Senses

THE HONG KONG COLLEGE OF OTORHINOLARYNGOLOGISTS NEWS MAGAZINE **August 2008**

THE HONG KONG COLLEGE OF OTORHINOLARYNGOLOGISTS

香 港 耳 鼻 喉 科 醫 學 院

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Tel: (852) 2871 8733 | Fax: (852) 2904 5035
E-mail: hkcorl@netvigator.com

Room 806, Hong Kong Academy of Medicine Jockey Club Building
99 Wong Chuk Hang Road, Aberdeen, Hong Kong

www.hkcorl.org.hk

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Message from the President

Time flies and summer is upon us. Despite the unusually heavy rain I hope you have been enjoying the season with the US Open, the European soccer, the Wimbledon, the Silverstone Formula One and so on.

We held our 2 day College Training Course on Rhinoallergology in January 2008 at the Academy. The meeting was well attended with Professor V. Lund and Dr. G. Scadding as our speakers. We thank UCB Pharma and GSK Ltd. for their support and sponsorship.

At the request of the Academy, a College Spokesperson was established to answer questions and queries from the press and other public media on matters related to our Specialty. Our Council decided to appoint Dr.Tang Shu On and Dr.Fung Kai Bun as our College Spokesperson for the first 6 months period. We would rather prefer our Spokesperson to be on a 6 month "rotational" rather than "permanent" basis, and to have two instead of one simply for convenience and coverage.

Our College Scientific Meeting, AGM, Diploma Conferment Ceremony and Dinner will be held on the afternoon of Sunday, 30th November 2008 at the Academy. The afternoon Scientific Meeting will feature the Trainees' Presentation leading to the award of the College Medal and the George Choa prize, and also prominent speakers from overseas. Dr.York Chow, our Health Minister, will be our Guest of Honour at the Diploma Ceremony and he will be delivering the 2nd College Oration to the Congregation. Kindly mark the date on your calendar and we look forward to your participation and support.

As usual Dr. Abdullah, the Hon. Secretary, will be briefing you elsewhere on the activities of the College Council and Dr. John Woo our Censor-in-Chief will highlight the work of the Education Committee. We also bought, finally after a period of observation and waiting, some HSBC shares for long term investment during the stock market downturn.

I trust you will enjoy reading the "Senses" as much as I do. Let us hope that these rainstorm and foul weather would stay away and I wish you all a bright, sunny, and productive summer.

Kai Bun FUNG

Message from the Editor

As I write this message in glorious sunshine, I echo the President's delight in that the thunder, lightning and rain might just be behind us. I welcome more of my colleagues to the Editorial Board. Dr Ambrose Ho from Queen Mary Hospital would make many colleagues envious with his overseas attachment in Luzern, Switzerland while Dr C L Lee from Queen Elizabeth Hospital will impress all with his review on the Thulium laser, one we think might just take over from the CO2 machines. Dr Joseph Chan from United Christian Hospital had a go, admirably, at reviewing two articles from the mainland in English and 'Chinese'. Dr H S Chan from the Prince of Wales Hospital interviewed an old friend of Hong Kong's Dr Ashok Sharha and wrote for us the 'Quiz' for those interested. I thank them all profusely and indeed all my other colleagues who dedicated so much of their valuable time and energy to support the College publication. It has been such a joy working with them all. I would like to congratulate Professor William Wei who will be on a 'World Tour' lecturing in the International Federation of Head and Neck Oncologic Societies' global CME program. Only the world's most respected leaders in the field of Head and Neck Surgery are invited to do so. We should all be very proud that Hong Kong could be part of it through the many years of quality surgery and hard work of Professor Wei's. Do have a look at the program in case you might be interested to drop in for several lectures in Barcelona, Athens, Moscow or why not Mumbai? Please enjoy the Summer issue of Senses and I wish you all a most enjoyable summer break, if you are taking one.

Victor ABDULLAH

Council News

The new Education Committee chaired by Dr John Woo, our Censor in Chief comprises of the following members:-

Dr Fung Kai Bun	President of the College	Prof Michael Tong	CUHK (NTE)
Dr Tong Fu Man	HA (HKE)	Dr Ngai Chi Man	HA (KW)
Dr Chong Hou Ming	HA (KC)	Dr Yuen Po Wing	Private
Dr Wong Yee Hang	HA (HKW)	Dr Ma Kwong Hon	Nominated by HKSORLH&NS
Dr Ho Fung	HA (NTW)		

The College Training Course was held in January 25th-26th. Professor Valarie Lund, Professor of Rhinology from London, United Kingdom and Dr Glenis Scadding, a world renowned Medical Rhinologist made it a great success. I am sure all who attended appreciated the update in the field of ENT Rhinology and Allergology. The College Council is most grateful to UCB Pharma and GSK for their most generous support in the educational event.

Dr G Scadding

Prof V Lund

Paying attention to the lecture

Council News

Prof Wei, Prof Lund, Dr Abdullah, Dr Scadding and Mr Leung

After Lectures Fellows and Members join together for lunch

Council News

Prof Lund and Dr Fung

Dr Scadding and Dr Fung

Dr Fung, Prof Lund and Dr Abdullah

Dr Fung, Dr Scadding and Dr Abdullah

Professor Lund left us a special message:

"Dr Glenis Scadding and I recently spent a most enjoyable three days in Hong Kong providing a Rhino-allergology course for members of the Academy. This was generously sponsored by UCB (GSK?) and we had a busy but most enjoyable time. We can especially recommend the Hong Kong Museum of History to all members of the College!

As Editor of the Journal 'Rhinology' I would like to let all the younger members of the Academy and trainees (less than 33 years or under) that they can have free membership of the European Rhinologic Society and access to the journal simply by applying through www.rhinologyjournal.com. This offers the electronic version of the journal which I am sure would be of considerable interest to them. Furthermore members may be interested to know that through this site anyone may

access the latest version of EP3OS.

EP3OS (the European Position Paper on Rhinosinusitis and Nasal Polyposis) is an evidenced based review on the management of rhinosinusitis, both acute and chronic and nasal polyposis. Although initially conceived as a European document, its advisory body is composed of a wide range of nationalities and medical disciplines and following the example of Allergic Rhinitis and its impact on Asthma (ARIA) seeks to provide the best level of evidence to informe clinical practice. It is presently available in English and a Chinese version will soon be accessible through this website which I hope will be of use in the management of your patients with these common though difficult problems.'

Valerie J LUND
Professor of Rhinology
University College London

You might have noticed the cover page of this issue of Senses, which carries the new President's insignia, designed and made by Fattorini, United Kingdom. If you wish to have a closer look, the opportunity would be at the College Conferment Ceremony on the 30th November, 2008 particularly if you wish to have a photo taken with the President.

The College Conferment day promises to be a most enjoyable one as the Annual Trainee Presentation has come under the care of the College as from 2008 with the blessings of the Hong Kong Society of Otorhinolaryngology, Head & Neck Surgery. This will take place before the ceremony. The overall winner will receive the College Medal for the Best Presentation and the runner up will receive the George Choa Prize for Originality. The award to the winner from the Thomas Cheung fund will also continue though the College is still awaiting full confirmation from the committee overseeing the funds.

Our Secretary for Food and Health Dr York Chow will be delivering the second College Oration on the day. We shall be sending our members and Fellows the full program once the details are finalized while your diaries could be marked for now.

The Conjoint HKCORL/Edinburgh exit examination has been postponed from October to December 2008 for logistic reasons. The exams would now be held on the 12th, 13th and 15th of December 2008.

As from 2009, Facial Plastic Surgery would become an integral part of the conjoint ENT exit examination in Hong Kong. The Censor in Chief would be advising further on provisions to be made at the training centers for appropriate training in this specialized field for our HSTs.

The College Council has, on the request of the Academy, appointed College spokespersons to represent our College. The Academy would be directing media

Council News

enquiries to the relevant spokespersons. Dr Peter Tang and the President would be responsible for the first half of the year and Professor Yuen Po Wing and Dr Victor Abdullah would look after the second half.

The American Academy of Otolaryngology had invited our College to observe the World Voice Day 2008 on the 16th April. The Council has asked Dr Paul Lam to translate the materials in the AAO voice fact sheets into Chinese which will be uploaded to our website when ready. We are most grateful to Dr Lam for his kind help and valuable time.

I would also like to draw the attention of our members and Fellows to the AAO website for their pocket guide to antimicrobial therapy which is :-

www.entnet.org/EducationandResearch/

which might be helpful in your practice.

The Royal College of Physicians has asked our College to promulgate their booklet on 'Hearing and Balance Disorders', The Council has ordered a copy and is presently studying the details prior to promulgation.

