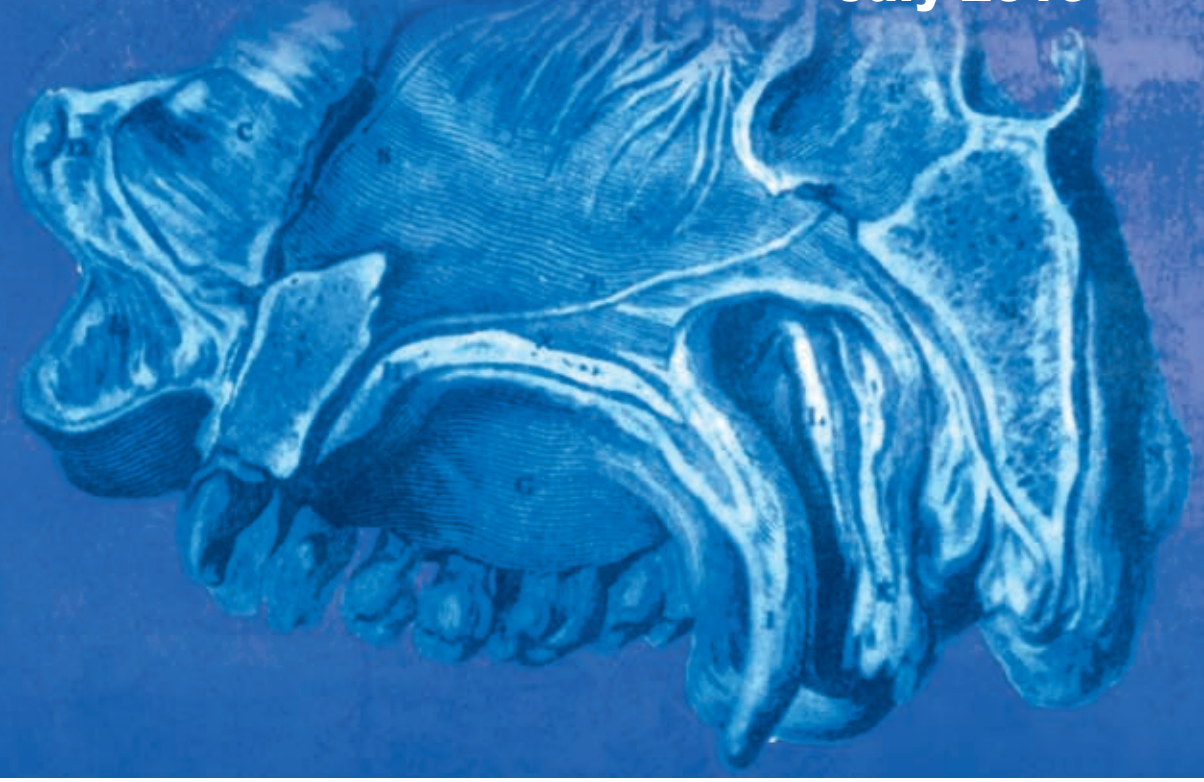
Senses

THE HONG KONG COLLEGE OF
OTORHINOLARYNGOLOGISTS NEWS MAGAZINE **July 2010**



THE HONG KONG COLLEGE OF OTORHINOLARYNGOLOGISTS

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Note on Cover

Dissection of the Olfactory Nerve by John Hunter

Contents

Editorial Board

Message from the President

Dear Fellows and Members

Welcome to the first issue of the SENSES in 2010.On behalf of the council, I would like to give my warmest wishes to you and your family.

Recently, the Academy has been revisiting the training system of our Colleges. The cultural change of our society coupled with the increasing demand for transparency and accountability of service delivery have made practising medicine in the 21th century much different from days of the past. While the rapid advancement of medical knowledge and technology have facilitated the development of high standard medical care to our patients, it has also put a demand on us to keep abreast of new advances and skills in our specialty. As our practicing field expands and becomes more complex, the call for subpecialisation comes into the limelight. Recently, the implementation of a work hour reform for doctors in the Hospital Authority have prompted the discussion on whether the quality of our training will be affected, given the reduction of working hours. In the limited period of six years of specialist training, one should give a second thought as to which is the best way to train our doctors to acquire all the competencies required of a specialist to meet the need of our society.

Six years of training is a relatively short time in our working lives. Our basic surgical training system has been under criticism for spending a considerable amount of time invested in training of specialties not so much related to otolaryngology, for we are obliged to do so under the basic surgical training system presently coordinated by the Intercollegiate Board of Surgical Colleges. The dilemma of having our own training system vis-a-vis a system that is Edinburgh led has confronted us from time to time. Will our future Fellows like one College diploma instead of two even though the Edinburgh diploma does not allow us to practise in UK? Will our training centres have any manpower problem if there is loss of reciprocal rotation of trainees from sister Surgical Colleges after dissociation of our College from the Intercollegiate Board? These and other potential areas of concern need more careful debate and consideration before we revamp our training system.

Subspecialisation of our specialty is another area for a deeper thought. Should we be producing more generalists or subspecialists? I think we should all approach this issue with an open mind, put aside our self interest and ask ourselves which approach can fulfill our ultimate goal of benefiting our patients and meeting the demand of our society. In an editorial of Clinical Otorhinolaryngology in 1996, Professor Maran has pointed out “It is unrealistic to expect all the skills encompassed by modern otolaryngology to be held by one person. The continued demand for our services will come because of our excellence and innovation, and not from clinging to out of date and inappropriate practices”. When knowledge and skill become very complex as a result of rapid advancement, subspecialisation in one area will facilitate development of surgical expertise to a higher standard. However, more subspecialisation may increase health care cost, limit the access to care of patients with multiple problems. For a small specialty like us, fragmentation of the parent specialty is a risk. Subspecialisation may negate the role of the generalist and may place those without subspecialisation or have chosen not to subspecialise at an unfair market advantage. Such development may affect every otolaryngologist and I welcome your thoughts and opinions on this important issue.

I hope reader will find this issue of Senses informative and interesting. On this occasion, I would like to express my sincere thanks to Dr.Victor Abdullah who has again taken up the important task of editor-in-chief and members of the editorial board for their continuing support in the preparation of our College News Magazine.

MA Kwong Hon

Message from the Editor

My heart sank or possibly stopped for several moments when I heard from WK (Dr Ho) that I had been reappointed to look after Senses in absentia. On second thoughts, it really has been most enjoyable working with my co-editors over the years and I must say their effort and selfless contribution of personal time deserves the highest of praises. My message remains that Senses does welcome contributions from all members and Fellows of our College. The editorial board will be looking at how the format could be further improved. We do owe it all to Dr SK Chow who years ago had the vision of establishing 'Senses', a name he coined, which now serves well our members and Fellows. In the present issue, the President and the new College Council sends their greetings. Dr Birgitta Wong has written a brilliant review on the recent breakthrough in the treatment of Haemangiomas with 'Propanolol' which is a must to read. Dr Chong Hou Ming shared his valuable clinical experience on Pseudotumours in his case reports. Dr Talen Wai visited Dr Lawrence Chow at Baptist Hospital in this issue though since the interview, Dr Chow has moved on to set up his own practice. Many congratulations Lawrence! I wish to thank in particular Dr S K Ng for looking after the section on Books, Articles and Websites so admirably over the past years. This is his last contribution and it is also his wish to see more of younger specialists contributing and I echo his wishes. Thank you SK for your superb work and support! Last but not least is Dr Eric Tang's African Trip which I really enjoyed reading perhaps setting the mood appropriately for a summer break? Please enjoy the July 2010 issue of Senses.

Victor ABDULLAH

Council News

Annual General Meeting 2009 was successfully held on November 28, 2009. A new Council was elected with members as follows:

President	Dr. Ma Kwong Hon
Vice-President	Dr. Victor Abdullah
Hon. Secretary	Dr. Ho Wai-kuen
Hon. Treasurer	Dr. Luk Wai Sing
Censor-in-Chief	Dr. Woo Kong Sang
Council Members	Dr. Fung King Hay
	Dr. Lam Tai Yiu
	Dr. Li Ming Fai
	Dr. Tong Fu Man
	Professor William I. Wei
Immediate Past-President	Dr. Fung Kai Bun

A new Education Committee was formed with the following members

Dr. John Woo	Censor-in-Chief,	Chairman
Dr. Ma Kwong Hon	President,	HA (KWC)
Dr. Chan Ka Chong		HA (HKEC)
Dr. Chong Hou Ming		HA (KCC)
Dr. Wong Yee Hang		HA (HKWC), HKU
Dr. Ho Fung		HA (NTWC)
Prof. Michael Tong		HA (NTEC), CUHK
Dr. Tang Shu On		private sector
Dr. Talen Wai		representative, HK Society of ORL-HNS

The Education Committee is responsible for looking over training and education issues and organizing exit examinations.

