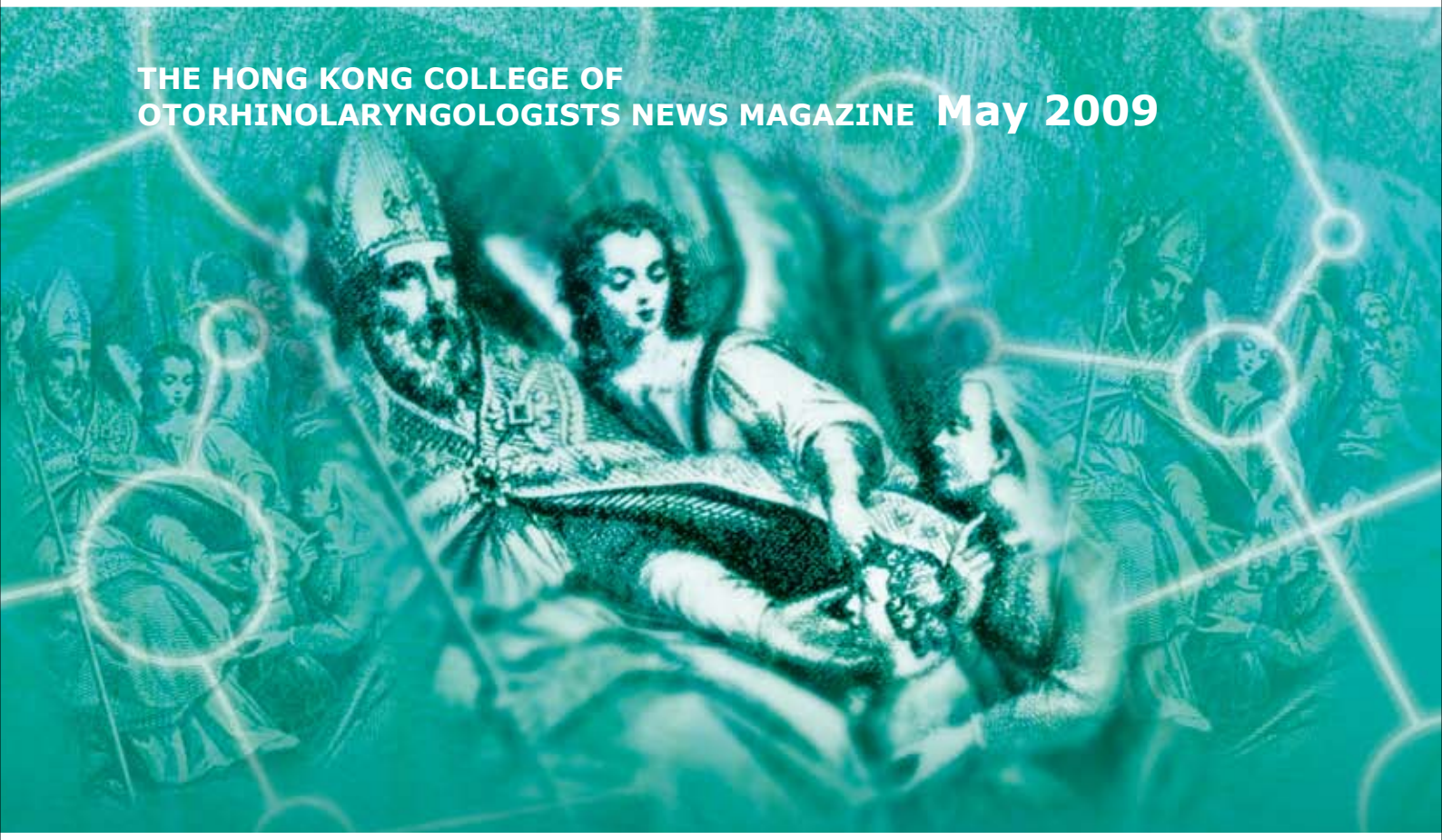
Senses

THE HONG KONG COLLEGE OF
OTORHINOLARYNGOLOGISTS NEWS MAGAZINE May 2009



THE HONG KONG COLLEGE OF
OTORHINOLARYNGOLOGISTS
香 港 耳 鼻 喉 科 醫 學 院

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Note on Cover

St Blaise, Bishop of Sebastea, Armenia, AD 316 if the patron saint of the 'Throat'. He was known to have performed many miracles on the throat including the saving of the life of a young boy who was on the brink of expiring on a choked fishbone.

Contents

Message from the President

The Year of the Ox certainly comes with a bang. While many of us may be still feeling the effect of the financial meltdown, I am happy to report that the financial situation of our College is healthily. Like many other institutions, we did suffer a loss with our investment in HSBC but the Council had indicated clearly beforehand that HSBC shares are for long term investment and not for speculation. For those interested, at the last Council Meeting we unanimously agreed to subscribe to the Rights Issue as suggested by the financial subcommittee.

We had a very successful Scientific Meeting held on the 24 and 25 of February at the Academy. The meeting was very well attended with very positive feedback. We were delighted to have Professor Paul Levine from the USA, Professor Ralph Margritz from Germany, and Dr. Kenny Pang from Singapore together with our own Dr. John Woo as speakers. I would like to thank Professor William Wei, Dr. Gordon Soo, Dr. John Woo and Professor Michael Tong for their kind assistance in organizing our College Scientific Meeting.

A meeting with Dr. Teoh, Regional Director of MPS, was arranged in our College Chamber on March 2, 2009. We have received a number of questions from our Fellows to be addressed to Dr. Teoh. Beside Council representatives we invited Drs. William Yip and Dr Herman Tang from the Society and Dr. Lawrence Li, College Fellow, to attend. Dr. Tang was unable to come but we had a fruitful and frank conversation with Dr. Teoh. He was very helpful and answered our questions readily giving us valuable information. A brief summary of the dialogue is being presented to you elsewhere in this edition of the Senses but in essence, any request for fee reduction will have to be requested individually and directly to MPS by our Fellows and they are not prepared to have different categories of fee structure. He told us also there is no cross subsidy between Specialties but our request for claim/settlement data for ENT in Hong Kong is not yet available as of today. For more details please refer to the summary.

The College Chamber renovation project is now complete and you are most welcomed to visit the Chamber at anytime. We have also purchased a projector and screen for presentation. The renovation fund raising drive will cease at the end of April and the Plaque of Donors will be arranged in due course. Thanks to your generosity and support the project is at a near 'break even' status but of course any contribution is most welcomed and appreciated.

I trust you will enjoy reading this edition of the Senses and I wish you happy summer months ahead.

Kai Bun FUNG

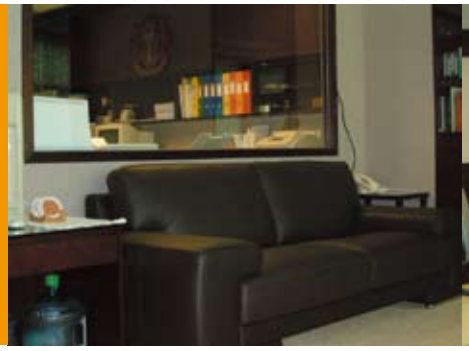
Message from the Editor

With the blessings of St Blaise, the patron saint of the 'Throat', Senses uncovers to yet another collection of wonderful work from our Colleagues. For the first time, we have HSTs contributing and may I introduce to you Dr Ng Yiu Wing (Queen Mary Hospital) who admirably reviewed two papers for us and Dr Joseph Chung (Queen Mary Hospital) who wrote on his fulfilling experience at a Sleep Surgery Course in Singapore. If this sounds too pedantic, let Buddy and SK Lau take you through their enviable trip to Nepal. The Himalayas were stunning and the great work of their entire team deserves the highest commendation. I was thankfully reassured as I read their article that they didn't just live on' Cup Noodles'. Dr Talen Wai takes us to Yan Chai Hospital in this issue and for the academically inclined, have a go at Dr Alex Lee's Quiz and earn a point. For me, I quite enjoyed Frederick's trip to Chateauneuf du Pape. I wish to thank all my colleagues once again, profusely, for their loyal and dedicated support as I proudly present to you the May 2009 issue of Senses.

Victor ABDULLAH

Council News

It is with great pleasure that I report the completion of renovation of the College Chambers to which so many of our Fellows generously contributed.



▲ A very comfortable sofa

▲ A new conference table

▲ Conference Room

▲ Presidents' portraits

▲ The secretariat corner

▲ College Logo

The College Council would like to make a special acknowledgement for their loyal support.

The President and Council wish to extend their heartfelt appreciation
To

Dr Cheung Amy	Dr Lau Bo Yee	Dr To Sau Ying	Prof Wong Tak Cheung
Dr Chiu Kit Yee	Dr Li Kwok Chang	Prof Tong Chi Fai	Dr Woo Kong Sang
Dr Chong Hou Ming	Dr Ma Kwong Hon	Prof CA van Hasselt	Dr Yue Virgil
Dr Fung Kai Bun	Dr Ng Kin Pong	Prof Wei William	Dr Yuen Hing Yiu
Dr Fung King Hay	Dr Tang Shu On	Prof Wong Kam Fun	

1. Dr Lawrence Li
2. Dr John Woo
3. Dr Fung King Hay
4. Prof Michael Tong
5. Dr Luk Wai Sing
6. Dr Tang Shu On
7. Dr To Sau Ying

Fellows who have contributed HK$ 10,000 or more will have their names inscribed on a special acknowledgement plaque in the College Chambers.

Fellows who wish to contribute still and have not had the opportunity to do so may have their donations forwarded to the College before the end of May 2009 after which the plague would be commissioned.

On the Examination front, I am delighted to report that all five candidates who took the conjoint exit examination in December 2008 passed. Many congratulations to them indeed! The President and Council had a special reception held at the Chambers to commend their success. Our new Fellows or Fellows to be are:- Dr Cheung Amy, Dr Chow Siu Wah, Dr Chow Wai Man, Dr To Shing Howe and Dr Wong Wai Yeung.

▼ The Council and Education Committee Members with New Fellows

▼ Dr Chow Man Wai, Prof Michael Tong, Dr Victor Abdullah Dr John Woo and Dr Wong Wai Yeung

1. The President, Dr Li Ming Fai & New Fellows
2. The Censor-in-Chief & New Fellows
3. Dr To Shing Howe
4. Dr Wong Wai Yeung
5. Dr Ho Wai Kuen, Dr Amy Cheung and Dr Wong Yee Hang
6. Dr Amy Cheung
7. Dr Chow Man Wai
8. Dr Li Ming Fai, Dr Chow Siu Wah and Dr To Shing Howe
9. Dr Chow Siu Wah

On the 2nd March 2009 our President, Dr K B Fung met with the regional Director of MPS Dr Teoh Ming-keang. In attendance were our respected Fellows and Council members, Dr Lawrence Li, Dr William Yip, Dr Ho Wai Kuen and Dr Luk Wai Sing. The following are key points in the dialogue as recorded on the day:-

Q How is the premium for ENT calculated?

A The Premium for ENT is calculated according to the experience of all the specialists in the specialty within Hong Kong. Each specialty is considered separately and has her own calculated premium. There is no cross subsidy for different specialties or different countries.

The principles for calculation are: legal costs, awards, the non-claim EO costs, administration fees, the incurred but not yet reported claims and a small levy of re-insurance, and equity reserves.

Q How could ENT specialists have their premium reduced?
Is there special consideration for ENT doctors whose practices do not involve surgical operations but just office procedures?

