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Prof. William I. Wei

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兒童的語言發展及常見的語言障礙

Certificate Course for General Public
The Development and Disorders of Speech and Language in Children



Jointly organized by

The Federation of Medical Societies of Hong Kong
香港醫學組織聯會

&
The Hong Kong Association of Speech Therapists
香港言語治療師協會



Objective : After the course, participants will have basic understanding towards the development of speech and language in children, common speech and language disorders, as well as basic components in assessing and treating speech and language disorders. With the above knowledge, participants will be able to develop greater awareness in identifying children with suspected speech and language disorders at their clinical practice or even in their own family.

Date	Topic	Lecturer
24 July 2007	Language Development (age 0-3) 兒童的語言發展(0-3歲)	Ms. Cecilia Au, Speech Therapist 言語治療師 區穎思
31 July 2007	Language Development (age 4 and beyond) 兒童的語言發展(4歲及以後)	Ms. Rachel Wong, Speech Therapist 言語治療師 王凱華
7 August 2007	Articulation Development and Common Disorders 語音發展及常見的發音障礙	Ms. Cecilia Lui & Ms. Janise Lee, Speech Therapists 言語治療師 呂潔玲 李偉玲
14 August 2007	Common Language Disorders 常見的語言障礙	Mrs. Lorinda Kwan, Speech Therapist 言語治療師 關陳立穎
21 August 2007	Assessment and Treatment of Speech and Language Disorders 語言障礙的評估及治療	Ms. Jess Chan, Speech Therapist 言語治療師 陳嘉霖
28 August 2007	Dyslexia 讀寫障礙	Mr. Dustin Lau, Speech Therapist 言語治療師 劉啟欣

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Seminar on: Head and Neck Surgery

Prof. William I. Wei

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Editor



Prof. William I. Wei

In the last two decades, Head and Neck Surgery as a surgical subspecialty has made significant progresses. The developments are in many facets, from diagnosis to treatment and then to rehabilitation. Diseases are diagnosed in their earlier stages and thus the outcome is better. The preparation of the patients for surgery has also improved, making the necessary surgical procedures more safe for the patient, despite the increased incidence of co-morbidities in these patients suffering from head and neck cancer and their increasing age on presentation.

The concept of surgical technique has also evolved, aiming at reducing the surgical trauma, while removing the pathology completely. Surgical resection is guided with different preoperative imaging studies and sometimes intraoperative computed tomography navigation. Thus precise extirpation of the lesion is possible without damaging the surrounding normal tissue, achieving optimal results. Even for advanced tumours in the head and neck region, successful curative treatment results are frequently seen. Through concomitant chemoradiation organ function is possible in some patients and surgical salvage is only performed for residual and recurrent tumour.

This series of articles starts with the development of molecular biology in head and neck cancer. The significant advance in this field has been the identification of molecular markers so that early detection of cancer becomes possible. Through these studies, we increase our understanding of the carcinogenesis of the malignant tumours and thus have opportunities to design options for their eradication such as the targeted therapies. All these are summarised by Professor Yuen in his article.

The development of the Head and Neck Surgery subspecialty in Hong Kong over the years has its share of difficulties. This is particularly so in a general hospital and all these are summarised by Dr. Tang in his article. We are delighted to see that he has done so well and has successfully integrated Head and Neck Surgery through collegiality with other specialties.

Dr. Fung, president of the Hong Kong College of Otorhinolaryngologists, has given a comprehensive background on how the specialty of Head and Neck Surgery started in the international arena. The achievements and the interactions with other surgical disciplines have accompanied the growth of the specialty. Taking into account all the developments in diagnostic and therapeutic measures over the years, he has defined the scope of the contemporary Head and Neck Surgery. A multiple discipline approach is essential to provide the best care for the patient suffering from head and neck lesions.

One of the major advances in Head and Neck Surgery is the ability to reconstruct these complex defects after curative resection of the disease in the head and neck region. Dr. Ho in his article detailed the contribution of plastic and reconstructive surgeons towards the



management of patients suffering from head and neck pathologies. The concept of both functional and aesthetic reconstruction was presented and the application of microvascular free tissue transfer was discussed.

One of the main reasons of the improved results of management of head and neck malignancies in the past 2 decades has been the radical resection of the tumour. The surgeon would carry out a resection with wide margin only when he knows that the defect could be adequately reconstructed. Dr. Ng in his article on reconstructive options detailed the various options of reconstruction ranging from skin graft to pedicled flaps, myocutaneous flaps and free flaps. The concept of when

to use which method of reconstruction and why, was clearly described. It is important for the readers to understand the current concepts of reconstruction for the head and neck region

Finally, Dr. Chan reported the results that a contemporary head and neck centre could achieve employing the concept of adequate tumour extirpation followed by the appropriate reconstruction. It is important that the evaluation of a patient suffering from head and neck pathology is carried out by specialties of different medical disciplines. Through this the optimal treatment option can be offered to the patient to achieve the best outcome.



The Hong Kong College of Paediatricians (HKCPaed) and the Royal College of Paediatrics and Child Health (RCPCH) will be holding a Joint Diploma in Child Health Clinical Examination in Hong Kong in November 2007, awarding DCH (HK) and DCH (International) to successful candidates.

The DCH Clinical Examination will be held on **1 & 2 November 2007** and will be run in a new format.

The DCH Clinical Examination is open to registered medical practitioners in Hong Kong. Candidates who have already successfully passed the Written Paper 1A since January 2004 are eligible to apply. In addition, candidates who passed the Part IA examination in May 2005 or thereafter should have at least 6 months of Paediatric practice (resident medical officer or intern within 5 years prior to the date of the DCH Clinical Examination) in a recognized institution with acute hospital admissions. There are no exemptions from the Paper 1A examination.

Application:

Candidates who wish to sit the DCH Clinical Examination in Hong Kong MUST apply through the Hong Kong College of Paediatricians. Application form, details of application and the new format can be found on the HKCPaed website at www.paediatrician.org.hk/entcnews.htm. Examination Fee is HK\$ 7,800. Available places are limited and will be allocated on a 'first come first served' basis.

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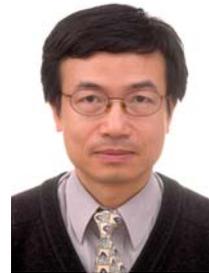
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Molecular Biology Developments in Head and Neck Cancer

Prof. Po-wing Yuen

MBBS, MS, FRCS (Edin & Glas), FRCS (Glas), FHKAM (ORL), FACS, DLO (Irc)
 Department of Surgery, University of Hong Kong Medical Centre, Queen Mary Hospital, Hong Kong



Prof. Po-wing Yuen

Molecular biology of carcinogenesis

The common head and neck cancers in Hong Kong are nasopharyngeal carcinoma (NPC), head and neck squamous cell carcinoma of oral cavity, oropharynx, hypopharynx and larynx (HNSCC) and thyroid carcinoma. The aetiology, pathology and treatment response differ among these three common head and neck cancers. Their underlying genetic aberrations and carcinogenesis pathways are also different.

The development of cancer involves multiple genetic abnormalities. A stepwise carcinogenesis process is sometimes found in HNSCC in which 5-20% pre-malignant dysplastic leukoplakia and erythroplakia lesions will develop into carcinoma in-situ and invasive cancer. Field cancerisation is also commonly observed in patients with HNSCC. There are already presence of aberrant genetic abnormalities in the apparently normal looking mucosa in upper aerodigestive tract due to wide-field carcinogenic effects of chronic smoking, drinking and betel leave chewing of HNSCC patients. Multiple upper aerodigestive tract carcinomas can develop in 10-20% of HNSCC patients in their life time.

In the early stage of carcinogenesis process, there are increased cellular proliferations and reduction of apoptosis (programmed cell death). Further development of invasive carcinoma will require the proliferation of blood vessels to supply sufficient nutrients to growing tumours (angiogenesis), breaking down of surrounding tissues for local invasion, lymphangiogenesis for regional nodal metastasis and reduced cellular adhesion for distant metastasis. These malignant cellular biologic properties are dictated by specific gene activation or inactivation. Aberrant upregulation or activation of gene function can be due to molecular mechanisms of gene overexpression (increased transcription), amplification (multiplication of gene copy), translocation (transfer of a gene to another chromosome), down-regulation of miRNA (reduced breakdown of RNA and reduced inactivation of protein production). Downregulation or inactivation of gene function can be due to molecular mechanisms of mutation (dysfunctional protein), deletion (absence of the gene), hypermethylation of gene promoter (inactivate gene transcription at its starting site) or overexpression of miRNA (increased breakdown of RNA and inactivate protein production). The genes responsible for the carcinogenesis of common head and neck cancers are shown in Table 1¹⁻⁹:

Molecular markers for screening early nasopharyngeal carcinoma

There is lack of consistent early symptom in most head and neck cancers and 50% patients in our clinic are already in stage III and IV at the time of presentation. Molecular screening of early cancers in high risk population is an important issue of current research.

DNA, protein and RNA materials are released from cancer cells either by active secretion from living cells or liberated from disintegrated cells upon cell death. These genetic materials can be detected in local tissues, exfoliated cells or local body fluids. These cellular materials are also absorbed into the systemic circulation. The development of technology has enabled us to detect the presence of a few copies of aberrant DNA materials using polymerase chain reaction (PCR) in tissue, exfoliated cell, local body fluid and peripheral blood.

Hong Kong has the highest incidence of NPC in the world. Screening of NPC has been carried out for decades using serum EBV IgA level as tumour marker. The sensitivity of detection of early stage I-II NPC is 81% for the serum EBV VCA or EBNA1 IgA antibodies¹⁰. The EB virus proliferates inside the NPC cancer cells and the EB virus DNA is absorbed into systemic circulation. The plasma EBV DNA can be detected by using PCR method. The sensitivity of plasma EBV DNA is 90% for early stage I-II NPC using 60 copies of EBV DNA per ml of plasma as cut off reference¹⁰. There are many aberrantly methylated genes for NPC and these methylated DNAs can also be used as specific plasma markers for detection of NPC. The sensitivity is however much lower than EBV DNA and requires up to 4 markers including E-cadherin, DAPK, p16, RASSF1A to enhance its sensitivity to 80-90%⁸. Small quantity of serum protein materials or peptide fragments derived from NPC cells can also be detected by using proteinchip technology nowadays. The proteinchip has sensitivity of 83%¹¹.

It may be difficult to enhance the sensitivity of tumour markers in blood because of the tremendous dilution factor by the 5000 ml of blood for the small quantity of absorbed genetic materials from early stage NPC. The alternative approach is to retrieve small quantity of exfoliated cancer cells and their genetic materials directly from nasopharynx non-invasively using brush or swab. The nasopharyngeal swab EBV DNA has sensitivity of 87-96% and specificity of 96-99% for primary NPC¹². The serum EBV DNA has significant value for prediction of distant metastasis, its sensitivity for detection of local and



regional recurrence is less than 50%¹³⁻¹⁴. However, the nasopharyngeal swab EBV DNA has sensitivity of 100% and specificity of 98% for detection of local recurrence¹⁵. Aberrantly methylated DNA has also been evaluated for detection of primary NPC with sensitivity of 78% and specificity of 100% using three genes including DAPK, RASSF1A and p16¹². Further studies are necessary to validate the accuracy of using these molecular markers for detection of early primary or recurrent NPC.

Targeted molecular therapy

With increasing knowledge of the genetic abnormalities of cancers, there are high hopes for the development of targeted molecular therapy of cancers. Although there is still no well proven successful molecular therapy available in the market for head and neck cancers, some of the clinical trial results are worth noting.

Among the many targeted therapy in clinical trials, anti-EGFR targeting the overexpressed EGFR of head and neck cancers is most promising¹⁶. EGFR regulates multiple cellular functions including cell proliferation, differentiation, apoptosis, cell motility and angiogenesis. Anti-EGFR can be achieved by using monoclonal antibody (Cetuximab) or tyrosine kinase inhibitor (Gefitinib, Erlotinib). The anti-EGFR monoclonal antibody competitively binds to the extracellular domain of the receptor preventing its activation by other growth factors. The EGFR tyrosine kinase inhibitor binds to the intracellular domain of the receptor to block its downstream signaling cascade effectors. A phase III randomised trial has shown that combined Cetuximab and radiotherapy is better than radiotherapy alone for primary HNSCC (median survival 49 versus 29 months)¹⁷. Phase III randomised study has shown that combined Cetuximab and cisplatin has improved response than cisplatin alone for recurrent or metastatic HNSCC, but there is no survival benefit¹⁸. Phase II study of gefitinib (Iressa) alone has shown only modest response of 10% for recurrent or metastatic HNSCC¹⁹. Anti-EGFR is well tolerated and toxicity is limited to cutaneous reaction and diarrhoea. There are many other potential molecular therapeutic targets that have already entered into various phases of clinical trials for head and neck cancers including demethylating therapy to reactivate the tumour suppressor genes and anti-angiogenesis therapy to inhibit growth of cancers. Since cancers have multiple genetic abnormalities, multi-targeting therapy is perhaps necessary to enhance the successful cure or palliation. Further research studies are necessary to evaluate the role of various molecular therapies for head and neck cancers.