Victor ABDULLH

Report from the Honorary Treasurer

The financial situation of the College remains healthy. All Members and Fellows had paid up their annual subscription for the current year.

Due to the present low bank rate, the aim of our investment in Blue Chip Stocks is mainly to acquire those with reasonable interest return in short term and potential high capital gain in long term. During the last six months, we had purchased another 800 shares of HSBC Holdings at an average price of HKD124.10 per share. Your valuable opinion and suggestions on our College future investment are most welcome.

Shu On TANG

Report from the Censor-in-Chief

Proudly, I would like to report to you that the last CME/CPD cycle completed with great success for our College. All fellows of our College obtained the required CME/CPD points. This is only achieved by a few other Colleges of our Academy.

I would also like to take this opportunity to keep you informed of the slight change in the CME/CPD requirement for the cycle commenced January 2008 and thereafter which requires fellows of all Academy Colleges to acquire a minimum of 15 "active" CME/CPD points per cycle. The definition of active and passive CME/CPD activities were well defined in the existing "Principles and Guidelines on Continuing Medical Education (CME) and Continuous Professional Development (CPD)" of our College.

A list of "active CME/CPD activities" is abstracted from the existing guidelines and attached for your easy reference. In addition to the above, the Academy and the Colleges have set up a website to facilitate fellows to acquire active CME/CPD points in two ways:

1) To earn 5 active CME/CPD points:

To submit a soft copy of a "peer reviewed article" of our specialty together with 4-5 set questions based on the article submitted to the secretary of our College. This will be put up in the Academy's Website for other fellows.

2) To earn 1 or more active CME/CPD points:

To visit the Academy's CME website and answer the questions set by other college fellows. 1 point will be awarded for achieving passing marks for each article. You may follow the steps below to get connected to the website.

1) Visit the website of the Academy for CME : www.icmecpd.hk
2) Go to member's area
3) Login (if you forget the password, you can contact Mr. Kelvin Leung at 2871 8748)
4) Go to the CME Learning page
5) Select our College
6) Read the article and answer the question

* Please note that you can only answer the question for each article once, and you are not allow to answer questions set by yourself!

Do try this new convenient way of acquiring active CME – it is both educational and interesting!

John WOO

Report for Censor-in-Chief

2008 CME/CPD Category explanation:

Category 1	Self-study (ENT related) (Maximum of 30 credits per cycle, including non-ENT related self-study)
Category 1.2	Self-study (Non-ENT related) (Self-study activity in other medical specialties is allowed but can only accumulate a maximum of 5 points out of the 30 points in three years.)
Category 3	Lectures, Chairpersons or Moderators
Category 4	Publications (Maximum of 30 credits per cycle)
Category 5	Research (Maximum of 5 credits per cycle)
Category 6	Development of New Technologies or Services (Maximum of 20 credits per cycle)
Category 7	Undergraduate Teaching (development of audio-visual teaching materials or problem based learning case) (Maximum of 5 credits per cycle)
Category 8	Postgraduate Teaching (Maximum of 5 credits per cycle)
Category 9	Conducting Examinations (Maximum of 5 credits per cycle)
Category 10	Quality Assurance & Medical Audits (Maximum of 15 credits per cycle)
Category 11	Mortality & Morbidity Meeting (Maximum of 5 credits per cycle)
Category 12	Postgraduate Courses (Maximum of 10 credits per cycle)
Category 13	Development of CME/CPD Materials (Maximum of 15 credits per cycle)
Category 14	Activities for Improvement of Patient Cares (Including Journal Club Meeting) (Maximum of 20 credits per cycle)
Category 15	Grand Round in Training Units (Maximum of 5 credits per cycle)

Local Activities

Date	Event	Venue	Contact
Monthly	Scientific Meeting	St Terasa's Hospital	Dr. Tang Shu On
Every Wednesday 9:30 – 10:30am	Journal Club Meeting	PWH	Michele Chan Tel:26323558
Every Monday 6:30pm- 7:30pm	Journal Club Meeting	PYNEH	Tel:25956454
Every Tuesday 4:30pm-5:30pm	Journal Club Meeting	TMH	Tel:24685397
Every Saturday 10:30am-11:30am	Journal Club Meeting	YCH	Tel:24178358
Every Tuesday 4:30pm-5:30pm	Journal Club Meeting	QEH	Tel:29586025
Every Tuesday 5:00pm-6:00pm	Journal Club Meeting	QMH	Tel:28554452

Report for Censor-in-Chief

Local Activities

Date	Event	Venue	Contact
8-9 September 2008	Wong Hau Yuen Distinguished Visiting Scholar - Prof Barbara Wollenberg	HKU	
9 September 2008	Laser Surgery of the Larynx	QMH & HKCORL	Tel 852 2871 8733
10-13 September 2007 (1st round)	5th Temporal Bone Dissection Course	CUHK	Tel 852 2632 3558 www.ent.cuhk.edu.hk/tbd-olc
16-19 September 2007 (2nd round)	5th Temporal Bone Dissection Course	CUHK	Tel 852 2632 3558 www.ent.cuhk.edu.hk/tbd-olc
14-16 November 2008	2008 CUHK ENT Conference	CUHK	Tel: 852 2632 2951 www.ent.cuhk.edu.hk/entconf2008
13 November 2008	2008 CUHK ENT Conference Pre-congress workshop: Paediatric ENT – A Surgical Tour	CUHK	Tel: 852 2632 2951 www.ent.cuhk.edu.hk/entconf2008

Overseas Activities

Date	Event	Venue	Contact
12-13 September 2008	Paediatric Airways Course 2008	Singapore	Tel: 65 6394 1676 Email: henry.tan.kk@kkh.com.sg
21-24 September 2008	AAO-HNS/Annual Meeting & OTO Expo	Chicago, USA	www.entnet.org/annual_meeting
1-4 October 2008	The Nose: inside & out	CharlottesvilleVirginia, USA	www.cmevillage.com
1-6 November 2008	ENT Instruction Course week 2008	Singapore	www.pgmi.com.sg/entweek08/ index.shtml
7-10 November 2008	Sleep Symposium 2008	Singapore	www.pgmi.com.sg/sleep08
20-21 November 2008	13 Asia Research Symposium in Rhinology	Thailand	www.arsr2008thailand.org
15-19 April 2009	Rhinology World	Philadelphia, Pennsylvania, USA	www.rhinologyworld.com

Famous People in Otolaryngology

Interview with Professor Ashok Shaha

Professor Ashok SHAHA

Dr Hing Sang CHAN

Dr Gordon SOO

Most of us are so used to professional academic meetings. They are opportunities to be updated about new developments in our profession, as much as reaffirming that our existing surgical concepts and practice remain sound. There is also that very refreshing prospect of meeting old friends and making new ones. We are sure to learn something but what will happen when those lights dim, when the speaker speaks – will I waft off slowly to sleep, will the chair be uncomfortable, will the room be unbearably hot or chillingly cold, will we be able to hear the speaker? So many, many imponderables…

There really wasn't any need for all those doubts. From the first moment we heard Professor Ashok Shaha, the world renowned head & neck surgeon from Sloan-Kettering Memorial in New York, speak - we were simply entertained. Yes, there was the relevant information all displayed on screen in either their didactic or flowing script….but it was more than that, much more.

Professor Shaha engaged us enchantedly on the subject, digging from surgical history, personal anecdotes and published studies in that lovely potpourri mix of fact and myths garnished liberally with humour. His wit amazed us, his humour had us all sniggering and guffawing like kids caught red-handed with candy, his humility charmed us and his humanity shone throughout our time with him.

The lectures were over too soon. I wanted an encore, we needed an encore – is there such a thing in surgical lectures? Everyone was entertained by Professor Shaha' s adept surgical mind. It was magical.

That day, our honoured guest, Professor Ashok Shaha did not just eloquently caroused us through the history and the art of head and neck surgery and imbibed on us the lessons for our patients; he did something else equally profound and memorable that only great teachers can. He made sure we would never forget his lesson by teaching us another with his immense wit and humour – a lesson of humanity that laughter is the best medicine after all.

Encore, Professore! Encore!

Famous People in Otolaryngology

Interview with Professor Ashok Shaha

Dr Chan Hing Sang: Professor Shaha, can you tell us your educational background?