A There is a special category: 'Part-time rate' which attracts a reduced premium. Each doctor applying for consideration for this rate is considered individually.

Q If a doctor should work for just a few hours a day yet he/she does risky operation, would MPS be able to identify these 'part-timer' applicants.

A Applicants would need to state their working hours, their exact nature of work and their years of working experience. There is a Subscription Committee to considerate each individual case.

Q Would the MPS not set categories? For example, Those who are doing office procedures only and those who are doing high risk procedures.

A No, the MPS would not set categories.

Q How about claims in ENT?

A There are figures of ENT claims, these data would be sent to the College.
There are educational activities and master courses on how to handle difficult patients.

Q For doctors who work in the Hospital Authority, their premium is covered by their employer (HA). If they have private practice within HA, would they need to pay their own private practice premium and if so, how would it be calculated?

A No, they don't need to buy any extra insurance. The HA would indentify exactly their work including private practice in their contract. If they were to do work outside their contract, they would have to pay for their own insurance.

Q Would caseload be considered as factor influencing the amount of premium?

A Difficult to say, for example, a doctor who does 100 operations/week is more risky then a doctor who does only 10 per week , the one who does more is often the more experienced.

Q A procedure which is high risk for patients may not be one at high risk for claims. Is there a list of procedures at high risk for claims?

A There is a list of high risk procedures for the MP over the last 5 years. This would be sent to the College. (Dr Teoh showed some slides to explain the claims)

Q What would happen if one day, the MPS goes bankrupt?

A That does not seem to be happening.

- ***Article for Hong Kong Medical Association Newsletter (March 2009)***
- ***How are MPS subscriptions set?***

One of the questions that I am often asked is how the Medical Protection Society (MPS) works out the subscription rates we charge. MPS is a mutual society owned by our members who have come together to share the risk of the legal problems faced in their clinical practice. It is therefore essential that we collect sufficient money to meet future claims and remain financially secure, as our only sources of income are subscriptions collected from our members plus investment income from our reserves.

In setting our subscription rates, we endeavour to share these risks fairly between members. This means that we try to ensure that we collect an appropriate sum from each individual after taking into account their clinical specialty, the country in which they practise, and the extent of the indemnity they need from MPS.

We begin by looking at recent experience, and then try to predict the future trends. This is no easy task – when MPS collects your subscription for a particular year, we have to collect enough money to pay for the outcome of any adverse incident you have faced during the year, irrespective of when the claim is subsequently reported. That means that once the year is over, you can forget about it, which is comforting for you, but makes the calculation of your subscription rate much more difficult. The problem is that the consequences of an adverse incident may not come to light for some considerable time (perhaps 10 to 20 years after the event for very serious injuries such as cerebral palsy), at which point MPS will need to have the money available to deal with the problem.

The challenge for MPS is to estimate what the future will look like in terms of legal costs and compensation awards for each country in which we operate, as we want to make sure, as far as is practicable, that each area is self-financing (in other words, no country subsidises, or is subsidised by, another over the medium to long term).

The forecast is done with the advice of independent actuaries, who will look at a wide range of factors. For Hong Kong, these include the frequency and size of claims, legal costs for other types of assistance given to members, the cost of buying insurance to protect against high claims, plus our claims handling and other administrative costs. They also need to project future claims inflation and make allowance for investment income after tax on the subscriptions held until the expected claims are paid.

The actuaries recommend an overall figure as their best estimate for the future, which is the minimum needed to fund the projected risk. To this we add a small margin to provide a cushion against unexpectedly adverse experience to arrive at the final subscription charged.

The result overall is fair as between all our members around the world, even if it does not always make pleasant reading. It is important to remember that MPS remains a truly not-for-profit organisation and if our claims experience is better than we expected, then the surplus money is held for the benefit of our members, allowing us at times to freeze or sometimes reduce future subscriptions. I realise that our rates may place a heavy burden on some of you but you would not forgive me or the MPS Council if we allowed subscriptions to be set a level that meant that MPS lacked the financial strength to respond to requests for assistance from you. Providing you with peace of mind is at the centre of what we do.

Tony Mason
Chief Executive – MPS

Our Fellows may have received a letter from the College inviting them to have their names and practice information uploaded to an 'accessible', meaning, accessible to any visitor, at our College website. Colleagues locally or abroad and sometimes patients looking for a specialist ENT surgeon can then locate the doctor they may wish to get in touch with. Only the minimal of information, practice address and contact telephone number need to be uploaded. If you wish to have yours uploaded but have misplaced the invitation letter, please do not hesitate to contact Miss Claudia Wong, our Chambers secretary who can help you do so. Do not worry if you don't wish to do so or do not wish to do so at this instance as there is no time limit and the College will respect your wish. No information will be uploaded without your full consent.

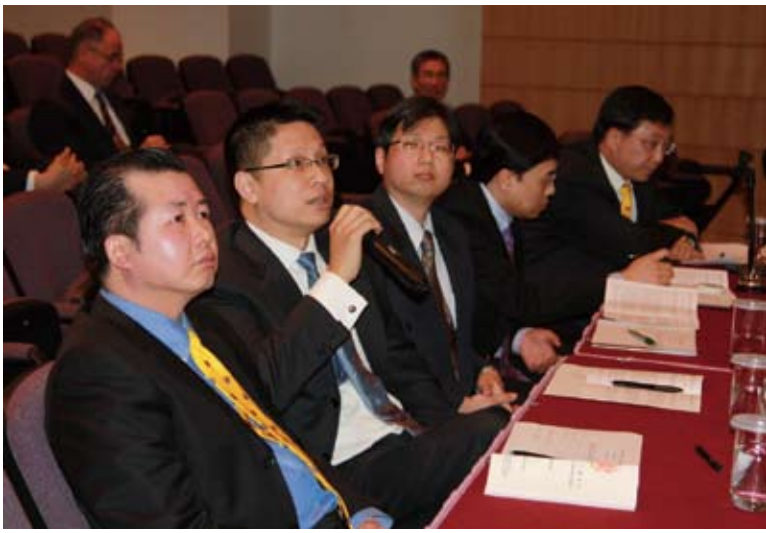
The College Conferment ceremony was held on the 30, November 2008. This was preceded by the College Trainee Presentations. We had three outstanding presentations:-

Randomised Clinical Trial to Compare the Post-operative Results of two Graft Covering Materials in Myringoplasty: Silicone Sheet (Silatos) and Gelatin Sponge (Spongostan) by Dr Chow Man Wai

Thyroid Dysfunction after Total Laryngectomy and Irradiation: 10 Year Follow up by Dr Joseph, Chung Chun Kit

Voice Disorders Among School Teachers in Hong Kong: Prevalence and Risk Factors by Dr Eric Tang Chi Ho

▼ The Adjudicators



▼ Dr Chow Man Wai

▼ Dr Chung Chun Kit

▲ Dr Tang Chi Ho

The College Prize for the best paper and presentation was awarded to Dr Eric. Tang Chi Ho

▼ The President presenting the awards to Dr Tang

The George Choa Prize was awarded to Dr Joseph, Chung Chun Kit

▼ The President presenting the award to Dr Joseph Chung

Dr Victor To, 'Winner' of the 2007 Joint College Society trainee presentations presented his overseas visit and was presented the 2007 George Choa Prize by the President of the Hong Kong Society of Otorhinolaryngology, Head & Neck Surgery, Dr William Yip Po Tin.

▼ Dr Yip Po Tin presenting the award to Dr To

Fellowship of the Hong Kong College of Otorhinolaryngologists was conferred upon Dr John Chan, Dr Chio Io Meng, Dr Ho Chung Wai, Dr Hung Che Wai, Dr Lee Chi Leung, Dr Lee Ting Hon and Dr Wong Ka Chun

▼ The New Fellows vowing the College Oath

▲ New Fellows

▲ Dr John Chan

▼ Dr Ho Chung Wai ▼ Dr Wong Ka Chun ▼ Dr Chio Io Meng ▼ Dr Lee Ting Hon ▼ Dr Lee Chi Leung

Drs Chung Chun Kit, Winnie Kan, Ng Yiu Wing, Wong Chui Yan, Lau Wai Yip, Cheung Kwan Ling, Fung Tin Cheung, Lam Wai Hung, Lee Chi Chung, Hui Yui Cheung, Li Hok Nam, Leung Moon Wah, Lai Kwong Lun, Lo Pui Yee and Chung Yiu Kei were formally admitted as Members of our College

1. Dr Wong Chui Yan
2. Dr Lee Chi Chung
3. Dr Li Hok Nam
4. Dr Lau Wai Yip
5. Dr Hui Yiu Cheung
6. Dr Lam Wai Hung
7. Dr Chung Yiu Kei
8. Dr Cheung Kwan Ling
9. Dr Chung Chun Kit, Joseph

10. Dr Lo Pui Yee
11. Dr Ng Yiu Wing

▼ College Fellows at the Conferment Ceremony

▼ Fellows and Members at the Conferment Ceremony

The Secretary for Food and Health, Dr York Chow, SBS, JP was our Guest of Honor at the ceremony. He delivered the Second College Oration on a timely subject, 'Thriving in the Midst of Adversity'.

▶ Dr York Chow delivering the second College Oration

▲ The President presenting a souvenir to Dr Chow

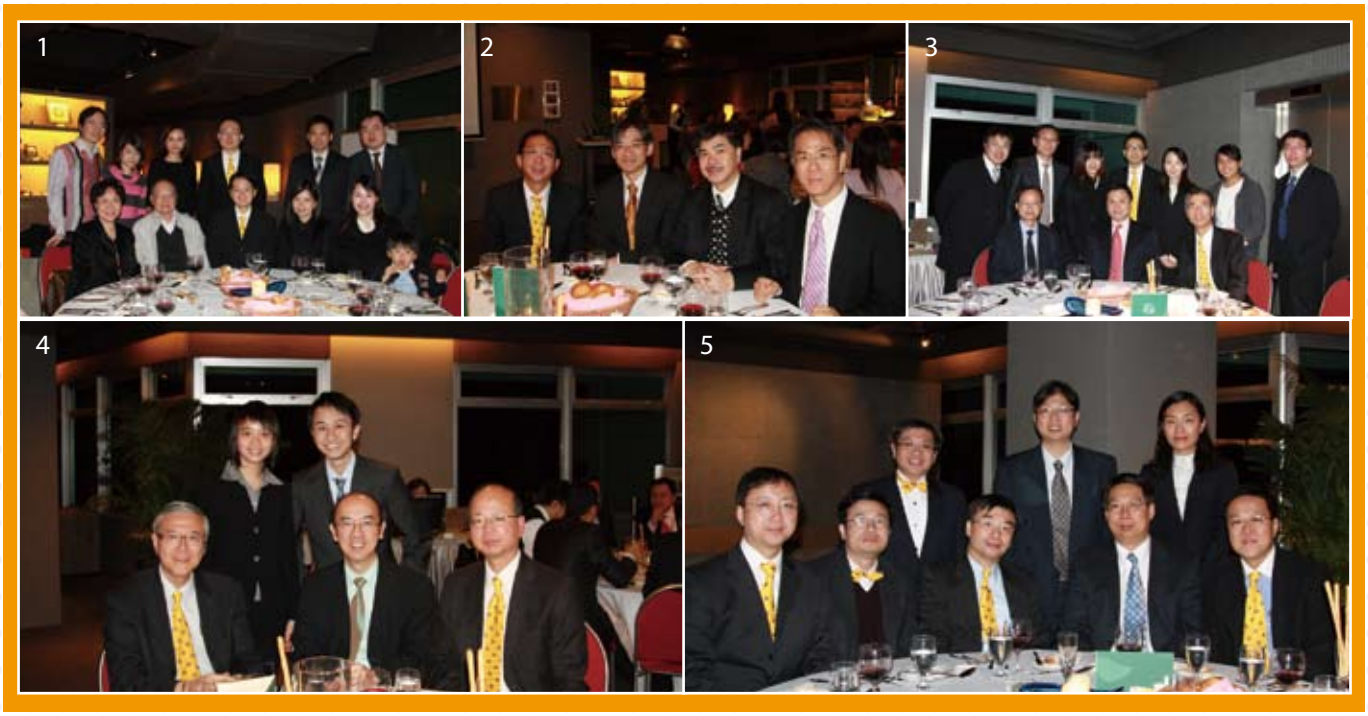
▲ Welcome Speech by the President

▲ Dr Frederick Wong, Public Orator of the Ceremony

▲ Speech by Prof Grace Tang

▼ Dr York Chow & Fellows

▼ The Platform Party

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We have had a great half year of educational events but prior to their listing, I would like to invite all our members and Fellows to the Facial Plastic Surgery Course, jointly held by our College, the Hospital Authority of Hong Kong and the Royal College of Surgeons of Edinburgh in May 2009, details as follows:-

