

# UNION

connection

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## Message from the *Chief Hospital Manager*

Dear Colleagues,

By the time this communication of Union Hospital reaches your hands, it will probably be in the middle of the holiday season and I shall be on my way to Hokkaido with my family and skiing enthusiasts from the Henderson Land Group for the much longed for Niseko Ski and gourmet trip. Despite the recent surge in the number of COVID-19 cases, I am in a very good mood of mind and shall give you the very much welcomed news on the multiple accolades our hospital recently received. First of all, the Hong Kong Institute of Facility Management has bestowed upon us quite a number of awards. These included the most prestigious Distinction Award in Excellence in Facility Management; Gold Award in Smart Technology; Silver Award in Outstanding Professional Integrity and a Bronze Award in the Most Popular Facility category.

Then in the Health Partnership Awards 2022 organized by ET-Net of the Hong Kong Economic Times we have been crowned 'Outstanding Comprehensive Hospital in the Medical and Professional Service category. Lastly but not the least, in a competition organized by the Capital Weekly Union Hospital has been given the much coveted Medical Service Award in Capital Service and Innovative Product Awards 2022. I am very thankful to all the staff of Union Hospital for their unflinching effort and altruistic attitude in serving our patients and clients thus achieving the above daunting feat.

In addition to the above, our maternity service is one of the most sought after amongst the private hospitals in Hong Kong. This is very much reflected by the postings in various social media websites concerning childbirths and care of infants like the Baby Kingdom. The quality of care rendered by the obstetricians and paediatricians as well as the team of nurses and patient care assistants in the maternity ward and nursery have always been highly acclaimed. It is no wonder that the number of deliveries in 2021 was 3345 and we may be able to surpass this by a small margin by the end of this month.

The above is not a feat that is easily achieved if it had not been for the effort of our hard-working staff. We have transformed the hospital culture into one of team spirit abiding by the guide-lines and documented policy and procedures according to the 'Quality Management System' of ISO accredited criteria and standards. Within this structured system, the hospital operates under strict 'governance' like a team of championship World Cup soccer players! Be that as it may our team of staff is also facing the crisis of human resource shortage from emigration and Covid-19! The department being most affected is nursing where a significant proportion of mid-level staff, by experience, had left for various seasons. Thanks to the resourcefulness and innovative ideas of the senior nurses under the leadership of Ms. Pun Tsz Kei, Director of Nursing, a series of training courses and educational smartphone apps have been successfully carried out and implemented, so that our quality service with patient safety first has been well maintained.

It is with such a high note that I would end this message and I wish you and your family or loved ones the Very Best in the Festive Season and Year 2023.

Yours most sincerely,

Dr Anthony KY Lee  
Chief Hospital Manager & Medical Director

## Antithrombotic and Thrombolytic Therapy in Ischaemic Stroke Patients with Cerebral Microbleeds

**Dr. Yannie Soo**  
Assistant Chief Hospital Manager  
Specialist in Neurology  
Union Hospital



Cerebral microbleeds (CMBs) on MRI Brain is a radiological marker indicating underlying bleeding-prone microangiopathy which is increasingly being recognized as a predictor for future intracerebral haemorrhage (ICH). It is commonly observed in elderly, as well as patients with hypertension, cognitive impairment, ischaemic and haemorrhagic stroke and cerebral amyloid angiopathy. As CMBs are observed in up to one-third of patients with ischaemic stroke, this raises concerns about safety of antithrombotics (i.e. antiplatelet agents and anticoagulants) and thrombolytic therapy in patients with CMBs who may be at higher risk of treatment-associated ICH, the most unwanted complication associated with high mortality.<sup>[1]</sup>