New Education Co-ordinators were appointed to co-ordinate training of trainees in the public sector:

Dr. Chan Ka Chong	PYNEH
Dr. Chong Hou Ming	QEH
Dr. Wong Yee Hang	QMH
Dr. Ho Fung	TMH
Dr. Ngai Chi Man	YCH
Dr. Peter Ku	PWH, UCH

Members from the private and public sectors are currently invited to be members of the CME/CPD Committee which will be responsible for CME/CPD activities for Fellows.

We welcome new Fellows joining the College in 2009. They are:

Dr. Amy Cheung	QMH
Dr. Chow Man Wai	PWH
Dr. Chow Siu Wah	TMH
Dr. To Shing Howe	TMH
Dr. Wong Wai Yeung	PWH

Dr Amy Cheung

Dr Chow Man Wai

Dr Chow Siu Wah

Dr To Shing Howe

Dr Wong Wai Yeung

Drs Chow Man Wai, Wong Wai Yeung, To Shing Howe, Amy Cheung & Chow Siu Wah

New Fellows Vow the College Oath

There are also two new Members in 2009. They are :

Dr. Alice Siu	UCH
Dr. Lau Kai Yum	QMH

Dr Siu Kwai Yee

Dr Lau Kai Yum

Currently, on January 31.2010, there are 131Fellows. 19 Members in the College.

Council News

A new website for the College is now available at http://www.hkcorl.org.hk/main.php. Important information about our College, our Fellows, training guidelines, CPD / CME guidelines, arrangement about examinations are now easily accessible through the webpage. The list of Fellows is also available on the website. Fellows and members are also most welcome to communicate with the College through the website or to the address info@hkcorl.org.hk by Email.

Spokesman of our College
Our president Dr. Ma Kwong Hon and Dr. Fung Kai Bun, our immediate past president, will serve as spokesmans of the College for the first half year of 2010 in communication with the media.

The renovated College Chamber on the 8th floor, HK Academy of Medicine Jockey Club Building is now in full function. A plaque with the names of donors with more than HK$10,000 donation is posted in the Chamber.

Beginning in 2010, the College and the Hong Kong Academy of Medicine will collect annual subscriptions separately. Fellows are reminded to settle these separate subscriptions as such.

The Trainees' Presentation on Research was held before the AGM 2009 on November 28, 2009.


Dr Eddy Lam


Dr Fiona Wong


Dr Fung Tai Hang


Dr Lee Chi Chung


Dr Stephen Lau

The winner of the College Prize for best paper and presentation was awarded to Dr. Lam Wai Hung, Eddy. His topic of research was on 'Any Potential Predictors of Malignancy in Cytologically Indeterminate Thyroid Nodule?' Dr. Lam also received a scholarship of HK$10000.00 from the HK Society of Otorhinolaryngology - Head & Neck Surgery Thomas Cheung Educational Fund. He will give a report on his training with the scholarship in the Trainee's Presentation 2010.

Dr Eddy Lam & Dr Fung Kai Bun

Dr Eddy Lam & Dr Yip Po Tin

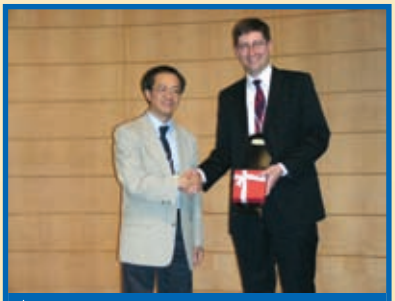
The George Choa Prize was given to Dr. Fung Tai Hang, Thomas. He spoke on his research on 'A Prospective Study on Efficacy of Topical Mitomycin C as an Adjuvant Treatment in Pinna Keloids'.

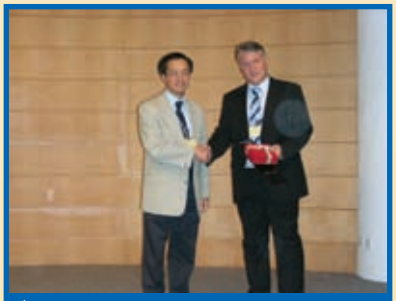
Dr Thomas Fung & Dr Fung Kai Bun

Visitors to the College

Mr. Trestram Lesser, Ullas Raghawan, Simon Watts, Stephen Lo and Carl van Wyk of the Royal College of Surgeons of Edinburgh came in May 2009 to present the 3-days' HA Commissioned Training Program 2009/2010 in Facial Plastic Surgery.


Fellows & Guest Speakers


Dr John Woo & Mr Carl van Wyk


Dr John Woo & Mr Tristram Lesser


Dr John Woo & Dr Stephen Lo


Dr Stephen Lo


Mr Carl van Wyk


Mr Ullas Raghavan


Mr Tristram Lesser


Mr Simon Watts & Dr Fung KB


Dr Stephen Lo & Dr Fung KB


Mr Tritram Lesser & Dr Fung KB


Mr Ullas Raghavan & Dr Fung KB


Mr Carl van Wyk & Dr Fung KB

Prof. Jochen Werner, Philipps University of Marburg, Germany, delivered talks on Application of Laser in Head and Neck Surgery and Laser Surgery for Larynx in July 2009.

Dr Fung Kai Bun, Dr Kwok Po Wong, Prof Werner and Dr Fung Shiu Kee

Fellows & Prof Werner at the College Chamber

Prof Jochen A Werner

Prof Werner & Dr Fung Kai Bun

Dr. Ahuja, the Chinese University of Hong Kong gave a talk on Ultrasonography and the ENT Professionals in the scientific meeting in November 2009.

Prof Anil T Ahuja

Council News

Professor SP Lee, Dean of the Faculty of Medicine, the University of Hong Kong delivered the College Oration in the College Conferment Ceremony in November, 2009.

Prof Lee Sum Ping & Dr Fung Kai Bun

Professor Bevan Yueh from University of Texas MD Anderson Cancer Centre, Houston, USA, gave a talk on Long-term Outcomes after Screening for Adult Hearing Loss on 26 March 2010.

Fellows & Prof Yueh

Prof. Ehab Hanna, University of Texas MD Anderson Cancer Centre, USA, gave a talk on Sinonasal Cancers: Progress, Challenges, and Future Directions in December 2009.

Prof Wei & Prof Hanna

Prof Ehab Hanna & Dr Ma Kwong Hon

Prof Yueh & Dr Ma Kwong Hon

Prof Bevan Yueh

Professor Carol Bradford from University of Michigan gave a talk on Laryngectomy in the Chemoradiation Era at the Academy on 23 June 2010.

⬆ Dr Simon Wong & Prof Bradford

⬆ Fellows & Prof Bradford at the College Chamber

⬆ Prof Bradford & Dr Ma Kwong Hon

Upcoming events

Professor William Wei of the University of Hong Kong will represent our College and speak in the Tripartite Congress on Advances in Minimal Invasive Surgeries in Otorhinolaryngology and Head & Neck Surgery in November, 2010.

The HK Academy of Medicine invites Fellows from our College as speakers in CME talks for non-specialists every year. Fellows interested to be speakers in 2011 can approach the College secretariat.

Coblation Tonsillectomy

Recently, one Fellow alerts us on the findings from the National Prospective Tonsillectomy Audit (NPTA)of the United Kingdom, published in May 2005. The focus was on the relative risks of complication of tonsillectomy by different methods. The audit (a non-randomized comparison) showed that hot surgical techniques (using diathermy or coblation) for tonsillectomy had a risk of haemorrhage three times larger than using cold instrument alone. Coblation tonsillectomy had a statistically significant increased risk that the patient needed to return to the theatre for haemostasis. The message from the audit was that "Surgeons who wish to start using new techniques should undergo appropriate training".

The College Council cannot agree less with the suggestion that all fellows should use new techniques only if they have adequate training. The Council would encourage all fellows to take proper training courses before a new instrument/technique is applied. For details of the NPTA and other evidence on Coblation tonsillectomy, fellows can read from the following resources:

http://www.entuk.org/audits/tonsil_html

Meulen J. Tonsillectomy technique as a risk factor for postoperative haemorrhage. Lancet 2004;364:697-702

Lowe D, Meulen J, Cromwell D, et al. Key message from the National Prospective Tonsillectomy Audit. Laryngoscope 2007;117:717-724

Burton MJ, Doree C. Coblation versus other surgical techniques for tonsillectomy. Cochrane Database of Systematic Revision 2007, Issue 3. Art.No: CD0004619. DOL:10.1002/14651858.CD004619.pub 2.