Hospital Authority Commissioned Training Programme 2009/2010 in Facial Plastic Surgery in conjunction with the Royal College of Surgeons of Edinburgh

	Friday, 8th May James Kung Meeting Room, 2/F, Hong Kong Academy of Medicine Building, Wong Chuk Hang Road, Aberdeen	"Saturday, 9th May James Kung Meeting Room, 2/F, Hong Kong Academy of Medicine Building, Wong Chuk Hang Road, Aberdeen"	"Sunday, 10th May Kai Chong Tong, Postgraduate Education Centre, Prince of Wales Hospital, Shatin"
0830 - 0900	Registration		
0900 - 0905	0900 - 0905 Welcome and Introduction of the Faculty		
0900 - 0920	"Exam Alert: How to approach the inevitable Carl van Wyk"	Clinical anatomy of the nose Frederick Wong	Common eyelid problems (ectropion, endopion, ptosis, tarsorraphy) Ben Wong
0920 - 0940	"Documentation techniques in facial plastic surgery (10 mins) Frederick Wong" "Aesthetic subunits of the face (10 mins) Frederick Wong"	"Assessing your patient (15 min) Carl van Wyk"	"Upper and lower blepharoplasty (Functional and aesthetic) Wilson Ho"
0940 - 1000	"Full and partial thickness skin grafting techniques Stephen Lo"	"When and when not to operate (15 min) Tristram Lesser" "Septorhinoplasty - Open vs closed techniques (15 mins) Peter Ku"	"Hair transplantation and the Juri flap Stephanie Lam"
1000 - 1030	Coffee break		
1030 - 1050	"Selection of grafting materials and sutures Stephen Lo"	"Principles of osteotomy Gordon Soo"	"Managing facial# - Nasal, nasoethmoidal & tripod# Tristram Lesser"

1050 - 1110	"Flaps for the face (pedicled nasolabial, melolabial, glabellar flaps and free flaps) Ullas Raghawan"	"Grafting techniques for the nose (spreader, cap, shield, batten, columella strut) Stephen Lo"	Dissection video
1110 - 1130	"Nasal reconstruction incl. paramedian forehead flap Tristram Lesser"	"Managing the twisted nose Stephen Lo"	
1130 - 1150	"Incisions and the reconstructive ladder, scar revision (Planning your incisions and closure, dog-ears, Z & W plasties) Simon Watts"	"Tip refinement & sculpture Simon Watts"	
1150 - 1210	"Lip reconstruction Simon Watts"	"Augmentation for the Asian nose - injection, ribs & implants	Lunch
1210 - 1230	"Diagnosis & management of skin cancers Carl van Wyk"	Peter Ku" "Saddle noses, parrot beaks and ski slopes: Causes and remedies Carl van Wyk"	"Cadaveric demonstration of facial plastic procedures Jockey Club Minimally Invasive Surgical Skills Centre, 3/F, Li Ka Shing Specialist Clinic (North Wing) Prince of Wales Hospital, Shatin (Hands on supervised dissection limited to selected HA personnel. Cadaver demonstration will be televised for general viewing to MISSC Seminar Room)"
1230 -1300	Questions and Answers		
1300 - 1400	Lunch		
1400 - 1420	"Filler technology (NASHA, PAAG, autologous fat) Simon Watts"	"Septal perforation and reconstruction surgery Ullas Raghawan"	
1420 - 1440	"Botox and applications in ENT Ullas Raghawan"	"Rhinoplasty for the cleft nose Victor Abdullah"	
1440 - 1500	"Chemical peels and dermabrasion principles Ullas Raghawan"	"Managing the paralysed face (Static and dynamic techniques) Ullas Raghawan"	
1500 - 1520	"Keloids and principles of treatment Stephen Lo"	"Lagophthalmos and lidchain surgery Gordon Soo"	
1520 - 1550	Coffee break		
1550 - 1610	"Principles of lasers Carl van Wyk"	"Functional browlift techniques Ullas Raghawan"	
1610 - 1630	"Lasers applications in FPS Tristram Lesser"	"The SMAS and surgery (Deep plane lift, SMASectomy & SMAS lift techniques) Simon Watts"	
1630 - 1650	"Management of the traumatised pinna Stephen Lo"	"The chin - sliding genioplasty & implants Peter Ku"	
1650 - 1710	"Otoplasty techniques Simon Watts"	"Ear reconstruction techniques Gordon Soo"	
1710 - 1730	"Mock exam demonstration Tristram Lesser and Carl van Wyk"	"Craniofacial prosthetic reconstruction Gordon Soo"	
1730-1800	Questions and Answers		

Facial plastic Surgery will be incorporated in the conjoint Exit Examination as from 2009.

Professor Barbara Wollenberg's lectured on 'Laser Surgery of the Larynx' on the 9, September 2008.

▼ Dr Ambrose Ho receiving a special gift from Prof Wollenberg

▼ The President presenting a souvenir to Prof Wollenberg

▼ Dr Fung Kai Bun, Prof Wollenberg, Dr Buddy Wong & Prof William Wei at the Chamber

▼ Prof Wollenberg signing the guest book

Professor John Wolfaardt presented on 'Converging on the Future: The Clinician Knowledge Worker-Fantasy or Fact' at the College Conferment ceremony on the 30, November 2008.

▼ The President presenting a souvenir to Prof Wolfaart

▼ Prof Wolfaart

Professor John House presented his wealth of experience in 'Current Management Strategies for Dizziness' on the 3, December 2008.

▲ Prof House

In February 2009, 24th-25th, our Annual Scientific Meeting was successful held, thanks to the tremendous effort of our Censor, Dr John Woo and Dr Gordon Soo. We had as guests, Professor Paul Levine from the University of Virginia, Dr Ralph Magritz from the Prosper Hospital, Recklinghausen, Germany and Dr Kenny Pang from the Pacific Sleep Centre, Singapore. We wish to thank in particular, SG Private Banking and Schering Plough for their generous support for the meeting.

▼ Dr Kenny Pang

▼ Dr John Woo

▲ Dr Ralph Magritz

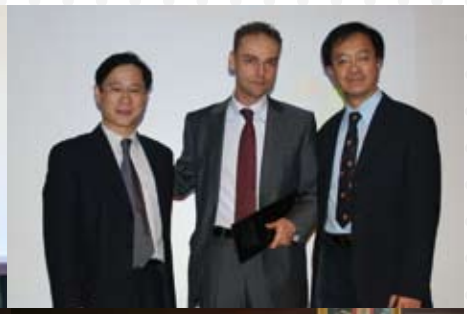
▲ Mr Matthew Choi

▲ Audience

▼ Dr Gordon Soo accompanies Dr Magritz in signing of the guest book

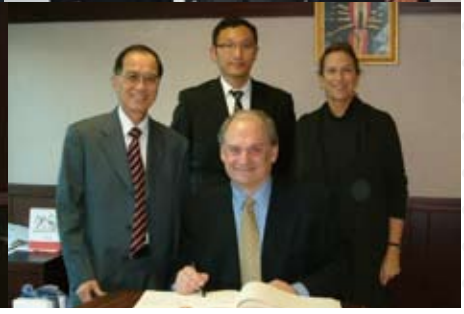
▼ Dr Frederick Wong, Dr Magritz and Dr Gordon Soo

▼ Dr Gordon Soo, Dr Magritz & Dr John Woo



▲ Dr Fung, Prof Levine, Mrs Levine & Dr Chung

▲ Dr Fung and Dr Kenny Pang



▲ Dr Fung Kai Bun & Dr Joseph Chung accompany Prof & Mrs Levine in singing of the guest book

▲ Dr Fung & Dr Pang

▲ Mr Choi & Dr Fung

▲ Dr Magritz & Dr Fung

▲ Mr Fung & Dr Fung

▼ Dr John Woo & Dr Kenny Pang

▼ Dr Fung, Mr Alex Fung and Mr Matthew Choi

On the 5, March 2009, Professor Robert Jackler from Stanford University School of Medicine enlightened us on 'The Future of Otology'

▼ Dr Amy Cheung & Prof Jackler

▼ Prof William Wei presenting a souvenir to Prof Jackler

▲ Prof Jackler

▲ Dr Amy Cheung, Prof & Mrs Jackler

Report from Censor-in-Chief

Dear Fellows,

I would like to give you an update on the following ongoing College Matters that I have been involved with:

Annual Scientific Meetings

The 2009 Annual Scientific Meeting of our College was a great success. The theme of the first evening was on "Epistaxis". On behalf of the COC(ENT) of the Hospital Authority, I presented the findings of the clinical audits on epistaxis amongst HA hospitals in Hong Kong. Professor Paul Levine lectured on the diagnosis and management of epistaxis. The second day program was themed on "Management of the Paralysed Face" and "Obstructive Sleep Apnoea" lectured by Dr. Ralph Magritz from Germany and Dr. Kenny Pang from Singapore respectively. Over 60 fellows attended the meeting and the feedbacks from fellows were excellent.

Examination and Training

As all five of our higher surgical trainees passed the conjoint exit examination last December, our College does not need to organize any examination this year. Being a conjoint exit examination, the syllabus needs to be revised in accordance with the requirement of the Edinburgh College. Thus, from 2010 onwards, the conjoint exit examination with have a specific part on facial-plastics.

In preparation of our trainees for the facial-plastic part of the examination, a comprehensive facial plastic training course with cadaver dissection will be held between 8 - 10 May, 2009. The course is funded by the Hospital Authority and co-sponsored by both the Edinburgh College and our College.

CME/CPD

At the beginning of the current CME/CPD cycle, some Fellows showed a concern about attaining adequate "active CME/CPD points". It is now almost half way through the current CME/CPD cycle, and I am glad to report that the majority of our fellows did obtain adequate CME/CPD points on a pro-rata basis.

I would like to repeat here that "active CME/CPD points" can be obtained easily by submitting ENT articles with a minimum of 4 questions set based on the article or answering such questions set by other fellows of our College. You may follow the steps below to get connected to the Academy's CME website - it is both educational and interesting!