### Histopathological Associations of Cerebral Microbleeds, a Marker of Small Vessel Disease

CMBs appear as small (2-10 mm diameter) dot-like hypointense foci, associated with blooming on MRI sequences sensitive for detecting haemosiderin products, e.g. T2\* gradient-echo and Susceptibility-weighted Imaging. (Fig. 1)<sup>[2]</sup> It is part of the spectrum of small vessel disease and often coexists with periventricular white matter hyperintensities, lacunes and dilated perivascular space. Histologically, they are associated with perivascular haemosiderin deposits indicating previous asymptomatic leakage from local vessel wall damage.<sup>[3]</sup>

Deeply located CMBs are commonly associated with hypertensive arteriopathy, while strictly lobar CMBs in patients with cognitive impairment are classically associated with cerebral amyloid angiopathy, which has a 4-fold increased risk of warfarin-associated ICH. (Fig. 1)<sup>[4,5]</sup> Several studies have shown that the addition of this biomarker to conventional clinical risk scores, e.g. ATRIA and HASBLED, could improve the predictive value of ICH.<sup>[6-8]</sup>



**Figure 1** (a) Example of strictly lobar CMBs classically associated with cerebral amyloid angiopathy in T2\* gradient echo MRI of a patient with cognitive decline. (b) T2\* gradient echo MRI of a patient with deep CMBs predominantly located in the basal ganglia and thalami associated with long-standing hypertension.<sup>[4]</sup>

### Risk of Antithrombotic-associated Intracerebral Haemorrhage in Ischaemic Stroke Patients with CMBs

In patients with ischaemic stroke or transient ischaemic attack, CMBs are observed in up to one-third of the patients. Earlier studies in Chinese population suggested increase in risk of aspirin- and warfarin-associated ICH in atrial fibrillation patients with  $\geq 5$  CMBs.<sup>[9,10]</sup> However, as growing evidence have shown that CMBs not only increase the risk of subsequent ICH, but also risk of recurrent ischaemic stroke, it causes clinical dilemma in treatment decisions which requires careful weighing of risk of antithrombotic-associated ICH vs benefit of protection from ischaemic stroke.

In the recent large-scale international pooled individual data analysis performed by the Microbleeds International Collaborative Network (MICON) which involved 20,322 patients with previous ischaemic stroke or transient ischaemic attack, the adjusted hazard ratio (aHR) for ICH increased significantly with burden of CMBs (aHR 2.45 for presence of CMBs, aHR 4.55 for  $\geq 5$  CMBs, aHR 5.52 for  $\geq 10$  CMBs). In parallel, the risk of recurrent ischaemic stroke also increased with presence of CMBs, but the effect was less marked (aHR 1.23 for presence of CMBs, 1.47 for  $\geq 5$  CMBs and aHR 1.43  $\geq 10$  CMBs).<sup>[11]</sup> As the absolute rate of ischaemic stroke still exceeds that of ICH irrespective of the CMBs distribution and burden, routinely withholding antithrombotic therapy for patients with CMBs are therefore not justified in general. However, despite the large sample size in this study, caveat exists as the analysis included patients with all subtypes of ischaemic stroke using different antithrombotics, which could have variations in risk-to-benefit profile. It remains uncertain if anticoagulants, which have higher risk of ICH than antiplatelets, could be of net harm to patients with atrial fibrillation and co-existing CMBs.

## Risk of Antithrombotic-associated Intracerebral Haemorrhage in Patients with Atrial Fibrillation

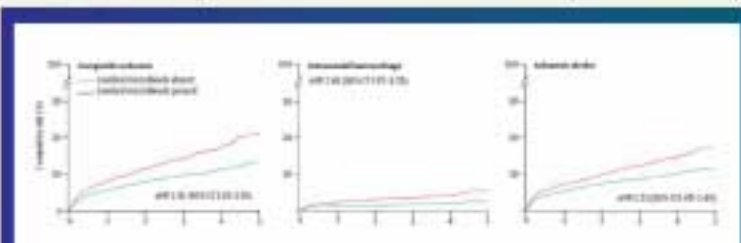
In a recent substudy of the MICON which included 7839 patients with atrial fibrillation, the risk of ICH and ischaemic stroke was further stratified among patients on different antithrombotic treatments (i.e. warfarin, direct oral anticoagulants, antiplatelets, combination of oral anticoagulant and antiplatelet) and CMBs burden.<sup>[11]</sup> In this study, the absolute risk of treatment-associated ICH was found to be doubled that of recurrent ischaemic stroke among those who received combination therapy with multiple CMBs. It remains uncertain if left atrial appendage occlusion could help reduce the risk of ICH in these patients by minimizing need of combination therapy. Further randomized controlled trials are warranted to determine the best stroke preventive strategy for this high-risk group.