Table 1. Comparison of genetic abnormalities of common head and neck cancers

cancer biologic properties	nasopharyngeal carcinoma	HNSCC	thyroid carcinoma
increased proliferation & reduced apoptosis	hypermethylation: p15, p16, RASSF1A &2A, RARb2, DAPK, RIZ1, MLH1, HIN1, THBS1 mutation: unknown overexpression: EGFR, cyclin D1, telomerase	hypermethylation: p14, p15, p16, RARb2, MGMT, MLH1 mutation: p53 overexpression: EGFR, cyclin D1, telomerase underexpression: Rb, FHIT, PTEN	hypermethylation: p16, RASSF1A, RARb2, DAPK, RIZ1, MGMT, PTEN mutation: p53, Ras, BRAF overexpression: EGFR, cyclin D1, telomerase
increased angiogenesis	overexpression: VEGF	overexpression: VEGF	overexpression: VEGF
increased lymphangiogenesis		overexpression: podoplanin, dysadherin	
reduced cellular adhesion	hypermethylation: Ecadherin underexpression: catenin, hemidesmosome	hypermethylation: Ecadherin underexpression: catenin,	hypermethylation: Ecadherin underexpression: catenin
increased invasion	overexpression: MMP-2&9	overexpression: MMP-2&9	overexpression: MMP-2&9 hypermethylation: TIMP3

RB - retinoblastoma
RIZ - retinoblastoma protein-interacting zinc finger gene
EGFR - epidermal growth factor receptor
RASSF - RAS association domain family
DAPK - death associated protein kinase
HIN - high in normal
MMP - matrix metalloproteinase
VEGF - vascular endothelial growth factor
FHIT - fragile histidine triad
PTEN - phosphatase and tensin homolog
TIMP - tissue inhibitor of metalloproteinase
BRAF - b type Raf kinase
RARb - retinoic acid receptor beta
MLH - Mut L Homolog
THBS - Thrombospondin
MGMT - O6-methylguanine-DNA methyltransferase

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Head and Neck Surgery in a General Surgery Department ,Q.E.H. — How the Service Started ?

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Dr. Lap-chiu Tang

I remember well ever since the grand opening of Queen Elizabeth Hospital in the '60, the department of surgery had been providing up-standard surgical care to the population in the Kowloon Peninsula and the New Territories . However, a special unit for cancer cases in the head and neck area was not heard of , or being introduced. Hence, these patients were not thoroughly looked after and may be sometimes seemingly being neglected. On the other hand, the Oncology Department had great concern towards this particular group of patients and cases that needed surgical resection were referred to the Queen Mary Hospital on the island side.This certainly created difficulties and problems in considering the inconvenience of the transportation and ferry services at that time, when everywhere was not easily accessible as now.

In the late '80, I had a very co-incidental opportunity in a conjoint-effort with the E.N.T. department treating patients with hypopharyngeal cancer. This sparkled my interest and curiosity into this related surgical field. Gradually, this led to a germinating ambition hoping to explore deeper in the presence of all the supports from Dr. S.T. Hwang, the C.O.S. of the department . On my return after an initiative overseas training in Australia, I found myself driven into a blind alley, without a choice, except to carry on with whatever I was supposed to handle in head and neck surgery . Seemingly, I was posted as if I were a " pioneer ".

I had been so naive in " begging " the Oncolgy Dept. to let me handle referral cases, not knowing that, for the past years, they were already very successful in their co-operations with colleagues in Q.M.H.. To win their confidence, much efforts were attempted to prove my capabilities, dedications and commitments. I had to educate myself by visiting the head and neck team in Q.M.H. to observe how cases were being managed. They were very co-operative, helpful and eager to spread the knowledge. Meanwhile, Q.M.H. was really overloaded with their work plus referrals from Q.E.H. Surprising enough , they too were very encouraging and supportive for me to start this new service in Q.E.H.

Then, I started to establish the combined head and neck clinic to be held once every week in my hospital. Here, oncologists, radiologists and surgeons were to come together and to assess patients with different head and neck cancers. These cases were being discussed in depth and the final treatment plan decided.This proved to be very efficient especially in time saving and avoiding conflicts as much as possible.

I had great supports from other departments, especially the followings :

1/ Department of anaesthesiology -- To cope with the long hours of surgery , a "never before" duties roster was created. The shift from afternoon to midnight was introduced. This was really like a "customed made" service and they definitely love me less with this !

2/ Department of Intensive Care -- In spite of their heavy workloads and limited beds available, they never turned down my patients on the post-operative care. I hoped I didn't exhaust their resources too much.

3/ The nurses had been very stressful as they too had to cope with the new surroundings which they had never witnessed before. I had demonstrated to them on the nursing skills and care to head and neck cases until they were knowledgeable enough to work on their own with confidence.

Personally, I had to vent my emotional feelings about the whole situation. Despite all the welcome supports from outside, in my own department, it seemed that I had only their moral support.

Struggling through long hours of work, I fortified myself through trials and errors and above all, in all the attempts, new problems never failed to arrive and to be solved. Luckily, I could always seek advice from the expertise . Occasionally, I was very frustrated and puzzled, not being aware that the results turned out to be better than expected. Moreover, I still felt that I was indulging myself in the role of solitary struggle with insufficient reinforcements. Could I blame myself for "volunteering" into this new survice?

I would like to mention that in the early '90, the technique and skills in pedicle flap was well acquired. Then, in the late '90, much efforts had been focused on the free tissue transfer for the complex reconstructive procedures. Nowadays, the free vascularised flap becomes the regular and almost routine treatment option in head and neck surgery.

Here, I really need to express my gratitude to Professor W. Wei's sound comment ---- " you can achieve if only you are willing to work hard. " This had enlightened me to the extent of where there's a will, there's a way. On top of this, I had professor's encouragements that led me to act like "there is no one else, but you doing it". My other acknowledgement with appreciations goes to Dr. C.M. Ho of Kwong Wah Hospital for his advice and generous share in easing part of my workload.

To conclude, my further expectations are that I am ready and willing to offer extra-trainings to surgeons who are genuinely interested and who are sincere, persevering and enthusiastic individuals to cope with the necessary demands. Hopefully, they do not have to undergo the hard ways like I did. With these selectively chosen ones, being in good shape, we can do better in treating our patients .By then, the QMH team will appreciate more and welcome the effort to lessen their overloaded burden. So now that I have come and seen, can these recommendations be materialised? The main objective is to build up a stronger team with the utmost efficiency to serve the patients with head and neck malignancy.



The Role of ENT Surgeons in Head & Neck Surgery

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Dr. Kai-bun Fung

Otorhinolaryngologists, frequently referred to as ENT surgeons, are physicians trained in the medical and surgical management and treatment of patients with diseases of the ear, nose, throat, and related structures of the head and neck. In Hong Kong ENT had a rather late start when compared to UK where ENT became a specialty in its own right in 1948 with the formation of the NHS. Here ENT was recognised as a specialty only in 1960 when the first ENT Consultant was appointed by the Hong Kong Government. The development however has since been rapid. Many ENT surgeons travelled widely to prominent centres overseas for study and training and brought back with them newly acquired knowledge and expertise. Centres of excellence were established providing service and training leading eventually to the establishment of the Hong Kong College of Otorhinolaryngologists.

Head & Neck Surgery presently forms a substantial part of the ENT training curriculum. It is perhaps more convenient for ENT surgeons to identify Head & Neck pathology as they are drilled in their every day work to look at the regions assessing appearance and function. Many took interest in the discipline, which has a plentiful of challenging open surgery, during training but one need to realise Head & Neck surgery involves a lot of anatomical knowledge, technical skill and a long learning period, and Head & Neck training programme therefore must be provided with sufficient manpower and financial support to be successful.

Head & Neck Surgery today is a specialty supported by ENT surgeons, Oral Maxillofacial Surgeons, General and Plastic Surgeons and on occasions Neurosurgical and Cardiothoracic Surgeons. It embraces too wide a spectrum of benign and malignant conditions to be dealt with by any one single discipline. This across specialty cooperation must remain so and develop in the multi disciplinary direction without territorialism. There is no reason why tumour surgery cannot be taken by any specialty which is comfortable with a lesion in their region of interest. Nonetheless there is always the need for all interested parties to come together to discuss and reach consensus in the management of an individual patient in a multi-disciplinary approach for the benefit of the patient.

If we look at benign Head & Neck pathology, Juvenile Angiofibroma has come a long way from the time of Emil-Jean Gabriel Moure's lateral rhinotomy approach with significant blood loss to the now endoscopic resection or mid facial degloving approach resection

with preoperative embolisation. There is little doubt that here the ENT surgeons play an important role in the management of these difficult conditions. Benign salivary gland tumours are however often dealt with competently by ENT as well as General and Oral Maxillofacial surgeons with a head & neck interests. In the fifties and sixties, general surgeons had been doing most of the thyroid surgery due to historic traditions. However in the UK more and more ENT surgeons have been doing thyroid surgery over the last 20 years, and it is estimated that General Surgeons still perform the majority(83%) but ENT surgeons are performing significant numbers (17%) as well¹. Nowadays thyroid surgery remains a common interest of different surgical disciplines and it is certainly one of the ENT surgeon's interest whether or not he is Head & Neck inclined. ENT surgeons have the added advantage and reassurance of being able to assess the vocal cords both before and after surgery and to manage vocal cord palsy by phonosurgery should the need arises.

In terms of Head and Neck cancers, ENT surgeons play an important role from the point of diagnosing the condition during examination to planning and executing treatment, followed by surveillance after treatment which is usually life long. In addition ENT surgeons, often working within a multidisciplinary team, can contribute to a number of adjunctive roles including airway management, voice management, visceral care and evaluation and treatment of cervical lymph nodes. His familiarity with the region clearly contributes well to the overall care of these cases.

One of the reasons why ENT surgeons have assumed a significant role in Head & Neck surgery is his familiarity with the larynx ever since Manuel Garcia discovered the use of the "laryngeal mirror". Garcia himself was, interestingly, a Professor of Singing at the Paris Conservatoire who managed to view his own larynx using a dental mirror he bought for 6 francs, sunlight and the help of a reflecting mirror. In our locality laryngeal cancer is the commonest Head & Neck cancer aside from nasopharyngeal carcinoma and carries the best prognosis amongst head & neck cancers. Today ENT surgeons have the fibre-optic endoscope, videoscopes and stroboscopes which allow accurate physical and functional assessments before and after treatment. Endoscopes were devised primarily for the examination of the urinary bladder, vagina and rectum, but Chevalier Jackson expanded its use to examining the auditory meatus, nasal cavities, pharynx, larynx and oesophagus. Hopkins developed a fibre-optic system in



1954 and Ikeda later developed a flexible endoscope^{2,3}. With recent advances early cord cancers and dysplastic lesions can now be treated with laser surgery without much compromise to the voice, and laser resection together with selective neck dissection is now feasible with T1 and T2 carcinoma of the supraglottic and glottic larynx^{4,5}. Transoral laser laryngeal surgery has become incorporated into higher ENT training and also at the specialist level. From the days of Professor Theodore Billroth, a general surgeon who performed the first laryngectomy in 1873, and resection of early laryngeal cancer via laryngofissure by St Clair Thomson, UK and Chevalier Jackson of USA in the early 20th Century, this has been a remarkable step forward for ENT surgeons.

Management of carcinoma of the hypopharynx, retromolar trigone, floor of mouth, tongue and oropharynx, aside from resection with various selective neck dissection which are within the management scope of ENT and Head & Neck surgeons, requires in the majority of cases reconstruction. This is where our colleagues in Plastic Surgery have made a significant and better outcome in allowing a two team approach; with a fresh team performing the reconstruction and using a wider selection of appropriate reconstructive techniques including free tissue microvascular transfer. It is humbling to look back at a time when the doyens before us perform magnificent pieces of surgery like the Wookey's lateral cervical flap, John Conley's mid-cervical flap, staged or one stage pedicled cutaneous and myocutaneous flaps to close off the defects over half a century ago. Nasal tumours are fortunately rare so is squamous carcinoma of the ear. The technique of resection of these of these lesions are already well established within the specialty of ENT. Craniofacial resection are undertaken with the neurosurgeons and craniofacial resection has made a big improvement in the survival of patients with Olfactory Neuroblastoma. Again the importance of team approach is seen in those patients where the ENT surgeon has performed maxillectomy or mandibulectomy and our colleagues the Oral maxillofacial surgeons are there to provide the

invaluable maxillofacial or prosthodontic rehabilitation. Today an entire range of open and endoscopic skull base surgical techniques around the temporal bone, anterior, middle and posterior fossae are mature and highly developed and are now attracting young ENT surgeons to the area of skull base surgery. Under expert hands transnasal endoscopic resection of pituitary tumours and selected olfactory neuroblastoma by ENT surgeons together with our neurosurgical colleagues are feasible. The advent of osseointegrated titanium implants have allowed disfiguring facial defects to be camouflaged even if reconstruction is not possible. ENT surgeons are now well versed in placing osseointegrated implants to help reconstructing a facial defect, for prosthetic ears, or for bone anchored hearing aids (BAHA).

The modern day Head & Neck surgeons, irrespective of their background specialty which is of least significance, should have acquired the appropriate specialist training, the necessary operative skill and expertise and be fully integrated and comfortable with a multidisciplinary approach. ENT surgeons have the blessing and knowledge of working right in the heart of the region of Head & Neck pathology. They have to assume an important responsibility in the continuing development of this specialty in terms of surgery, functional rehabilitation and research alongside our interested colleagues of other disciplines. I believe this is the best way to improve the outcome for our Head & Neck cancer patients.

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The Contribution of Plastic and Reconstructive Surgeons to Head and Neck Surgery

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Introduction

Head and neck cancer represents a diverse group of tumours and is the sixth most prevalent cancer in the world. Management of head and neck cancer patients is distressing because multiple vital functions that affect daily living are impaired. These include breathing, swallowing, chewing, coughing, speech, vision and smell. Treatment of these aggressive cancers involves significant disfigurement either because of loss of tissue or surgical scars placed over the head, face and the neck region. Most of the patients are elderly, come from lower social class, have multiple co-morbid medical problems and previous smoking and drinking history. A lot of these patients also have previous radiotherapy that affects the local tissue vascularity and healing potential.

Reconstruction after extirpation of head and neck cancer is complicated because of the complex anatomy that requires restoration in 3 dimensions. It also involves different components involving mucosal lining, bone and various soft tissues including adipose tissue, muscle and glandular structures.