HO Wai Kuen

Report from Censor-in-Chief

Dear Fellows,

I would like to give you an update on the following ongoing College Matters since my last report 6 months ago :

Scientific Meetings

Lectures cosponsored by our College :

1 "Sinonasal Cancer: Progress, Challenges and Future Directions" by Prof Ehab Hanna on 10 December 2009

2. "Long-term outcomes after screening for adult hearing loss" by Prof Bevan Yueh on 26 March 2010

Examination and Training

Exit Examination :

The conjoint exit examination will be held on 22 – 25 October 2010, and as mentioned in previous reports, the syllabus will be slightly modified by having a viva on facial plastics.

BST Training and Examination :

Parallel changes in BST training in UK, similar changes are slowly being implemented locally through the coordination of the Intercollegiate Board of Surgical Colleges. One of the major change is the part 3 of the intermediate examination will take the form of "OSCE" instead of the usual viva and clinical examinations. A "Mock OSCE" will be organized by the Intercollegiate Board soon.

CME/CPD

Registration for CME/CPD points :

I would like to pass on a gentle reminder to all Fellows to submit any CME/CPD activities that are still outstanding to our College secretary. This is important as we are drawing near the end of our current CME/CPD cycle.

Non-ENT related CME/CPD Activities :

As suggested by many fellows, our College Council has revised the accreditation guidelines on non-ENT related CME/CPD activities. The revised guidelines were approved by the Education Committee and Council of HKAM and will take effective as from 1 May 2010. The new scoring system for non-ENT related activities are as follows :

1 The limit of 2 CME/CPD points per meeting was removed
2 A maximum of 10 CME/CPD points per cycle of 3 years remains unchanged

Thus although the maximum non-ENT related CME/CPD points that can be accredited remains unchanged, the number of such CME/CPD points that can be obtained has increased.

Re-accreditation of training posts in TMH

As requested by the ENT department in TMH, inspection and re-accreditation of training posts was done on 25 March 2010. With implementation of ENT services in Pok Oi Hospital, the 4th HST training post was accredited to the ENT Department of TMH

With best regards

John WOO

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/UCH	Michele Chan/Carrie Chan Tel:26323558/35135195
Every alternate Monday 5:30pm- 6:30pm	Journal Club Meeting	PYNEH	Tel:25956454
Every Friday 5:00pm-6:00pm	Journal Club Meeting	TMH	Tel:24685397
Every 2nd & 4th week of Monday 4:30pm-5:30pm	Journal Club Meeting	YCH	Tel:24178359
Every Tuesday 5:15pm-6:15pm	Journal Club Meeting	QEH	Tel:29586025
Every 1st Tuesday 5:30pm-6:30pm	Journal Club Meeting	QMH	Tel:28554452
12-14 November 2010	Tripartite Congress, AMM, AMS & HKAM	HKAM	Tel: 28718841
10 July 2010	George Choa Distinguished Visiting Professorship Lecture: Head & Neck Surgery- The Path We Have Treaded	HKU	Tel: 22554885
12-15 October 2010	5th Portmann Course on Advanced Otological Surgery	CUHK	Tel: 2947 8284 Fax: 2145 8876
15 October 2010	Audiology Workshop - "Advanced Audiological Assessments for Better Rehabilitation" (co-organised with the Hong Kong Society of Audiology)	CUHK	Tel: 2947 8284 Fax: 2145 8876
16 October 2010	Wilson T.S. Wang Visiting Professorial Lecture by William M. Luxford, House Ear Clinic, USA	CUHK	Tel: 2947 8284 Fax: 2145 8876
16-17 October 2010	Advances in Otology and Related Sciences 2010	CUHK	Tel: 2947 8284 Fax: 2145 8876
16-17 October 2010	Speech Therapy Workshop – Habilitation of Children with Hearing-impairment and Additional Needs	CUHK	Tel: 2947 8284 Fax: 2145 8876

Overseas Activities

Date	Event	Venue	Contact
20-21 August 2010	Paediatric Airways Course 2010	Singapore	Tel: 65 6394 1676 Email: henry.tan.kk@kkh.com.sg
10-12 September 2010	2nd International Congress of Minimal Invasive Plastic Surgery	Seoul, Korea	www.mips.or.kr/eng/index.asp
17-20 October 2010	IFHNOS World Tour 2010 54th Annual Convention of the Philippine Society of Otolaryngology-H&N Surgery	Philippines	www.ifnosworldtour2010.org www.psohns.org.ph
26-29 October 2010	AAO-HNS/Annual Meeting & OTO Expo	Boston, Massachusetts, USA	www.entnet.org/annual_meeting
27-30 October 2010	10th International Rhinoplasty and Cosmetic Facial Surgery Workshop 2010	Thailand	www.cosmeticrhinoplastyindia.com
29, 30, 31 October 2010	Singapore Sleep Surgery Course	Singapore	www.thesnoringdoctor.com

Report from Honorary Treasurer

I am pleased to report to you that the financial status of the College is stable and healthy. The total College funds amounted around 2.4 million at the end of the year 2009.

The primary income of the College is from Fellows' and Members' subscription. The general expenditure of the College is mainly staff and rental expenses. The College subscription should be sufficient to meet the daily operational need. Scientific meetings and Annual College Functions are well sponsored by pharmaceutical companies, medical equipment suppliers and even banks.Fellowship examination fees received from the candidates are usually adequate to cover the examination expenses. If the number of candidates is too few, the examination account could be in red and the College would have to absorb the deficit. Fellows' donation is another source of funding. Our College chamber was renovated in 2008 and the project was nearly entirely funded by Fellows' donation.

A College Investment Fund was established in 2007 and it aims at capital appreciation and strengthening recurrent income in the form of dividend and interest. The initial capital was around 577K. The investment fund account was opened in September 2007 when the financial market was bullish. Fortunately, the College Investment Fund survived the financial turmoil in 2008-2009 fairly well. The balance of the College Investment Fund was around 595K at the end of 2009. 60% of the Investment Fund is put in HSBC and Tracker Fund, slightly more than 40% of the Investment Fund is now in cash.

The College could collect the Fellows' and Members' subscription in full every year, usually after rounds of reminders. Autopay would save the Fellows the trouble of sending cheques and save the manpower of the College Secretarat. Please kindly consider using autopay to settle College subsription (enclosed is the direct debit authorization form).

Albert LUK

An Interview with Professor Ralf Siegert


Dr Frederick Wong


Dr Gordon Soo

Interviewed by Dr Frederick Wong
Foreword and Epilogue by Dr Gordon Soo

It was a lovely Spring afternoon, and we had just arrived at Essen train station from Frankfurt. There was a chill in the Spring air as well as an excitement as we waited for our connection to Recklinghausen. There we would find the one man we had travelled all the way from Hong Kong to visit – a fellow otorhinolaryngologist, a facial plastic surgery guru, a student of Professor Hilko Weerda, and a giant in his own right.

Professor Ralf Siegert's reputation for ear reconstruction par excellence and facial plastic surgery, are well known. Perhaps it was the fact that Professor Siegert is an otorhinolaryngologist that we were so intrigued; his complete approach to aesthetic pinna and functional ossicular and canal surgery, was something we had come to see.

Frederick and I were not disappointed. His department was a gem of a find, from the surgery on the ears and noses that we saw, to his surgical team members that supported his work. The teutonic approach to surgery of planning step-by-step and the technical details executed clinically – we marvelled, we "ooh-ed and aah-ed" (in Cantonese of course) like little kids watching their first magic show, were thoroughly impressed, and most importantly, learnt.

F Frederick S Prof Siegert

F *First of all, I would like to thank you for your time.*

Let's talk about your career first. We all know you are now a renowned expert in facial plastic surgery, especially otoplasty and ear reconstruction. What stimulated your interest in facial plastic surgery?

S Facial appearance is the human's gateway to others and is of utmost importance for the quality of life and interpersonal communication. Even when intellectual people are trying to search for the inner value of a person, they are emotionally influenced by the expression of the face they are looking at. Facial plastic surgery is the challenging task, for a physician's hands and mind, to increase a patient's self-image and social acceptance by improving his or her appearance.

F *About what time in your career did you start showing an interest in facial plastic surgery? Was there any particular event that triggered your interest?*

S In the second part of my student training, I was exposed to patients in the Intensive Care Unit with severe facial trauma or serious facial tumour. I saw it as a great challenge to reconstruct these huge defects and that was very important for my decision to go into this field.

F *What percentage of of your patients now are facial plastic patients in comparison to other general ENT patients?*

S It has gone up to about 60% - 70% of my work now. I also do other ENT procedures as I am in charge of the whole ENT Department. But my main interest

lies in reconstructive and facial plastic surgery.