## Thrombolytic Therapy in Acute Ischaemic Stroke with Pre-treatment Cerebral Microbleeds

Data about safety of reperfusion therapy (i.e. intravenous thrombolysis and endovascular thrombectomy) in ischaemic patients with CMBs are scarce. Most evidence are limited to observational studies as most patients do not undergo MRI before this treatment in acute setting. In an individual patient data meta-analysis of 1973 patients with acute ischaemic stroke receiving intravenous thrombolysis who had pretreatment MRI done, the presence of  $\geq 1$  CMB in general was not associated with increased risk of symptomatic ICH after intravenous thrombolysis. However, for the very small subset of patients with  $>10$  CMBs ( $n=35$ , 1.8% of included patients), a significant increase in risk of ICH (adjusted OR 3.65) and poor functional outcome (adjusted OR 3.99) were observed.<sup>[12]</sup> However, due to various limitations in these studies in acute stroke setting, low pre-treatment probability of having  $>10$  CMBs and high efficacy of improving functional outcome with reperfusion therapy, these findings should be interpreted cautiously. Currently, the American Heart Association Guidelines does not recommend routine use of MRI brain to exclude CMBs before intravenous thrombolysis.<sup>[13]</sup>

## Conclusion

In patients with ischaemic stroke, CMBs are commonly identified on MRI brain, which provides precious insights for prognostication of future vascular events. For patients on antithrombotics, the presence of CMBs was associated with increased risk of both subsequent ICH as well as recurrent ischaemic stroke, with stronger association with the former. As the absolute rate of recurrent ischaemic stroke still exceeds that of ICH for most patients, routinely withholding antithrombotic therapy for patients with CMBs is not justified. There is also insufficient evidence to support routine screening of CMBs with MRI brain before reperfusion therapy which is time-critical. Nevertheless, CMBs help identify patients at increased risk of treatment-associated ICH who require preemptive measures to mitigate the risk of ICH (which include stringent blood pressure control, close monitoring of INR for warfarin users, avoidance of concurrent NSAIDs and consideration of agents with lowest ICH risk). Further studies are needed to optimize stroke prevention strategies for patients with atrial fibrillation and multiple CMBs who require combination of oral anticoagulants and antiplatelets, whose risk of ICH might exceed that of recurrent ischaemic stroke.



**Figure 2** Outcome of patients with history of ischaemic stroke or transient ischaemic attack from the MICON pooled individual data analysis. Patients with CMBs had increased risk of both subsequent ICH (aHR 2.45) and recurrent ischaemic stroke (aHR 1.23) during follow-up. However, the absolute rate of ischaemic stroke exceeded that of subsequent ICH.<sup>7,8</sup>

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## Bronchial Artery Embolization (BAE) – An Invaluable Treatment Option For Haemoptysis

Dr. Yu Chun Hung, Kevin  
Specialist in Radiology  
Union Hospital



### Bronchial Artery Embolization (BAE) – An Invaluable Treatment Option For Haemoptysis

Haemoptysis is a common clinical presentation, with reported annual incidence of 0.1%. It is estimated that 5-14% patients presenting with haemoptysis will have life-threatening haemoptysis, with reported mortality rate of 9-38%<sup>[1]</sup>. Of particular concern are massive (>300mL per day) or prolonged haemoptysis (>100mL per day for >3 days)<sup>[2,3]</sup>, where BAE has become an indispensable option in addition to bronchoscopic and surgical haemostasis. It was first described by Jacques Rémy et al in 1977, on the basis that the high pressure bronchial arteries (BA) are the culprit of massive haemoptysis in 90% of cases<sup>[1]</sup>, which are proliferated and hypertrophied in chronic inflammatory conditions.

