院訊
News Letter
Apr – Sept 2024

vol. 115
第一百一十五期
齊服務 展關懷 We Serve & We Care

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Hospital Activities

聖保祿醫院
St. Paul's Hospital

Dr. William Ho
Chief Medical Executive

More Than Just Business

With 126 years since inception, St. Paul's Hospital holds the longest history among the current 14 private hospitals. In the local context, a private hospital is one which is non-public, either for-profit or not-for-profit (the majority), which means receiving no public funding. Throughout Hong Kong's history, there had been other private hospitals that no longer exist. Many others began accepting Government subsidy during the course of their development to become "subvented hospitals" and later merged into the Hospital Authority system. To maintain private status, it had not been easy to weather such challenges as the onslaught of SARS and later COVID-19 epidemics, and cycles of economic recession like in 1997, 2008 and 2020.

While staying afloat and financially sustainable is obviously important, this has never been the raison d'etre for our hospital. The purpose has always been serving the community by providing holistic patient care under the Christian spirit and teaching of St. Paul. Our emphasis on quality and safety through robust clinical governance structure/processes and numerous clinical improvement projects often entails injection of considerable human and material resources that is not directly helping our bottom line – all for the benefit of patients.

Even when the hospital invests heavily on continuous upgrading and redevelopment to keep up the with the time and modern technology, fees and charges are kept comparatively low. We have also been active conducting Corporate Social Responsibility activities. The big one this year took place in Caritas Ma On Shan Secondary School where 126 staff members/Sisters/volunteers sacrificed their Sunday to serve more than 800 district citizens through health education talks, game booths, and health checks ranging from blood tests, ECG, bone densitometry to ultrasound examinations etc. We successfully carried out in-hospital blood donation recently after more than 100 staff members signed up; and secured 40 organ donation forms signed by citizens during the outreach program. Our Environment Committee actively explores ways to reduce waste, and consumption of paper, water and energy. Our Elderly Day Care Centre – the only one run inside a private hospital under a social model – has become hugely popular with the community.

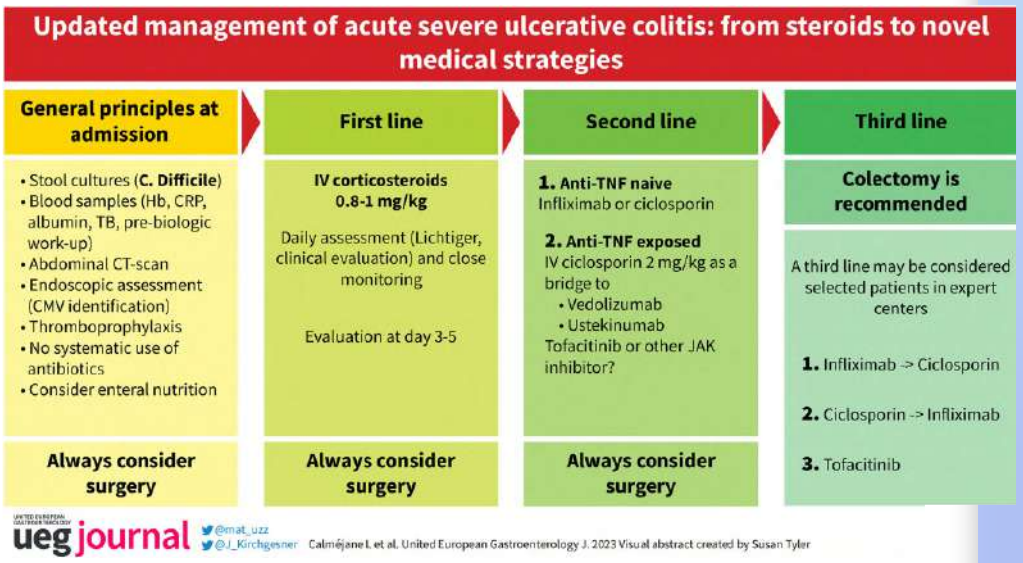
It will always be how well we serve the needy and society with our hearts and available means that matters most, not merely how successful the business is.

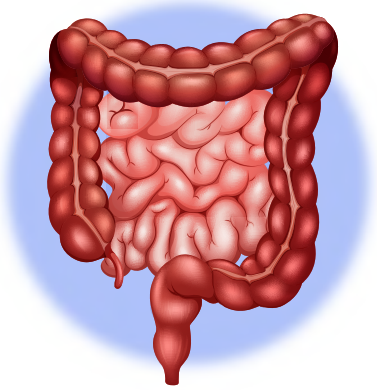
Dr. Au Hon Da, Kenneth
Resident Consultant Gastroenterologist & Hepatologist

Update management of acute severe ulcerative colitis

Acute severe ulcerative colitis (ASUC) occurs in up to 25% of patient with ulcerative colitis. Intravenous corticosteroid has been the standard first-line treatment for acute severe ulcerative colitis (ASUC). However, despite its effectiveness, up to 30-40% of patient do not respond and require a second line therapy. Infliximab and ciclosporin are effective second ling therapies, new strategies are being developed using newly approved treatments for moderate to severe UC.