Head and neck reconstruction evolves in past decades from the use of local flaps, regional or pedicled flaps to microsurgical free tissue transfer. Single-staged reconstruction is the standard of care at present. With the help of Plastic Surgeons, we are no longer contemplated in plugging a hole but to address the functional and aesthetic needs.

Functional restoration - What can be achieved?

The most readily achieved purpose of reconstruction is to separate the vital structures from contaminated area. Reconstruction after the skull base resection separates the intracranial cavity from the contaminated nasal and paranasal cavities and prevent ascending infection intracranially. The oral and pharyngeal cavities are highly contaminated with various bacteria and a successful reconstruction to form a barrier from the vital vascular structures in the neck is necessary to prevent fatal complications such as blowout of the carotid artery..

Despite the effort and innovations, it is hard to restore the function that is damaged as a result of resection of tumour. In most cases the extent of surgical resection is the most crucial factor affecting function. The amount of tongue musculature left intact after resection of a tongue cancer dictates the postoperative speech and swallowing

functions. The role of the reconstructive surgeons is to preserve and maximise the function of the tissue that is left intact. Putting a well-vascularised flap in a partial glossectomy defect prevents scar contracture of the raw muscular defect and provides tissue bulk for deglutition¹.

The swallowing function after a pharyngo-cervical oesophageal function is never normal with prolonged transit time even in the absence of stenosis of the anastomosis. Reconstruction with the tubed skin flap and free jejunal graft serves no more than a passive conduit for food transit.

It has been shown that regional zones of anaesthesia in the oral cavity impair chewing function in experimental conditions. Attempts have been made to reinnervate the flap placed intraorally by coapting the lingual nerve to the sensory nerves of the flap. It was demonstrated that flap sensation was superior to the donor skin, apparently due to the much larger cortical representation of the recipient nerve^{2,3}. Adequate sensory recovery may also improve swallowing and overall patient satisfaction¹.

Functional muscle transfer for tongue reconstruction has been infrequently used and produces uncertain results. Tongue has a complex array of interwoven intrinsic and extrinsic muscles that enable fine intelligent movements, and it is technically impossible to restore all of its functions¹.

Aesthetic restoration

Restoration of form and external appearance is important otherwise these unfortunate patients can neither function as a normal individual nor socialise freely. Patients who had their mandible resected in the past were left with laterally "drifted" jaw and difficulty in swallowing because of a lack of reliable method to stabilise and align the jaws. State of the art management of the oromandibular defect tries to restore function in terms of speech, deglutition, mastication, taste and airway maintenance as well as cosmesis⁴. Significant advances have been made by reconstructive surgeons in the past 2 decades with the use of free microvascular bone and bone/soft tissue flaps. Commonly used donor sites are the fibula, radius, scapula and iliac crest.

Microvascular free tissue transfer

The use of microvascular free tissue transfer revolutionised head and neck reconstruction by providing a reliable one-stage reconstruction. It enables



resection of extensive tumour and reconstruction of complicated composite defect that is not possible in the past. Spearheaded by plastic surgeons and nurtured by their creative imagination, microvascular free tissue transfer survived the most skeptical criticism. After more than 3 decades of existence, it is being performed at an ever-increasing rate for increasingly wider indications. Its application is no longer limited to specialised academic centres but available practically in every plastic and reconstructive surgery centre.

Microvascular free flaps have evolved gradually from being an extreme procedure of last resort to a first-choice reconstructive procedure. Improved success rates, reduced operative time and patient morbidity and the superior quality of the reconstruction help to popularise this reconstructive method. A prospective study of 493 microvascular free flaps performed by 23 microvascular surgeons over 6 months showed a flap failure rate of 4.1% and a postoperative thrombosis requiring re-exploration of 9.9%⁵.

Significant advancement is made with the introduction of perforator flap surgery in reconstructive microsurgery. The muscle, once regarded as essential to bring blood supply to the more superficial structures such as the skin and subcutaneous fat could be left in its native place to maintain its original function. Only the small perforators that traverse through the muscle are isolated and it has been shown to be adequate to support the vascular supply of the flap. This not only minimises the donor site morbidity but also allows a more refined reconstruction⁶.

By virtue of the improved technical ability to transfer tissue, and through a better understanding of functional anatomy, the plastic surgeon can select the most appropriate part of the body as the initial raw material and with his artistry he can shape that tissue into graceful anatomic form to restore lost parts or functions⁷.

Conclusion

Significant advances are made in the past 3 decades to make reconstruction of complex defects safer, more reliable and better. The quality of life of these patients with head and neck cancer is thereby improved. I would like to take this opportunity to salute all the head and neck extirpative surgeons and reconstructive microsurgeons whose commitment to the care of the underprivileged cancer patient population goes mostly unrecognised in these times of diminishing health care resources.

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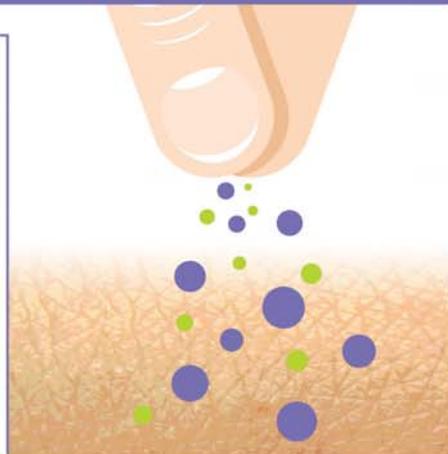
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Reconstructive Options in Head and Neck Surgery

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Dr. Wai-man Ng

Introduction

The head and neck is a relatively small but densely packed bodily part, which contains many functionally important organs and structures. Besides, it is a nearly always exposed part of our body and its appearance is of greatest importance for social reasons. Accordingly, the reconstructive procedures of the head and neck region should give an acceptable result in terms of both the functional and aesthetic outcomes.

Aesthetic considerations

As far as possible, the reconstruction should mimic the lost tissue in terms of size, shape, contour, and surface features (such as the hair distribution, skin colour and texture). Besides, the facial symmetry should be restored and the anatomical landmarks should be maintained. In addition, the ability of facial expressions is essential both aesthetically and functionally and should be preserved or restored to the degree that is possible.

Functional considerations

The main functions of head and neck structures include:

1. Maintain patent airway and prevent aspiration
2. Speech production
3. Maintain oral continence and facilitate swallowing
4. Protect vital structures such as airway, major blood vessels and cranial nerves
5. Visual ability
6. Hearing ability

Many of these functions are essential for the survival and some of them are key factors in the determination of a good quality of life.¹ Preferably these structures should be preserved or restored providing the treatment of the disease condition is not being violated, while safeguarding all these mechanisms.^{2,3}

Diseases affecting the head and neck regions

With regard to the head and neck diseases, there are two basic categories of patients that may need reconstruction: those who have congenital deformities, otherwise known as birth defects such as cleft-lip and palate, and those with developmental deformities, acquired as a result of trauma, infection, neoplasm, or in some cases, aging. Different entities tend to involve different groups of patients who are of different characteristics. Some

conditions are treated without the need of reconstruction while some treatments necessitate the careful preoperative planning of reconstructive choices.

Choice of reconstructive methods

The different kinds of defects that need reconstruction can range from small laceration to wounds that involve missing structures. The goal of the reconstruction is to restore the function and form as well as possible using a variety of surgical approaches. The surgical options are best visualised as a hierarchy of possibilities arranged in a 'reconstructive ladder'.^{4,6} The successive step of the ladder is defined by the degree of complexity of the operations: primarily closure, healing by secondary intention, skin graft, local flap, pedicle flap and free flap (Table 1). In addition to the reconstructive ladder, the use of implants, tissue expansion techniques, and external prostheses are sometimes very helpful.

For the majority of small defects, they can be closed by direct suture. Whereas skin grafts are often used to cover a bigger wound that is clean and does not have exposed raw tendon, bone, or nerve. However, skin graft will inevitably undergo various degrees of contracture, is less durable to trauma and qualitatively inferior to flaps. Furthermore skin graft cannot survive in the presence of wound infection, on the irradiated tissue, and in deep seated defects.

In situations where skin graft is not feasible, flaps provide a better choice of reconstruction. 'Flaps' denote repositioning of tissue that maintains some form of blood supply, and they are named for the types of tissues that are involved. Because of the robust blood supply and availability of different tissues, a flap can be designed to provide the most appropriate, suitable and durable tissue according to the defect. 'Fasciocutaneous flaps' as in deltopectoral flap consist of the skin, subcutaneous fat, and dense supportive fascia, and they are often preferable to skin grafts because of the better skin match and healing without excess additional scarring. 'Myocutaneous flaps' such as the pectoralis major myocutaneous flap include the muscle, overlying subcutaneous tissues and skin. The muscle component provides tissue bulk to fill up any potential dead space and healthy tissues for oxygen and blood supply to combat for infection. The skin portion of myocutaneous flap is suitable for either the internal mucosal lining or external skin coverage. The vascularised bone of 'bone flaps' can replace a segment of bone loss and it gives a better successful rate for bone repair than free bone graft.



Flaps can be further classified according to their type of blood supply. 'Random flaps' receive their blood supply through a random array of blood vessels at their attached base, rather than through a defined blood supply. 'Pedicule flaps' remain attached through their pedicle of vessels that continue to provide their normal blood supply. 'Free flaps' have their normal blood supply disconnected from the native territory, moved in a new region, and then re-established blood supply in the new location by microscopic surgery.

Free flap has an established role for reconstruction of the head and neck defect in the recent decades. It enables selection of the most appropriate type of tissue in the appropriate amounts to precisely reconstruct the acquired defects. Moreover both resection of tumour and harvesting of the free tissue can usually be performed simultaneously, thus reducing the operating time and duration of general anaesthesia. Besides using microsurgical reconstruction, the resection of tumour can often be even more aggressive since repair of even large defects is possible. Finally, many patients with head and neck cancer require radiation treatment or chemotherapy, thus augmenting the need for a well vascularised tissue reconstruction.⁷

Decision on the use of reconstructive methods

Reconstruction should be individualised to each patient. The decision to choose the correct type of reconstruction will depend on:

1. Patient's factors: the health status, age, donor sites conditions, willingness etc.
2. Defect's factors: conditions of the defect, previous radiation, contaminations etc.
3. Surgeon's factors: training and experience

By and large, the simple methods are most economical and have higher success rate. The more complex methods are more costly and risky, but the outcomes are better. Some reconstruction methods involve multiple-staged operations while some are one staged. Some important questions related to choice of reconstruction are listed in Table 2.

Characteristics of head and neck cancer patients

According to the Hong Kong Cancer Registry of 2003, the head and neck cancers represent the tenth most prevalent cancer in Hong Kong. Unfortunately, patients often present with advanced disease that requires aggressive treatment for cure. In addition, many of them are elderly, chronic smokers and/or drinkers, with compromised nutritional status. The tumours often involve the aerodigestive tract affecting the airway, swallowing and speech functions. Some have history of radiotherapy with its associated complications.⁸

Surgical treatment of head and neck cancers, in certain cases, inflicts large and contaminated tissue defects.

Some of these defects are associated with devastating functional deficits and disfiguring deformities. In addition, radiation therapy, whenever necessary, often leads to wound breakdown, dehiscence and fistula formation due to impaired healing mechanism.^{7,9-11}

Following extirpation of tumour in the head and neck region, there are essentially four types of defect needed to repair.

1. Following resection of intraoral tumour or dermatological pathology, the subsequent mucosal or cutaneous defect requires coverage.
2. When segmental mandibulectomy is performed for tumour arising from the lower alveolus, the bony defect and the intraoral mucosal deficiency need to be reconstructed simultaneously.
3. After circumferential pharyngectomy, the gap between the oropharynx and oesophagus must be filled to reconstitute the continuity of the alimentary tract.
4. Finally, after removal of a bulky tumour, the tissue defect, with, or without the overlying skin, has to be reconstructed to achieve a functional or aesthetic outcome.

Ideally, reconstruction should aim at single stage replacement of lost tissue in volume and form, preferably with similar tissues, which are well-vascularised to combat the contaminations and achieve early complete healing and restoration of any lost functions. Nowadays free tissue transfer suits all of these purposes and is safe and reliable in experienced hand.

Accordingly the free flap used for the first type of defect includes the radial forearm flap, ulnar forearm flap, lateral arm flap and groin flap. Patches of colonic mucosa or gastric mucosa have also been used for reconstruction of intraoral mucosal defects. For the reconstruction of mandibular defects, the fibula and overlying skin island constituting an osteocutaneous flap are frequently used. In the early years, the radial forearm flap carrying with it a narrow block of radius bone has been used. To repair circumferential pharyngeal defects, free jejunal grafts are most frequently employed and occasionally, a tubed radial forearm flap is used. Free rectus abdominis muscle or myocutaneous flap and free latissimus dorsi myocutaneous flap have been employed to fill bulky defects. The latter has also been used to cover a large cutaneous defect.^{7,9}

Conclusion

In conclusion, there are various methods available for head and neck reconstruction depending on the condition of the patient and complexity of the defect. Irrespective to the choice, the primary aim of the procedure should give a satisfactory result in terms of both the functional and aesthetic outcomes. Today such goal can be accompanied for the most part with the free tissue transfer.



Table 1. The cascade of reconstructive ladder.