Professor Ashok Shaha: I received my medical education and surgical training in Baroda, India. After completing my surgical post graduate training, I became interested in surgical oncology, and spent a year at the Tata Memorial Hospital (a major cancer center of Southeast Asia in Bombay). After arriving in the United States in 1975, I spent a year and a half as a Surgical Oncology Fellow at Memorial Sloan-Kettering Cancer Center, and then repeated surgical training at Downstate Medical Center. I spent a year at Memorial Sloan-Kettering Cancer Center as a Head and Neck Fellow in 1981 – 1982. I was on the faculty at Downstate Medical Center from 1982 to 1993, rising to the rank of Professor in 1992. In August of 1993, I moved to Memorial Sloan-Kettering Cancer Center on the Head and Neck Service, where I continue my head and neck practice.

Dr Chan Hing Sang: Is there any particular reason why you decided to go to the United States for further surgical training?

Professor Ashok Shaha: There is always an ambition for a person from a third world country to see different parts of the world, needless to say, freedom, and more opportunities, both from an academic and educational point of view. After realizing the opportunities for training, practice, and institutional support, I decided to stay in the United States after my training.

Dr Chan Hing Sang: How did you and Professor Jatin Shah know each other?

Professor Ashok Shaha: I met him in India when I was a medical student. He has been a great teacher and mentor to me since then. He has taught me everything that I know in the head and neck. He is an extremely dynamic individual, with outstanding leadership and a friend at all times.

Dr Chan Hing Sang: Apart from Professor Shah, are there any other influential persons in your career?

Professor Ashok Shaha: Yes, there are quite a few other influential persons. Professor Trivedi and Dr. Praful Desai were my mentors and teachers during my training in India. They guided my surgical career to oncology. The other person in the United States is Professor Bernard Jaffe, who was the Chairman of Surgery at Downstate Medical Center. He is a workaholic with a great sense of academic dedication for surgical training. He helped me develop my academic career during the early years of my faculty position.

Famous People in Otolaryngology

Interview with Professor Ashok Shaha

Dr Chan Hing Sang: What made you choose head and neck surgery amongst all the surgical specialties?

Professor Ashok Shaha: I developed my interest in head and neck surgery when I was at Tata Memorial Hospital in Bombay. After arrival in the United States, I worked closely with Professor Jatin Shah, who encouraged and inculcated head and neck surgical interest in me.

Dr Chan Hing Sang: It seems that the extent of surgical resection in head and neck squamous cell carcinoma is becoming less radical nowadays, and there is an increasing number of head and neck squamous cell carcinoma that are being managed by clinical oncologists with chemoradiation. What is the future for head and neck surgery?

Professor Ashok Shaha: There is always a fear and concern about the future of head and neck surgery. There clearly is a paradigm shift. However, there are many other interesting facets of head and neck surgery, such as cancer prevention, early diagnosis, post-treatment follow ups, and salvage surgery. Cancer of the oral cavity continues to be a major surgical problem. There is an increasing incidence and interest in melanoma and thyroid surgery. The volume of thyroid surgery has increased enormously in the last few years. We are going to see some further paradigm shifts. We are going to do less and less hypopharyngeal and laryngeal surgery as a primary surgical specialty. The oral cavity continues to be a surgical problem. The head and neck surgeon must always be in command and control of the head and neck cancer patients, even though the patients may be treated by non-surgical modalities. There are always complications of chemoradiation, which need intense management. We will be learning how to take care of the salvage surgery and recurrences, which is quite complex at this time. There will be a paradigm shift for sure, but will it extinguish head and neck surgery? Absolutely not. I doubt that will happen.

Dr Chan Hing Sang: Is there any advice you would like to give to future generations of head and neck surgeons?

Professor Ashok Shaha: I can't give any advice because I do not think I am in the position to do so. But I can give them some recommendations:

1. Head and neck surgery is a dynamic specialty with meticulous surgical techniques. You need to know the anatomy of the head and neck, and the biology of head and neck cancers.

2. The treatment of head and neck surgeries cannot be learned from a cookbook. You cannot use the same protocol to treat every patient.

3. Work hard and respect your patients and your colleagues.

4. Have a good mentor that you can approach, and you will find head and neck surgery to be very enjoyable.

Dr Chan Hing Sang: To work hard usually means you have to work for long hours. Does it affect your family life?

Professor Ashok Shaha: Yes, but in the surgical specialty, head and neck surgery is not the only area that affects family life. What is important is the understanding between you and the family. You need the family to understand that spending time in the hospital is part of your life and career. You absolutely have to work hard. The family has to recognize this, and appreciate your dedication to the patients afflicted with head and neck cancer. It is important to enjoy your free time with your family whenever you are at home. You can't take them to every ball game and every movie. It is easy if they would understand your commitment. If they do not, then there will be friction and a continued unhappiness. I have been very lucky that my family is very understanding, and my wife, Mamta, is very supportive.

Dr Chan Hing Sang: What is your impression of Hong Kong and our trainees?

Professor Ashok Shaha: I think the training here is very good. I know many surgeons who practice here, and they are undoubtedly comparable to surgeons in the United States. Some of their work that you read in the literature is excellent. I have been impressed with the system here, as well as the residency training. I am also very impressed by the young faculty, and I think they will have a bright future in head and neck surgery. Overall, Hong Kong is a very impressive and dynamic city, especially with its concrete infrastructure.

Dr Chan Hing Sang: How do you spend your leisure time?

Professor Ashok Shaha: I spend most of my leisure time reading. I like reading biographies and history of surgery. I do like to do exercise and play tennis. I also enjoy walking my dog on the weekends. I like to meet people, visit various parts of the world, and talk to other head and neck

surgeons, exchanging ideas with them. I enjoy attending national and international meetings, present our work, and learn from others.

Dr Chan Hing Sang: Where will you go for your retirement?

Professor Ashok Shaha: I have not made my decision yet. It may be very hard for me to go back and settle in India, because I have been living in the United States for the past 32 years. But what I might do is spend some time partly in India, and partly in the United States. India is a very exotic country. I have my entire family there, and clearly the Indian food, people, and hospitality is very enjoyable.

Dr Chan Hing Sang: Professor Shaha, thank you for sharing with us your thoughts on life, work and family.

Interview by Dr Hing Sang CHAN
Foreword and edited by Dr Gordon SOO

Hospital Tour

Union Hospital is located up on a small hill in Tai Wai. It is the first and only private hospital in the Eastern New Territories. Although this is the "youngest" private hospital in Hong Kong, it still provides quality medical care with a wide spectrum of expertise.

Union Hospital

The corridor in the private ward!

Situated at the entrance of the main hospital complex, the customer service counter provides all the information one would need. The 4-floor extension on the pre-existing main block was completed two years ago. It consists of the Minimal Invasive Centre, Day Therapy Centre, Surgical Ward and the 5-star-hotel-like private wards. The design and decorations on the private floor is impressive. The wards are designed to provide a comfortable and luxurious environment for patient to recover (photo 4, 5, 6). Even

Customer service

Like a resort room

with medical facilities

the cleansing agents used are odourless in order to provide maximal comfort for the patients. One could be mistaken to be staying in a hotel president suite having a vacation rather than receiving treatment in a hospital ward.

There are two well-equipped ENT consultation rooms in the hospital. Both have cost-effective arrangements and high quality audio-visual systems, such that a full-range ENT service is provided. One is situated in the Minimal Invasive Centre in the main building and the other on the first floor of the medical block.

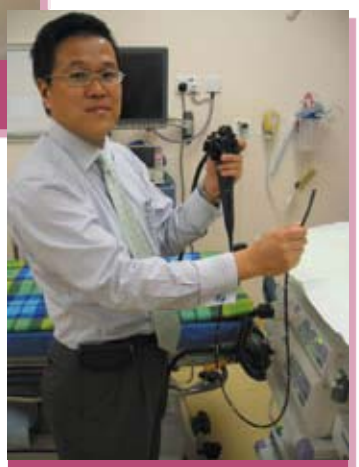
Consultation room in the Minimal Invasive Center

Consultation in the Medical Block

There are some special features of this hospital. To mention a few, the Accident and Emergency Department is the first one in private hospitals to provide a 24-hour emergency service. It is also the only recognized training center in the private sector.

The Gastrointestinal and Liver Centre has been in service since April 2008 which is composed of a team of expert gastroenterologists, surgeons and radiologists. It is incorporated into the endoscopy and day surgery center for obvious reasons. Apart from conventional upper and lower GI endoscopy and capsule endoscopy, Union Hospital is the first private hospital to be equipped with the state-of-the-art single balloon enteroscopy system. It allows examination and even therapy in the small intestine which was previously not accessible by conventional endoscopes.

Like a resort room



Dr. Tsang holding the Transnasal esophagoscopy

The hospital is still growing. The Plastic Centre and the Cyclotron Center are under construction. This will definitely widen the scope of the medical care provided.