1) Visit the website of the Academy for CME: www.icmecpd.hk
2) Go to member's area

3) Login (if you forgot the password, you can contact Mr Kelvin Leung at 2871 8748)
4) Go to CME Learning page
5) Select our College
6) Read the article and answer the question

Once again, a list of forth coming local and international CME/CPD activities are in print with the current issue of "Senses"

With best regards

John WOO

Local Activities

Date	Event	Venue	Contact
Monthly	Scientific Meeting	St Terasa's Hospital	Dr. Tang Shu On Tel:2526 8608
1st, 3rd & 4th Wednesday 9:30am - 10:30am	Journal Club Meeting	PWH	Michele Chan Tel:2632 3558
2nd Wednesday 9:30am- 10:30am	Journal Club Meeting	UCH	Juana Ng Tel:3513 5442
Every other Monday 5:30pm- 7:30pm	Journal Club Meeting	PYNEH	Cecilia Chick Tel:2595 6454
Every Friday 4:30pm-5:30pm	Journal Club Meeting	TMH	Peony Ng Tel:2468 5397
2nd and 4th Monday 4:30pm-5:30pm	Journal Club Meeting	YCH	Daisy Tel:2417 8358
Every Tuesday 5:15pm-6:15pm	Journal Club Meeting	QEH	Candy Chan Tel:2958 6025
1st Tuesday 5:30pm-6:30pm	Journal Club Meeting	QMH	Michelle Chow Tel:2855 4452
8-10 May 2009	Facial Plastic Course	HKCORL/PWH	Secretariat Tel:2871 8733
23-24 May 2009	Fiberoptic Endorscopic Examination of Swallowing (FEES) Workshop 2009	CUHK	Rebecca Chan Tel:2632 3950
19-20 September 2009	Fiberoptic Endorscopic Examination of Swallowing (FEES) Workshop 2009	PWH	Rebecca Chan Tel:2632 3950
18-19 June 2009	Head and Neck Course 2009	QMH	Secretariat Tel:2855 4855

Overseas Activities

Date	Event	Venue	Contact
20-21 June 2009	1st Asia Pacific Rhinoplasty Expert Forum	Seoul, Korea	Email: hrjin@snu.ac.kr Tel: 82 2 870 2441
11-15 June 2009	Advances in Rhinoplasty	Seattle, WA, USA	Email: info@aafprs.org Tel: 703 299 9297 Ext 239
1-5 June 2009	XIX IFOS World congress	Sao Paulo, Brazil	Email: info@ifossaopaulo2009.com.br
2-4 July 2009	11th International Otology Course	France	www.clinique-causse.com/course2009
8 July 2009	British Academic Conference in Otolaryngology	Liverpool, UK	Email:conferences@entuk.org
4-7 August 2009	10th Asia Pacific Congress on Deafness	Bangkok, Thailand	Email: congress@apcd2009.org www.apcd2009.org
24-26 September 2009	Paediatric Airway Course	Singapore	Tel: 6394 2395 Email: ong.lim.liew@kkh.sg
4-7 October 2009	113th American Academy of ORL-HNS Annual Meeting & OTO Expo	San Diego, USA	Email: servicecentral@entnet.org www.entnet.org/annual_meeting

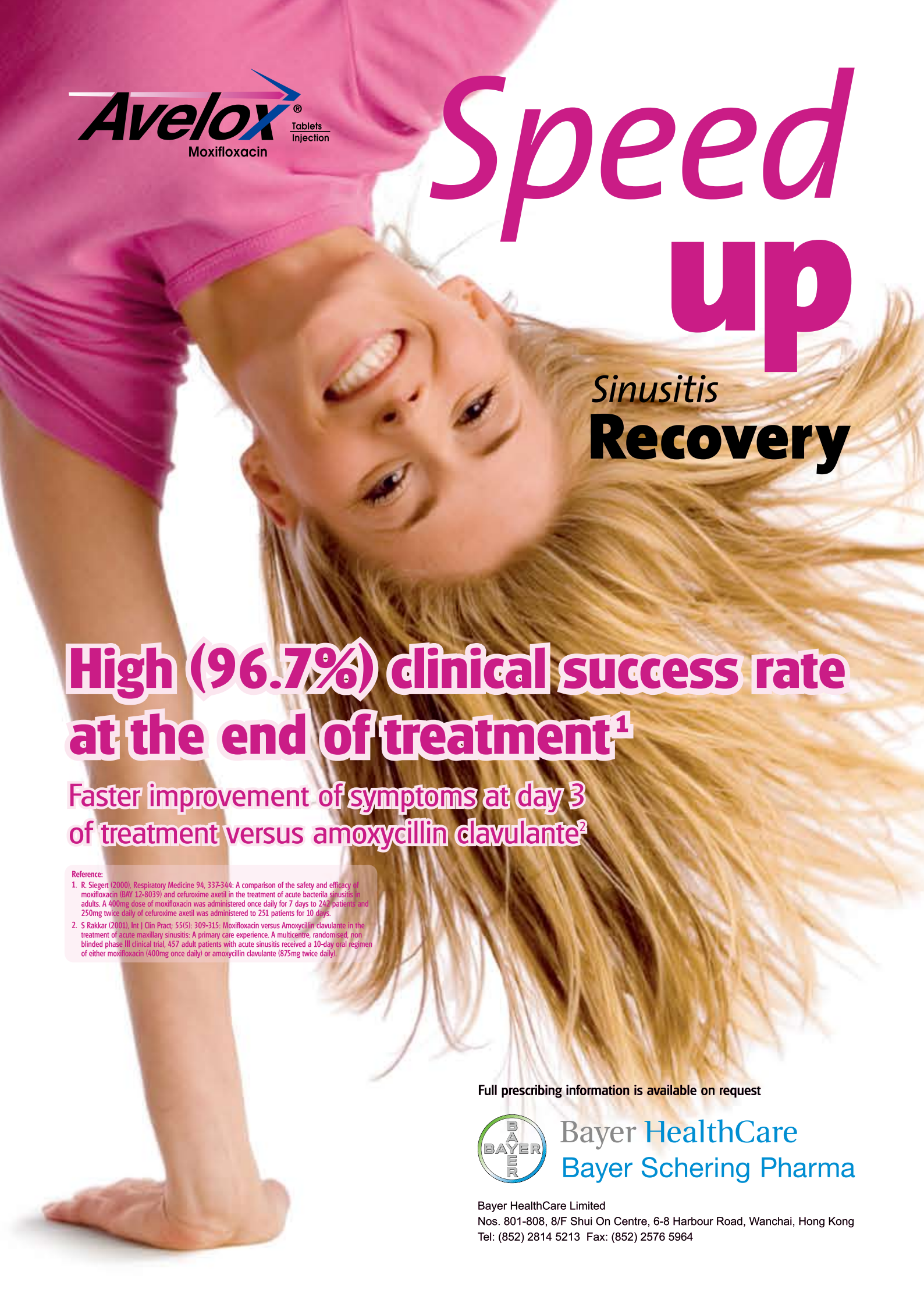
Report from Honorary Treasurer

The College finance is in healthy state with comfortable reserve.

The Council had decided in early 2007 to set up a separate Investment Fund (which comprised not more than 30% of the College General Reserve Fund) on Bonds and Blue Chip Stocks. Up to the end of March 2009, the Council has invested half of the Investment Fund in Blue Chip Stocks (HSBC & Tracker Fund). The recent Financial Tsunami has caused some loss (paper value) in our Fund. The Investment Sub-Committee will continue to invest and monitor cautiously in these volatile financial markets so as to minimize risk and enhance long term returns. Your valuable suggestions and advices on our College future investment are most welcome.

The due date of the annual subscription for the current year was on 1st January 2009. It has come to our attention that some of our Fellows have still not forwarded their subscriptions. Crossed cheque should be made payable to "The Hong Kong College of Otorhinolaryngologists". Pursuant to Article (40) of the Memorandum & Articles of Association of the College, any member who shall fail to pay his annual subscription four months after the due date, his name shall be removed from the College Registry. Should he wish to reinstate his Fellowship, he has to pay all his arrears and an administration fee. I would like to take this opportunity to remind Fellows who have not yet paid the 2009 subscription to settle their accounts immediately. In order to ease administrative work and avoid delay payment penalty, Fellows are encouraged to pay by auto-pay arrangements. The direct debit authorization form is enclosed herewith for your kind action.

Shu On TANG



Reference:

1. R. Siegert (2000), Respiratory Medicine 94, 337-344: A comparison of the safety and efficacy of moxifloxacin (BAY 12-8039) and cefuroxime axetil in the treatment of acute bacterila sinusitis in adults. A 400mg dose of moxifloxacin was administered once daily for 7 days to 242 patients and 250mg twice daily of cefuroxime axetil was administered to 251 patients for 10 days.
2. S Rakkar (2001), Int J Clin Pract; 55(5): 309-315: Moxifloxacin versus Amoxycillin clavulante in the treatment of acute maxillary sinusitis: A primary care experience. A multicentre, randomised, non blinded phase III clinical trial, 457 adult patients with acute sinusitis received a 10-day oral regimen of either moxifloxacin (400mg once daily) or amoxycillin clavulante (875mg twice daily).

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Hospital Tour
• Yan Chai Hospital

The hospital tour for this issue of Senses takes us to Yan Chai Hospital (YCH) . This is my very first visit to the Hospital.

The hospital is located very close to the community. Situated in the center of the densely populated Tsuen Wan district, it provides readily accessible medical service for patients in the area. Beside the hospital main complex is a public park for leisure.

As I stepped into the main lobby, the photos of the Board of Directors caught my eyes. As countless restaurants surround the hospital, a canteen or cafeteria within the hospital premise is not necessary for obvious reasons. The only thing you may need is a small convenience shop for snacks!

The ENT department in YCH was established in 1994. It started with only three doctors providing service in South Kwai Chung Clinic. Now the ENT department has developed into a team with fourteen medical doctors: one consultant, five senior medical officers / associate consultants and eight medical officers / residents. Under the leadership of the Chief of Service Dr. Ma Kwong Hon, the ENT service extends its broad coverage to include the four hospitals in the Kowloon West Cluster - Yan Chai Hospital, Kwong Wah Hospital, Princess Margaret Hospital and Caritas Medical Center. The coverage is probably the widest in Hong Kong.

The ENT in-patients are looked after in a mixed surgical ward. The compact treatment room provides all the essentials. Apart from the ENT facilities, a well-equipped sleep study room is also incorporated into the ward. Despite the setting of mixed surgical wards, all the nurses are professionally trained in ENT nursing care and are also able to handle patients undergoing polysomnographic sleep study.

The outpatient clinic is located on the first floor of Block E. The waiting area is capacious. There is a long back corridor connecting all the consultation rooms. This allows smooth workflow and increases efficiency. The audiology service and assessments rooms are all located in the same clinic. Patients obviously benefit from it all.

▼ capacious

consultation rooms ▲

On the same floor is the Yan Chai Hospital Board Yuen Yuen Institute Surgery Clinic. It was set up in 2007 under the collaboration of Yan Chai Hospital and Tsuen Wan Adventist Hospital. This serves as a public private interface and provides patients with another healthcare service option.

The government has approved a re-development plan of YCH. The existing Blocks C, D, E and F will be re-built into a community health wellness center. It will

provide a “one-stop” integrated ambulatory healthcare service centre which focuses on health education, primary healthcare and specialty care. The project is expected to finish in 2014.

Short Interview with Dr. Ma Kwong Hon

Being the one who established the unit and had been running it for more than 15 years, Dr. Ma witnessed the evolution of the service in Yan Chai Hospital and the Kowloon West cluster.