Method of reconstruction	Definition
Simple closure	The area is closed primarily after excision.
Skin Graft	The entire epidermis and various thickness of the dermis is taken from one area and placed on a prepared recipient site. A composite graft requires lifting all the layers of skin, fat, and sometimes the underlying cartilage from the donor site, for example graft from helical rim for alar nose defect.
Local Flap	A local flap is rearrangement of tissue adjacent to the wound basing on some geometrical principle. The donor site can usually be closed primarily. Common examples include advancement flap, transposition flap, and rotation flap.
Pedicle Flap	A pedicle flap is a composite of tissue that is transferred on a named vascular pedicle and is sutured into place at the recipient site. The vascular pedicle is in direct connection with the artery and vein at the recipient site. The flap can further be named after the type of tissue being composed of such as the fasciocutaneous flap, myocutaneous flap, and osteomyocutaneous flap.
Free Flap	A free flap is a piece of tissue that is completely detached from its donor site with an artery and a vein and the vascular supply will be reestablished to an artery and a vein at the recipient site. Free flaps are more complicated because they require microsurgery.

Table 2. Important questions to ask before choosing the reconstructive procedure.

What types of structures are missing?
What are the options for replacing these missing tissues?
Which options are best for restoring normal form?
Which functions are missing?
Which options are best for restoring function?
What are the risks involved with the types of surgery available?
What are the donor site morbidities such as scarring and loss of function?

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● **Dima Ali, M.D.** Dr Ali is an internationally recognized aesthetic and anti-aging medicine expert, and has trained under world renowned experts including Dr Zein Obagi and Dr Pierre Fournier.

● **Michel Delune, M.D.** Founding member of the European Academy of Dermatology and Venereology, Honorary President of Union Internationale de Madecine Esthetique (UIME). Dr Delune is noted for his contributions in the private fellowship with the famed Dr Obagi at the Obagi Dermatology Medical Clinic.

● **Melvin Elson, M.D.** Dr Elson holds the US Patent #5,510,391 for the use of topical vitamin K, was the first to discover the treatment of stretch marks with Retin A and has acquired many firsts in his research armamentarium.

● **Christopher Coles Brown, M.D.** Dr Brown has vast experience in the diagnosis and treatment in cosmetic medicine, general internal medicine and infectious diseases. He offers valuable research counsel and has conducted abundant research studies.

● **Jose Marquez-Serres, M.D.** A renowned Spanish anti-aging specialist, President of the Spanish Society of Anti-Aging and Longevity, member of Honour of the French Society of Aesthetic Surgery and European Laser Association.

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Current Results of Treatment of Head and Neck Surgery

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Dr. Yu-wai Chan

Introduction

Head and neck surgery deals with pathologies, both benign and malignant. These lesions can be located anywhere from the skull base to the oral cavity down to the lower neck including the upper mediastinum. The availability of advanced diagnostic strategies, for example CT scan, MRI and PET scan, as well as improved therapeutic measures result in better local and regional control of disease, on the other hand, without scarifying the quality of life for patients. These can only be achieved by close collaboration between surgeons and other specialties, including diagnostic radiology, clinical oncology, pathology, physiology as well as speech therapy.

Advances in surgical resection

Surgical approaches for tumour extirpation

Access to certain anatomical areas of the head and neck region is notoriously difficult and adequate exposure for surgery in these areas poses particular challenges to surgeons. Examples include tumours situated at the nasopharynx and anterior skull base.

The anterolateral approach to the nasopharynx using maxillary swing operation for surgical resection of recurrent nasopharyngeal carcinoma was first introduced by Professor William I. Wei in 1991¹. The advantage of this approach is that it offers a wide exposure of the whole nasopharynx and parapharyngeal space for an adequate oncologic surgical procedure. After resection is complete, the facial skeleton is restored by returning the maxillary osteocutaneous flap and fixing with titanium microplates. After curative resection, a 5-year local tumour control rate of 62% can be achieved².

Anterior skull base tumours often necessitate co-operation between head and neck surgeons and neurosurgeons for surgical resection. A combined craniofacial approach has been used via a bicoronal scalp incision and midface deglove incision, resulting in an adequate exposure of the region. Adequate tumour resection with long-term survival is possible³.

Tools for tumour extirpation

The advent of technology has significantly improved the results of many surgical procedures. Ultrasonic-activated surgical instruments have been widely used in recent years, especially in minimally invasive endoscopic abdominal and thoracic procedures. Its use in head and neck regions has been reported, for example tonsillectomy,

submandibular sialoadenectomy and thyroidectomy. The use of ultrasonic scissors in glossectomy for patients with carcinoma of tongue was proven successful, due to the benefit of combined effect of cutting and haemostasis. The median blood loss in our series of patients was zero⁴.

In patients with early glottic tumour, it was well known that radiotherapy allows organ preservation while achieving similar local tumour control rate comparing to laryngectomy. However, it is often associated with changes in quality of voice, which significantly affects the quality of life of these patients. Endoscopic CO₂ laser cordectomy in early glottic cancers offers good oncologic results with rapid post-operative recovery as well as superior voice outcomes, especially with subepithelial (type I) and subligamentous (type II) cordectomies⁵.

Management of clinically N0 neck of head and neck malignancy

The management of clinically N0 cervical nodal status in patients with head and neck malignancy continues to be a subject of debate in the literature. Oral tongue carcinoma is well known for its propensity of subclinical nodal micrometastasis in stage I and II tumours, and these are, unfortunately, not detectable by the best diagnostic technology. Locoregional recurrence is the main cause of treatment failures of carcinoma of tongue⁶. In our series, tumour thickness was the only significant factor that had predictive value for subclinical nodal metastasis, local recurrence and survival⁷. Tumour up to 3mm in thickness has 8% subclinical nodal metastasis and these patients will be followed up closely to detect possible regional recurrence; tumour more than 3mm and up to 9mm thick had 44% subclinical nodal metastasis and for these patients, elective selective neck dissection should be offered; tumour more than 9mm thick had 53% subclinical nodal metastasis, and in these patients the large size primary tumour warrants post-operation adjuvant radiotherapy, the neck can therefore be irradiated together with the oral cavity.

Advances in reconstruction

Advances of head and neck reconstruction have improved the functional and aesthetic outcome of patients following extensive surgical resection. Before the era of microvascular free tissue transfer, pectoralis major myocutaneous flap, first described by Ariayan in 1979⁸, has been the workhorse for head and neck reconstruction. Although it has been proven to be reliable and versatile, it has several limitations, including large



muscle bulk, limitation of the reach of the flap, lack of bone for reconstruction of composite bony defects as well as significant donor site morbidities.

Microvascular free tissue transfer had opened a new door to the reconstruction of complex tissue defects in the head and neck region. It has revolutionised the traditional concept of reconstructive ladder for defect repair. The ability to transfer tissue from a distant site has enabled surgeons to reconstruct defects with aesthetic and functional outcomes that can never be matched by using traditional regional myocutaneous flaps. The refinement of surgical techniques has improved the overall success rates of free tissue transfer to 96.3% in recent years in our series of patients. Moreover, resection and reconstruction can be performed by two separate teams of surgeons of the division. Both teams are involved in the resection of the primary tumour. While having an idea of the resultant defect, the second team can start harvesting of free tissue. This greatly shortens the operating time, and hence, the anaesthetic time of the patient⁹.

In general, four different types of defects will be encountered after tumour resection, each requiring free flaps with special characteristics to optimise the result of reconstruction.

(1) Defects of cutaneous or mucosal lining

These occur after resection of cutaneous malignancies, especially squamous cell carcinoma or malignant melanoma where wide local excision is usually required. Oral mucosa defects are also created after excision of intra-oral tumours, such as carcinoma of the buccal mucosa, palate and tongue. In these situations, reconstruction requires flaps which are thin and pliable. Free radial forearm flap, which has been the gold standard for reconstruction in such situations, has been criticised for potential donor site morbidities. With the advent of the technique of perforator flap harvesting, free anterolateral thigh perforator flap is now one of the most popular options when thin flaps are required. The donor site can usually be closed primarily with minimal morbidity, but the technique of perforator dissection is more demanding to surgeons.

(2) Defects of soft tissue bulk

After radical maxillectomy, the resultant defect of the orbit and maxilla requires soft tissue to fill up the cavity. Defects of the skull base created after craniofacial resection of tumor also requires reconstruction using bulky flaps of good vascularity in order to separate intracranial cavity from paranasal sinuses to prevent cerebrospinal fluid leakage and life threatening infection. Free vertical rectus myocutaneous flap is reliable and easy to harvest with long pedicle length. It provides the necessary muscle bulk and when indicated, includes cutaneous component to reconstruct the palatal defect to obviate the need of an obturator

(3) Bony defects

Defects of the mandible can be debilitating and may significantly affect the quality of life of patients, both functionally and cosmetically. For composite defects of mandible and oral mucosa, free fibular osteocutaneous flap remains the dominant choice for reconstruction. It provides a long segment of well vascularised bone of

adequate bone stock that can tolerate multiple osteotomies and the fitting of osteointegrated dental implants in the future, if necessary. Its cutaneous component is thin and pliable and can be used to reconstruct oral mucosal defect. The secondary defect in the leg is usually repaired with partial thickness skin graft. Donor site morbidity is unusual, but the flap may not be an option for use in patients with severe peripheral vascular disease.

(4) Circumferential defects of upper digestive tract

Circumferential pharyngectomy defects are best reconstructed using free jejunal graft. It results in superior functional outcome compared with skin tubes as the jejunal graft has peristalsis and the mucosa secretes mucus, which facilitates food passage through the conduit. Drawbacks to this procedure include the need for laparotomy and difficulty may be encountered in patients with previous abdominal surgeries.

Summary

The head and neck surgeons have always been the leader of a multidisciplinary team that takes care of patients with head and neck pathologies, especially cancer. Over the years with advancement of surgical resection, better locoregional control of tumour and hence better disease free survival can be achieved. In the past, the worrisome of creating composite defects that are difficult to reconstruct may compromise surgical resection of the primary tumour. Nowadays, with the advancement of reconstruction, especially the development of microvascular free tissue transfer, complicated defects can be reconstructed with improving functional and aesthetic outcomes. On going research is being performed aiming to optimise the outcome of surgery and quality of life of patients.

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**MCHK CME Programme Self-assessment Questions**

Please read all the articles in this issue and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded 1 CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 July 2007. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please choose the best answer:

1. **The best reconstruction method after extirpation of large head and neck cancer is:**
 - i. pectoralis major myocutaneous flap
 - ii. deltopectoral flap
 - iii. pedicled flap
 - iv. microvascular free flap
 - v. local flap
2. **The primary aim of reconstruction after extirpation of head and neck cancer is to achieve:**
 - i. Fine facial scar
 - ii. Functional restoration
 - iii. Aesthetic reconstruction
 - iv. Facial contour
 - v. Balanced facial features
3. **The most useful molecular marker for nasopharyngeal carcinoma is:**
 - i. Epstein Barr Virus DNA
 - ii. IgA against viral capsid antigen of Epstein Barr Virus
 - iii. Carcinoembryonic antigen
 - iv. IgA against early antigen of Epstein Barr Virus
 - v. IgA against latent membrane antigen of Epstein Barr Virus
4. **The most promising agent that has evolved recently for the management of head and neck cancer is:**
 - i. tyrosine kinase inhibitor (e.g. Gefitinib)
 - ii. monoclonal antibody (e.g. Cetuximab)
 - iii. Gene therapy
 - iv. Anti viral agent
 - v. Anti VEGF agent
5. **For stage I & II carcinoma of tongue, the single factor that has the most significant prognostic value is:**
 - i. Irregular shape of the tongue ulcer
 - ii. Depth of the tongue ulcer
 - iii. Repeated bleeding from tongue ulcer
 - iv. Long history of drinking
 - v. Long history of smoking
6. **When a curative nasopharyngectomy is carried out for post-radiotherapy recurrent nasopharyngeal cancer, the 5-year local tumour control rate is:**
 - i. 82%
 - ii. 75%
 - iii. 66%
 - iv. 54%
 - v. 35%
7. **The best reconstructive option for a circumferential hypopharyngeal defect is:**
 - i. free jejunal graft
 - ii. free colonic graft
 - iii. tubed pectoralis major myocutaneous flap
 - iv. tubed deltopectoral flap
 - v. staged reconstruction
8. **Currently in the international arena, most head and neck surgeons has training in:**
 - i. Plastic and reconstructive surgery
 - ii. General surgery
 - iii. Maxillofacial surgery
 - iv. Otorhinolaryngology
 - v. Neurosurgery
9. **For management of T1 carcinoma of larynx, the following modality is as effective as radiotherapy in eradicating the tumour while preserving voice:**
 - i. chemotherapy
 - ii. partial laryngectomy
 - iii. CO₂ laser surgery
 - iv. Brachytherapy
 - v. Immunotherapy
10. **Specialty of Head and Neck Surgery started in Queen Elizabeth Hospital in:**
 - i. 1960
 - ii. 1970
 - iii. 1980
 - iv. 1990
 - v. 2000



ANSWER SHEET FOR JULY 2007

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New Childhood Immunisation Programme in Hong Kong

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Introduction

In Feb 2006, the Department of Health in Hong Kong started to implement a new universal immunisation programme for children. The old and new immunisation schedules are shown in Table 1. In the new programme, oral polio vaccine (OPV) is replaced by inactivated polio vaccine (IPV) and whole cell pertussis vaccine (wP) is replaced by acellular pertussis vaccine (aP). In addition, vaccines against diphtheria, tetanus, pertussis and poliovirus are given as a combined quadruple vaccine (DTaP-IPV) instead of separate DTaP and IPV vaccines. In this article we shall review the rationale behind and evidence supporting the change in the immunisation programme. We shall also briefly review other combination vaccines widely used in private sector in Hong Kong, as well as the differences between our local childhood immunisation programme and that of the United States and the United Kingdom.

