessed under the Business Sustainability Index (BSI) framework developed by the Centre for Business Sustainability of The Chinese University of Hong Kong Business School.

From enhancing energy efficiency and reducing waste to supporting community health initiatives, sustainability is embedded across our hospital operations. Through the collective efforts of all departments, these initiatives contribute to a more sustainable healthcare environment and support the hospital's long-term development.



Post-Event Highlights

CME Programme – Neonatal Respiratory Disorders and Management: A Practical Update

On 11 September 2026, Union Hospital hosted a CME lecture titled 'Neonatal Respiratory Disorders and Management: A Practical Update'. Dr Fung Po Gee, Genevieve, Clinical Assistant Professor in the Department of Paediatrics at The Chinese University of Hong Kong, and Honorary Associate Consultant in the Department of Paediatrics at Prince of Wales Hospital, presented the latest updates on the diagnosis, immediate management, and recent clinical advances, incorporating insightful case studies.

The lecture was chaired by Dr Pau Chee Kit, Benjamin, Consultant in Paediatrics at Union Hospital. This interactive session facilitated a vibrant Q&A and contributed to ongoing professional development. This lecture attracted over 120 doctors, nurses, and allied healthcare professionals, both onsite and online.



Public Health Talk – 護「腦」有法 健康講座

Union Hospital partnered with Nutricia to co-organise the public health talk '護「腦」有法 健康講座' on 19 September 2026 at Synloc Tower, Jordan. The event aimed to raise public awareness of brain and cognitive health, highlighting the importance of early awareness and the role of nutrition in supporting healthy ageing. A total of 68 participants attended the talk.

The programme featured a multidisciplinary team of specialists and dietitians, including Dr Yuen Mang Ho, Specialist in Neurology; Dr Kwok Shun Lai, Specialist in Geriatric Medicine; and Union Hospital dietitians Ms Joy Li and Ms Phoebe Fong. Through their professional sharing, the speakers explored key aspects of brain and cognitive health, the nutritional considerations for healthy ageing, and practical ways to maintain brain health as we age.



New Clinical Sessions

Minimally Invasive Centre		
Booking & Enquiry: 2608 3383	Time Schedule	
General Surgery Dr Cheng Tsz Ling	Wed Sat	16:00 – 18:30 09:00 – 13:00
Otorhinolaryngology Dr Mok Siu Wai, Johnny	Tue Wed Thu	16:00 – 18:00 16:00 – 18:00 15:30 – 17:30

Specialty Clinic		
Booking & Enquiry: 2608 3315	Time Schedule	
Haematology & Haematological Oncology Dr Lau Chi Kuen	Mon Wed	10:00 – 13:00 10:00 – 13:00

Plastic and Aesthetic Multidisciplinary Centre		
Booking & Enquiry: 2608 3211	Time Schedule	
Oral and Maxillofacial Surgery Dr To Wai Hei, Edward	Tue (By Appointment) Wed	13:00 – 17:00 13:00 – 17:00

Union Oncology Centre		
Booking & Enquiry: 2159 6100	Time Schedule	
Haematology & Haematological Oncology Dr Lau Chi Kuen	Tue Thu Fri	09:00 – 13:00 09:00 – 13:00 09:00 – 13:00
Oncology Dr Ng Wai Tong, Lewis	Mon Wed Thu	14:00 – 17:00 09:00 – 17:00 14:00 – 17:00

Union Healthcheck Centre		
Booking & Enquiry: 2682 2313	Time Schedule	
Paediatric Immunology, Allergy & Infectious Diseases Dr Chua Gilbert T.	Tue	09:30 – 13:00

Union Hospital Polyclinic (Tsim Sha Tsui)		
Booking & Enquiry: 2375 3323	Time Schedule	
Cardio-thoracic Surgery Dr Cheng Wai Yeung, Rechard	Wed Fri	10:00 – 13:00 10:00 – 13:00
Otorhinolaryngology Dr Mok Siu Wai, Johnny	Mon Fri Sat	10:30 – 13:00 15:30 – 18:00 10:30 – 12:30

Union Hospital Polyclinic (Ma On Shan)		
Booking & Enquiry: 2608 3377	Time Schedule	
Otorhinolaryngology Dr Mok Siu Wai, Johnny	Mon Wed Thu	15:30 – 17:30 10:30 – 12:30 10:30 – 12:30

Regular Meetings

Meeting :	X-Ray Meeting
Date : Time :	9 December 2026 (Wednesday) 8:30am – 9:30am
Co-ordinator:	Dr Chan Chi Sang, James **Head, Department of Medical Imaging, Union Hospital**
Venue:	Training Room, 8/F, MIC, Hospital Building, Union Hospital
Booking & Enquiry:	2608 3160 (Quality Assurance and Training Department)

New Clinical Members

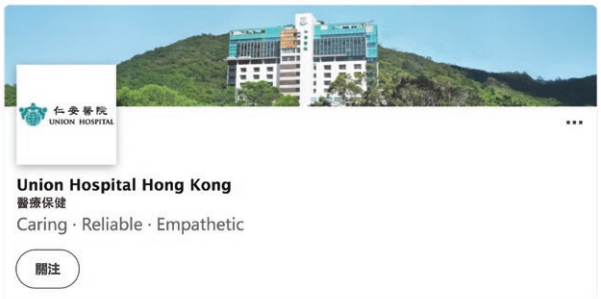
Please extend a warm welcome to the following health professionals joining our clinical team!



Dr Cheng Wai Yeung, Rechard
Consultant in Cardio-thoracic Surgery



Dr Lau Chi Kuen
Consultant in Haematology & Haematological Oncology



Connect with Union Hospital on *LinkedIn*

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

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