Last but not least, I would like to thank my old friend and ex-colleague, Dr. Raymond Tsang, the Consultant Otorhinolaryngologist in Union Hospital for his precious time providing me the hospital tour.

Talen WAI

declaration of competing interests: none declared

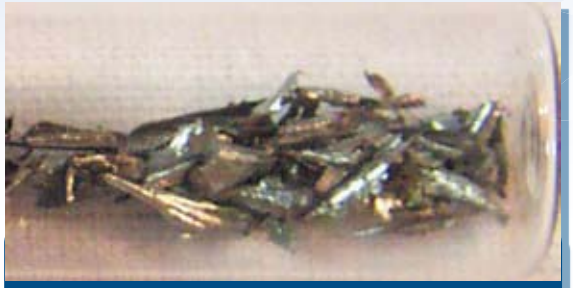
Thulium laser in ENT surgery

Since its first demonstration by Theodore in 1960 and introduction in laryngeal surgery by Jako in 1972, laser has become a robust workhorse in ENT as well as head and neck surgery with expanding versatility. Numerous kinds of lasers were explored in the ENT field and the carbon dioxide (CO2) laser is probably the most extensively used one nowadays. It enjoys the advantages of minimal tissue charring, superficial penetration and good control of energy transfer. However, it also has the drawbacks of difficulty in tangential resection and low efficiency in debulk surgery. Although the shortcomings of CO2 laser are not noted in the high-powered holmium and Nd-YAG laser, which could be delivered through glass fiber and allow dissection or vaporization of harder and more bulky tissues, the significant thermal effect and low cutting precision obsolete their utilizations in many delicate head and neck structures.

To fill up this gap, a new armament was introduced into ENT practice recently and is gaining increasing popularity. Thulium laser, despite having been used extensively in the urological surgery for prostate resection and lithotripsy, was not utilized in the otolaryngological field until the last decade. Begin with a brief introduction, thulium (Tm69) is a "rare earth" metal belongs to the lanthanoid group which also consists of the familiar neodymium, holmium & gadolinium1. Solid-state laser generated by thulium is similar to CO2 laser in many aspects, while at the same time retains some properties of those generated by the lanthanoid elements such as neodymium and holmium. The wavelength of thulium laser is 2013nm and the laser energy was absorbed by water just like CO2 laser (wavelength: 10600nm). It retains the good characteristic of precision cutting of CO2 laser with a comparably low penetration of about 0.3mm only3. Haemostatic power of thulium laser is even more superior to that of CO2 laser, but without the formation of rapidly expanding and contracting steam bubbles as in holmium laser and a much less tissue penetration than Nd-YAG laser, it causes significantly less tissue vaporization and thermal damage of surrounding structures. Unlike CO2 laser which needs to be delivered through the complicated articulation arms, thulium laser could be transmitted through glass fiber just like the holmium and Nd-YAG laser with good preservation of spatial beam quality. Tissue cutting or abrasion could be achieved by either contact or non-contact mode. The contact mode is good at haemostatic cutting and the non-contact mode is similar to the defousing mode of CO2 laser which is used for tissue ablation.

Mentioned in an article published by Zeitels from Boston in 2006, thulium laser was used in thirty-two endoscopic excisions of benign and malignant laryngeal

Thulium laser in ENT surgery



Thulium is silvery-gray metal in natural occurrence

A compact Tm laser delivery device

lesions performed betweem 2004-2005 (papillomatosis 20, microinvasive carcinoma 6, benign supraglottic lesion 3, edema 2, granuloma 1)2. The author concluded that thulium laser is an efficient tool for excision of laryngeal lesions with comparable cutting precision to CO2 laser and more superior haemostasis. Also, the laser could be delivered by fiber and thus allows better tangential cutting, which is especially useful in laryngeal surgery. The laser is delivered through 0.365mm glass fiber which could be fitted into ordinary fiberoptic laryngoscope nicely. Besides, the laser generation system is compact and power saving. The typical power setting is 4-7W in continuous mode. All these allow laryngeal surgery to be done under local anaesthesia in ordinary office-base settings with operative magnitude comparable to those done in operation theatre. Similar descriptions were also mentioned in a review by Ayari-Khalfallah from France in 2008, which named thulium laser as an "interesting tool" and "facilitated a new style of surgery" in paediatric airway management for various conditions including laryngomalacia, laryngeal granuloma, subglottic stenosis and subglottic haemangioma. Also, it allows good control of lesions during endoscopic surgery while at the same time allow adequate visualization of the surgical field3.

The main concern of using thulium laser is its greater thermal effect in comparison to CO2 laser4, but healing was not adversely affected in actual practice2,3. Without the need for haemostasis by electrocautery as in CO2 laser, the overall thermal injury may even be less. And recent study implicated that the thermal damage could simply be minimized by air cooling system in future5. Although not yet been widely used in ENT surgery, thulium laser surgery enjoys a good reputation of safety with no reported case of significant complication in literature search up to the present moment.

In summary, thulium laser is similar to CO2 laser in precision cutting but the haemostatic power is more superior. It could be delivered by glass fiber inserted through ordinary fiberoptic laryngoscope and allow tangential resection which is crucial in laryngeal surgery. Together with a small, compact and flexible laser generation and delivery system, laryngeal surgery previously needed to be done in operation theatre could now be performed in an ordinary ENT office, with our patients freed from the costs and risks of general

anaesthesia. The indications of thulium laser surgery is still expanding and more technical development and studies are needed in future to determine the optimal power setting, minimize possible drawbacks and justify the safety of this new technology.

Chi Leung LEE

Reference:

1. *Topic: thulium; wikipedia, world-wide-web.*
2. *Zeitels SM, Burns JA, Akst LM: Office-based and microlaryngeal applications of a fiber-based thulium laser; Ann Otol Rhinol Laryngol. 2006 Dec;115(12):891-6.*
3. *Ayari-Khalfallah S, Fuchsmann C, Froehlich P: Thulium laser in airway diseases in children; Curr Opin Otolaryngol Head Neck Surg. 2008 Feb;16(1):55-9.*
4. *Unpublished data, American Society of Laser Medicine and Surgery, 26th Meeting, Massachusetts, Boston, 2006*
5. *Burns JA, Kobler JB, Heaton JT: Thermal damage during thulium laser dissection of laryngeal soft tissue is reduced with air cooling: ex vivo calf model study; Ann Otol Rhinol Laryngol. 2007 Nov;116(11):853-7.*

The Journal Club

To improve is to change

This article was written by an experienced facial plastic surgeon on his experience of change and improvement. He regarded growth and change as an integral part of success for a surgeon. The reasons to change are to improve our results, to incorporate new techniques, and to increase our speed. Practices which facilitate a constant improvement include the use of virtual simulation in patient assessment, detailed mental surgical exercises before the surgery, keeping of an own log of intra-operative decisions which was reviewed regularly and development of an easy-to-retrieve system of notes from courses and meetings. Despite his extensive experiences he still actively participates in cadaveric dissection course, watches videotapes and learns from his colleagues. The article is a useful guideline for all surgeons who would like to take their skills to the next level.

The evolving surgeon: how, when and why change is for the better
Miller P J.
FACIAL PLASTIC SURGERY
2007; 23(1): 3-6

Medpor Implantation for Revision Rhinoplasty

Rhinoplasty can go wrong and one of the complications is nasal deformity leading to undesirable cosmetic and functional outcome. This study describes a series of fourteen patients who suffered from nasal deformity and obstruction after primary rhinoplasty. On examination they showed alar collapse, supratip depression, and asymmetry. A saddle shaped Medpor spreader graft was inserted through a pocket created superficial to both upper and lower lateral cartilages. Patients were followed up for a mean of 30 months and all of them were satisfied with the cosmetic outcome, and reported improvement in nasal patency. There was only one case of malpositioning of the implant, which was readily corrected by implant shaving. According to the authors this is the first study describing a saddle shaped Medpor implant. The study will be more complete if the type of primary surgery were described in more details. Nevertheless this study has shown the importance of addressing functional as well as cosmetic aspect when performing septorhinoplasty.