IPV vs OPV

The Salk formalin-inactivated polio vaccine and the Sabin live-attenuated oral polio vaccine were licensed in the US in 1955 and 1961 respectively. Though developed later, OPV soon replaced IPV in most countries as it is inexpensive, requires no needle, produces mucosal immunity and herd immunity. More than 95% of recipients develop long-lasting immunity to all 3 types of poliovirus after 3 doses of OPV. On the other hand, the immunogenicity of the original IPV was low and was replaced in 1988 by enhanced-potency IPV which has greater antigenic content. Both IPV and OPV induce mucosal immunity of the gastrointestinal tract, but that induced by OPV is superior,¹ though pharyngeal mucosal immunity is comparable for both vaccines. Herd immunity induced by the spread of the live polioviruses of OPV offers distinct advantage and contributes to the global eradication of poliomyelitis. Routine and mass administration of OPV in the past 40 years has markedly reduced the incidence of paralytic poliomyelitis in most parts of the world as well as in Hong Kong; and OPV is still the type of polio vaccine recommended by WHO for eradication of polio in endemic countries. Although the public health benefit of OPV is enormous, there is a trend in the switch of OPV to IPV in many developed countries because OPV is associated with a severe adverse effect, namely vaccine-associated paralytic poliomyelitis (VAPP), which occurs in approximately 1 per 1.4 million OPV doses in England² and 1 per 2.5 million doses in the

US³ Apart from VAPP, vaccine-derived poliovirus can be excreted in faeces and cause outbreaks of poliomyelitis.⁴

After eradication of poliomyelitis in the US since 1979, the risk for VAPP is considered to outweigh its benefits. Consequently, in 1997, the US Advisory Committee on Immunization Practices (ACIP) recommended replacing the all-OPV schedule with a sequential schedule of IPV followed by OPV to decrease the risk for VAPP while maintaining the benefits of OPV. This sequential schedule was accepted with no decline in immunisation coverage despite the need for additional injections. In 2000, ACIP went on to recommend exclusive use of IPV to eliminate the risk of VAPP. However, ACIP reaffirms OPV as the only vaccine recommended to eradicate polio from endemic countries. Based on similar circumstances and rationale, Hong Kong has now switched to IPV for universal childhood immunisation.

Studies have confirmed that 99%-100% of children develop protective antibodies after administration of three doses of IPV.⁵ The response is not inferior to OPV in a randomised controlled trial.⁶ In addition, more than 90% of vaccinated persons have serum antibodies 25 years after the fourth dose.⁷ Although there is no direct evidence that IPV is equally effective as OPV in preventing outbreaks of poliomyelitis, switching from OPV to IPV is considered unlikely to result in resurgence of poliomyelitis given the current eradication of polio in our locality. Furthermore, an extensive review has not found any serious adverse event caused by IPV.⁸ Therefore, switching from OPV to IPV in Hong Kong is likely to have a good risk-benefit ratio, and experience from the US has shown that vaccine uptake is unlikely to be compromised by the switch.

Acellular vs Whole cell pertussis vaccine

Vaccines made from killed whole *Bordetella pertussis* organisms have been available since the 1950s. However, whole cell pertussis vaccines have many adverse effects which include reactions such as fever, irritability and injection site pain commonly, and transient severe reactions such as hypotonic-hyporesponsive episodes, convulsions and acute encephalopathy rarely. Acellular pertussis vaccines containing purified or recombinant *Bordetella pertussis* antigens instead of intact organisms have been



developed hoping that they would be as effective as wP but less reactogenic. Introduction of aP in Japan in the 1980s was followed by a steady decline in the incidence of pertussis;^{9,10} and a variety of different aP has been developed since then.

A recent systematic review including 6 efficacy and 45 safety trials found that aP with three or more pertussis antigens were more effective than those with one or two antigens.¹¹ They were also more effective than one type of wP, but less effective than two other types of wP. However, differences in trial design precluded pooling of the efficacy data and results should be interpreted with caution. Nevertheless, most systemic and local adverse events were significantly less common with aP than with wP. In conclusion, aP is probably not inferior to wP in efficacy, but shows fewer adverse effects in general. However, in areas where pertussis is endemic and highly fatal, the most effective types of wP might be preferable despite its higher toxicity. As the incidence of pertussis in Hong Kong is not high in recent years (5-32 cases reported annually) and most cases can be treated effectively, aP with better toxicity profile is now considered more appropriate for universal childhood immunisation.

Combination vaccines

Combination vaccines are developed to avoid multiple injections during single clinic visits and its use may improve immunisation uptake and compliance. Other benefits include reduction in pain for the infant and anxiety for the parents, decreased costs as a result of fewer office visits, storage of fewer vials, decreased risk of needle sticks as a result of handling fewer syringes, and potentially improved record keeping and tracking.¹²

A combined DTaP-IPV vaccine is now recommended for universal childhood immunisation in Hong Kong. In a randomised controlled trial involving 400 healthy children aged 4-6 years, non-inferiority of the DTaP-IPV vaccine to separate DTaP and IPV vaccines was demonstrated.¹³ No significant differences were observed in adverse events between the two groups. In addition, the DTaP-IPV vaccine had no negative effect on the response to co-administered MMR vaccine. Another randomised controlled trial also demonstrated that DTaP-IPV is comparable to DTaP + OPV in immunogenicity and reactogenicity.¹⁴

Table 1: Immunisation schedules in Hong Kong, United States and United Kingdom

	Hong Kong before Feb 2007	Hong Kong after Feb 2007	United States	United Kingdom
Newborn	BCG ^a HBV ^b OPV ^c type 1	BCG HBV	HBV	
1 month	HBV	HBV	HBV	
2-4 months	DTwP ^d OPV	DTaP-IPV ^e	Rotavirus vaccine DTaP ^f Hib ^g PCV ^h IPV	DTaP-IPV-Hib PCV
3-5 months	DTwP	DTaP-IPV	Rotavirus vaccine DTaP Hib PCV IPV	DTaP-IPV-Hib MCV ⁱ
4-6 months	DTwP OPV			DTaP-IPV-Hib PCV MCV
6 months	HBV	HBV DTaP-IPV	HBV Rotavirus vaccine DTaP Hib PCV IPV Influenza (yearly)	
12 months	MMR	MMR	MMR Hib PCV Varicella HAV ^j	Hib-MCV
13 months				MMR PCV
18 months	DTwP OPV	DTaP-IPV	DTaP HAV	
3 years 4 months - 5 years				MMR DTaP-IPV
6 years (Primary 1)	MMR DT OPV	MMR DTaP-IPV	MMR DTaP IPV Varicella	
11-12 years (Primary 6)	Td ^k OPV	dTaP-IPV	MCV4 ^l HPV ^m	
13-18 years				Td-IPV

- a. BCG -
b. HBV-hepatitis B vaccine
c. OPV - trivalent oral polio virus vaccine
d. DTwP- combined diphtheria, tetanus, whole cell pertussis vaccine
e. IPV - inactivated polio vaccine
f. DTaP - combined diphtheria, tetanus, acellular pertussis vaccine
g. Hib - conjugated Haemophilus influenzae type b vaccine

- h. PCV - conjugated pneumococcal vaccine
i. MCV - meningococcal group C vaccine
j. HAV - hepatitis A vaccine
k. Td - combined tetanus and reduced dose diphtheria vaccine
l. MCV4 - tetavalent conjugate meningococcal vaccine
m. HPV - human papillomavirus vaccine



Other commonly used combination vaccines also demonstrate comparable efficacy and safety as individual component vaccines in controlled clinical trials, such as MMR-varicella,^{15,16} DTaP-HBV,¹⁷ DTaP-HBV-IPV,¹⁷ DTaP-IPV-Hib,^{18,19} and DTaP-HBV-IPV-Hib combination vaccines.²⁰ One trial even found a higher response to HBV when DTwP-HBV was used.²¹ Furthermore, a controlled trial comparing DTaP-IPV-Hib with DTaP-IPV and Hib injected at separate sites showed that the combined injection group tended to have fewer local reactions and was more acceptable to parents and minimised distress to infants.²²

Although combination vaccines are similar to individual component vaccines in immunogenicity and safety, long-term effectiveness in preventing infection is not entirely certain for these recently licensed vaccines. Post-marketing efficacy surveillance should be enhanced so that material reductions in efficacy could be detected. Besides, combination vaccines are generally more expensive. Whether they are cost-effective for universal childhood immunisation requires further evaluation.

Differences in immunisation programme in US, UK and Hong Kong (Table 1)

Vaccines recommended in all children in the US but not in Hong Kong include pneumococcal, Haemophilus influenzae type b (Hib), meningococcal (MCV4), influenza, varicella, rotavirus, hepatitis A and human papillomavirus (HPV) vaccines. In the UK, Hib vaccine is also given to all children but meningococcal group C vaccine is used instead of MCV4. All these vaccines have been shown to be safe and effective in randomised controlled trials. They are also found to be cost-effective in the US and UK settings. In Hong Kong, accurate estimates of disease burden are not available for these infections, especially for pneumococcal, Hib, rotavirus and HPV infections which are not notifiable. Therefore the cost-effectiveness of universal immunisation against these infections cannot be accurately determined. Since meningococcal and invasive Hib infections are much less frequent in Hong Kong, universal immunisation against these infections is likely not cost-effective. On the other hand, the incidence of varicella infection in Hong Kong is as high as in the US or the UK. Varicella immunisation might be cost-effective in Hong Kong. However, formal economic analyses need to be performed before recommendations can be made.

Conclusion

The new childhood immunisation programme that switches OPV to IPV and wP to aP is likely to reduce adverse effects while maintaining efficacy. However, continual surveillance of immunisation uptake and local incidence of vaccine preventable infections is essential to guard against resurgence of these infectious diseases. Further investigations into the cost-effectiveness of different combination vaccines are needed. Epidemiological studies of population disease

burden of invasive pneumococcal and Hib diseases should be performed so that public health and economic impact of universal immunisation against these infections can be more accurately estimated for policy formulation. Considerations should be given to make pneumococcal and Hib infections notifiable. Those vaccines universally provided in the Western developed countries with success should be seriously and carefully considered to be included in childhood immunisation programme in Hong Kong.

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A Pilot Study on the Prevalence of Domestic Violence Against Male Partners of Pregnant Women in Hong Kong

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Abstract

Objective: To study the prevalence of domestic violence against male partners of pregnant women in Hong Kong.

Methods: A pilot study using a modified questionnaire adapted from the Abuse Assessment Screen was performed on 100 male partners who were requested to go to our clinic for blood taking because their pregnant partners were found to have low mean corpuscular volume (MCV) in the thalassaemia screening programme. Socio-demographic factors were compared between the abused and non-abused groups using Student's t-test and Chi-square test or Fisher's exact test as appropriate.

Results: One hundred men were interviewed. Thirteen of them had a history of abuse. Eight men had been abused in recent one year. Five men had been abused during the current pregnancy of their female partners. One man said that he had been sexually abused three times by a stranger in recent one year. Twenty men said that their female partners had refused to have sex with them in recent one year. The intimate female partner was the perpetrator in the majority of cases. The nature of abuse was limited to verbal, slapping or pushing without any injury.

Conclusion: Thirteen percent of male partners of pregnant women had been abused. Research on domestic violence should not be focused only on female victims.

Introduction

Domestic violence against pregnant women has been well recognised by health care professionals and the community. Between 11 and 41% of pregnant women attending antenatal clinics in American studies had reported a history of domestic violence, and 4 to 17% reported domestic violence during the current pregnancy¹⁻⁴. A local study performed in our hospital showed that 17.9% of pregnant women attending the antenatal clinic had a history of abuse and 4.3% of them had been abused during their current pregnancy⁵.

While many studies have looked at female victims of domestic violence, data on the male counterparts is scanty. An American study⁶ showed that 13% of male patients presenting to an emergency department had been victims of domestic violence committed by a female intimate partner within the previous year. There

was also a study suggesting that many male victims of domestic violence were injured in self-defence by the female victims⁷. In other words, domestic violence can be bi-directional affecting both the male and female partners. In order to understand the complete picture of domestic violence in pregnancy in a particular community, it would thus be important to study the prevalence of domestic violence against the male partners of pregnant women as well. To the best of our knowledge and from the literature search, similar study has not been performed in a Chinese community.

Methods

Between December 2000 and November 2001, a pilot study was performed on 100 male partners in the antenatal clinic. In our community, husbands do not often accompany their pregnant partners to the antenatal clinic and they might only turn up for medical needs. One of such occasions was to undergo blood test for thalassaemia screening when their pregnant partners were found to have low mean corpuscular volume (MCV) from the routine antenatal blood tests usually performed in the first trimester of pregnancy. The male partners were interviewed by a designated research assistant in a private setting using a modified questionnaire (Table 1) adapted from the Abuse Assessment Screen^{4,8}. Written consent were obtained before the interview. The study was approved by the local Ethics Committee.

Men who answered 'yes' to questions 1, 2, 3 or 4 (a) were considered to be the abused group. The following socio-demographic data of the couple were compared between the abused and non-abused groups: age, race, number of years in Hong Kong, second marriage, number of years of present marriage / relationship, number of children, occupation, income, unplanned pregnancy, smoker, drinker and drug abuse. Statistical analysis was performed with Student's t-test and Chi-square test or Fisher's exact test as appropriate using the SPSS/PC software package. A p value of <0.05 was considered to be statistically significant.

Results

One hundred and five men were invited to join the study. Five of them refused to be interviewed with no specific reason given. Figure 1 shows the incidences of domestic violence. Thirteen men had a history of abuse.



Eight of them had been abused in recent one year and five of them had been abused during the current pregnancy of their female partners. One man said that he had been sexually abused three times by a stranger in recent one year. Three men from the abused group would like to be referred for further management. Twenty men said that their female partners had refused to have sex with them in recent one year and the number of episodes varied from one to ten. Five of these twenty men (25%) belonged to the abused group. Only 3 men said that they were afraid of their female partners. All of them did not belong to the abused group.