F *Do you think that is the right percentage? Would you like to make any adjustment on it?*

S It has more or less adjusted automatically because the demand is there, and more and more patients approach me to ask for facial plastic procedures. In the beginning, the demand was not that high. But I have been doing facial plastic and reconstructive surgery for 25 years, and ear reconstructive surgery for 18 years, so more and more patients are coming. They do not just request ear reconstructive surgery, but are asking for rhinoplasty and aesthetic surgery on the one side, and tumour reconstructive surgery on the other side. Now we have increased our reputation by word of mouth, and we are seeing more patients. Actually, I do not mind as that is my biggest interest.

F *Within the area of facial plastic surgery there are still lots of sub-specializations, for example, laser surgery, face lifting, etc. Do you have any special sub-interest in any of them aside from ear reconstruction?*

S I would come from another perspective. You talked about laser surgery and minimally invasive facial plastic surgery. I think these territories are more special tools for special problems. So I would look from the other way round. What is the patient's problem? If we look into their problems, there is a huge amount of fear. One is the more functional and reconstructive aspect. The reconstructive part is about tumour surgeries, which in most cases are huge and long surgery. On the other hand there is the aesthetic part. In this part we can distinguish between minor malformations and rejuvenation surgery, which is a completely different field, and with a completely different patient collective. Now especially in rejuvenation surgery, I think you have to take the care to achieve a very low morbidity for the patients, and that means excercising great prudence in performing minor procedures. Laser is a possibility, but that is not the only one. So does this answer your question?

F *Yes. What particularly interested you in ear reconstruction surgery?*

S I think it is fascinating because we treat mostly young patients. Most of them have congenital malformations, and about 10-20% of them have tumours or traumas. What we try to do is to make them feel normal from the aesthetic point. So by changing the ear, we change their self image. That is one aspect whilst the other one is we try to improve their hearing at the same time. And hearing, of course, is absolutely important for communication.

So the great challenge for me is to try to combine aesthetic surgery and functional surgery and bring them together. If we are able to do this, we might be able to achieve good aesthetic results, improve psychosocial function, and a better hearing. That is very fascinating for me.

F *Amongst all the clinicians that you have met, who has impressed you the most and why?*

S I am glad that I have had several good teachers, but if you ask for "the one", I would like to name Professor Wolf Höltje. He was the consultant during my training in Hamburg. What is fascinating about him is he combined great manual skills, and a very sensitive feeling for the tissue with meticulous planning of each procedure in advance. A great many hours have been spent, sitting together looking over models, and in the dissection hall planning, and discussing new and challenging procedures. When you went into the OR, you always knew precisely what he was going to do. He also had a what he called "Plan B" in his mind, which was an alternative if something did not go the way he expected. So his attitude was being very responsible to the patients, very meticulous planning, and his excellent manual skills, which helped me a lot in my style in surgery.

F *Can I say you look up to him as your idol?*

S Yes, from a surgeon's standpoint, yes.

F *And his main interest is also in ear reconstruction surgery?*

S No (laughs).

He is now retired, and he was an Oral Maxillofacial surgeon. We have together done a lot of orthognathic procedures for craniofacial malformations; Huge changes for the patients and also innovative techniques for a lot of patients.

F *Did he do a lot of flaps?*

S Yes.

F *As a head of your department, what have been the biggest challenges and what has given you the most satisfaction?*

S The biggest challenge has been to convince the managers of the hospital and the health insurances that facial plastic and reconstructive surgery is for the patients' benefit, and is affordable at the same time. A lot of people are looking at the fears associated with the procedures. One is the long operative hours, and the other is the cost of the procedure, but the results are actually much better than what you will gain from prostheses. Also some people are critical of the aesthetic procedures but I think both functional and aesthetic procedures are justifiable in our society.

The most satisfaction for me is when I see my younger colleagues, whom I have been training for many years, improving on their surgical skills, being innovative and developing modifications on their own that help to improve our current state of the art. They go on from the point that they have learnt and develop new techniques.

F *Facial plastic surgery faces similar challenges in Hong Kong. On the one hand, we are aware that they will help the patients, but on the other hand we are facing a continuous demand to justify it.*

S In many countries I see the practice of two different systems. One is in the public service where people do purely functional surgery, and another one is in the private sector where people almost do purely aesthetic surgery. I think that this dichotomy is unnecessary and that functional and aesthetic surgery can and should be combined.

It is important to convince the managers in the public health system that facial reconstructive surgery is very important for patients and has to be done. Those who know about the basic anatomy and tissue structure of the face and head are the ENT doctors, and those who know about the functions are again, the ENT doctors. And then we can go from there to convince them that the aesthetic aspects are also very important to the patients because that affect the psychosocial aspect of their lives.

Another level of discussion is the financial aspect. When you start to discuss with the managers about this aspect you can tell them aesthetic procedures are good for the hospital because they can generate more income. If more money can be made and put into the system, then other patients can be helped as well.

F *What do you think will be the direction of facial plastic in the future?*

S There are many different directions that I can think of. One is that we are working on surgical modifications that will reduce the morbidity of the operations that we are doing, which also means a higher acceptance by the public. However less morbidity does not mean a less desirable result. We always have to look into what results we can achieve, the morbidity of the operations, and combine them.

Second is, I think we have come to the point where we no longer do purely aesthetic surgery, or functional surgery. We combine both of them. More and more patients come to us, for example, and want to have nice ears and want to hear; want to have nice noses and want to breathe well; want to have nice eyelids and proper lid function.

And then I think some surgeons have made a huge step by performing the first facial transplantation. I think that is a completely new challenge for us. We have been working with various flaps and improving our techniques to close different defects, but facial transplantation is a tremendous step ahead, and is much better than all the flaps that we are doing so far. Its indication will be limited to a few patients, but facial transplantation is a technique that we

would like to offer to our patients in the future.

F *What sort of a time frame are you talking about on the development of facial transplantation in your centre?*

S I think we are already in the phase. We have seen it work, and I think in 5 years time, you will hear more and more about those procedures. We will have it as an option for patients with huge defects of the face.

F *Will it be more indicated for congenital conditions, or acquired conditions?*

S More for acquired defects for example severe trauma cases. I think it's very important to discuss this procedure in the public. Because there is a huge fear in the public, that we will become so powerful to change patients completely. But that's not the case, we only want to reconstruct them in an optimal way, and that can be one part of our techniques.

F *What advice would you give to aspiring facial plastic surgeons?*

S It has been old tradition in Germany that craftsmen, having finished their apprenticeships, put on their special traditional costumes and go out searching for various masters to learn from. They had to go out for three, four, five, six years. And then they came back to set up their own little business. The philosophy behind this is also good for facial plastic surgeons. They should be like these old craftsmen. So I would advice young, ambitious colleagues to go out and learn, and not stay in their places.

In particular I would advise them to read, read and read again, also the old books, not only the new books. Because many of our pioneers had performed great operations and we should know about them. Second I would advise them to go out and watch skilled surgeons in the operation room, as many as they can. They have to be exposed to different techniques. And they have to be trained, which can only be done in the dissection hall. They should try to do what they had seen and perform it. Then they have to plan, plan and plan again and make alternatives. Whenever they go into the operation room, they should have a clear concept in their mind, with a plan A and plan B, and they have to do it. They should be able to perform the operation without fear, because they have prepared themselves; without boastfulness, because you are just a beginner, and never with carelessness, because nature does not forgive any mistake.

F *Your work is demanding as we have seen. How do you balance between your work and your personal life?*

S It is difficult sometimes. I have a wife who has a deep understanding and acceptance of my professional commitments.

In our clinic I am glad to have what I call a "Power-Team". There are tremendously skilled colleagues in my team with great ambitions. They help me a lot to fulfil our professional skills and to run the department. And to keep the balance also means to organize. Personal life must have its place and time – even if the desks and to-do-lists are still full. At a certain point you have to stop and say ok, now it's time to leave for a while.

F *Do you work on weekend, or bring your work home?*

S I try not to be in the clinic, but I am available when my colleagues need me, although they are very experienced and they hardly do. However, I take some work home at weekends.

F *Thank you again Professor Siegert. We have learnt a lot from your experience.*

S Thank you for having an interview with me.

It was a frank interview of substance with such a modest man….and the honour and the delight was all ours.

We took our leave from Professor Siegert and our new friends after ten magnificent days, and hit the famed Autobahn. We took turns at the wheels of the other German marque, Mercedes Daimler, as we sped back to Frankfurt by road. Our surgical lives had been changed forever and we could never see our work in

the same way again. How could anyone ever be the same again after rubbing shoulders and minds with Professor Siegert, understanding his passion and revelling in the sight of his work.