Flexible bronchoscopy and CT thorax are frequently performed before BAE and complementary to each other. Flexible bronchoscopy can frequently identify the laterality, etiology and severity of the underlying condition, as well as securing haemostasis and toileting the airway. CT thorax can assess for lung parenchymal disease and provide a vascular roadmap of the BA, extra-bronchial collaterals, any aneurysm/pseudoaneurysm or active contrast extravasation, latter two fortunately being rare<sup>[4,5]</sup>. In a recently presented retrospective review of 5 consecutive years' BAE experience from my previous tertiary institution, most of our patients suffered from post-TB sequale eg. cavitation (25%) or bronchiectasis (25%), in line with existing literature<sup>[4,5]</sup>, followed by aspergilloma (13.3%), severe/necrotizing pneumonia (11.7%), and lung malignancy (8.3%).

BA anatomy was classically described to have four types by Cauldwell et al in 1948, most commonly with one right intercostobronchial trunk (ICBT) and one or two left BA (Type I and II), but this was subsequently shown to be much more variable. They can also be described as orthoptic (arising from aorta at T5-6 level) or ectopic<sup>[6,7]</sup>. BA >2mm are considered to be pathologically hypertrophied<sup>[2]</sup>. Extra-bronchial collaterals may be present from intercostal arteries, internal thoracic (mammary) artery, supreme intercostal artery from costocervical trunk, lateral thoracic artery, inferior phrenic artery amongst others, which can be involved in up to two-thirds of patients<sup>[2]</sup>. Broncho-pulmonary shunting was found in up to 30% of patients in our series, vast majority from bronchial artery to pulmonary artery rather than to pulmonary vein, with mean diameter averaging 325µm<sup>[2,12]</sup> which has important implications on the appropriate sizing of particulate embolic agents in order to avoid pulmonary infarction or systemic non-target embolization.

Transfemoral approach is typically used, though transradial approach is rapidly gaining popularity among the IR community for improved patient experience and allowing for earlier ambulation<sup>[13]</sup>. It can be performed in the angiography suite under local anaesthesia in stable and cooperative patients. Flush aortogram with pigtail catheter may not be necessary with a high quality pre-procedural CT. Reversed curve (eg. Simmons, SHK, Mikaelsson) or curved (Cobra) catheters are commonly used to engage the ICBT/BA, and angled catheters (eg. Headhunter, Multi-Purpose or Vertebral) for the extra-bronchial collaterals arising from the subclavian arteries. Diagnostic digital subtraction angiograms (DSA) are performed, most commonly showing hypertrophied

bronchial arteries (91.8%), increased parenchymal contrast staining (84.7%), and bronchopulmonary shunting (35.3%) in our series. From there it is only a matter of performing super-selective catheterization with micro-catheters and micro-guidewires into as distal as possible, bypassing and safeguarding important branch vessels, and then applying the embolic agent(s) of choice. Historically the gold standard embolic agent is particulate agents, especially polyvinyl alcohol (PVA) particles sized around the 355-500µm to 500-710µm ballpark, but this is increasingly debated as PVA is also known to induce inflammation. Other embolic agents including liquids eg. N-butyl cyanoacrylate (NBCA) glue have been more recently shown to be similarly effective and safe<sup>[9]</sup>. Coils on the other hand are infrequently used as it creates a permanent "roadblock" to future interventions, except in some specific scenarios eg. aneurysm/pseudoaneurysm or severe bronchopulmonary shunting.