Table 1. Abuse Assessment Screen Questionnaire

- Have you ever been emotionally or physically abused by your partner or someone important to you?
[1] yes
[0] no
- Within the last year, have you been hit, slapped, kicked or otherwise physically or emotionally hurt by someone?
[1] yes
[0] no
If yes, by whom? [1] wife
[2] ex-wife
[3] girlfriend
[4] stranger
[5] others (specify) _____
No. of times ()
- Since your partner has been pregnant, have you been hit, slapped, kicked or otherwise physically or emotionally hurt by someone?
[1] yes
[0] no
If yes, by whom? [1] wife
[2] ex-wife
[3] girlfriend
[4] stranger
[5] others (specify) _____
No. of times ()
Indicate the area of injury: _____
Score the most severe incident to the following scale:
[1] threats of abuse, including use of a weapon
[2] slapping, pushing; no injuries and/or lasting pain
[3] punching, kicking, bruises, cuts and/or continuing pain
[4] beaten up, severe contusions, burns, broken bones
[5] head, internal, and/or permanent injury
[6] use of weapon, wound from weapon
- (a). Within the past year, has anyone forced you to have sexual activities?
[1] yes
[0] no
If yes, by whom? [1] wife
[2] ex-wife
[3] girlfriend
[4] stranger
[5] others (specify) _____
No. of times ()
- (b). If no, has your partner refused to have sex with you?
[1] yes
[0] no
No. of times ()
- Are you afraid of your partner or anyone you listed above?
[1] yes
[0] no
- Do you think you need a referral for further management? (for those answered yes to questions 2/3/4a)
[1] yes
[0] no

Table 2. Socio-demographic factors of male partners

	Abused group N=13	Non-abused group N=87	P value
Age (years)	32 ± 7	34 ± 7	NS
Chinese	6 (46)	67 (77)	0.04
No. of years in Hong Kong	18 ± 6	27 ± 14	0.04
Second marriage	0 (0)	7 (8)	NS
No. of years of present marriage / relationship	4 ± 4	4 ± 4	NS
No. of children ≥ 1	4 (31)	28 (32)	NS
Occupation			0.03
Professional	6 (46)	20 (23)	
Clerical	1 (8)	17 (20)	
Manual worker	4 (30)	38 (43)	
Unemployed	1 (8)	0 (0)	
Student	0 (0)	1 (1)	
Others	1 (8)	11 (13)	
Income (US \$1 = HK \$7.8)			NS
< 10,000	4 (31)	8 (9)	
10,001 - 20,000	5 (38)	41 (47)	
20,001 - 30,000	1 (8)	23 (27)	
≥ 30,001	3 (23)	15 (17)	
Unplanned pregnancy	8 (62)	37 (43)	NS
Smoker	6 (46)	32 (37)	NS
Drinker	7 (54)	26 (30)	NS
Drug abuse	1 (8)	0 (0)	NS

Data are expressed as mean + SD or number (%); NS = non-significant

Table 3. Socio-demographic factors of pregnant women

	Abused group N=13	Non-abused group N=87	P value
Age (years)	27 ± 5	29 ± 6	NS
Chinese	6 (46)	61 (70)	0.04
No. of years in Hong Kong	9 ± 9	16 ± 14	NS
Second marriage	0 (0)	9 (10)	NS
No. of years of present marriage / relationship	4 ± 4	4 ± 4	NS
No. of children ≥ 1	5 (38)	26 (30)	NS
Occupation			NS
Professional	1 (8)	16 (19)	
Clerical	2 (15)	22 (25)	
Manual worker	3 (23)	10 (12)	
Housewife	6 (46)	28 (32)	
Unemployed	0 (0)	6 (7)	
Student	0 (0)	2 (2)	
Others	1 (8)	3 (3)	
Income (US \$1 = HK \$7.8)			NS
≤ 10,000	11 (85)	57 (66)	
10,001 - 20,000	2 (15)	18 (20)	
20,001 - 30,000	0 (0)	6 (7)	
≥ 30,001	0 (0)	6 (7)	
Smoker	0 (0)	4 (5)	NS
Drinker	0 (0)	2 (2)	NS
Drug abuse	1 (8)	0 (0)	NS

Data are expressed as mean + SD or number (%); NS = non-significant

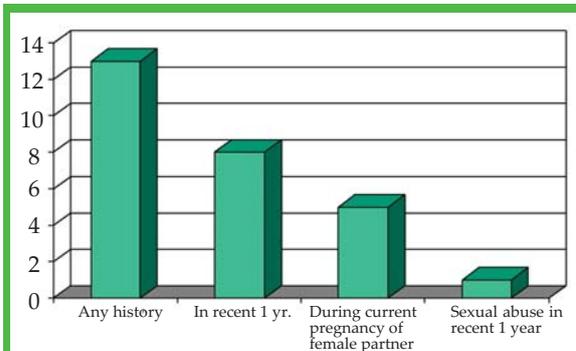


Figure 1. Incidence of domestic violence (%) against male partners of pregnant women



The perpetrator of abuse was the intimate female partner in 11 out of the 13 cases in the abused group. In the other 2 cases, the perpetrators were the employer and a stranger respectively. Regarding the nature of abuse, apart from one case of 'forced to have sex', there were 4 cases of slapping or pushing with no injuries or lasting pain. The remaining cases were verbal abuse.

The socio-demographic factors of the couple between the abused and non-abused groups were compared in Tables 2 and 3. There were more non-Chinese men (Indian / Pakistani / Filipino / Caucasian) in the abused group (7/13=54%) as compared to the non-abused group (20/87=23%). The abused group had a shorter stay in Hong Kong. In the abused group, more male partners (46%) were professionals. Unplanned pregnancy was more common (62%) in the abused group but did not reach statistical significance. This was probably because of the small sample size in our study.

Discussion

Our data showed that the incidence of domestic violence against male partners of pregnant women (13%) is the same as that from an American study conducted in an emergency department⁶. The incidence is also comparable to that against pregnant women (18%) in our community⁵. Within the same community, the nature of abuse tends to be similar against both male and female counterparts i.e. mainly verbal abuse in our community as compared to that of a stronger element of physical abuse in American studies^{1-4,6}. One hypothesis is that domestic violence is bi-directional affecting both the male and female partners. When the husband scolds his wife, his wife would scold him as well and vice versa. There were less Chinese men in the abused group. Either domestic violence is less common against Chinese men or Chinese men are more reluctant to reveal this problem. Twenty men said that their female partners had refused to have sex with them in recent one year. Seventeen of them (85%) are Chinese which may be related to the traditional Chinese taboo of avoiding sex during pregnancy.

Studies on domestic violence against male partners of pregnant women are more difficult to be conducted than those on pregnant women. First of all, it is difficult to find a representative sample of the male population to perform the study. If the study is conducted on those male partners who accompanied the pregnant women to the antenatal clinic, the incidence of domestic violence might be under- or even overestimated because they may be a biased group. If we send the questionnaires by mail to all the male partners, it is difficult to get a good response rate. Obviously, we cannot rely on the pregnant women to pass on the questionnaires to their male partners. Our present study was performed on those male partners who were requested to go to our clinic for blood taking because their pregnant partners were

suspected to be thalassaemia carriers. As the thalassaemia carriers are clinically asymptomatic, we think that this is unlikely to give rise to any bias regarding domestic violence. Secondly, there is no universally accepted definition of what constitutes domestic violence against men. The Abuse Assessment Screen has not been validated in the male population. Thirdly, men are less likely to admit that they have been assaulted by their female partners because of a sense of embarrassment or stigma. Fourthly, there is much less public or media attention on the male victims of domestic violence. There is also concern that the acknowledgment that some women are violent against their male partners will be used to defend male violence⁹. The problem has thus been assumed to be minor or even nonexistent. We disagree with this approach because we think that domestic violence is bi-directional between the couple¹⁰. Research and intervention should thus be bi-directional as well on both male and female partners. It would be interesting if we can study the incidence and characteristics of domestic violence against corresponding male and female partners to test this bi-directional hypothesis.

Nevertheless, our pilot study showed that the problem of domestic violence against male partners of pregnant women does exist in our community. At least three of the thirteen abused men (23%) would like to be referred for further management. Further studies on domestic violence against male partners of pregnant women are certainly warranted.

References

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Doctors' Associations in Community Services

Dr. Ben YF Fong

MPH(Syd), FHKAM(Community Medicine)

Vice-Convenor, Hong Kong Primary Care Foundation
c/o University Health Service, The Chinese University of Hong Kong



Dr. Ben YF Fong

Little is publicised by the media and our professional bodies on how much our medical colleagues have contributed to the society as volunteers.¹ As groups, medical organisations have contributed tremendously to the society in many ways such as prevention, fighting against epidemics, etc. The One School One Doctor scheme initiated by the Hong Kong Medical Association in conjunction with the Education and Manpower Bureau during SARS in 2003 is a very good example of collaborative community service.

Elsewhere in the United States, Missouri physicians have shared with European Georgia physicians humanitarian aid, in terms of medications, medical publications, used equipment and supplies, and exchanged medical knowledge with sister medical organisations, sister medical schools and sister cities in specialties of family medicine, paediatrics, endocrinology, ophthalmology, obstetrics, gynaecology, anaesthesiology and surgery, etc.²

In response to the Indian Ocean tsunami of 26 December 2004, medical colleges in Australia and the Australian Government have established the Australian Health Alliance to assist with Post-tsunami Reconstruction in an efficient, coordinated and appropriate manner. The goals of this Alliance include providing a forum for discussion, identifying specific local needs, coordinating health services and helping local organisations to develop action plans.³

Another example is the collaborative international endeavours by the Royal College of Paediatrics and Child Health and the American Academy of Pediatrics to advance the practice of community paediatrics to ensure that the children receive appropriate health care. They have developed strategies and programmes to address concerned issues and to support paediatricians who work in the communities to improve the lives of children.^{4,5}

In Hong Kong, there is a long tradition of medical organisations serving the society in all kinds of situations. The Hong Kong Primary Care Foundation was founded by Hong Kong Public Hospital, Department of Health and University Doctors Association (PHUDA) in June 2003 to concentrate on the important primary care part of our health system. This public health concern is natural, particularly in the fight against SARS and emerging infectious diseases, plus the growing impact of chronic conditions in our ageing population.

The Mission of the Foundation is to promote the services and development of primary care in Hong Kong. The Foundation aims to participate in primary care activities via public education, professional development, collaboration with professional, government and community organisation, research, submission of suggestions to the Government, so that our people live happily and enjoy good health. A panel of consultants and specialists in the medical and allied health professions from the public, academic and private sectors

contribute in the advisory as well as the educational roles.

Courses are organised for doctors, allied health professionals, clinic assistants, etc to strengthen the standard, to update knowledge and to enhance the professional services of our colleagues. On the other hand, public education in health topics, especially in health prevention and promotion are provided to schools, the lay public and the community at large by means of public talks, appearance in television and radio shows, regular newspaper columns, press conference and the Foundation's Website (www.hkpcf.org.hk), newsletter and pamphlets.

The Foundation has staged Campaigns on specific health subjects. The "One Goal One Heart" is concerned about hypertension and the "Healthy Ageing" includes the various aspects of ageing and the impact on our body and health, with focus on prevention at a younger age. Lectures for health professionals, printed materials for doctors' clinics and the public, souvenir gadgets, etc are produced as educational tools. Press conferences have been held to disseminate the messages via the media and to draw the public's attention to the issues of everybody's concern.

The Foundation is also an advocate in primary care. Two forums were organised for doctors to discuss the Government's consultation paper released in 2005, "Towards a Healthy Tomorrow". Prominent experts and academics were invited to address and discuss with the audience. Findings and opinion collected from the two forums were collated and submitted to the Government and published in the Hong Kong Practitioner.⁶ Moreover, interviews and responses to issues of public health concern are often made by our members.

Hong Kong Primary Care Foundation shall continue to educate the public with programmes in the electronic media and in various formats for doctors, especially family doctors, allied health professionals, the public, etc. The programmes shall continue to be comprehensive, coordinated and reaching out to the community. Professional development is the other major area of our endeavour in future. This is one example of the approaches in community health programmes.⁷

References

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Clinical Quiz

Dr. Helen KS Tung

MBBS, FRCR, FHKCR, FHKAM (Radiology)

Associate Consultant, Department of Radiology, Queen Mary Hospital



Dr. Helen KS Tung



Clinical History :

This is a KUB film of a 60-year-old man who presented with hypertension and occasional flank pain.

Questions:

- What do you see on the KUB film?
- What is the likely diagnosis and how would you confirm your diagnosis?

(See P. 30 for answers)



The Federation of Medical Societies of Hong Kong

Members' Benefits

We are pleased to announce a new benefit for our members. The Federation, in cooperation with Kingsway Concept Limited, will offer a discount on petrol and diesel purchases of HK\$0.9/litre from **Caltex, Shell, Esso and Sinopec** to members and their families of all Ordinary and Associate member societies under the Federation. Please contact our Secretariat at 2527 8898 and info@fmshk.org or Kingsway Concept Limited at 2541 1828 and kingswayconcept@yahoo.com for further details and terms for this offer.



News from Member Societies:

British Medical Association (Hong Kong Branch)

Updated office-bearers and council members for the year 2007-2008 are as follows: President: Dr. Jason BROCKWELL, Vice President: Dr. Christopher TONG, Hon. Secretary: Dr. Raymond LO, Hon. Treasurer: Dr. Clarence LEUNG, Council Members: Dr. Adrian WU, Dr. Bernard MURPHY, Prof. Brian TOMLINSON, Dr. David KAN, Dr. Donald GREIG, Dr. Natalie CAVES, Dr. Penny NICOLLE and Dr. Sally FERGUSON

Hong Kong Society of Transplantation

New council members are as follows: Dr. CHAN See Ching, Dr. YIU Ming Kwong, Dr. LAM Tsze Ho, Philip, Dr. LI Fu Keung.