We were excited, empassioned and speeding off to our facial plastic surgery horizon back in Hong Kong, as fast as the German Autobahn would allow us….but even then, just… *not fast enough!*

Dr Frederick Wong, Professor Ralf Siegert & Dr Gordon Soo

Professor Ralf Siegert

Hospital Tour

It was a sunny Friday morning when I stepped into Hong Kong Baptist Hospital. I received the warmest welcome by Dr. Lawrence Chow Chun Kuen, consultant otorhinolarygologist and Director of the Ear Nose and Throat Centre. 1

The waiting area provides a cozy environment for patients and their relatives. 3 The audiology and speech centre, located on the same floor, is equipped with all the essential otological tests an ENT surgeon needs. 4 They are all done by the certified speech therapist who also holds a master degree in audiology. The compact and efficient setting allows patients to receive one-stop professional service. In particular, as Dr. Chow is an otologist and a cochlear implant surgeon, his patients can definitely benefit from the confluent assessment and rehabilitation pre- and post-operation.

Photo1

Meeting the Director

Photo3

Photo4

The ENT Centre is located on the 7th floor of Block B. 2 Being the first hospital-based ENT Centre in Hong Kong, it is dedicated to provide quality, comprehensive services to meet both paediatric and adult ENT healthcare needs.

Photo2

The consultation room is comfortable for both patients and their relatives. 5

Photo5

Hospital Tour

In the examination room, all the findings from microscopic, endoscopic and even videeostroboscopic examination are shown on the monitor dedicated for patient's information if interested. 6 7

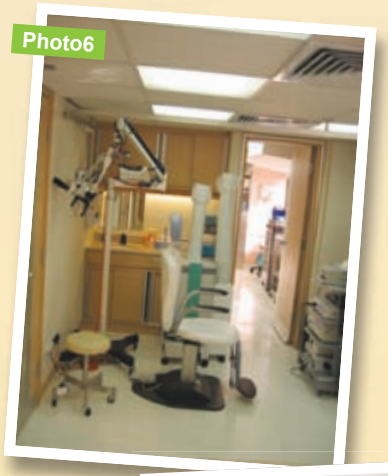


Photo6


Photo7

Screen dedicated to patients

Another door would lead you to the spacious operating area where ENT procedures and minor operations are performed. The big windows allow daylight to be shed upon the examination room and the scenic environment outside provides immediate relief for the anxious patient. 8


Photo8

Daylight relieves the anxiety

The new Block D was established in 2008. 9 It represents a significant milestone in the Hospital's development. This magnificent building provides a wide range of quality medical service. The Heart Centre, Urology and Endocrinology Centre and Upper Gastrointestinal Surgery Centre are all located there to provide state of the art service.


Photo9

To improve the health awareness of the community and to advocate healthy lifestyle, the Wellness Centre provides primary preventive care for all walks of life. In Mrs. Au Shue Hung Memorial Centre, different health screening programs are tailored according to individual needs, and specialists are always available to help and advise. 10 11


Photo10

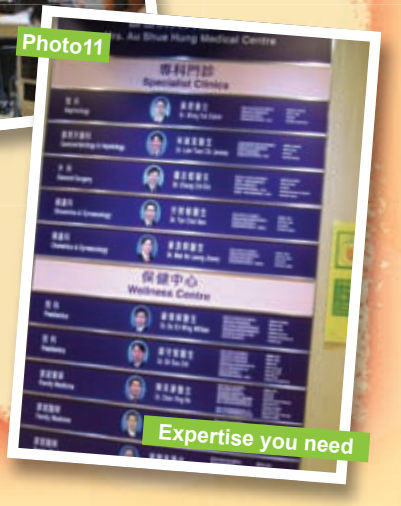


Photo11

Expertise you need

The private rooms and suites in the new Block D are located on the 6th to 8th floor. The suction apparatus and wall-mounted oxygen are all hidden behind screens, the impession of a first class suite in an executive hotel. 12 Outside the window is the panoramic view of the Kowloon peninsula. 13 This definitely serves as part of the patients' prescription! Moreover, as a Christian hospital, one can have spiritual support available anywhere. 14

Photo12

Photo13

Photo14

Spiritual supports everywhere

A short interview with the Director of the ENT Center, Dr. Lawrence Chow. 15

Photo15

What is the secret of managing the centre?
"Apart from a doctor, our team also includes nursing staff, heath care assistant and clerical workers. Teamwork is of paramount importance. Every member is crucial to the team and the contributions should be fully recognized." Dr. Chow explained. "In addition, continuous education and self-development opportunity have to be given. Every staff has incentive to improve."

I was curious if there were any difficulties in practice over these years of running the centre.

"ENT is a specialty with emphasis on improving the patient's quality of life. Occasionally, patient's expectations may not be rational and it is not always possible to fulfill. Complaints are becoming an increasing and genuine problem." Dr. Chow added, "We are seeing more patients from the Mainland China. They usually come with strict time limitation. In some cases, even a follow up appointment to see the progress is not possible!." To tackle these problems, Dr. Chow emphasized the importance of thorough communication and spending time to explain to patients in detail. The professional medical service can never be jeopardized by time constraints.

This trip to Baptist Hospital was fruitful. I would like to express my sincere gratitude to Dr. Chow for all his help in making this tour possible.

The Effect of Multilevel Upper Airway Surgery on Continuous Positive Airway Pressure Therapy in Obstructive Sleep Apnea/ Hypopnea Syndrome

By Joseph Chung

Upper airway surgery (UAS) provides an alternative treatment to obstructive sleep apnea/hypopnea syndrome (OSAHS) patients who refuse or are intolerant of continuous positive airway pressure (CPAP) therapy. A systemic review of multilevel surgery demonstrates 64% success rate. Some patients still have persistent disease requiring CPAP therapy. There has been some debate concerning the effect of UAS on postoperative CPAP pressures. Previous literatures which showed UAS had adverse effect on CPAP usage were small scale studies using outside control group. This makes the statement questionable.

In this study, Friedman presented fifty-two patients who had persistent symptoms of OSAHS after multilevel UAS, i.e. uvulopalatopharyngoplasty, radiofrequency tongue base reduction and a variety of nasal procedures. All patients underwent both preoperative and postoperative manual CPAP titrations and the study designed to use their own setting as controls. Results of this study showed that CPAP pressure setting decreased significantly from mean 10.6 cmH2O to 9.8 cmH2O postoperatively. Fifty patients (96.2%) maintained optimal pressure setting without mouth leak. With the above findings, the CPAP therapy compliance increased from a mean 0.02 hrs/night prior to surgery to 3.2 hrs/night following operation.

In patients who had residual OSAHS after multilevel UAS, the operative procedures did not lead to mouth leak that precluded CPAP therapy. Furthermore these might have facilitated CPAP therapy because both pressure setting as well as compliance improved postoperatively.

Friedman M, Soans R, Joseph N, Kakodkar S, Friedman M
Laryngoscope, 119:193-196, 2009

Evaluation of ApneaGraph in the diagnosis of sleep-related breathing disorders

Sleep-related breathing disorders (SRBD) affect about 4% of the population. The identification of level of obstruction might help predict the success of surgery for SRBD. There are various methods to determine the segment of upper airway obstructions ranging from Friedman clinical stage for the tonsil sizes and palate position, endoscopic assessment using Muller Maneuver or drug-induced sleep to imaging by lateral cephalometry and dynamic CT/MRI. ApneaGraph is a new technology designed for the evaluation of SRBD. It consists of a catheter with two different sites of micro-pressure and temperature transducer. After insertion through the nostril during sleep, it measures the pressure and airflow, analyzes the cardio-respiratory pattern and hence determines the apnea-hypopnea index (AHI). Besides it has the potential advantage of identifying the level of obstructions for surgery at the same time.

The study recruited forty-nine patients, first group had thirty patients underwent an overnight polysomnography (PSG) with ApneaGraph study to validate the system. The result showed that there is no significant differences between ApneaGraph compared to PSG in terms of AHI, AI, average O2 saturation and maximum desaturation. For the remaining nineteen patients who had simultaneous ApneaGraph and sleep endoscopy (SNE), there was poor correlation between them. If ApneaGraph showed a predominant upper site of obstruction, SNE would agree

the finding. In contrast, in cases that ApneaGraph identified obstruction mainly at a lower pharyngeal contribution, only half were confirmed by sleep endoscopy.
The finding of the study showed that ApneaGraph provides reliable measure of AHI and pulse oximetry. However ApneaGraph should be used only as screening tool for identifying level of obstruction because it places greater emphasis on a lower pharyngeal obstruction. Further evaluation is needed to ascertain the data regarding upper and lower pharyngeal obstruction before formulation of surgical intervention.