“The scale of our hospital is not big. We can cooperate with all the departments easily. We know each other very well and the atmosphere is always friendly! Small is sometimes beautiful!

“We have department lunch meetings every Tuesday. All the staff including doctors, speech therapists and audiologists sit together to enhance the team cohesiveness.

“As we are now serving more and more patients over a very large area involving four hospitals, our work schedule is very hectic. It would be ideal if the services could be centralized. Streamlining the on-call system would help but further increase in manpower is certainly necessary.”

I would like to thank Dr. Ma for this interview and the hospital tour.

Kin Hang WAI

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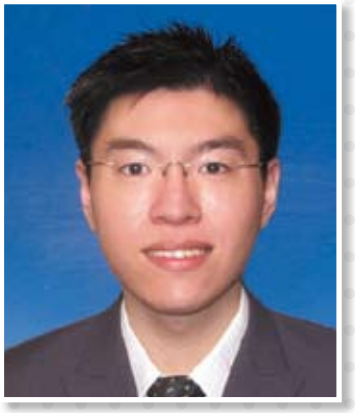
• Drainage for Descending Necrotizing Mediastinitis



Descending Necrotizing Mediastinitis (DNM) is a rare condition. It is different from other forms of acute mediastinal infection e.g. post-esophageal perforation or trans-sternal cardiac procedure contamination. It is usually a result of deep neck infection secondary to odontogenic cervicofascial infection or cervical trauma. Infection spreads along fascial planes into the mediastinum. It is associated with high mortality up to 40% in some case series.

DNM is classified into Type I (above tracheal bifurcation), Type IIA (extension to anterior lower mediastinum) and TypeIIB (posterior lower mediastinal involvement).

There are different drainage methods developed for different types of DNM. The common methods include transcervical mediastinal drainage with a suprasternal incision, thoracotomy, median sternotomy, posterolateral thoracotomy and thoracoscopic drainage. The general consensus for drainage is to undertake a sternotomy or thoracotomy for DNM with lower mediastinum involvement ie. Type IIA/B.

However, there is controversy concerning the policy of drainage for DNM with isolated superior mediastinal involvement, sparing the lower mediastinum, because of the fear of gravity pooling of pus and necrotic material leading to insufficient drainage. There are 2 large series with clearly documented DNM types from Japan and Taiwan. One showed 73% and the other showed 100% success rate of managing Type I DNM with transcervical suprasternal drainage.

Besides the drainage methods, both series also confirmed Klebsiella Pneumonia being the most common pathogen. The second common one is Streptococcus viridians. Klebsiella associated DNM is more common in elderly patients and diabetics. Klebsiella associated DNM is also associated with higher rate of re-operation and mortality.

NG Yiu Wing

References:

Optimum drainage method in descending necrotizing mediastinitis.

Inoue Y, Gika M, Nozawa K, Ikeda Y, Takanami I.

Interact Cardiovasc Thorac Surg. 2005 Jun;4(3):189-92. Epub 2005 Mar 24.

Descending necrotizing mediastinitis: a 10-year surgical experience in a single institution.

Chen KC, Chen JS, Kuo SW, Huang PM, Hsu HH, Lee JM, Lee YC.

J Thorac Cardiovasc Surg. 2008 Jul;136(1):191-8. Epub 2008 May 22.

• Taste loss after tonsillectom

Sometimes an uneventful tonsillectomy is complicated with post-operative loss of taste despite normal olfactory and nasal function.

Possible causes of this phenomenon include injury to LBGN (Lingual Branch of glossopharyngeal nerve), gag pressure, zinc deficiency and medication side effects.

LBGN receives gustatory fiber from posterior one third of tongue. Cadaveric anatomy study showed that 23% population with pharyngeal constrictor separating LBGN from tonsils, 55% with muscle separation between LBGN and tonsil partially lacking, and 22% with complete lack of muscle coverage over LBGN. In cases of completely deficient muscular coverage of LBGN, the nerve is only separate from tonsil by 1 to 2mm thick loose connective tissue or the nerve may even be adherent to the lower pole of tonsil. Thus, LBGN is predisposed to injury during lower pole dissection of tonsil in some patients.

Zinc is an important cofactor for alkaline phosphatase, which is the most abundant enzyme in taste bud membranes. ALP is a component of parotid salivary protein, which is important for the development and maintenance of normal taste buds. Some antibiotics and pain control medications can also cause zinc deficiencies. However, the underlying mechanism is not yet found. With documented serum zinc deficiency, taste loss after tonsillectomy is usually reversible with zinc supplement.

A study showed 9% incidence of taste loss immediately after tonsillectomy. However, another study, with sample size of 3583 patients after 15 years of tonsillectomy, showed only 0.31% of patients with persistent taste problem. Among the persistent taste loss patients, 27% of cases were found to have documented LBGN dysfunction by electrogustometry.

In conclusion, persistent loss of taste after tonsillectomy is rare but injury to LBGN during lower pole dissection may account for a significant portion of persistent post-tonsillectomy taste loss.

NG Yiu Wing

References:

Anatomy of the tonsillar bed: topographical relationship between the palatine tonsil and the lingual branch of the glossopharyngeal nerve.
Ohtsuka K, Tomita H, Murakami G.
Acta Otolaryngol Suppl. 2002;(546):99-109.

Taste disturbance after tonsillectomy and laryngomicrosurgery.
Tomofuji S, Sakagami M, Kushida K, Terada T, Mori H, Kakibuchi M.
Auris Nasus Larynx. 2005 Dec;32(4):381-6. Epub 2005 Jul 19.

Taste disturbance after tonsillectomy.
Tomita H, Ohtuka K.
Acta Otolaryngol Suppl. 2002;(546):164-72.

• Hoarseness: Is It Really Laryngopharyngeal Reflux

Laryngopharyngeal reflux is an increasingly diagnosed health problem. From 1990 to 2001, prescription of proton pump inhibitor (PPI) was reported to have a 14-fold increase. Because of non-specific symptoms and shortcomings in laryngeal examination and pH probe testing, the problem may be overdiagnosed, PPIs may be over-prescribed, and hoarse patients may be subjected to ineffective treatment. This is a retrospective study in a tertiary voice centre to explore PPI use among patients referred for hoarseness and their ultimate diagnoses and voice outcomes. A total of 264 patients were recruited. The mean age was 47.2 years. Among them, 148 (56%) had tried PPI or currently on PPI treatment. 44 (29%) stopped taking PPI because of continued hoarseness (group 1) and 104 (70%) had persistent hoarseness and throat complaints despite continuing the treatment (group2). However, 62.7% of these 148 patients had improvement after voice therapy. Besides, 43.2% of group 1 and 35.4% of group 2 were subsequently found to have muscle tension dysphonia (MTD) which may often be misdiagnosed as LPR. Of the remaining 116 patients who had not received PPI before, 85.4% also improved with voice therapy. In conclusion, diagnosis of laryngopharyngeal reflux is still limited by the lack of objective and simple testing. Patients may be overtreated with PPI leading to delay in diagnosis, persistent symptoms and raising the health care costs.

Brigitta WONG

Reference

Cohen SM, Garrett G. Hoarseness: Is It Really Laryngopharyngeal Reflux? Laryngoscope 2008, 118; 363-366.

• Calcium hydroxylapatite vocal fold injectable enhances on positron emission tomography

Tissue fillers have been used for years to improve the glottic insufficiency of vocal cord palsy by increasing the bulk of the paralyzed cord. Teflon was the material introduced in 1960s but was abandoned because of the exuberant foreign body reaction and formation of Teflon granuloma. Ideal fillers should have minimal tissue reaction, does not migrate, lasts predictably and easy to use. Nowadays, common materials used include fat, hyaluronic acid, gelfoam and calcium hydroxylapatite (CaHA). Injectable CaHA has been FDA-approved for vocal cord augmentation since 2002. It was prepared in the form of CaHA microspheres 25-40μm in diameter

bathed in 70% carboxymethylcellulose gel. Studies in the past few years have shown good phonation results. However, this paper is the first to report an interesting finding of a patient receiving CaHA injection for treatment of vocal cord palsy. PET scan was performed one and four months after vocal cord injection and was found to have a focal uptake in the larynx, deep to the thyroid lamina, in the area of injection. There was also interval increase in SUVs from 4.1 to 6.7 g/ml in the patient's two post-injection scans. These findings lead to two important clinic points. First is the possibility of breakdown of the CaHA gel causing subsequent higher metabolic activity over time. Second, is the diagnostic confusion of the PET scan in differentiating a benign event from metastasis. Further studies on long-term results of CaHA injection are probably needed to investigate for its safety and use.

Brigitta WONG

Reference

Grant N, Sulica L, DeCorato D. Calcium hydroxylapatite vocal fold injectable enhances on positron emission tomography. Otol Head Neck Surg 2008; 138; 807-808.

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HAHOS in Nepal, 2009

Nepal means the Himalayas and trekking to most of us. It also means voluntary work to me since Jan 2009. Dr Buddy YK Wong offered me the opportunity to join him to perform otological surgery in Nepal for the poor. I immediately realized this was an excellent opportunity to combine trekking with work in one trip. The only question I asked Buddy before I committed myself was whether my wife could come along. The expedition is jointly provided by the Hong Kong Adventist Hospital Otology Service (HAHOS) and the Scheer Memorial Hospital of Banepa, Nepal. The Hospital is a missionary one run by Seventh Day Adventist. At present, it has no ENT service. Buddy conceived the idea after he performed surgery for charity in another similar camp organized by Mr. Weir in the Western part of Nepal in March 2007. Mr. Weir is a British ENT consultant who masterminded 30 surgery camps in different parts of Nepal. Prominent otologists had joined in the past.

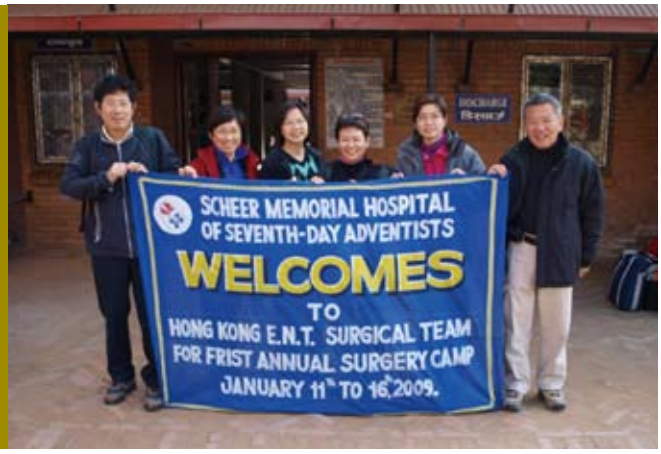
▼ Scheer Memorial Hospital

Nepal is a poor country, 90% of the population lives in rural areas and has limited access to hospital health care.

Actual work began long before I joined. Dr. Kashi Gyawali, a Nepalese ENT consultant who graduated from Ukraine, saw patients and enlisted them for surgery. Three otological surgery sets, two electric drills and sterile disposable OT drapes were packed. A seldom-used operating microscope, donated by HK Adventist Hospital, was shipped to Nepal weeks before. Preparatory work had been planned to minute details. Numbers of lignocaine/ adrenaline ampoule and stitches were estimated for the number of surgery we wanted to achieve. Obviously more hours were spent in preparation than in actual surgery. I must confess that my only preparatory work was to attend the last meeting before the trip. Thanks to the three nurses in the team, Clara, Operating Theatre Manger of HKAH, Kathy scrub nurse, Bonnie, Dr B Wong's Clinic nurse, all the necessary medical equipment was well packed. Clara persuaded the equipment providers to donate surplus supply to this mission. Our Lady of Maryknoll Hospital also contributed.