The Hong Kong Paediatric Society

Updated office-bearers and council members for the year 2007-2008 are as follows: President: Dr. TSOI Nai Shun, Vice President: Dr. YU Chak Man, Hon. Secretary: Dr. LI Albert Martin, Hon. Deputy Secretary: Dr. WU Shun Ping, Hon. Treasurer: Dr. KONG Yim Fai, Social Convenor: Dr. CHAN Chi Fung, Council Members: Dr. CHAN Chok Wan, CHENG Man Yung, CHIU Cheung Shing, Dr. IP P. K. Patrick, Dr. KO Po Wan, Dr. LEUNG Chik Wa, Dr. LIU Kam Wing, Dr. NG Pak Cheung, Dr. POON W. K. Grace, Dr. WONG H. L. Lilian, Dr. William WONG and Dr. YAM Ka Ling.

The Hong Kong College of Psychiatrists was founded in September 1990. Its forerunner was the Hong Kong Psychiatric Association. The College's objectives include:

- (1) To promote the study and advancement of the science and practice of psychiatry and ancillary sciences and branches of medicine
- (2) To contribute to the improvement of mental health care for Hong Kong citizens through the provision of specially trained psychiatrists
- (3) To ensure the highest professional standard of competence and ethical integrity in Psychiatry

Hong Kong Surgical Laser Association was founded in 1990 with the aim to promote, for the benefit of the public, the application of laser technology in medicine and the safe operation of lasers in medical management.

Hong Kong Nutrition Association is proud to present our newly published book "營養瘦身自由行". It is written by a group of dietitians and nutritionists who work in both private and public sector. This book provides hands-on and practical behavioral modification skills that help to tackle the problem of overweight. With overflowing information on weight loss methods available nowadays, we analyze the pros and cons of different ways and come up with the most effective techniques to help sustain diet and/or lifestyle change, which is very important to maintain health. Check this out in the nearest bookstore!



Answer to Clinical Quiz

Answer :

Radiographic Findings:

Bilateral renal shadows are enlarged. Multiple ring-shaped and curvilinear calcifications are present diffusely in both renal shadows.

Diagnosis:

Autosomal dominant polycystic renal disease.

Definitive diagnosis is established by ultrasound, which will show typical finding of multiple cysts of varying sizes in the enlarged kidneys. Ultrasound would also be able to detect complications of these cysts such as haemorrhage, infections, cyst wall calcifications and renal calculus disease.

Dr. Helen KS Tung

MBBS, FRCR, FHKCR, FHKAM (Radiology)
Associate Consultant, Department of Radiology, Queen Mary Hospital



Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
<ul style="list-style-type: none"> HKMA Structured CME Programme at Queen Elizabeth Hospital Year 07/08 (IV) - ENT 	<ul style="list-style-type: none"> Definitive Surgical Trauma Care (DSTC) Course Certificate Course in Mentoring in Nursing (Code No. TC-MN-0207) 	<ul style="list-style-type: none"> Definitive Surgical Trauma Care (DSTC) Course FMSHK Officers' Meeting HKMA Newsletter Editorial Meeting 	<ul style="list-style-type: none"> Definitive Surgical Trauma Care (DSTC) Course Laser CME Lecture Hong Kong Neurosurgical Society Monthly Academic Meeting - Head Injury Management: Current Perspectives 	<ul style="list-style-type: none"> HKMA Council Meeting H K M A W a n c h a i Community Network-Seminar on Safe Dispensing in Clinical Settings HKMA Yau Tsim Mong Community Network-Seminar on Safe Dispensing in Clinical Settings 	<ul style="list-style-type: none"> HKMA Wong Tai Sin Community Network-Seminar on Safe Dispensing in Clinical Settings 	<ul style="list-style-type: none"> The 50th Hong Kong Surgical Forum Refreshers Course for Health Care Providers 2006/2007 (XI) - Update Management of Parkinson's Disease
8	9	10	11	12	13	14
<ul style="list-style-type: none"> Summer Vigor Mini Dragon Boat Races 	<ul style="list-style-type: none"> Certificate Course in Mentoring in Nursing (Code No. TC-MN-0207) 	<ul style="list-style-type: none"> HKMA Eastern Community Network-Seminar on Safe Dispensing in Clinical Settings 	<ul style="list-style-type: none"> New Insights and Clinical Evidence of Fibrate Therapy in Type 2 Diabetic Patients 	<ul style="list-style-type: none"> HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2007 (VII) - Update in Skin Rejuvenation The 1st Nursing Forum The 50th Hong Kong Surgical Forum Updates and Advances in Obstetric Nursing Rimonabant : The Novel Treatment to Manage Multiple Cardiometabolic Risk Factors 	<ul style="list-style-type: none"> The 50th Hong Kong Surgical Forum 	<ul style="list-style-type: none"> HKMA Kwan Tong Community Network-Seminar on Safe Dispensing in Clinical Settings
15	16	17	18	19	20	21
<ul style="list-style-type: none"> HKMA Structured CME Programme at Kwong Wah Hospital Year 07/08 (IV) - Neurosurgery 10th Anniversary of HKSAR - Charity Concert for the Elderly 	<ul style="list-style-type: none"> Certificate Course in Mentoring in Nursing (Code No. TC-MN-0207) 			<ul style="list-style-type: none"> FMSHK Executive Committee Meeting (1) A gentleman with generalized lymphadenopathy and bilateral lung infiltrates (2) Common salivary Pathogen? 	<ul style="list-style-type: none"> HKMA Kwan Tong Community Network-Seminar on Safe Dispensing in Clinical Settings 	<ul style="list-style-type: none"> Seminar on Infectious Diseases - Update on Vaccines
22	23	24	25	26	27	28
	<ul style="list-style-type: none"> Certificate Course in Mentoring in Nursing (Code No. TC-MN-0207) 					
29	30	31				
	<ul style="list-style-type: none"> Certificate Course in Mentoring in Nursing (Code No. TC-MN-0207) 					



Date / Time	Function	Enquiry / Remarks
5 THU 8:00 pm 1:00 pm 1:00 pm	HKMA Council Meeting Organised by: The Hong Kong Medical Association Chairman: Dr. K CHOI # HKMA Head Office 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Christine WONG Tel: 2527 8285
	HKMA Wanchai Community Network- Seminar on Safe Dispensing in Clinical Settings Organised by: The Hong Kong Medical Association Chairman: Dr. N.T. CHAN Speaker: Dr. CHOI Kin & Dr. CHENG Chi Man # HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Gloria CHEUNG Tel: 2527 8285 (Registration is required) 1 CME Point
	HKMA Yau Tsim Mong Community Network- Seminar on Safe Dispensing in Clinical Settings Organised by: The Hong Kong Medical Association Chairman: Dr. C.P. HO Speaker: Dr. TSOI Lai To & Dr. GAM Wai Chu # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon	Miss Gloria CHEUNG Tel: 2527 8285 (Registration is required) 1 CME Point
6 FRI 1:00 pm	HKMA Wong Tai Sin Community Network- Seminar on Safe Dispensing in Clinical Settings Organised by: The Hong Kong Medical Association Chairman: Dr. Y.K. CHUNG Speaker: Dr. CHOI Kin & Dr. CHENG Chi Man # Training Room II, 1/F., OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon, Hong Kong	Miss Gloria CHEUNG Tel: 2527 8285 (Registration is required) 1 CME Point
8 SUN 8:00 pm	HKMA Structured CME Programme at Queen Elizabeth Hospital Year 07/08 (IV) - ENT Organised by: The Hong Kong Medical Association and Queen Elizabeth Hospital Speaker: Various # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration fee is required) 3 CME Points
9 MON (10,11) 6:30 pm - 9:30 pm (16, 23, 30)	Definitive Surgical Trauma Care (DSTC) Course Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Centre; Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons # Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Centre, Queen Mary Hospital, Pokfulam, Hong Kong	Program Manager Tel: 2855 4885 Fax: 2819 3416 Email: hnsrg@hkucc.hku.hk Website: http://www.hku.hk/surgery
	Certificate Course in Mentoring in Nursing (Code No. TC-MN-0207) Organised by: College of Nursing, Hong Kong	Secretariat Tel: 2572 9255 Fax: 2838 6280 28.5 CNE Points
10 TUE 8:00 pm - 10:00 pm 8:00 pm	FMSHK Officers' Meeting Organised by: The Federation of Medical Societies of Hong Kong # Gallop, 2/F., Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Ms. Carmen CHEUNG Tel: 2821 3512 Fax: 2865 0345
	HKMA Newsletter Editorial Meeting Organised by: The Hong Kong Medical Association Chairman: Dr. H.H. TSE # HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Tammy TAM Tel: 2527 8941
11 WED 7:00 pm 7:30 am	Laser CME Lecture Organised by: The Hong Kong Medical Association & Hong Kong Surgical Laser Association Chairman: Dr. C.O. MOK & Dr. C.Y. THAM Speaker: Various # HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Viviane LAM Tel: 2527 8452 1.5 CME Point
	Hong Kong Neurosurgical Society Monthly Academic Meeting - Head Injury Management: Current Perspectives Organised by: Hong Kong Neurosurgical Society Chairman: Dr. WONG Wai Kei Speaker: Dr. LAU Chi Yan Jane # Seminar Room, G/F., Block A, Queen Elizabeth Hospital, Kowloon	Dr. Y.C. PO Tel: 2990 3788 Fax: 2990 3789
12 THU 2:00 pm (13, 14) 6:30 pm - 8:30 pm 7:00 pm - 10:30 pm	HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2007 (VII) - Update in Skin Rejuvenation Organised by: The Hong Kong Medical Association & Hong Kong Sanatorium & Hospital Chairman: Dr. KING Wing Keung Walter # HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Viviane LAM Tel: 2527 8452 (Registration fee is required) 1 CME Point
	The 1st Nursing Forum Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong; American College of Surgeons, Hong Kong Chapter & Department of Nursing Studies, Li Ka Shing Faculty of Medicine, The University of Hong Kong # Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong	Forum Secretary Tel: 2855 4885 / 2855 4886 Fax: 2819 3416 Email: hks@hkucc.hku.hk Website: http://www.hku.hk/surgery
	The 50th Hong Kong Surgical Forum Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong & American College of Surgeons, Hong Kong Chapter # Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong	Forum Secretary Tel: 2855 4885 / 2855 4886 Fax: 2819 3416 Email: hksf@hkucc.hku.hk Website: http://www.hku.hk/surgery
	Updates and Advances in Obstetric Nursing Organised by: Hong Kong Society for Nursing Education Limited Speaker: Ms. SO Suk Ching # Lecture Room G08, School of General Nursing, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon	Mr. Jacky LAM / Ms. Annie LAM Tel: 9524 6160 / 6184 8578
Rimonabant : The Novel Treatment to Manage Multiple Cardiometabolic Risk Factors Organised by: The Federation of Medical Societies of Hong Kong Speaker: Prof. Jean-Pierre DEPRES & Prof. Julio ROSENSTOCK # 5/F, Ballroom, Island Shangri-La Hotel, Pacific Place, Supreme Court Road, Admiralty, Hong Kong	Ms. Charlene CHEUNG Tel: 2105 4873 Fax: 2506 2537	
14 SAT 2:30 pm	Refresher Course for Health Care Providers 2006/2007 (XI) - Update Management of Parkinson's Disease Organised by: The Hong Kong Medical Association & Lady of Maryknoll Hospital Chairman: Dr. T.C. SHIH Speaker: Dr. LAU Siu Wah Herrick # Training Room II, 1/F., OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon, Hong Kong	Ms. Clara TSANG Tel: 2354 2440 2 CME Points
17 TUE 1:00 pm	HKMA Eastern Community Network- Seminar on Safe Dispensing in Clinical Settings Organised by: The Hong Kong Medical Association Chairman: Dr. Y.N. YOUNG Speaker: Dr. CHOI Kin & Dr. CHENG Chi Man # Lecture Theatre, 1/F., Pathology Block, Pamela Youde Nethersole Eastern Hospital, Hong Kong	Miss Gloria CHEUNG Tel: 2527 8285 (Registration is required) 1 CME Point
18 WED 1:00 pm	New Insights and Clinical Evidence of Fibrate Therapy in Type 2 Diabetic Patients Organised by: The Hong Kong Medical Association Speaker: Dr. B.L. WONG # Sportful Garden Restaurant, Room V11, 1/F. & 2/F., Tai Tung Building, 8 Fleming Road, Wanchai, Hong Kong	Mr. C. K. LEUNG Tel: 2895 9691 Fax: 2576 9409 1 CME Point
19 THU 8:00 pm - 10:00 pm	FMSHK Executive Committee Meeting Organised by: The Federation of Medical Societies of Hong Kong # Council Chambers, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Carmen CHEUNG Tel: 2821 3512 Fax: 2865 0345