Singh A, Al-Reefy H, Hewitt R, Kotecha B.
Eur Arch Otorhinolaryngol (2008)365:1489-1494

Successful treatment of subglottic haemangioma with propranolol

By Dr. Birgitta Wong

Subglottic haemangioma is a well recognized although rare cause of stridor in infant. Many types of treatment have been proposed including tracheostomy, systemic and injection steroid, laser ablation, interferon and open surgery in recent years. I first came across the use of propranolol for treatment of cutaneous haemangioma last year during a discussion with Dr Abdullah and the consultants from Great Ormond Street Hospital for children at the Paediatric Airway Course. I would therefore like to take this opportunity to review on the application of propranolol in subglottic haemangioma.

85% of subglottic haemangiomas presented by 6 months of age as inspiratory or biphasic stridor. 50% of patients with subglottic haemangioma have a concomitant cutaneous lesion while 1-2% of patients with a cutaneous haemangioma have a subglottic lesion. The proliferative phase lasted for 3-9 months followed by involution. However the rapidly growing haemangioma can lead to complete airway obstruction at the narrow subglottis and therefore require intervention. Tracheostomy for circumferential haemangioma has been used but is associated with severe morbidity. Systemic steroid used alone has a proven benefit in 25% of patients [1] but is accompanied by side effects including hypertension, Cushing syndrome, growth retardation , hirsutism and cardiomyopathy although we have been trying to reduce these with an alternate-day regime. Local injection of steroids may require postoperative intubation and prolonged ICU hospitalization due to further swelling of the airway. CO2 laser surgery is good for unilateral haemangiomas but may bear the risk of subglottic stenosis. Open submucosal resection for bilateral and circumferential haemangiomas has been proven successful in large centres with expertise.

Effect of propranolol therapy on cutaneous haemangiomas in 11 children was first described in 2008 by Leaute-labreze [2]. Propranolol is a non-selective ß blocker and beta-2 receptors for propranolol are expressed in the haemangioma endothelial cells. The proposed mechanisms of propranolol include apoptosis induction and decrease in production of endothelial vascular and fibroblastic growth factors (VEGF and FGFß) [2]. With the success of propranolol in the treatment of cutaneous haemangiomas, effect was studied on subglottic haemangiomas. In the literature, there are two papers published on this. Denoyelle F. et al reported 2 infants with both cutaneous and obstructing subglottic haemangiomas which were resistant to steroid and vincristine therapy. After initiation of propranolol orally 3mg/kg/day for 4 months and 2mg/kg/day for 2 weeks respectively, the haemangiomas rapidly decreased in size [3]. The other paper by Hartley BE et al from Great Ormond Street Hospital published this year further demonstrated the successful treatment of isolated subglottic haemangioma with propranolol alone in a 4-month old infant [1]. The haemangioma initially presented with 95% obstruction of the airway. With 5 weeks of

oral propranolol, the lesion decreased to 50% obstruction while after 5 months, the lesion was less than 50%. Finally the medication was stopped at the 12 months of age.

Propranolol can have potential side effects including bradycardia, hypotension, bronchoconstriction and masking the symptoms of hypoglycaemia. A useful guideline has been suggested by GOSH for its use with an initial dosage of 1 mg/kg/day in three divided doses for 1 week and then 2mg/kg/day in three divided doses for the second week onwards. Pretreatment investigations include a full cardiovascular and respiratory assessment, blood tests for complete blood picture, liver and renal function test, glucose, thyroid function test, electrocardiogram and echocardiogram. Blood pressure and pulse have to be monitored for 4 hours after the first initiation of the treatment. Blood glucose has to be checked monthly [1].

Propranolol therapy appears to be effective and non-invasive. However, in small unilateral subglottic haemangiomas, the risk and benefit of a few sessions of laser surgeries compared to potential side effects of months of oral propranolol is still lacking. Future large scale studies on the recommended duration of treatment and the concomitant use with surgery or steroid are needed.

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Pseudotumor of Nasopharynx::--Report of Two Cases

By Dr Chong Hou Ming

Like inflammatory pseudotumor of the upper airway, post irradiation “pseudotumor” of nasopharynx (NP) clinically mimics a neoplastic process and is an uncommon lesion of nasopharynx (1). We report two patients of post radiotherapy inflammatory mass of the nasopharynx.

Case 1 :

Female 43 with nasopharyngeal carcinoma stage III and radiotherapy given in 1992. She had local recurrence in 1993. Left radical neck dissection was performed for level II metastatic lymph node in 1995. Patient was found to have a nasopharyngeal mass in 2003. Repeated biopsy showed inflammation, radiation effect only. Deep biopsy and debulking of the mass in July 2004 showed acute inflammation and radiation effect again.

CT scan showed bony erosion of skull base and floor of right sphenoid. Nasopharyngeal mass persisted and patient had left epistaxis repeatedly which required nasal packing.
Nasopharyngeal biopsy in December 2005 showed again inflammatory exudate and fibrin.

Angiogram and embolization was done on 12/12/05 when patient had more frequent epistaxis. Angiogram showed increased staining in his left nasal cavity, NP region and right tonsillar region. No more epistaxis after embolization and patient planned for conservative management till April 2006. The NP mass then filled up whole NP requiring debulking under general anaesthesia . Biopsy again showed irradiation changes only.

Patient had recurrent nasal obstruction requiring nasoendoscopic debulking again on 20/6/06. Oral steroid therapy was started in March 2006 and changed to low dose steroid post operation in April 2006 til June 2006 for maintenance. Patient was however admitted in July 2007 for further debulking to relieve her nasal obstruction again despite long term low dose steroid. Patient has a patent nasal airway since July with maintenance low dose steroid till April 2009. Rhinoscopy and debulking was required again for nasal obstruction. Pathology showed inflammation and no malignancy. A Recent rhinoscopy was required again for nasal obstruction on 26-3-2010 and the pathology showed no malignancy but merely acute on chronic inflammation consistent with irradiation change..

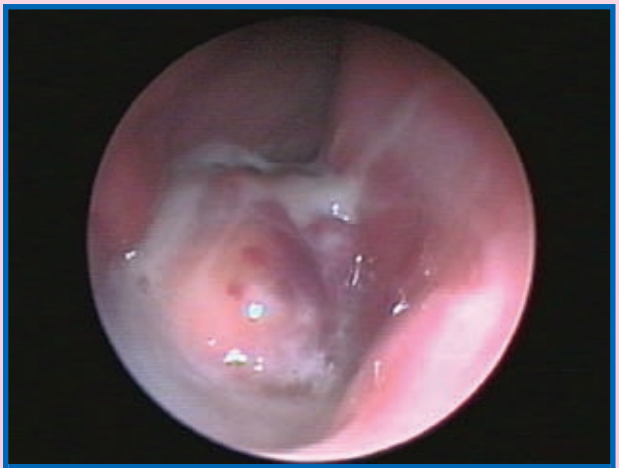

Fig.1: Case 1, July 2007,
NP mass obstructing whole posterior choana

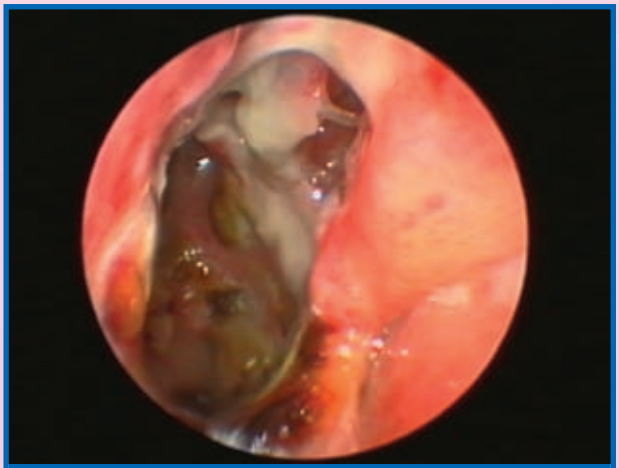

Figure 2: Case 1, July 2007
Left side patent nasal airway after debulking

Case 2 :

Male 48 with NPC and local relapse which required local RT.
He presented with bilateral nasal obstruction since 5/2005.
Nasoendoscopy showed bilateral nasal cavities filled up with necrotic tissue and vascular tumor
Carotid angiogram and embolization.was arranged by the oncologist and the angiogram showed abnormal staining of bilateral nasal mucosal areas with no other abnormal collateral flow. and no pseudoaneurysm.
Embolization of bilateral IMA was performed in June 2005.
The NP mass persisted and grew to obstruct posterior choana completely. Repeated biopsy showed irradiation change and no malignancy. Patient was started on low dose steroid in November 2006 and although the NP mass was still slowly growing the nasal bleeding actually was improving.
The patient has to mouth breathe and has been reluctant for surgery all along until he developed sarcomatous change proven by biopsy at which point it was inoperable.