When performed properly, BAE has a reported high technical success rate of 81-100% and immediate clinical success rate of 70-99%<sup>[2]</sup> (93.9% and 89.6% respectively in our series). There were also a variety of local publications cementing its role<sup>[14,15]</sup>. However, recurrence rate is also high at 9.8-57.5%<sup>[1,2,6,10]</sup> (47.1% in our series). Common side effects includes transient chest or back pain, dysphagia and post-embolization syndrome<sup>[6]</sup>. The most frequently mentioned and dreaded side effect of anterior spinal artery infarction is actually pretty uncommon, reported to be 0.19% in a recent Japanese nation-wide study<sup>[11]</sup>, lower than previously reported, possibly due to increased awareness and improved endovascular arsenal. The artery of Adamkiewicz is the largest and most important radiculomedullary artery, and it occasionally originates from an intercostal artery or intercostobronchial trunk. It can therefore uncommonly be visualized during BAE with its signature hairpin appearance, where it must be safeguarded with utmost attention. All in all, BAE is an invaluable treatment option to be considered for selected patients with haemoptysis.



Patient with right upper lobe post-TB cavitation and mycetoma presenting with massive haemoptysis. DSA showing Simmons-1 catheter engaging the orthotopic, grossly hypertrophied and tortuous right ICBT with pronounced broncho-pulmonary shunting and abnormal opacification of almost the entire right pulmonary artery tree. In such case, upsizing of particulate embolic agent will be prudent to reduce the risk of pulmonary infarction.

## References

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## Grand Opening of Union Endoscopy and Day Procedure Centre, Union Hospital Polyclinic (Tsim Sha Tsui)



From left: Ms. Pun Tsz Kai, Dr. Lance Chua, Prof. Henry Chan, Dr. Anthony Lee, Mr. Suen Kwok Lam, Prof. Sydney Chung, Dr. Clara Wu, Dr. Yannie So, Dr. Terence Fung



04 Officiated by Mr. Suen Kwok Lam, Executive Director of Henderson Land Development Company Group, together with members of the Union Hospital Management Board and hospital management team, the grand opening ceremony of Union Endoscopy and Day Procedure Centre at Union Hospital Polyclinic (Tsim Sha Tsui) was successfully held on 22 November 2022.



Dedicated in providing high standard endoscopy and day procedure services, the 6000 sq. ft. Centre is equipped with advanced facilities and hygiene solutions. The Centre is so far the only day procedure centre in Hong Kong that houses the ADVANTAGE PLUS™ Pass-Thru Automated Endoscope Reprocessor together with the ENDODRY™ Drying and Storage System, providing stringent infection control measures aligned with international recommendations. The Centre also features individual resting rooms with a central patient monitoring system, which greatly enhances patient safety and privacy.



- 01 Welcome speech by Dr. Anthony Lee, Chief Hospital Manager & Medical Director, Union Hospital
- 02 Opening address by Prof. Henry Chan, Deputy Chief Hospital Manager, Union Hospital
- 03 Simulation of endoscopy equipment and procedure
- 04 Spacious and comfort environment
- 05 Advanced hygiene solutions with high-standard endoscope reprocessor and storage system
- 06 Procedure rooms for endoscopy and surgical procedures
- 07 State-of-the-art technology and equipment
- 08 Individual resting rooms for high privacy



### Appointment & Enquiry

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📍 Unit 1804-6, 18/F, Mira Place Tower A, Tsim Sha Tui

## CME Programme: Updates in Interventional Endoscopy

**Date:** 20 January 2023 (Friday)

**Time:** 1:00pm-2:00pm

**Venue:** Online Zoom or Seminar Room, 2/F, Main Building, Union Hospital

**Speaker:** **Prof TEOH Yuen Bun, Anthony**  
Deputy Director of Endoscopy  
Professor, Honorary Consultant  
Division of Upper Gastrointestinal and Metabolic Surgery  
The Prince of Wales Hospital  
The Chinese University of Hong Kong

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



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Zoom CME registration



## Union Hospital received Excellence in Facility Management Award 2022

The Estate Department is so honored and privileged to gain four awards for Union Hospital from the HKIFM in 2022. First, the "Excellence in Facility Management Award" Distinction Award indicated the high recognition to the excellence performance in the facility management team of Union Hospital. Second, the "Theme Award - Smart Technology" Gold Award demonstrated our effective use of "FacTech" in provision of quality service and enhancement in management practice. Third, the "Outstanding Professional Integrity Award" Silver Award stressed our ethical practice and professional integrity in daily management operations at nominated facility projects. In addition, the "Most Popular Facility Award" Bronze Award proved an inspiring public recognition to us.