Date / Time	Function	Enquiry / Remarks
6:30 pm - 8:00 pm 19 THU	(1) A gentleman with generalized lymphadenopathy and bilateral lung infiltrates (2) Commensal or Pathogen? Organised by: Hong Kong Thoracic Society / ACCP (HK & Macau Chapter) Chairpersons: Dr. YEE Kwok Sang Wilson & Dr. CHAN Yuk Choi Speaker: Dr. LAW Tse Sam Grace & Dr. WONG King Ying # LG1, Lecture Room, Ruttonjee Hospital, Wanchai, Hong Kong	Dr. C.Y. TAM / Dr. Maurine M.L. WONG Tel: 2468 5407 Fax: 2468 6188 1 CME Point
20 FRI 1:00 pm	HKMA Kwun Tong Community Network- Seminar on Safe Dispensing in Clinical Settings Organised by: The Hong Kong Medical Association Chairman: Dr. K.M. LEUNG Speaker: Dr. CHOI Kin & Dr. CHENG Chi Man	Miss Gloria CHEUNG Tel: 2527 8285 (Registration is required) 1 CME Point
21 SAT 2:00 pm	Seminar on Infectious Diseases - Update on Vaccines Organised by: Princess Margaret Hospital, The Hong Kong Medical Association & The Hong Kong Society for Infectious Diseases Chairman: Dr. T.C. SHIH & Dr. H.H. TSE Speaker: Various # Hospital Hall, 8/F., Block G, Princess Margaret Hospital, Kowloon	Miss Nina HUNG Tel: 2521 1979 2.5 CME Points
22 SUN	Summer Vigor Mini Dragon Boat Races Organised by: The Hong Kong Medical Association Chairman: Dr. H YEUNG & Dr. I CHAN # Sai Kung	Ms. Dora HO Tel: 2527 8285
29 SUN 2:00 pm	HKMA Structured CME Programme at Kwong Wah Hospital Year 07/08 (IV) - Neurosurgery Organised by: The Hong Kong Medical Association & Kwong Wah Hospital Speaker: Dr. KWOK Ching Kwong John # Lecture Theatre, 10/F., Yu Chun Keung Memorial Medical Centre, Kwong Wah Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration fee is required) 2 CME Points
8:00 pm	10th Anniversary of HKSAR - Charity Concert for the Elderly Organised by: The Hong Kong Medical Association Charitable Foundation Limited Chairman: Dr. P.C. CHOW # Concert Hall, City Hall, 5 Edinburgh Place, Central, Hong Kong	Ms. Candy YUEN Tel: 2527 8285 (Admission ticket required)

Calendar of Events



Meetings

8/9/2007	Keeping Healthy, Opportunities of Ageing Organised by: Hong Kong College of Community Medicine Speaker: Various # Pao Yue Kong Auditorium, Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong Enquiry: Secretariat Tel: 2871 8745 Fax: 2580 7071 Email: fanny_hkccm@hkam.org.hk
20/9/2007	Annual General Meeting Organised by: Hong Kong Society for Coloproctology # World Trade Centre Club Hong Kong, 38/F., World Trade Centre, 280 Gloucester Road, Causeway Bay, Hong Kong Enquiry: Miss Christina LO Tel: 2595 6416 Fax: 2515 3195 Email: cloyy@ha.org.hk
29/9/2007 9:00 am - 6:00 pm	Health Research Symposium 2007 Organised by: Health, Welfare and Food Bureau Speaker: Various # Hong Kong Academy of Medicine, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong Enquiry: Ms. Lenora YUNG Tel: 2871 8841 Fax: 2871 8898
19-22/10/2007	16th Asian Congress of Surgery & 3rd Chinese Surgical Week Organised by: Asian Surgical Association & The Chinese Surgical Society of the Chinese Medical Association # Grand Epoch City, Beijing, China Enquiry: ASA Congress Secretariat Tel: 2855 4235 / 2855 4993 Fax: 2818 1186 Email: info@AsianSurgAssoc.org Website: www.AsianSurgAssoc.org
20/10/2007 1:00 pm - 5:30 pm	The Federation's Annual Scientific Meeting 2007 - Targeted Therapy in Cancers Organised by: The Federation of Medical Societies of Hong Kong # M/F, Lecture Theatre, Hospital Authority Building, Kowloon Enquiry: Ms. Karen CHU Tel: 2821 3515 Fax: 2865 0345 Website: www.fmshk.org
17-18/11/2007	Annual Scientific Meeting in Anaesthesiology 2007 - Expanding the Boundaries Organised by: The Hong Kong College of Anaesthesiology & The Society of Anaesthetists of Hong Kong # Hong Kong Convention and Exhibition Centre Enquiry: CMPMedica Pacific Limited Tel: 2559 5888 Fax: 2559 6910 Email: meeting.hk@asia.cmpmedica.com Website: www.hkca.edu.hk/asm2007.htm
24-25/11/2007	4th Asian Pacific Diabetic Limb Problems Organised by: Various # William MW Mong Block, Li Ka Shing Faculty of Medicine, The University of Hong Kong, 21 Sassoon Road, Hong Kong Website: http://www.diabeticlimb.hk/

Courses

3,10/9/2007	Child Massage and Play Workshop Organised by: Hong Kong Society for Nursing Education Limited Speaker: Ms. CHAN Cheung Lung Sharon # Room 133, Nursing Laboratory 3, 1/F, School of Nursing, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon Enquiry: Mr. Jacky LAM (9524 6160) / Mr. Tommy HUNG (6282 3275) / Ms. Annie LAM (6184 8578)
6,13,20,27/8/2007 3,10/9/2007	Certificate Course in Mentoring in Nursing (Code No. TC-MN-0207) Organised by: College of Nursing, Hong Kong Enquiry: Secretariat Tel: 2572 9255 Fax: 2838 6280
24,25,26/8/2007	Advanced Trauma Life Support (ATLS) Student Course Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Centre; Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons # Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Centre, Queen Mary Hospital, Pokfulam, Hong Kong Enquiry: Program Manager Tel: 2855 4885 Fax: 2819 3416 Email: hnsrg@hkucc.hku.hk Website: http://www.hku.hk/surgery
28,29,30,31/9/2007 1,2/10/2007	PALS Course 2007 Organised by: Hong Kong College of Paediatricians Speaker: Various # Hong Kong Academy of Medicine, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong Enquiry: Miss Karen YU Tel: 2871 8773 Fax: 2785 1850

CERTIFICATE COURSE FOR GENERAL PUBLIC

Enhancing Medical Practice: The Role of Psychotherapy in Promoting Physical and Mental Health

(Course No. 122)
Jointly organized by



The Federation of Medical Societies of Hong Kong
&
Psychotherapy Society of Hong Kong

Date & Time	Topic	Speaker
8 October 07	The Individual under Stress: Divorce, Death and Chronic Illness	Jadis Blurton, Ceilidh Halloran
15 October 07	Dealing with Couples under stress: Divorce, Death and Chronic Illness	Jadis Blurton, Ceilidh Halloran
22 October 07	Helping Children under Stress: Divorce, Death and Chronic Illness	Jadis Blurton, Ceilidh Halloran
29 October 07	Psychological Approaches to Chronic Pain Management	Rhoda Yuen
5 November 07	Working with people with Emotional Difficulties	Katherine Kot
12 November 07	Caring for the Bereaved	Lawrence Chen
19 November 07	Common Sexual Problems and Their Management	Nia Pryde

Date : 8 October 2007 - 19 November 2007

Time : 7:00 p.m. - 8:30 p.m.

Venue : Lecture Hall, 4/F, Duke of Windsor Social Service Building,
15 Hennessy Road, Wanchai, Hong Kong

Course Fee : HK\$875 (7 Sessions)

Language : English

Certificate : Awarded to participants with a minimum attendance of 70%

Enquiry : The Secretariat of the Federation of Medical Societies of Hong Kong

Tel. : 2527 8898 Fax : 2865 0345 Email : info@fmshk.org

CME/CPD Accreditation applied for

To download the application form, please visit our website: <http://www.fmshk.org>

CERTIFICATE COURSE FOR GENERAL PRACTITIONERS & PARAMEDICALS

Certificate Course on General Ophthalmology

眼科證書課程

(Course No. C118)

Jointly organized by



The Federation of Medical Societies of Hong Kong
香港醫學組織聯會



Hong Kong Ophthalmological Society
香港眼科學會

Date & Time	Topic	Speaker
16 Oct 2007	Red Eyes 紅眼症 Ocular Trauma and Emergencies 眼部創傷及急症	Dr Alvin L YOUNG 楊樂啟醫生 Dr Fai-to LAI 黎輝濤醫生
23 Oct 2007	Retinal Detachment 視網膜脫落 Cataract 白內障	Dr Donald CF WOO 賀澤烽醫生 Dr Chi-keung JON 莊志強醫生
30 Oct 2007	Paediatric Ophthalmology 兒童眼疾 Squint 斜視眼	Dr Chun-yu WONG 王震宇醫生 Dr Christopher BO YU 于秉安醫生
6 Nov 2007	Glaucoma 青光眼 Refractive Errors 屈光不正	Dr Kenneth YW KWAN 關焯榮醫生 Prof Ernst GOLDSCHMIDT
13 Nov 2007	Common Macular Diseases 常見的黃斑點疾病 Diabetic Retinopathy 糖尿眼	Dr Chi-ming FAN 樊志明醫生 Dr Wai-Man CHAN 陳偉民醫生
20 Nov 2007	Oculoplastic Surgeries 眼部整形手術 Laser Treatment of Eye Diseases 激光在眼科疾病中之應用	Dr Pak-Man CHENG 鄭柏文醫生 Dr David HY CHAN 陳浩然醫生

Date : 16 October 2007 - 20 November 2007

Time : 7:00 p.m. - 8:30 p.m.

Venue : Lecture Hall, 4/F, Duke of Windsor Social Service Building,
15 Hennessy Road, Wanchai, Hong Kong

Course Fee : HK\$750 (6 Sessions)

Language : English

Certificate : Awarded to participants with a minimum attendance of 70%

Enquiry : The Secretariat of the Federation of Medical Societies of Hong Kong

Tel. : 2527 8898 Fax : 2865 0345 Email : info@fmshk.org

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THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG
香港醫學組織聯合會

Duke of Windsor Social Service Building, 4/F, 15 Hennessy Road, Hong Kong
Tel: (852) 2527 8898 Fax: (852) 2865 0345 Homepage: www.fmshk.org E-mail: info@fmshk.org

Application Form for Certificate Course

Name of Applicant:(Prof/Dr./Mr./Ms./Mrs.)* _____ (English) _____ (Chinese)

*Please delete as appropriate

(in block letters)

Correspondence Address: _____

Tel. No. : _____ Fax No.: _____ Age: _____ Sex: _____

Email Address: _____ Occupation: _____

Course Title: The Development and Disorders of Speech and Language in Children (C125)
(please tick) Enhancing Medical Practice: The Role of Psychotherapy in Promoting Physical and Mental Health (C122)
 Certificate Course in General Ophthalmology (C118)

Education : Secondary Undergraduate Postgraduate Others _____
(please tick)

Fee enclosed (please tick):

Cheque No: _____ made payable to **The Federation of Medical Societies of Hong Kong**

Cash HK\$ _____

Signature

Date

Note:

1. The application form together with the appropriate fee should be sent to the Secretariat of the Federation of Medical Societies of Hong Kong, 4/F Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong.
2. Fees are not refundable, except in the event of a course being oversubscribed or cancelled.
3. The Federation of Medical Societies of Hong Kong reserves the right to cancel the course should too few participants enroll for the course.
4. No classes will be held when typhoon signal No. 8 or above or black rainstorm warning is still hoisted after 12:00 noon. Please contact the Secretariat at 2527 8898 to enquire matters regarding cancellation of class due to typhoon or black rainstorm.

For office use:

Registration confirmed on : _____ Registration Number : _____

Cheque Issuing Bank : _____ Cheque Number: _____





THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG
香港醫學組織聯會

The Federation's Annual Scientific Meeting 2007 Targeted Therapy in Cancer

20 October, 2007 (SAT) 1:00 p.m. - 5:30 p.m.

Lecture Theatre, M/F, Hospital Authority Building, 147B Argyle Street, Kowloon

APPLICATION FORM

Surname: Prof. / Dr. / Mr. / Ms. _____ First name: _____
(block letters please) (block letters please)

Position: _____

Address: _____

_____ E-mail: _____

Tel. No.: _____ Fax No.: _____

Please tick as appropriate:

- I will attend the Federation's Annual Scientific Meeting 2007.
- I will have/not have lunch.
- I am a member of _____
(member society of the Federation of Medical Societies of Hong Kong)
Enclosed please find a cheque in the amount of _____. (HK\$100 for medical, dental,
nursing and healthcare professionals).
- I am not a member of member society of the Federation of Medical Societies of Hong Kong.
Enclosed please find a cheque in the amount of _____. (HK\$200 for medical, dental,
nursing and healthcare professionals).

Signature

Date

Remarks: Please send registration form with cheque made payable to "**The Federation of Medical Societies of Hong Kong**" to 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong. Registration will be on first-come-first-served basis. No refund will be made if you have to cancel your registration afterwards.

=====
For office use:

Registration confirmed on _____ Registration Number _____

Cheque Issuing Bank _____ Cheque Number _____





THE FEDERATION OF MEDICAL SOCIETIES
OF HONG KONG

The Federation's Annual Scientific Meeting

2007

Targeted Therapy in Cancer

20 October, 2007 (SAT)
1:00 p.m. - 5:30 p.m.
Lecture Theatre, M/F,
Hospital Authority Building,
147B Argyle Street, Kowloon



- **Overview and Breast Cancer**
Prof. Richard J. Epstein
Department of Medicine, Queen Mary Hospital, The University of Hong Kong
- **Head and Neck Cancer**
Dr. Daniel TT Chua
Department of Clinical Oncology, Queen Mary Hospital, The University of Hong Kong
- **Lung Cancer**
Dr. James CM Ho
Department of Medicine, Queen Mary Hospital, The University of Hong Kong
- **Gastrointestinal Tract Cancers**
Prof. Benjamin CY Wong
Department of Medicine, Queen Mary Hospital, The University of Hong Kong
- **Haematological Malignancies**
Dr. James CS Chim
Department of Medicine, Queen Mary Hospital, The University of Hong Kong
- **Childhood Malignancies**
Dr. Godfrey CF Chan
Department of Paediatrics, Queen Mary Hospital, The University of Hong Kong

Registration Fee

HK\$100 Members of member societies
HK\$200 Non-member

Registration

Registration forms can be obtained by calling our Secretariat at 2527 8898 or the homepage <http://www.fmskhk.org>. Please send registration form and cheque to: The Federation of Medical Societies of Hong Kong, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong. Registration will be on first-come-first-serve basis.

CME/CPE: Please refer to our homepage <http://www.fmskhk.org> for details