▼ Buddy SK Kashi

Our team arrived in Kathmandu at midnight after a 5 hour flight with 11 pieces of baggage, 165 kg in weight on 9th, Jan, 2009. The CEO of Scheer Memorial Hospital, Mr. Lincoln Morikone welcomed us at the airport. After praying in a circle, we started another 90-minute journey to our hotel in Dhulikhel in near total darkness, because, Nepal has electricity shortage and no streetlights. Duhlikhel 1.5 km above sea level was 3 km east of Banepa. It is the gateway to Tibet and Mount Everest. Spirit was high inside the van as most team members were first time visitors. Everyone wondering what Nepal was like in daytime.



▲ the team

We started work on Sunday. Saturday is holiday in Nepal and Sabbath for the Hospital. The first job was to unpack. All equipment was put on easily reachable shelves. Team members were pleased to find that the theatre condition was not as bad as Buddy's warning. The most important work of the first day was to set up the microscope shipped from HK weeks before. We managed to locate the microscope in three boxes in a storeroom full of disused medical equipment including an unused old-fashioned CT scan. We all had a moment of relief when we confirmed that the microscope was working properly. Imagine what else an otologist can do without a microscope. Nothing! Although Dr Gyawali had brought his operating microscope from his surgery in Kathmandu, we could not achieve our target operations with just one microscope.

▼ Buddy installing the microscope

The next hurdle was to get the license to practice from the Medical Council of Nepal. For this, we had to travel back to Kathmandu. Kathmandu was a crowded, dusty, chaotic city with many cars and men on the road. Three medical council members interviewed Buddy and me. They asked if this was our first visit to Nepal and what we had intended to do. After a few minutes, our practicing licenses were granted.

The next 5 days became a routine quickly. I woke up at 0615 and watched the sunrise in the hotel lawn, which overlooked the Himalaya. A group of Taiwanese Buddhist in our hotel told me that on a clear morning, one could see the reflection of sunrise just like diamonds from the three peaks of Himalaya. Unfortunately, these more than 6500 meter peaks were hidden in the clouds during most days of my stay.

▼ Kathmandu Valley

▼ Himalaya viewed from Duhlikhel

At 0715, we had our big breakfast. We had more confidence in the hygiene of hotel food. At 0800, the same hospital van took us to SMH 4 km from our hotel. Once in the hospital, surgeons did the ward round to discharge previous day's patients. The nurses prepared the instruments. At 0900, a patient was put under general anesthesia by an anesthetic technician who was very good. A medically qualified anesthetist was not available in the hospital. On the other side of the same operation room, tympanoplasty was performed under local anesthesia. The nurses had to rush the instrument processing for the next case. Surgery usually finished before 5 pm. We did the ward round to see the post-op and pre-op patients. In the ward, we saw many smiling faces, probably because the patients finally got what they had been waiting for, for 'years'. Before going back to the hotel, we had cups of the Nepalese tea and Chinese vegetable dumplings (called momos) in the hospital canteen. We had delicious dinners in the hotel at 7 pm. We chatted, laughed, and had a few jokes and beers before returning to our hotel rooms to adjourn for the day.

▼ Operation Theatre

▲ Cup Noodle

We had performed seven modified radical mastoidectomies for large cholesteatomas, 23 tympanoplasties, mostly subtotal, and 1 excision of preauricular sinus in five days. There is tremendous prevalence of middle ear diseases in Nepal. Amongst the population, age 20-40, the incidence of CSOM is 20-30%. In the afternoon of Friday, we packed up the instruments again. Buddy left some instruments in the Hospital because he is planning to return next year.

On Saturday, we went site seeing and trekking. The first site was Namo Buddha located in the mountaintop

about 1½ hours from Banepa. This supreme sacred place is one of the most important Buddhist pilgrimage sites in Nepal. It is known as the place where the Buddha, in a previous life as a prince, threw his own body to a starving tigress and her cubs. In the temple, we met Tibetans. Then we trekked in the countryside to a village Panuti. Nurse Kathy was handing out sweets to Nepalese children on the way. The next site was Lakuri Bhanjyang. Located at an altitude of 2000 m, this vantage point offered the panoramic views of the snow capped mountain peaks of the Himalayan range. It also overlooked the broad expanse of the Kathmandu valley. Contrary to the choking feeling while we were in Kathmandu, the city was calm and quiet below our feet at a distance.

The Himalayan mountains were magnificent in the winter sunshine. Everyone was highly motivated. The local staff was helpful. Trekking was peaceful. If you want to combine voluntary ear surgery with trekking in the foot of Himalaya, Banepa, Nepal is the place.

Sai Kit LAU

▼ Treking to Namo Buddha.jpg

▲ Kathy and Nepalese child

◀ Farewell Party

Robotic Surgery in Otorhinolaryngology, Head and Neck Surgery

Recent advances in robot technology have opened a new era in minimally invasive surgery. The versatility of the surgical robot has evolved rapidly since its clinical introduction in 1980.

The application of the surgical robot in cardiothoracic surgery, urology, gynecology and abdominal surgery is now well established. However, its application in otorhinolaryngology, head and neck (ENT) surgery is still in its infancy.

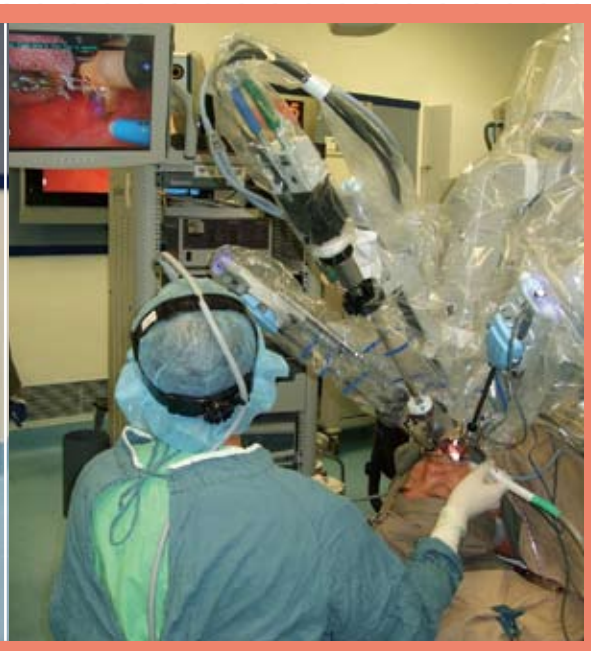
When compared with conventional endoscopic surgery, the robot system offers better 3-dimenional visualization of the operative field through its binocular optical system, enhancing depth perception during surgery. The robot endowrist system is designed to allow additional degrees of freedom of movement, which is scaled and tremor-filtered. This facilitates precise dissection in a confined space. (1)

Similar to the previous model, the DaVinci-S system is a semiactive telerobotic system. The surgeon sits in a remote console, which contains a 3-D imaging system and control input. The input signal is translated to the robot for directed and powered activity. The "S" system is equipped with three surgical arms and one lens holder arm. The extra arm offers constant retraction, allowing the remaining two arms to carry out the dissection. A 5mm robotic arm was designed for the new system to work in a more confined space, such as the oral and nasal cavities.

The first successful clinical application of the robot in ENT surgery was transoral robotic surgery (TORS)

▼ DaVinci system

▼ Intra-operative photos during TORS



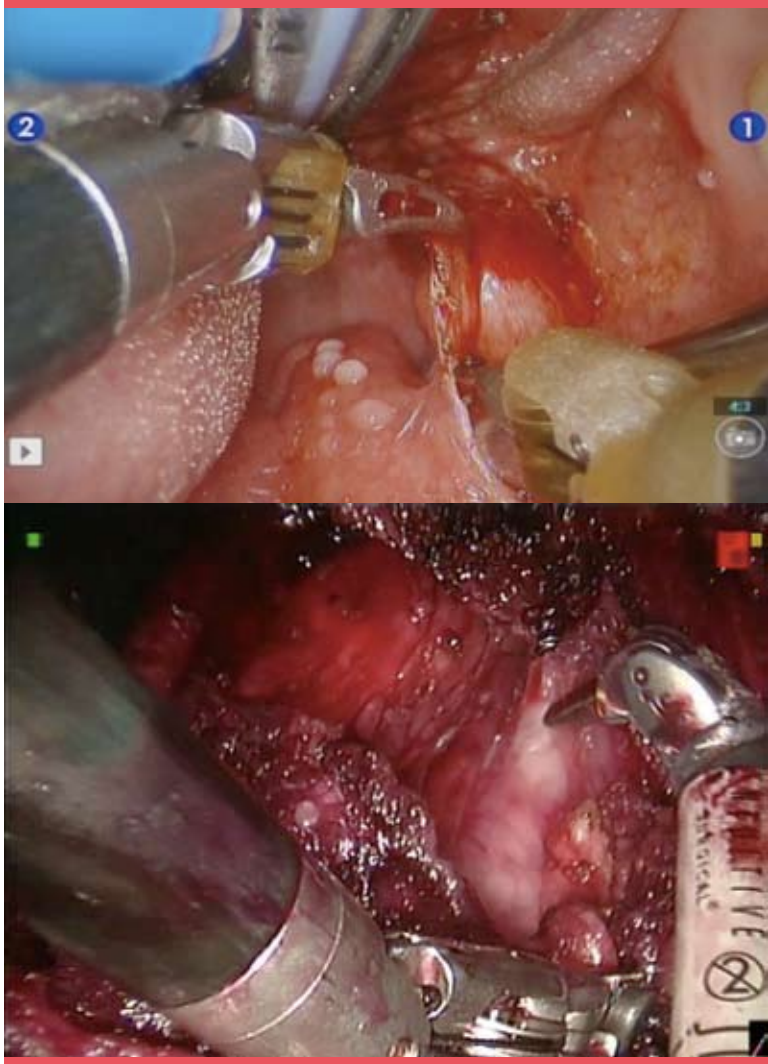
by Weinstein (2). There are total 27 patients with T1-T3 cancer of tonsil being recruited in this study. He achieved complete tumor excision using the DaVinic surgical system. The surgery was followed by staged neck dissection. Most patient recovered well with no significant surgical morbidity. Postoperative radiation was administered to 33% of patient. 56% of patient receives postoperative chemoirradiation and 7% of patient requires no postoperative irradiation.

By combining laser and robot, Densai (3) has successfully treated 8 patients with oral cavity and supraglottic cancer. This technique enables dissection down to confined space such as supraglottis by fixing laser fiber to the robotic arm. Carbon dioxide laser has the advantage of minimal thermal injury over traditional diathermy. It produces less burn artifact on histological margin analysis and facilitates fine mucosal dissection for local flap reconstruction.

Other applications of robotic in ENT remain in the stage of cadaver and animal study.