Frederick WONG

Aesthetic and functional restoration using dorsal saddle shaped Medpor implant in Secondary Rhinoplasty.
Turegun M, Acarturk T O, Ozturk S, Sengezer M.
ANNALS OF PLASTIC SURGERY
2008; 60(6): 600-603

Randomised trial of botulinum toxin injections into the salivary glands to reduce drooling in children with neurological disorders

Drooling is common in children with cerebral palsy and other neurological disorders. It may cause chronic irritation of facial skin, choking, aspiration, chest infection, social embarrassment and loss of self-esteem. Oral sensorimotor therapy, anticholinergic medications, surgery and intraoral appliances have been used to reduce drooling with varying side effects and success. Botulinum toxin A (BoNT-A) injection was first published to reduce drooling in adults with Parkinson's disease in 2000. Since then, a number of studies have demonstrated its use in treatment of drooling in children. However, all of them are individual cohort studies with varying number of glands injected, different injected dosages with no conclusion drawn on the duration of effect. This is the first randomized, controlled trial of botox injection into both the parotid and submandibular glands. Children with significant drooling between the age of 6 and 18 were recruited and randomized into either receiving botox injection or no intervention. 100 units of BoNT-A were diluted into 4ml normal saline. Under a short general anaesthesia and ultrasound guidance, 25 units were injected into each gland. Parents were asked to fill in a validated Drooling Impact Scale (DrI) questionnaire at baseline and at monthly intervals up to 6 months. There were a total of 48 participants with 24 children randomized to the treatment group. Mean age was 11 years. 20 children (83%) responded to botox injection which was defined as a reduction of more than 10 points on the DrI scale. Maximal response was at 1 month postinjection. The effect remained statistically significant at 6 months. One of the drawbacks of this study is the lack of objective measurement in the reduction of drooling. Besides, further studies are needed to investigate the response to repeated injection and the ideal frequency for them.

Reid SM, Johnstone BR, Westbury RN et al. Randomized trial of botulinum toxin injections into the salivary glands to reduce drooling in children with neurological disorders. Developmental Medicine & Child Neurology 2008; 50; 123-128.

Paediatric sialoendoscopy

Sialoendoscopy was first mentioned by Katz in 1991 with a flexible endoscope for extraction of salivary calculi in a blind technique. Konigsberger in 1993 used a flexible endoscope combined with an intracorporeal lithotriptor for fragmentation of stones. Nahieli in 1994 introduced the use of 'rigid' mini-endoscope. In 2000,

Nahieli further published the use of this technique in paediatric sialolithiasis. Paediatric stones account for 3-5% of all salivary stones. With new semi-rigid sialoendoscope of 1.1mm external diameter and smaller basket of 0.4mm diameter, sialoendoscopy has allowed better management of salivary stones and stenoses in young children. This paper is a review on the techniques of paediatric diagnostic and therapeutic sialoendoscopy including laser and extracorporeal shockwave lithotripsy. The author discussed on greater sensitivity of sialoendoscope than conventional ultrasound and MRI in detecting paediatric stones less than 2mm. Besides, the application of sialoendoscopy in the treatment of juvenile recurrent parotitis was particularly described. This disease is characterized by the lack of vascularity in the ductal system causing inability to drain saliva out of the parotid gland which leads to chronic infection and stricture obstruction. Sialoendoscopy allows diagnosis which has a typical whitish appearance of the ductal layer and treatment with deep irrigation and dilatation of the Stensen's duct.

Birgitta WONG

Faure F, Froehlich P, Marchal F. Paediatric sialoendoscopy. Curr Opin Otolaryngol Head Neck Surg 2008; 16; 60-63.

Nasal Surgery for Snoring in Patients with Obstructive Sleep Apnea

The relationship between nasal obstruction and obstructive sleep apnoea (OSA) has been reported repeatedly. The mechanism and the extent of the contribution of nasal obstruction to OSA is not yet fully understood. This is a prospective study on the improvement of OSA and nasal obstruction after nasal surgery alone. Interestingly, statistical methods were used to support an explanation of how nasal surgery could improve snoring.

Fifty-two patients with obstructive sleep apnea (AHI 38.5 +/- 33.2 events/hr) and symptomatic nasal obstruction secondary to deviated nasal septum were recruited. Septomeatoplasty was done. Nasal patency was assessed by visual analogue scale (VAS) and anterior rhinomanometry. Snoring was assessed by Snore Outcome Survey (SOS) and the Spouse/Bed Partner Survey (SBPS). All assessment was done at the baseline and approximately 3 months after nasal surgery.

Results from this study showed that there was statistical significant improvement in nasal obstruction shown by VAS scoring and total nasal resistance shown by anterior rhinomanometry. 82% of patients had improved in SOS scores, with the average improvement of 46%. The degree of improvement is similar when repeated by the spouse using SBPS (52%). Complete relief of

snoring was reported by the sleep partners of six (12%) patients. Changes in SOS scores were used to correlate with various parameters including age, BMI, AHI, VAS of nasal obstruction, nasal resistance, modified mallampati grade and tonsillar size. Interestingly, changes in SOS were found to be statistically correlated to tonsillar size but not all other parameters mentioned above. That means smaller the tonsils, the greater improvement in SOS after nasal surgery in OSA patients. The explanation was that nasal obstruction will increase the speed of airflow and create turbulent flow in oropharyngeal level and causing snoring and nasal surgery can improve snoring by improve the mechanism mentioned. In patients with large tonsils, the airflow is high primarily due to the tonsils and the relief in nasal obstruction contributes minimally to the oropharyngeal soft tissue vibration.

Hsueh-Yu Li, Li-Ang Lee, Pa-Chun Wang, Ning-Hung Chen, Ying Lin, Tuan-Jen Fang
Laryngoscope, 118:354–359, 2008

Unusual complications of tonsillectomy: a systematic review

Common complications of tonsillectomy such as primary haemorrhage, secondary haemorrhage, oral cavity and temporomandibular joint injury are well recognized. This is a systematic review which serves as a reminder of the unusual complications of this routine procedure. The author used the system of Medline, Embase, Cinahl, and the Cochrane Library electronic databases to search with keywords using the terms tonsillectomy, complications, unusual, and rare. 10 articles fulfilled the criteria. Those are either a case report or a series with limited number of patients. Those complications were categorized into intraoperative and immediate postoperative (<24 hours), intermediate (<2 weeks), and long-term (>2 weeks) complications.

In intraoperative and immediate postoperative complications, there was a case of significant haemorrhage and angiogram found that bleeding is from the pseudo aneurysm of an aberrant lingual artery. Surgical emphysema is a rare but well known complication. It can be caused by vomiting, coughing and straining. There was a case that the patient developed laryngeal spasm after estuation and need manual positive pressure from face-mask and the patient developed unilateral cervical surgical emphysema after that. In intermediate complications, there was a case of hecatomb developed in the floor of mouth 3 days after tonsillectomy and it resolved spontaneously. There was another case that the patient developed unilateral painful neck swelling and CT revealed jugular vein thrombosis. Geisel syndrome, or nasopharyngeal torticollis, is the sublimation of the atlantoaxial joint occurring several weeks after tonsillectomy. It was thought to be related to hyperemia after infection or surgical trauma that leads to decalcification of the anterior arch of the atlas and to laxity of the anterior transverse ligament between the atlas and the axis. In long-term complications, taste disorders may result as a consequence of the damage to the glossopharyngeal nerve during

tonsillectomy particularly attempts to control the lower pole haemorrhage was made. The range of disorders described in patients includes (1) hypogeusia, (2) ageusia, (3) dysgeusia, and (4) phantogeusia (persistent abnormal taste in the absence of stimulus). Recovery was usually slow and incomplete. Persistent neck pain after tonsillectomy being reported. This was thought to be related to exacerbation of eagle syndrome due to post-tonsillectomy fibrosis. Diagnosis was based on a detailed history, palpation of the tonsillar fossa, and radiographic evidence of the styloid process. A series with 3 cases were described and all reported complete resolution of symptoms after shortening of the styloid process via an intraoral approach.

This is a paper which can illustrated a point well that rare complications can be occurred in some common procedures in our daily practice.

Dennis LEE

Samuel C.L. Leong, Peter D. Karkos, Sotirios M. Papouliakos, Maria T. Apostolidou
American Journal of Otolaryngology–Head and Neck Medicine and Surgery 28 (2007) 419– 422

同期懸雍垂 咽成形術聯合頦前移舌骨懸吊術治療重度阻塞性睡眠呼吸暫停低通氣綜合徵

Obstructive sleep apnea hyponea syndrome (OSAHS) is a common problem. Severe OSAHS carry significant morbidity and mortality. Continuous positive airway pressure CPAP is the most successful treatment but tolerance is low. Surgical treatment can be considered in case of failed or refused CPAP. Different modalities of treatment have been tried in patient but success varies. Uvulopalatopahryngoplasty (UPPP) is the most commonly used surgery but it is only effective in treating the velopharyngeal obstruction. Hyoid suspension and genioglossus advancement is considered in case of oropharyngeal or hypopharyngeal obstruction.