Discussion:

Post irradation complications in NPC post RT patients can range from mucositis to sarcomatous change. The nasopharyngeal mass may result from chronic skull base osteoitis and erosions often clearly evident on CT scans. The clinical presentation can mimic a local relapse of NPC. The patient can have repeated epistaxis requiring various forms of management including embolization. If repeated biopies confirm no recurrence nor malignant transformation a conservative treatment regimen could be planned. Long term steroid has its side effects and low dose maintenance dose is used to keep the symptoms of nasal obstrucion and epistaxis to the minimum. Regular MRI of the NP may be considered to rule out underlying relapse if the tumor is on observation as repeated biopsy may only be taken from the more superficial layers. The accuracy of MRI NP however needs further evaluation but it does guide regarding the need for a deeper biopsy if suspicious findings are obvious (2, 3,4,5,6). Pseudotumour can undergo malignant change and sarcoma is one form which had occurred in one of our patients.

Reference:-

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A 75-year-old gentleman with underlying HT, CVA, AF and IHD was referred to us for blood stained sputum. Physical examination of oropharynx, nasopharynx, larynx and pirifrom fossa was unremarkable. However, tiny yellowish raised lesions were found in the buccal mucosa bilaterally (Figure.1 & 2).

Osan HO

Figure.1

Figure.2

1. What is the spot diagnosis?

a. Aphthous ulcer
b. Epidermoid cyst
c. Fordyce's granule
d. Sebaceous adenoma

2. What is the aetiology of the lesion?

a. Infection
b. Developmental anomaly
c. Idiopathic
d. Immunosuppression

3. Which of the following is incorrect about the lesions?

a. It is an ectopic sebaceous gland
b. Painful
c. It can be diagnosed clinically
d. No treatment is required

4. Lesions occur in the following sites except :

a. Oesophagus
b. Tonsillar area
c. Scalp
d. Penis

5. Percentage of the population being affected :

a. 20%
b. 40%
c. 60%
d. 80%

The following are the correct answers of last CPD Quiz :

1. c 2. b 3. b 4. c 5. d

CPD Quiz **July 2010**

Name | Date

Contact

Your Email

Please return the answer to the College by fax at 2904 5035 before 16 September 2010. 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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both nasal and ocular symptoms[1-5]

for allergic rhinitis patients in

an advanced delivery system[6-8]

* Statistically significant nasal and ocular symptom improvement in adults and adolescents in SAR and PAR studies (1-5)

- **Highest glucocorticoid receptor affinity+[9]**
- **Lowest treatment volume with more prolonged anti-inflammatory effect#[9]**
- **No aftertaste, fine mist, little or no drip down to the patient's throat[6]**
- **For patients as young as 2 years old**

\+ Compare with fluticasone propionate, mometasone furoate, ciclesonide AP, budesonide, dexamethasone
\# Compare to fluticasone propionate, mometasone furoate

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INS= intranasal steroid

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AVAMYS™ NASAL SPRAY INDICATIONS: AVAMYS is indicated for the treatment of the symptoms of seasonal and perennial allergic rhinitis in patients 2 years of age and older. **DOSAGE AND ADMINISTRATION** Administer AVAMYS (27.5mcg/spray) by the intranasal route only. Adults & adolescents ≥12 years: The recommended starting dosage is 110mcg (2 sprays in each nostril) once daily. When the symptoms have been controlled, reducing the dosage to 55mcg (1 spray in each nostril) once daily may be effective for maintainence. Children 2-11 years: The recommended starting dosage in children is 55mcg (1 spray in each nostril) once daily. Children not adequately responding to 55mcg may use 110mcg (2 sprays in each nostril) once daily. Once symptoms have been controlled, the dosage may be decreased to 55mcg once daily. **CONTRAINDICATIONS** Hypersensitivity to any of the ingredients. **WARNINGS AND PRECAUTIONS** AVAMYS undergoes extensive first-pass metabolism by CYP3A4, therefore the pharmacokinetics of AVAMYS in patients with severe liver disease may be altered. Co-administration with ritonavir is not recommended. **INTERACTIONS** Caution is required with the co-administration of AVAMYS and ketoconazole or other potent CYP3A4 inhibitors. Enzyme induction and inhibition data suggest that AVAMYS is unlikely to significantly alter the cytochrome P450-mediated metabolism of other compounds at clinically relevant intranasal dosages. Therefore, no clinical studies have been conducted to investigate interactions of AVAMYS on other drugs. **PREGNANCY AND LACTATION** Adequate data are not available regarding the use of AVAMYS during pregnancy and lactation in humans. AVAMYS should be used in pregnancy only if the benefits to the mother outweigh the potential risks to the foetus. Following intranasal administration of AVAMYS at the maximum recommended human dose (110mcg/day), plasma AVAMYS concentrations were typically non-quantifiable and therefore potential for reproductive toxicity is expected to be very low. **ADVERSE REACTIONS** Epistaxis, nasal ulcerations. **OVERDOSE** Acute overdose is unlikely to require any therapy other than observation.

Abridged PI (GDS 02)

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)** Ratner P, Andrews C,van Bavel J *et al.* Once-daily fluticasone furoate* nasal spray (FF) effectively treats ocular symptoms of seasonal allergic rhinitis (SAR) caused by mountain cedar pollen.*USAN approved name. *J Allergy Clin Immunol* 2007; **119**(Supp 1):S231. **5)** Keith PK, Scadding GK. Are intranasal corticosteroids all equally consistent in managing ocular symptoms of seasonal allergic rhinitis? *Curr Med Res Opin* 2009; **25**:2021-41. **6)** 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. **7)** 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 Supp):S231. **8)** 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. **9)** Salter M, Biggadike K, Matthews JL *et al.* Pharmacological properties of the enhanced- affinity glucocorticoid fluticasone furoate *in vitro* and in an *in vivo* model of respiratory inflammatory disease. *Am J Physiol Lung Cell Mol Physiol* 2007; **293**: 660-667. **10)** HKAPI Sales Data, Topical Nasal Preparation, R1A, 2009. *Private market refers to private practice doctors and private hospitals

Full prescribing information is available upon request

N10AS052/31052010

Revised American Thyroid Association Management Guidelines for Patients with Thyroid Nodules and Differentiated Thyroid Cancer

http://www.liebertpub.com/products/product.aspx?pid=55

Thyroid nodule is a common clinical condition that we encounter every now and then. In North America, the prevalence of palpable thyroid nodules is 3% to 7%; the prevalence is as high as 50% based on ultrasonography or autopsy data. While most of them are benign, around 10% are malignant. The diagnostic capability has been greatly improved by the use of fine needle aspiration cytology and the advent of high resolution ultrasonography. Despite that, there are still a significant proportion of patients who will require diagnostic lobectomy because of uncertain pre-operative diagnosis. Controversies exist on the optimal diagnostic work up that can maximize the yield of surgery without under-treating patients with malignant disease. Even after the diagnosis of malignancy is confirmed, some other controversies exist on the extent of surgery, post-operative adjuvant treatment and the follow up strategies. Therefore, a well-accepted set of clinical guidelines is very welcome by practicing clinicians.

In 1996, the American Thyroid Association (ATA) published treatment guidelines for patients with thyroid nodules and thyroid cancer (Arch Intern Med 28;156:2165–2172). Later, because of the advances in the diagnosis and therapy of both thyroid nodules and differentiated thyroid cancer, a task force was appointed by the ATA to update the guidelines using principles of evidence-based medicine. Members of the taskforce included experts in thyroid nodule and thyroid cancer management with representation by endocrinology, surgery, and nuclear medicine. The recommendations made were linked to the levels of available evidence and they were published in 2006 (THYROID,Volume 16, Number 2, 2006).

Very recently, the ATA has published another update of the 2006 management guidelines. This final document was approved by the ATA Board of Directors and endorsed by the American Association of Clinical Endocrinologists, American College of Endocrinology, British Association of Head and Neck Oncologists, The Endocrine Society, European Association for Cranio-Maxillo-Facial Surgery, EuropeanAssociation of Nuclear Medicine, European Society of Endocrine Surgeons, European Society for Paediatric Endocrinology, International Association of Endocrine Surgeons, and Latin American Thyroid Society.