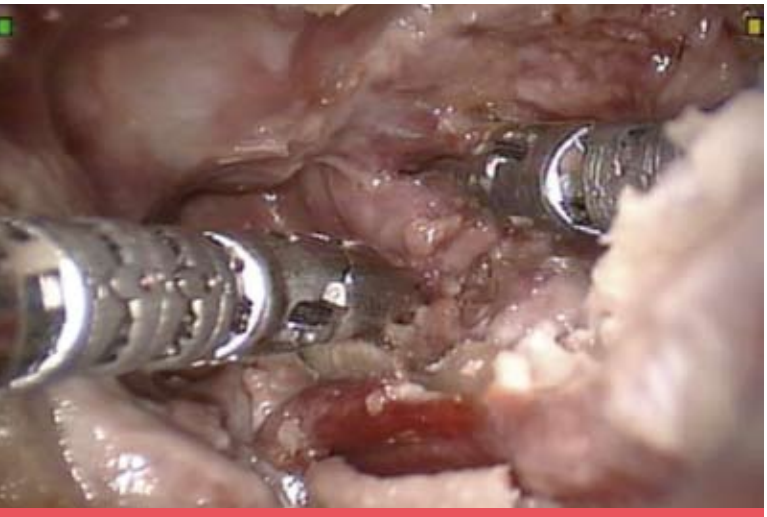
The application of robot in transnasal surgery opens a new horizon for endoscopic skull base surgery (4). It provides adequate access to the anterior and central skull base, including the cribiform plate, medial orbits, suprasellar and parasellar regions, nasopharynx, pterygopalatine fossa and clivus. The 3D visualization obtained by the dual-channel endoscope provided excellent magnified view. The highly articulated robotic arm offers tremor-free endoscopic closure of dural defects.

▼ Robot tonsillectomy lens view



▲ Porcine robotic thymectomy

▼ adaver transnasal nasopharyngectomy



In one cadaver model, Ozer showed the feasibility of complete transpalatal nasopharyngectomy, including clival resection and internal carotid artery dissection (5). Robot has also been successfully applied in various

neck surgeries including robotic submandibulectomy and robot assisted thyroidectomy (6).

Robotic surgery potentially promises to offer minimally invasive surgery while preserving the functional capacity of the patient. Like all new technologies, the cost and safety of the surgery need to be addressed before it matures enough to become standard state-of-the-art surgery performed for a wide spectrum of diseases.

Hing Sang CHAN

Reference

1. *Gourin CG, Terris DJ. Surgical robotics in otolaryngology: expanding the technology envelope. Curr Opin Otolaryngol Head Neck Surg. 2004 Jun;12(3):204-8.*
2. *Weinstein GS, O'Malley BW Jr, Snyder W, Sherman E, Quon H. Transoral robotic surgery.Arch Otolaryngol Head Neck Surg. 2007 Dec;133(12):1220-6.*
3. *Desai SC, Sung CK, Jang DW, Genden EM. Transoral robotic surgery using a carbon dioxide flexible laser for tumors of the upper aerodigestive tract. Laryngoscope. 2008 Dec;118(12):2187-9.*
4. *Hanna EY, Holsinger C, DeMonte F, Kupferman M. Robotic endoscopic surgery of the skull base: a novel surgical approach. Arch Otolaryngol Head Neck Surg. 2007 Dec;133(12):1209-14.*
5. *Ozer E, Waltonen J. Transoral robotic nasopharyngectomy: a novel approach for nasopharyngeal lesions. Laryngoscope. 2008 Sep;118(9):1613-6.*
6. *Terris DJ, Haus BM, Gourin CG, Lilagan PE. Endo-robotic resection of the submandibular gland in a cadaver model. Head Neck. 2005 Nov;27(11):946-51.*

Overseas Courses and Attachments

• Sleep Course

▼ Prof R Goode gave his talk in the Symposium

Sleep surgery is one of the youngest, yet rapidly expanding field in Otolaryngology. There are always new advancements in managing various types of sleep-related breathing disorders. In early November 2008, I had the chance to attend a three days course of 'Snoring and Sleep Apnoea Surgery' organized by Singapore General Hospital which updated my knowledge in this aspect of my career.

The first day was a whole day symposium which consisted of a series of core lectures on sleep medicine and the basics of obstructive sleep apnoea (OSA). Different specialties of 'sleep' doctors, including otolaryngologists, psychiatrists, respiratory physicians, paediatricians, who dealt with 'sleepy' patients stayed in the auditorium and attended the talks with or without falling assleep……. Bedside local speakers from Singapore, the faculty also invited world famous sleep surgeon Professor Richard Goode from Stanford University Medical Centre and overseas faculty from all over the world from Japan, Korea, Taiwan and Hong Kong to share their experience in this field. They all presented balanced and comprehensive views of the assessment and management of sleep disorders and OSA.

The second and third day were more interesting to surgeons as it had morning lectures focused on surgical techniques for OSA and hands-on cadaveric dissections in the afternoon. There was a comprehensive discussion in assessing and managing different levels of obstruction in OSA patients: nasal, retropalatal, retrolingual and hypopharyngeal obstruction. Various types of surgery, ranging from minimally invasive, office-based radiofrequency treatment to lingual excision and maxillomandibular advancement, were taught and demonstrated in lectures and videos.

Being a surgeon, the most exciting part of the course must be the hands-on cadaveric dissections. Every head specimen was shared by two participants. During the first session, I had the chance to perform hyoid suspension and genioglossus advancement. These were the first major sleep surgical procedures I had performed in my training. However, I could not put them in the logbook as they were on cadaver heads only! On another day, there were demonstrations on techniques of transoral palatal advancement pharyngoplasty and maxillomandibular advancement by the faculty. I also had the opportunity to use the Coblator machine as well as perform radiofrequency surgery on the palate and tongue base.

▲ Dennis Lee, Dr. Ignatius Mark and myself in the dissection lab

After the days' activities, I was still energetic with my wife and friends to explore all sorts of delicious food in Singapore: Hainanese chicken rice, pepper crab, Laksa and Bak Kut Teh etc. We had a ride on the Singapore Flyer to enjoy the panoramic night scenes of Singapore, visited the night Safari, took a drink at Clarke Quay and enjoyed the beaches of Santosa.

▲ Myself, Dr. Fiona Ho and Dr. Calvin Chan were enjoying the Pepper Crab

Finally, I would like to thank Prof Wei and Dr Ho for granting me this opportunity to attend the course as well as my colleagues who were burdened by extra work during my stay in Singapore. I would also like to introduce this course to all trainees and Fellows for the future as this was a fruitful and enjoyable memory for me, both the course and sightseeing in Singapore.

Joseph CK CHUNG

▼ Sightseeing in Santosa

▲ Hainanese chicken rice

Books, Articles and Websites

• The Clinical Value of Pharyngeal pH Monitoring Using a Double-Probe, Triple-Sensor catheter in Patients With Laryngopharyngeal Reflux

Archives of Otolaryngology, Head and Neck Surgery/ Vol 135(no.2), February 2009. 163-167

Larygnopharyngeal reflux (LPR) or gastroesophageal reflux disease (GERD) is widely regarded as an important etiological factor for a myriad of ENT symptoms and diseases: chronic or intermittent hoarseness, voice fatique and breaks, frequent throat clearing, sore throat, cough, excessive mucus or postnasal drip, sinusitis, otitis media, etc. The quoted symptoms and signs are subjective and by no means pathognomonic of LPR. This is why LPR is often a dubious diagnosis. The uncertainties and skeptics surrounding this condition stem from one fundamental problem: an accurate diagnostic tool for LPR does not exist.

How about the use of a single probe pharyngeal pH monitor?

No.

The problem with its use is the inability to differentiate true acid reflux from 2 important artifacts: 1. Ingestion of acid food and 2. low pH values due to occasional loss of mucosal contact or drying of the electrodes.

Isn't that 24-hour dual probe pH monitor a reliable diagnostic tool?

There is no consensus on the placement of proximal sensor: 15 or 20cm above the lower esophageal sphincter, or just below or up to 2cm above the upper esophageal sphincter (UES). If the both sensors were placed within esophagus, LPR cannot be confidently diagnosed as one might argue that the UES may still be effective as the last line of defense against pharyngeal reflux. If the upper sensor was placed at the hypopharynx, the position of the distal esophageal sensor in relation to the lower esophageal sphincter (LES) may differ in different patients because the catheter has a fixed inter-sensor distance. Yet, the constant position of the distal sensor in relation to the LES (standard being 5cm above) is important in standardization of the distal esophageal acid exposure data.

What is this paper about?

This paper aimed to investigate the clinical value of a 2-probe-3-sensor catheter in the investigation of LPR. This study involved application of this new pH monitoring device in 33 patients. By using the data obtained, the authors also analyzed and correlated the pH findings with the symptom scores and physical findings.

What was this new catheter composed of?

The catheter was in the form of a bifurcated pH probes, essentially 2 separate probes but fused at the proximal part. On one probe, there were 2 sensors and this would be placed as in routine dual-probe esophageal pH study i.e. one sensor located at the

proximal esophagus and the distal sensor positioned at 5cm above LES. On the other probe, there was one pharyngeal sensor and this was to be placed 1cm above the upper esophageal sphincter under flexible endoscope guidance.

What data were recorded?

All the participants had clinical features suggestive of LPR. The following data were recorded:

1. patients' symptoms on a standard short questionnaire- reflux symptom index (RSI)
2. laryngopharyngeal signs and translated to a reflux finding score (RFS)
3. a diary documenting the starting and ending times of meals, liquid swallows, sleep, periods while supine, heartburn, regurgitation, and any other notable symptoms.
4. 24-hour pH values at all 3 sensors:
   a. No of reflux episodes (pH<4)
   b. acid exposure time (% of time that the pH <4) at all recording sites

What was good about this 3-sensor catheter?

It allowed placement of sensors at standardized positions. It also allowed hypopharyngeal pH- the area of interest- to be directly measured. A drop in pH value at the pharyngeal sensor site was recorded as a pharyngeal reflux episode only if the following occurred: 1. A drop in pH value below 4; 2. The drop in pH immediately followed the distal esophageal acid exposure; 3. No drop in pH during eating or swallowing; 4. A rapid sharp drop in pH value rather than a gradual one. Using these criteria, the artifacts would be minimized if not completely filtered away.

What was the cut-off for abnormality in this study?

A pH result was considered abnormal:

1. at hypopharynx- if a **single** reflux episode was detected
2. at proximal esophagus- if the total percentage of time the pH <4 was 1% or higher.

What were the findings?

There was no correlation between RSI values (symptom scores) and the degree of pH abnormalities at the hypopharynx and proximal esophageal sensor. Similar findings were found for the RFS values (physical signs score), except that there was a slight correlation between RFS values and the proximal esophageal acid exposure time. In other words, there was no apparent relationship between the intensity of symptoms and the magnitude and patterns of acid reflux.

Using the different cut-offs at the pharynx and the proximal esophagus, this study also found that abnormality of proximal esophageal pH did not accurately reflect pH abnormality at the pharynx. Both false positive and false negative results occurred.

Comments

This device looks promising to correctly depict the pH picture of the upper digestive tract. Nevertheless, the results obtained were probably not very concrete because of the lack of a well validated cut-off for abnormal pharyngeal pH status. Until good normative data is available, this device is unlikely of great clinical use. Having said that, this is probably a valuable tool for research to fill in this important knowledge gap.

Siu Kwan NG

CPD Quiz

A 30 years-old gentleman has extraction of left lower wisdom tooth 3 days ago. He developed fever, progressive neck swelling and pain subsequently. CT neck was done.