The study was performed to explore the surgical approach of genioglossus advancement and hyoid suspension plus UPPP on the treatment of severe OSAHS. They selected those patient who had severe OSAHS with evidence of velopharyngeal and hypopharyngeal narrowing but refused nasal CPAP treatment as subjects. The patient received a short pre-operative course of CPAP to correct the hypoxic status. They performed the genioglossus advancement and hyoid suspension plus uvulopalatopharyngoplasty.

Outcome measures include RDI (Respiratory distress index), ESS (Epworth sleepy scale), oxygen saturation and radiological measurements of upper respiratory airway size.

They performed these operations on 18 suitable patients. There was no significant complication. The average blood loss was 200ml. Polysmonography (PSG) was repeated at least 6 months after operation. Successful rate was 66.67%. All parameters were reduced except BMI. RDI reduced from 63.83 +/- 16.34 to 21.43 +/- 20.34.

Method of identification of level of obstruction in OSAHS patient is still controversial. The authors employed a combination of clinical-Muller's test and radiological-X ray or CT scan methods. Some units in Hong Kong use sleep nasoendoscopy to locate the level of obstruction. Those patient suffering from velopharyngeal obstruction should be responsive to UPPP. Those cases having hypopharyngeal or tongue base obstruction should have treatment to tackle the obstruction like the described operations. Reported post-operative complications include the lower teeth numbness, vascular and dental root damage or mandibular fracture. The complications reported by authors include submental hardening, floor of mouth haematoma and nasal regurgitation.

OSAHS is condition difficult to cure. Medical treatment is effective but tolerance is low. Efficacy of surgical treatment is worth exploring for patient refused CPAP.

同期懸雍垂齶咽成形術聯合頦前移舌骨懸吊術治療重度阻塞性睡眠呼吸暫停低通氣綜合徵；殷善開，易紅良，魯文鶯，吳紅敏，關建，曹振宇，陳挺；臨床耳鼻咽喉科雜誌2005年8月第19卷第15期

阻塞性睡眠呼吸暫停低通氣綜合症(OSAHS)是常見的疾病，嚴重的阻塞性睡眠呼吸暫停低通氣綜合症對患者帶來甚高的發病率和死亡率，持續氣道正壓通氣治療 (CPAP)是目前最成功的治療方案，但其耐受性低，當病人於未能或拒絕接受鼻腔持續氣道正壓通氣治療方案時，就可以考慮外科手術的治療，現時已有不同的手術治療方法，但其成功率不盡相同。懸雍垂齶咽成形術(UPPP）是目前最常用的手術，但它只可有效治療齶咽的阻塞，而頦前移舌骨懸吊術可用於口咽及下咽阻塞的病人。

該項研究目標為探討頦前移舌骨懸吊術加懸雍垂齶咽成形術對治療嚴重的阻塞性睡眠呼吸暫停低通氣綜合症的成效。作者選定的這些病人都有證據是嚴重的阻塞性睡眠呼吸暫停低通氣綜合症的患者及其齶咽和下咽有狹窄的情況，但這些病人都拒絕鼻腔持續氣道正壓通氣治療治療方案，病人在手術前先接受短期鼻腔持續氣道正壓通氣治療，以改善缺氧狀態，再進行同期的頦前移舌骨懸吊術加懸雍垂齶咽成形術。再量度呼吸紊亂指數(RDI)，Epworth嗜睡評估表(ESS)，血氧飽和度及一些放射性的測量上呼吸道的大小為結果量度。

有18個合適的病人進行了這些手術，他們全部沒

有明顯的並發症，平均失血量為二百毫升，手術後再等至少六個月為這些病人重複多道睡眠監，成功率為66.67 % ，除體重指數外其餘所有的參數均有明顯減少，呼吸紊亂指數從63.83 + / -1 6.34減少至2 1.43 + / -2 00 .34。

阻塞性睡眠呼吸暫停低通氣綜合症患者的阻塞位置的鑑定方法仍有爭議，作者應用臨床-Muller測試和放射性- x線或電腦斷層掃描的方法，一些香港的醫生則使用睡眠內窺鏡來尋找阻塞位置，懸雍垂齶咽成形術對齶咽阻塞病人會有幫助，但是那些有舌根或者下咽部阻塞病人，應該採用上述治療以解決阻塞。

文獻已報導的手術並發症包括有牙齒麻木，血管及牙科根損害或下顎骨骨折，作者所報導的並發症包括頦下區厚硬化，口底血腫和鼻腔逆流。

阻塞性睡眠呼吸暫停低通氣綜合症是難以治癒疾病，持續氣道正壓通氣治療是有效的，但耐受性低，面對拒絕接受持續氣道正壓通氣治療的病人應考慮使用外科的治療。

參考文獻:

同期懸雍垂齶咽成形術聯合頦前移舌骨懸吊術治療重度阻塞性睡眠呼吸暫停低通氣綜合徵；殷善開，易紅良，魯文鶯，吳紅敏，關建，曹振宇，陳挺；臨床耳鼻咽喉科雜誌2005年8月第19卷第15期

鼻通氣手術對懸雍垂齶咽成形術效果的影響

Obstructive sleep apnea syndrome (OSAS) is a common condition. Multi-level obstructive OSAS is difficult to treat. Nasal obstruction is one contributor to upper respiratory airway resistance and OSAS.

Relieve of nasal obstruction can be part of the treatment of OSAS. It can be performed in isoplation or in combination with other sleep related surgery.

The aim of the study is to find out if any additive effect is imparted in corrective surgery of nasal obstruction to patients with OSAS undergoing uvulopalatopharyn goplasty (UPPP). The recruited patients were confirmed to have OSAS with polysomnography (PSG). They suffer from velopharyngeal obstruction and mechanical nasal obstruction such as deviated nasal septum or inferior turbinate hypertrophy. They underwent UPPP first. PSG was repeated 3-6 months after UPPP. The AHI and Epworth sleepy scale (ESS) reduction were confirmed statistically. The successful rate was 78%. Then, nasal operations were performed according to the nasal pathology. PSG was repeated again 1-3 months later to find out the final AHI. This result was compared with pre-nasal operative AHI to see the additive effect of nasal surgery. There were 50 subjects who underwent the operations with PSGs completed. The AHI, lowest oxygen saturation and ESS were further significantly reduced after nasal surgeries. The successful rate was 88%. There was no significant reduction of BMI.

Nasal obstruction can increase the severity of OSAS. Surgical reduction of nasal resistance can reduce the OSAS. They can be performed solely or in combination with other operations such as UPPP as in the study.

Finally, treatment of OSAS should be considered individually and the obstruction tackled one by one.

REFERRENCE:
鼻通氣手術對懸雍垂愕咽成形術效果的影響；李延忠，王岩，王欣;臨床耳鼻咽喉頭頸外科雜誌2007年12月第21卷第23期

阻阻塞性睡眠呼吸暫停低通氣綜合症(OSAHS)是一種常見的疾病，多層性阻塞的阻塞性睡眠呼吸暫停低通氣綜合症更加是難以治癒的。鼻塞會增加上呼吸道阻力和阻塞性睡眠窒息綜合症患者的嚴重性。

減輕鼻塞可以治療部分阻塞性睡眠呼吸暫停低通氣綜合症的情況，減輕鼻塞的手術既可以單獨或與其他睡眠有關的手術同時進行。

本研究的目的是要找出減輕鼻塞的手術對懸雍垂齶咽成形術(UPPP) 是否有額外的果效，參加的病人必須經多重睡眠監測(PSG)證實患有阻塞性睡眠呼吸暫停低通氣綜合症，這些病人必須患有齶咽阻塞及鼻腔阻塞性的病變，如鼻中隔偏移或下鼻甲肥厚。他們首先經進行懸雍垂齶咽成形術，在3-6個月後再次進行多重睡眠監測，睡眠呼吸暫停低通指數(AHI)及Epworth嗜睡評估表(ESS)都在統計學上證實有明顯的減少，成功率為78%。然後根據鼻腔的病理情況進行減輕鼻塞的手術，1-3個月後重複多重睡眠監測，找出最後呼吸暫停低通指數。再以這最後呼吸暫停低通指數與進行鼻腔手術前呼吸暫停低通指數作比較，找出鼻腔手術的效果。有50個病人完成研究，結果呼吸暫停低通指數，最低血氧飽和度及Epworth嗜睡評估表都有顯著降低，手術成功率為88%，其BMI沒有顯著的減少。

鼻塞可以增加阻塞性睡眠呼吸暫停低通氣綜合症患者的嚴重性，以外科手術減少鼻塞可以減少阻塞性睡眠呼吸暫停低通氣綜合症的程度。鼻塞手術可以單獨或與其他手術一起進行如懸雍垂評咽成形術。最後，對阻塞性睡眠呼吸暫停低通氣綜合症的治療應根據個別患者的情況作治療的考慮。

Joseph CHAN

參考文獻:
鼻通氣手術對懸雍垂愕咽成形術效果的影響；李延忠，王岩，王欣；臨床耳鼻咽喉頭頸外科雜誌2007年12月第21卷第23期

Overses Courses and Attachment

My time in Luzern

The diversity of the landlocked, mountainous country is the essence of Switzerland which gives the country its unique identity. Still, it is best known for its financial institutions, fine cheese and chocolate, watch-making industry and for its marvelous scenery. I had the honour to undertake my visiting fellowship in the Department of Otolaryngology, Head and Neck surgery in Kantonsspital Luzern and also University of Zurich, Switzerland from July to September 2006. The traveling expenses were sponsored by my department in Queen Mary Hospital and the accommodation was provided by the FIMF (Fisch International Microsurgery Foundation) fellowship.