Mr. Harry Ho, Chief Estate Manager of Union Hospital received the trophy at the Excellence in Facility Management Award 2022 presentation ceremony

## Union Hospital Breast Cancer Symposium 2022

### *Impact of COVID-19 on Breast Cancer Treatment and Updates on Breast Cancer Pathology*



From Left: Dr. Cindy Wong, Dr. Clara Wu, Prof. Kwok Leung Cheung, Dr. Sung Inha Soong, Prof. Li Sean Khoo, Dr. Bonnie Law, Dr. Mimi Lee, Dr. Cynthia Yeung, Dr. Louisa Lui

Organized by "Union Oncology Centre" and "Hong Kong Women Doctors Association", the Breast Cancer Symposium was held on 17 December, 2022 at the Hotel ICON in Tsim Sha Tsui. Through the symposium lecture series, veteran medical professionals from UK and HK delivered insightful lectures and provided in-depth discussion on the impact of COVID-19 on breast cancer treatment and updates. The symposium was well received with great response from the participants. Special thanks to the symposium speakers and moderators to make the event a great success!



Dr. Harry Cheng, Director of Union Oncology Service, presented the certificates to the speakers as appreciation

# New Clinical Sessions

## Minimally Invasive Centre

Booking & Enquiry: 2608 3383

Time Schedule

### Neurology

Dr Soo Oi Yan, Yannie

Fri 14:00-17:30

## Union Hospital Polyclinic (Tsim Sha Tsui)

Booking & Enquiry: 2375 3323

Time Schedule

### Neurology

Dr Soo Oi Yan, Yannie

Tue 15:00-17:30

## Specialty Clinic – Paediatrics Cardiology

Booking & Enquiry: 2608 3366

Time Schedule

Dr. Poon Kam Ha, Louisa

Tue 16:30-18:30

## Specialty Clinic – Internal Medicine/ Infectious Disease

Booking & Enquiry: 2608 3315

Time Schedule

Dr. Wong Tin Yau, Andrew

Mon 09:00-10:00

## Specialty Clinic – Obstetrics & Gynaecology

Booking & Enquiry: 2608 3222

Time Schedule

Dr. Chow Kei Man

Mon 10:00-13:00  
Thu 15:00-18:00

Dr. Choi Sze Ngar, Sylvia

Mon 0:00-13:00  
Tue 09:30-12:30  
Fri 10:00-13:00  
15:00-18:00

Dr. Kwok Sui Yee, Karen Kateleen

Thu 15:00-18:00  
Sat 15:00-18:00

## Union Hospital Polyclinic (Tseung Kwan O)

Booking & Enquiry: 2721 0100

Time Schedule

### Obstetrics & Gynaecology

Dr. Chow Kei Man

Wed 10:00-13:00  
15:00-18:00

## Union Hospital Polyclinic (Tsuen Wan)

Booking & Enquiry: 2608 3399

Time Schedule

### Orthopaedics & Traumatology

Dr. Lee On Bong

Tue 11:00-12:00  
Fri 16:00-17:00

# New Doctors

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



**Dr. Wu Young Yuen, Adrian**  
Consultant in Immunology & Allergy



**Dr. Chan Chik King, Jason**  
Specialist in Radiology



**Dr. Li Birgitta Yan Wing**  
Specialist in Radiology

# Regular Meeting

## Clinical Pathologic Conference

Date : 11 January 2023 (Wednesday)

Time : 8:30 am – 9:30 am

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, B/F MIC,  
Hospital Building, Union Hospital

Booking & Enquiry: 2608 3151  
(Quality Assurance & Training Department)

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