1. What is the most likely diagnosis
   a. Infected branchial cyst
   b. Ludwig angina
   c. Parotiditis
   d. Angiodema
   e. Cystic hygroma

2. Which one of the following organisms is unlikely to be involved
   a. Bacteroides
   b. Prevotella
   c. Actinomyces
   d. Streptococcus
   e. Stenotrophomonas

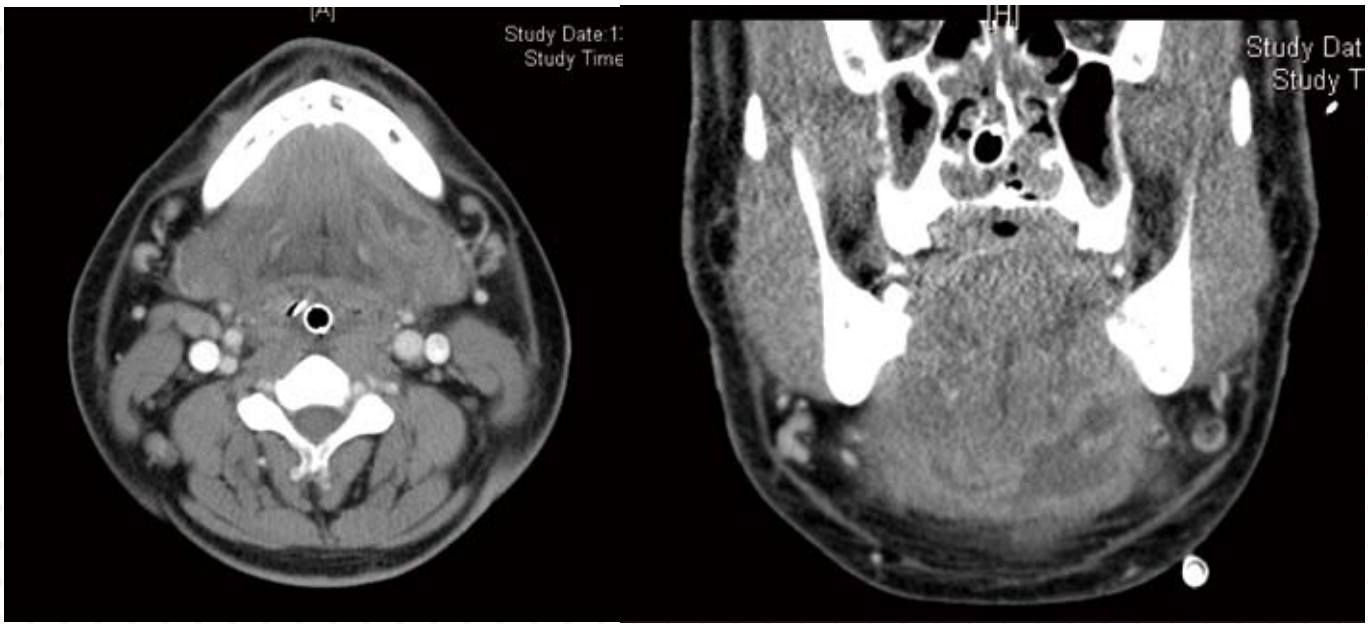
3. Treatment of this patient may require the following except
   a. Intubation
   b. Intravenous antibiotic
   c. Incision and drainage
   d. Excision of submandibular gland
   e. Tracheostomy

4. Infection of which of the following space results in Ludwig's angina
   a. Sublingual and submaxillary space
   b. Masticater space
   c. Paraglottic space
   d. Pre-epiglottic space
   e. Parapharyngeal space

5. Which one of the following is unlikely to be a cause of Ludwig's angina
   a. fractured mandible
   b. infected nasolabial cyst
   c. submandibular sialoadenitis
   d. peritonsillar abscess
   e. infected thyroglossal cyst

6. In Ludwig's angina, angina refers to
   a. Sensation of chest pain
   b. Association with cardiac ischaemia
   c. Feeling of strangulation
   d. Intense neck pain
   e. High mortality

Ting Hon LEE



The following are the correct answers of last CPD Quiz:
1. d 2. b 3. a 4. c 5. b

CPD Quiz

April 2009

Name: _____ Date: _____

Contact: _____

Your Email: _____

Please return the answer to the College by fax at 2904 5035 before 16 May 2009. Answers with scores over 75% will be awarded one CPD points. The correct answers will be published in the next issue of Senses.

A Leisurely Note

• Domaine du Pegau

Domaine du Pegau was the last vineyard of our wine trip in Chateauneuf-du- Pape, Southern Rhone last year. Our appointment was at 5 o'clock in the afternoon but no one was there when we arrived. Actually, this should not be surprising because our visit took place in late September, their harvesting season. Everyone was working feverishly in the fields.

▲ The luckiest dog on earth, tasting grapes which are grown to become 90-pointer wines

Just as I was wondering how much longer should we would wait, we saw a car coming in our direction. And here they were: Madame Laurence Pegau, the current proprietor of the Domaine, accompanied by her husband Mark, and their daughter, Maxim. Seeing their clothes so full of dirt and sweat, I was quietly embarrassed by my impatience. At the same time, I was so excited to finally have the opportunity to meet the makers of the famous Pegau wines.

The Domaine building was relatively modest given its international reputation. There was a building for fermentation, and an underground barrel-cellar, where the actual tasting was conducted.

▼ Inspired by their pet dog I decided to taste some grapes from their fermentation vats

Madame Pegau was extremely friendly. She explained to us in detail their wine production process, and showed us the cement fermentation vats and storage barrels. The red grape varieties they use include Grenache, Syrah, Mourvedre and other varietals. Such extensive red blending gives different dimensions to their wines.

The true highlight of the visit was the tasting. We started with a tasting of 2006 Cuvee Reservee (Parker Score 92-94). The wine was full of jammy black fruits, with nose of spice, game and pepper. The wine was exceptionally smooth for a wine from Chateauneuf du Pape, and I was not surprised when Madame Pegau told me she was a big admirer of Burgundy wines. Indeed their wines showed a true balance of strength and elegance, making them very unique amongst other Rhone wines.

▼ All of their wines are bottled in the property

The next wine in line was a 2005 Cuvee Reservee (Parker score 92-94), which was a more reserved wine showing great potentials for cellaring. Then I was totally stunned by their 2007 Cuvee Reservee (Parker score 94-96) and finally the 2007 Cuvee da Capo (Parker score 98-100). They were the greatest wines I had ever tasted from barrels, showing vibrancy of a young wine with an excellent structure indicating their cellaring potentials. I still remember them vividly today. It was truly the perfect way to end my wine trip in Rhone, and I shall definitely go back when the opportunity comes up again. In the mean time, I will keep stocking up Rhone wines before their prices go too high with growing attention from investors worldwide.

Frederick WONG

• Two Light Hearted Verses from the Esteemed Journals

Let Your Yea Be Yea

There is the story of the examiner who was a bully. He became quite impatient with an Indian candidate and bawled at him: "Answer me, yes or no. Has this patient got mitral stenosis?" The gentleman from the East edged up to him until he was quite close and gave the answer in a whisper – "Perhaps."

As the Examiner sees it
Lancet, 1947

Mind What You Say

A young man went to a doctor for a life insurance examination. The doctor took his pulse and tested his heart and in doing so looked at his watch, shook his head, and said, "Dear, dear!" The patient was perfectly convinced that this was his death sentence, and his mournful reflections on it so turned his mind that eventually he came under the care of a psychiatrist. The psychiatrist investigated the matter and, knowing the insurance examiner, rang him up and asked what was organically wrong with this young man. "Sound as a bell," was the reply. "But he says," the other went on, "that when you examined him you looked at your watch, shook your head, and said, "Dear, dear!" The doctor reflected a moment and then said, "So I did. I looked at my watch and found the darned thing had stopped again."

B.M.J.1947

A Physician's Prayer

Lord give skill to my hand, clear vision to my mind, kindness and sympathy to my heart. Give me singleness of purpose, strength to lift at least a part of the burden of my suffering fellowmen, and a true realization of the rare privilege that is mine, Take from my heart all guile and worldliness, that with the simple faith of a child I may rely on Thee. Amen.

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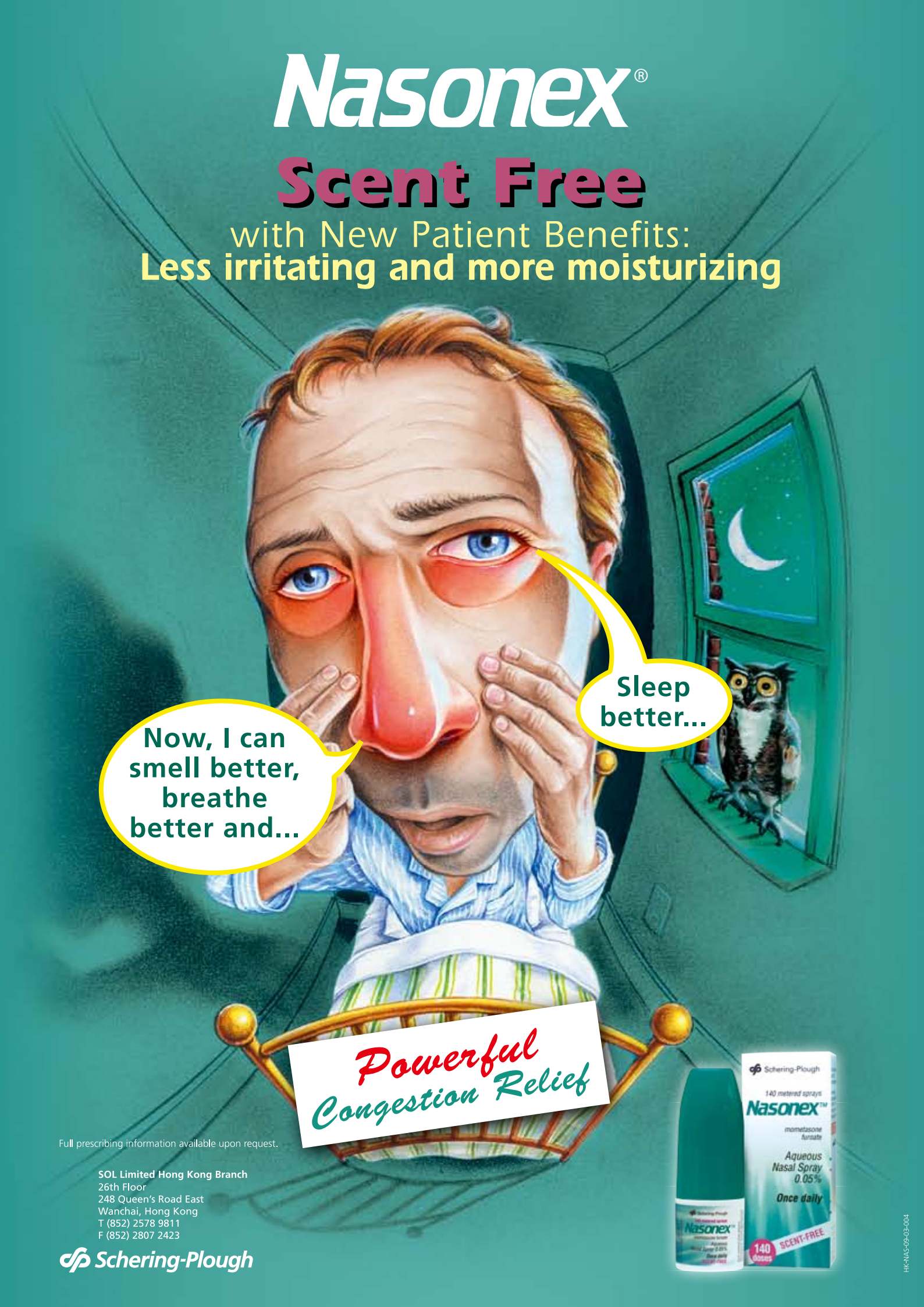

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