The dying lion of Luren

Chapel Bridge

Lucern or Luzern (the German name) is located in the central part of Switzerland which is also called the Switzerland of Switzerland because it encompasses all the merits of the country: the city-the lake-the mountains. The city of Luzern is embedded within an impressive mountainous panorama, the beautiful lakeside setting and the nearby excursion on the mountains of Rigi and Pilatus. "The dying Lion of Lucern" monument and the Chapel Bridge are the well-known landmarks of Luzern. In the summer 2006, the weather was extraordinarily hot and there was neither air-conditioning nor electric fan in my room. The cost of living was also much higher than expected, plus the official language in the Eastern and Central part of Switzerland is Swiss German. Staying in Luzern was not as easy and comfortable despite the fact that I had had

6 months of tuition in German lauguage. The Swiss are, nonetheless, very generous and hospitable.

The department is chaired by Prof Thomas Linder who is a well-known otologist in Europe. I had the chance to observe and assist many of the ear operations, from otoplasty to meatoplasty, from canaloplasty to ossiculoplasty, from stapedotomy to mastoidectomy and from petrosectomy to cochleostomy. I also met the legendary Prof Ugo Fisch who was still operating at that time. I was fortunate enough to assist him in several skull base procedures and infra-temporal fossa approaches. Apart from learning in the OR, I was lucky to have direct personal teaching from Prof Fisch and Prof Linder. During the 3 months, it was highly educational; I attended the BAHA workshop in Luzern, one advanced temporal bone dissection course and one skull base dissection course in Zurich and also joined the EAONO (European Academy of Otology and Neuro-otology) instructional course in Cologne, Germany. The course in Zurich was the most interesting by the fact that the use of 3D-glasses when viewing the surgical videos. Many trainees including myself, who look through the side arm of the operating microscopes, cannot fully appreciate the depth of the operating field until one day they do the operation themselves. With the help of such technology, young otolaryngologists may have a better perception of the complex anatomy of the temporal bone and an earlier understanding of various skull base procedures.

Beside all these learning opportunities, sharing with other residents both academically and culturally were equally stimulating. I had the chance to join their excursion to Mount Pilatus enjoying the sunshine and their boating trip to swim in the Lake of Luzern. A visit

Prof Linder and Dr HO

3D-glasses

Prof Fish and Dr HO

Overses Courses and Attachment

Operating

to Switzerland is not complete without going up to one of the snowy mountains to ski. Take a train from Interlaken to the highest railway station in Europe – Jungfraujoch at over 11,000 feet or 3454 metres – and then look down onto the magnificent scenery of eternal ice and snow, it may be the "high" light of your trip to Switzerland.

To conclude, overseas elective training in Switzerland was unbelievable and truly unforgettable. It is obviously one of my most rewarding and enjoyable journey both academically and socially. It has broadened my academic knowledge, given me new insight and enhanced my professionalism. I treasure the time learning in the OR and the teaching from Prof Fisch; and I missed all the nice sceneries, the chocolate and the Käsefondue (cheese fondue).

Dr Ho and the ENT residents.

Ambrose HO

Books, Articles and websites

NCCN Website

In this issue, I would like to introduce our Fellows to a website where you can find clinical practice guidelines of virtually all cancers:

http://www.nccn.org/professionals/default.asp

This website belongs to The National Comprehensive Cancer Network which is an alliance of 21 American cancer centers. The following is an excerpt taken from the web page.

"The National Comprehensive Cancer Network is an alliance of 21 of the world's leading cancer centers, working together to develop treatment guidelines for most cancers, and dedicated to research that improves the quality, effectiveness, and efficiency of cancer care. NCCN offers a number of programs to give clinicians access to tools and knowledge that can help guide decision-making in the management of cancer.

The NCCN Clinical Practice Guidelines in Oncology ™ – the recognized standard of care in oncology – are the most comprehensive and most frequently updated clinical practice guidelines available in any area of Medicine. Covering 97 percent of all patients with cancer and updated on a continual basis, the NCCN Guidelines are developed through an explicit review of the evidence integrated with expert medical judgment by multidisciplinary panels from NCCN Member Institutions. Treatment recommendations are specific and are implemented through performance measurement. NCCN Guidelines Panels address cancer detection, prevention and risk reduction, workup and diagnosis, treatment and supportive care."

On-line registration is required to access the guidelines.

Siu Kwan NG

The International Federation of Head and Neck Oncologic Societies

presents

Global Continuing Education Program

Current Concepts in Head & Neck Surgery and Oncology

Jean-Louis Lefebvre ■ Christopher O'Brien ■ Patrick Gullane ■ Jatin Shah ■ Arlene Forastiere ■ Kie-Kian Ang ■ William Wei

September 29 - November 4, 2008

The IFHNOS Global CME Program

The International Federation of Head and Neck Oncologic Societies is offering a global continuing medical education program featuring the most respected leaders in the field of head & neck surgery and oncology. This worldwide program will cover locations in a sequence (shown below). Subsequent cycles will cover other parts of the world. Nations are clustered into regions to offer access to as many individuals as possible at each session. Leaders in the specialty of head and neck oncology have organized this program for each region.The program will provide state-of-the-art knowledge and explore the frontiers of head and neck cancer diagnosis and treatment. Ample opportunity for interactive sessions between the local faculty, attendees and the traveling faculty will be provided.

Tour Schedule

Date	Location	Conference Coordinator
Sept. 29 & 30, 2008	**London, England** (for Iceland, Ireland, UK, Scandinavia)	**Peter H. Rhys-Evans, FRCS, FACS**
Oct. 2, 3 & 4, 2008	**Barcelona, Spain** (for France, Belgium, Netherlands, Spain, Portugal)	**Guillermo Raspall, MD**
Oct. 6 & 7, 2008	**Rome, Italy** (for Austria, Germany, Italy, Switzerland)	**Giuseppe Spriano, MD**
Oct. 9, 10 & 11, 2008	**Athens, Greece** (for Cyprus, Greece, Egypt, Israel, Jordan, Lebanon, Turkey)	**Alexander D. Rapidis, MD, DDS, PhD**
Oct. 13 & 14, 2008	**Warsaw, Poland** (for Croatia, Czech Republic, Hungary, Poland, Romania, Slovakia)	**Wojciech Golusinski, MD, PhD**
Oct. 16, 17 & 18, 2008	**Moscow, Russia** (for Belarus, Kazakstan, Latvia, Russia, Ukraine, Tajikistan, Kyrgyzstan, Armenia, Azerbaijan, Georgia, Moldova)	**Somasundaram Subramanian, MD**
Oct. 20 & 21, 2008	**Mumbai, India** (for Bangladesh, India, Pakistan, Sri Lanka)	**Anil K. D'cruz, MD**
Oct. 23, 24 & 25, 2008	**Bangkok, Thailand** (for Indonesia, Malaysia, Philippines, Singapore, Thailand)	**Pakpoom Supiyaphun, MD**
Oct. 27 & 28, 2008	**Beijing, China** (for China, Taiwan, Japan, Korea, Mongolia)	**Zhenkun Yu, PhD, MD**
Oct. 31 & Nov. 1, 2008	**Buenos Aires, Argentina** (for Argentina, Brazil, Chile, Paraguay, Uruguay)	**Marcelo Figari, MD, FACS**
Nov. 3 & 4, 2008	**Bogota, Colombia** (for Colombia, Ecuador, Honduras, Mexico, Panama, Peru, Venezuela)	**José Antonio Hakim, MD**

CPD Quiz

Clinical case quiz:

1. What further investigation is required to make the diagnosis?
   a. Fine needle biopsy
   b. Open incision/excision biopsy
   c. Positron Emission Scan (PET)
   d. No further investigation is required

2. What is the origin of the tumor ?
   a. Nerve sheath cells
   b. Paraganglionic neural crest cell
   c. Lymph node
   d. Blood vessels

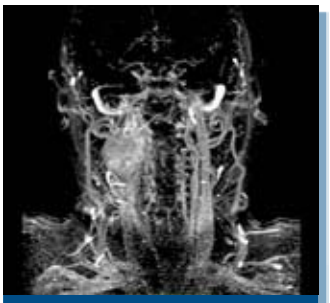
3. In case of carotid body tumor, which of the following parts of the world is NOT associated with high incidence rate ?
   a. Netherlands
   b. Peru
   c. Colorado
   d. Mexico City

4. Which of the following is correct in relation to the tumor:
   a. There is high rate of malignancy (>20%)
   b. They are often bilateral
   c. Most are non-functional (ie, not secreting catecholamine)
   d. Most are familial

5. Concerning the treatment, which of the following is correct ?
   a. Radiotherapy is the primary treatment
   b. Surgical excision is the primary treatment and pre-op embolization is advocated
   c. Hormonal therapy is useful
   d. Hyperbaric oxygen is the treatment of choice

Hing Sang CHAN

MRI



MRA

The following are the correct answers of last CPD Quiz:

FIGURE 1	FIGURE 2	FIGURE 3	FIGURE 4
Answer: B	Answer: A	Answer: D	Answer: A

CPD Quiz

August 2008

Name: _____ Date: _____

Contact: _____

Your Email: _____

Please return the answer to the College by fax at 2904 5035 before 16 September 2008. Answers with scores over 75% will be awarded one CPD points. The correct answers will be published in the next issue of Senses.

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NEW Avamys™ is the ONLY intranasal steroid that consistently provides broad symtomatic relief* for allergic rhinitis patients in an advanced delivery system[1-2]

*Statistically significant nasal and ocular symptom improvement in all SAR studies[1-3]

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REFERENCE:

1. Fokkens WJ, Jogi R, Reinartz S et al. Once daily fluticasone furoate nasal spray is effective in seasonal allergic rhinitis caused by grass pollen. Allergy 2007; 62: 1078-1084 2. Martin BG, Ratner PH, Hampel FC et al. Optimal dose selection of fluticasone furoate nasal spray for the treatment of seasonal allergic rhinitis in adults and adolescents. Allergy Asthma Proc 2007; 28(2): 216-225 3. Kaiser HB, Naclerio RM, Given J et al. Fluticasone furoate nasal spray: a single treatment option for the symptoms of seasonal allergic rhinitis. J Allergy Clin Immunol 2007; 119(6): 1430-1437 4. Berger WE, Godfrey JW, Slater AL. Intranasal corticosteroids: the development of a drug delivery device for fluticasone furoate as a potential step toward improved compliance. Expert Opin. Drug Deliv. 2007; 4(6): 689-701 5. GSK data on file 6. Berger W, Godfrey JW, Grant AC et al. Fluticasone furoate (FF) nasal spray-development of a next-generation delivery system for allergic rhinitis. J Allergy Clin Immunol 2007; 119(1 Suppl): S231 7. Godfrey JW, Grant AC, Slater AL. Fluticasone furoate (FF) nasal spray-ergonomic considerations for a next generation delivery system. J Allergy Clin Immunol 2007; 119 (1 Suppl): S230

Full prescribing information is available upon request. Please refer to the full prescribing information before adminstration.

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A Leisurely Note

Sauterne and Foie Gras

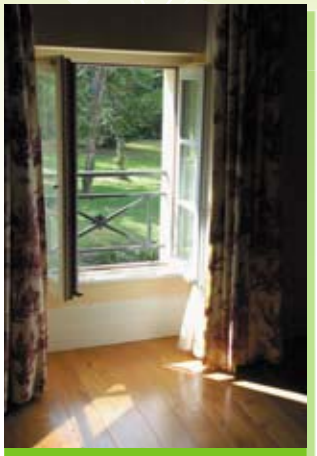
Fond memories of Chateau Sudiraut, 'sue' 'dee' 'row' in proper French, in Brodeaux prompted me to write a short article on 'Foie Gras', 'fwa' 'gra' in French meaning 'fat liver'. I must stopping eating too much of it before all my vessels clog up or I develop Alzheimer's. The magical combination of a fine vintage Sauterne and Foie Gras is a delectable treat.

Chateau Sudiraut

The welcome note

I attended a Paediatric round table dialogue, by undeserved invitation, as usual, in the opulent ambience of Chateaux Sudiraut in the Sauterne district, thirty minutes or so by car from Bordeaux Airport. We did miss the turning so it could have been a shorter journey.

I must confess it felt more like a Holiday than a meeting but provided thoughts of a possible seminar for the Hong Kong gang one day in the same



A lovely garden outside the room

A few lightning spells every now and again

The seminar room

A Leisurely Note

Sauterne and Foie Gras

setting. I did, nonetheless, learnt a lot from leading colleagues all over the world as we shared experience. We did spend more time, I believe, sharing thoughts on wine and vintages, helped very much by the Head Chef who would personally explain the menu and the food and wine match for 'every meal' which turned out to be the real seminar.

The seminar

The grapes

We had a superb Vintage Sauterne, Chateau Sudiraut, 2003 (I would rate, non-Robert Parker, outstanding) which was served with non-pretentious pan-fried foie gras, served with the usual French passion for

What happened straight after class

St Emillion , 45 minute drive away with GPS across the country fields. Could have brought more back if it were not the tax then.

presentation. The experience went far beyond the creamy Chablis/ Oyster magic. You might have to tap into the pocket a little to do the same in our city though

A Leisurely Note

Sauterne and Foie Gras

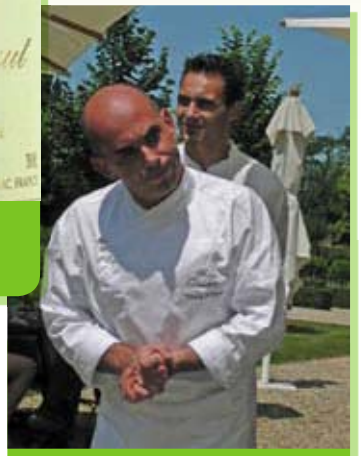
without the beautiful vineyards around.

Each time I enjoy foie gras I can't help having horrible flashes of ducks and geese forced fed with gavage to have their liver fattened to provide the treat. I think too much perhaps. Animal rights groups are naturally against it though the French, the leading producer of almost 18,000 tons of foie gras per year love it. Hungary, the producer second to France produces 2,000 tons per year. China, for comparison, produces 150 tons per year.

Walking along the small alleyways of St Emillion

The hors-d'oeuvre for lunch

Sauterne Ch Sudiraut 2003, a superb vintage!



Head Chef explaining his selection for our palate

Force feeding, via tubes, of ducks or geese dates back to 2500 BC when the Egytians used to fatten birds to substantiate their popular food then. Corn mash, 50% dry and 50% liquid by weight, is used via pneumatic tubes going into the bird's oesophagus today in France for 18 days or so before slaughter.

In France, foie gras manufacturing has to conform to certain legal limits, which are as follows:-

A Leisurely Note

Sauterne and Foie Gras

Dave Albert making his comments

Dinner at the Chateaux

Foie gras entire- the liver lobes themselves, one or two of them cooked or fresh

Foie gras- usually refers to pieces of liver reassembled

Bloc de foie gras-

- fully cooked and moulded block of at least 98 % foie gras
- if avec morceaux (with pieces), it's less but must have 50% foie gras of goose and 30% foie gras of duck

Mousse de foie gras – must have 50% of foie gras

Parfait de foie gras- must have 75% of foie gras

Foie gras is best served with something sweet such as prunes, apples, figs etc. In as much as liquors like Cointreau might match it, there is nothing to beat the dessert wine and foie gras combination and forgive me for describing the combination of vintage Sauterne and foie gras as ecstacy unrelated to the alcohol content

The 2003 Chateau Sudiraut is not too expensive where as Chateau d'Yquem, Sauterne 2002 would be HK$1600 (A truly outstanding vintage d'Yquem!). If you are interested to just have a taste of Sauterne wine, the 2004 has been rated as a top Summer wine (not the same caliber as the above two) which is going for HK$ 160, something for Summer 2008 perhaps.

Wishing all a wonderful Summer after the rain.

Studying the next bottle

Victor ABDULLAH

declaration of competing interests: none declared

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