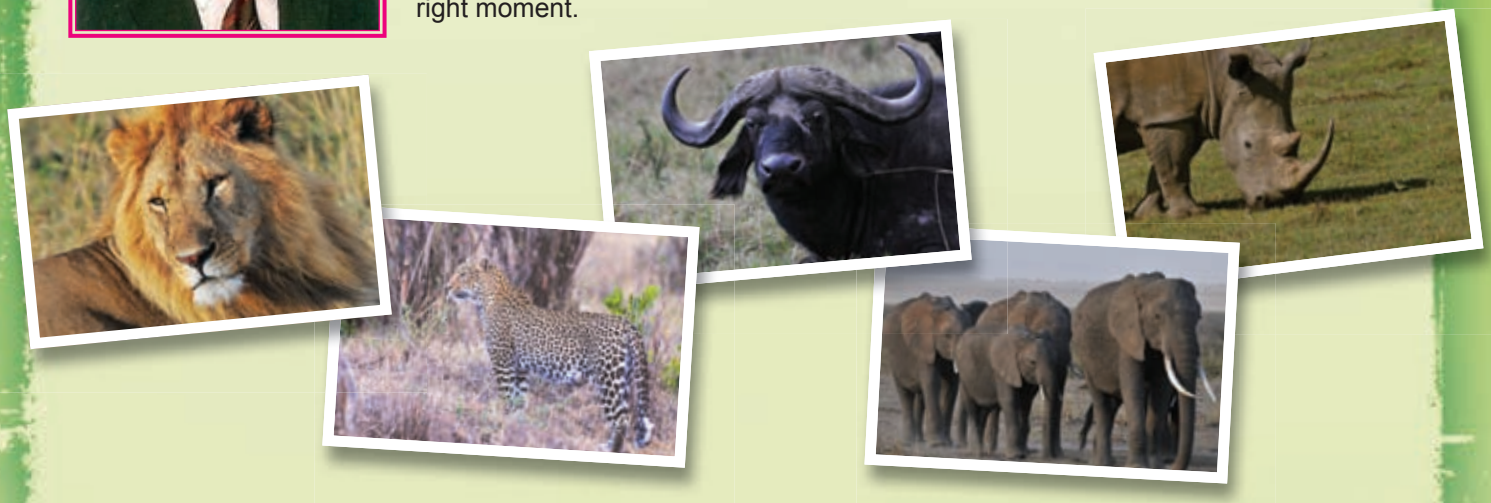
This latest set of guidelines and 4 accompanying editorials are available and downloadable from the above website. This is a very valuable resource and I hope you find it useful and interesting.

NG Siu Kwan

A Leisurely Note

Africa

Africa, a continent full of mysteries and natural beauty, has always been my dream place to travel to. The wildebeest migration, which takes place in Kenya and Tanzania from July to September every year, is always one of the greatest wildlife show on earth. Previously, I could only enjoy the grandiose via the TV program “National Geographic”, as the travelling fees are most discouraging! The rapid expansion of human population at the boundaries of National reserves has unfortunately jeopardized the survival of many animal species over the past 20 years and because of this, I decide to move on to explore this piece of wonderland at this right moment.



Kenya, a country located at East Africa, has a population of nearly 38 million. It was a British colony after World War One but became independent since 1963. The place enjoys a tropical climate with daytime temperature ~22-26°C and 8-10°C during night, so it is a must to bring along jackets/pullovers during the visit. Sometimes we could experience short spells of rain during the day, in particular the afternoons and evenings.

I started this wonderful journey from 5th September 2009, for a total of 13 days. I began my research and booking one year ahead as the more popular lodges and campsites are usually fully booked several months before the start of the migration. Most of the places I stayed were lodges that composed of a modern incarnation of traditional African village of domed huts, and most of them have swimming pools for relaxation! At Massai Mara, the world famous national reserve where the Massai River migration took place, I had chosen a tented camp that gave me a vast stunning experience. It is a real, lovely bush camp situated at the top of the escarpment with amazing views. Tents are very comfortable and quite “eco”. Hot water for showers has to be ordered and it comes in a bowl and pulled up at the top of the tent for you to use! No TV, no loud music, just the sound of birds to accompany your sweet dream. A highly recommended accommodation you should not miss!

The food provided was marvelous every place I stayed. Most of them was a Western buffet-styled but the taste was gorgeous. The saloon beef or the lamb chops were far tastier than the ones available at high end “City-Super”. I enjoyed the champagne breakfast carried along as my tea time dishes.

Amboseli, the second most popular park of Kenya (after the Masai Mara National Reserve), was my first destination. The place lies in the shadow of the mighty Mount Kilimanjaro, the highest mountain in Africa (around 5300m height). Clouds often cover it but we were lucky to have this opportunity to get the stunning view. I met a few people who actually came here to spend a trip of 7 days ‘hiking’ and I am really looking forward to get to the summit in the near future. A large part of the park consists of open plains and this makes wildlife spotting much easier. There is an Observation Hill that allows an overall view over the whole park, similar to the peak in Hong Kong. For animal spotting, the park is elephant country par excellence. Hippos can be seen bathing in the many water and swamp channels. Yet the lion population is small around this territory, probably due to the prolonged lion killing activities by the Masai people. In the past, the male of the Masai tribe needed to kill a lion before they were considered as adults. Of course this tradition is changing as a Amboseli, the second most popular park of Kenya (after the Masai Mara National Reserve), was my first destination. The place lies in the shadow of the mighty Mount Kilimanjaro, the highest mountain in Africa (around 5300m height). Clouds often cover it but we were lucky to have this opportunity to get the stunning view. I met a few people who actually came here to spend a trip of 7 days ‘hiking’ and I am really looking forward to get to the summit in the near future. A large part of the park consists of open plains and this makes wildlife spotting much easier. There is an Observation Hill that allows an overall view over the whole park, similar to the peak in Hong Kong. For animal spotting, the park is elephant country par excellence. Hippos can be seen bathing in the many water and swamp channels. Yet the lion population is small around this territory, probably due to the prolonged lion killing activities by the Masai people. In the past, the male of the Masai tribe needed to kill a lion before they were considered as adults. Of course this tradition is changing as a result of the government’s conservation policy. Apart from game drives, it is possible to visit Masai villages inside the park. Programs like looking around their living houses (actually they are huts making of cow faeces), watching traditional dancing and of course buying souvenirs. You need to get someone who is really good at bargaining otherwise ……

A Leisurely Note

The next destination is Lake Nakuru, one of the Rift Valley soda lakes. The place is a “bird watchers paradise” and in particular, famous for the presence of vast quantity of flamingos nesting along the shores due to the abundance of algae (a form of cyanobacteria). Black rhinoceros, Rothschild’s giraffe and waterbuck are the highlights of the national park.

The Masai Mara National Reserve is probably the most famous and most visited reserve in Kenya. It offers breathtaking views (as seen in the National Geographic channel), an extraordinary density of animals including the “Big Five” (lions, leopard, elephant, buffalo, rhinoceros). It is also the place to capture the impressive feature of the “migration”. Wildebeests, zebras and gazelles start the migration from the plains of the Serengeti that cross the Tanzanian border and rivers to reach the Mara’s grasslands from late June. Their predators, including lion, leopard, cheetah and hyena all track them along this long distance journey. Of course, everybody was anticipating their dramatic river crossing, the final obstacle of this journey, with the crocodile families awaiting their delicious meal at the Mara River.

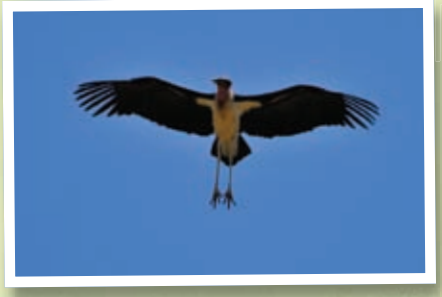
Masai Mara Balloon safari- an experience of a lifetime! It is the most wonderful and spiritual experience throughout my journey, lifting off from the dark to experience the magnificent African sunrise, with the animals saying good morning below my feet, I could just dream myself as Alice in her wonderland. The adrenaline in the body overrode any fear or tiredness and definitely it is a must see adventure!




I have to apologize for not being able to share all my interesting and exciting experience. I believe ultimately, it is best to experience the beauty of nature yourself. The weather condition was not that good last year as Kenya is experiencing its devastating drought period over the past few years. The Mara River dropped to its lowest level and it made the famous annual wildebeest crossing the Mara River look like a joke, because the animals just walked across the shallow river instead of facing the risk of being drowned! I searched through the web recently and noted that the country started the year with lots of rain. The plains look greener and the animals look more lively. Hopefully, this piece of wonderland can still be shared by our next generations.








A Leisurely Note

Some travel tips to share here. Before the journey, we were advised to have yellow fever vaccine injection and were prescribed anti-malaria medications from the Travel Health Centers, Department of Health (address: Rm 26, 18/F, Wu Chung House, 213 Queen's Road East, Wanchai). For the transportation, I took minivans throughout the journey; it is much cheaper than the 4x4 vehicles (at least ~$1500), though I must say the minivans are bumpy. I solved this problem by bringing along a cushion and it worked well. It also helped to support my big camera!

Eric TANG

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References: 1. MIMS HK, 1st issue 2010 2. HKPC (NASONEX, MSD)

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