Diagnosis of ASUC is based on the Truelove and Witts criteria. The score links to the risk of colectomy at days 3 and 5. Lichtiger score is mostly used in clinical trials and to assess response to treatment.





Modified Truelove and Witt's criteria

(definition of ASUC is based on 6 or more bloody stool per day with 1 or more of the other criteria)

Parameter	Mild	Moderate	Severe
Bloody stool per day, n	<4	4–6	>6
Pulse, beats per minute	<90	≤90	>90
Temperature,°C	<37.5	37.5–37.8	>37.8
Haemoglobin, g/dL	>11.5	11.5–10.5	<10.5
ESR, mm/h (or CRP, mg/L)	<20 (normal)	20–30 (<30)	>30 (>30)

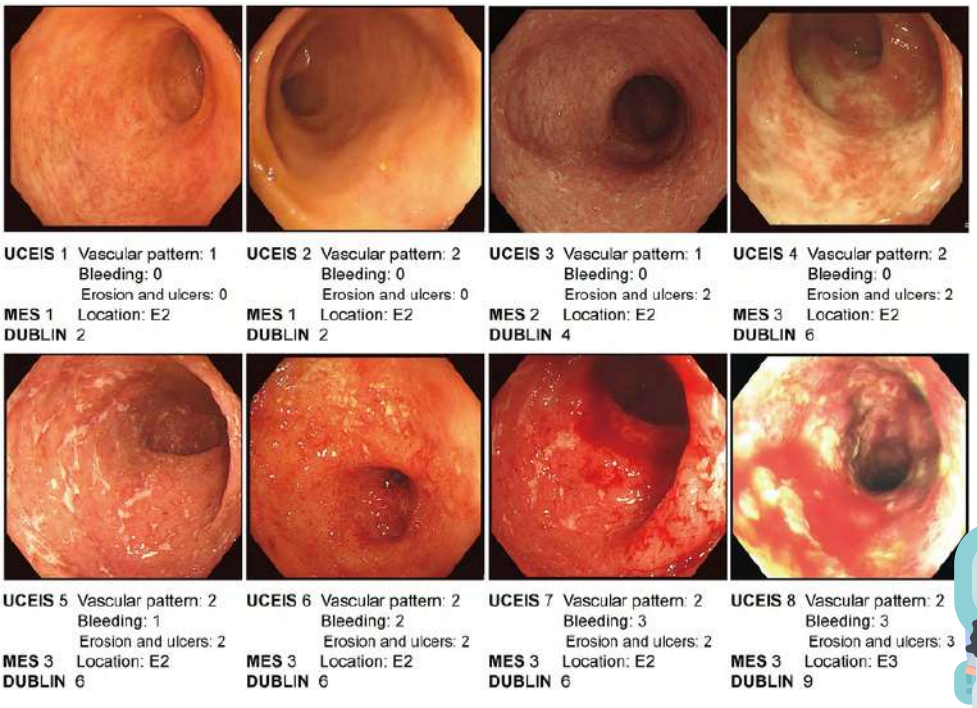
General principle at admission

Initial workup including blood and stool test, imaging and starting intravenous steroids and antibiotics if clinical suspicion of infection. Potential triggering and worsening factor such as NSAID use and enteric infection should be looked for. Clostridium difficile related colitis and cytomegalovirus are associated with high morbi-mortality and high colectomy rates especially in patients on steroids or ciclosporin. Endoscopic biopsies are useful to detect viral inclusion bodies and viral load in favor for initiating antiviral treatment.

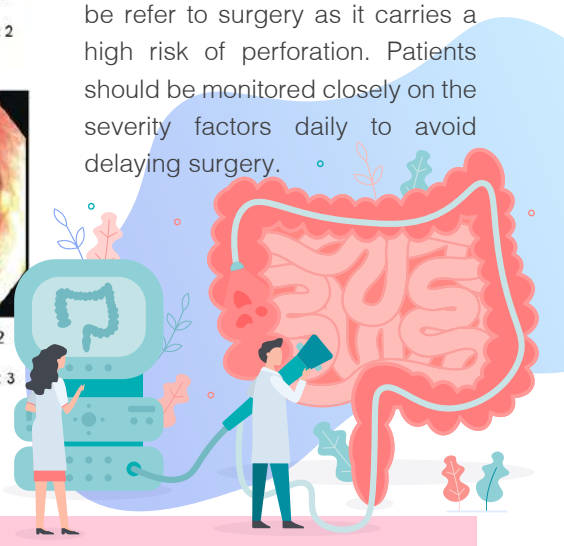
Evaluation of biological treatment eligibility should be performed including testing for viral antibodies and latent TB. Endoscopic evaluation of the colonic mucosa using UC Endoscopic Index of Severity (UCEIS) has good intra investigator and moderate inter-investigator agreement. Deep ulcers are associated with high risk of colectomy.

Ulcerative Colitis Endoscopic Index of Severity (UCEIS)

Variable	Scores			
	0	1	2	3
Vascular pattern	Normal	Patchy obliteration	Complete loss of vascular pattern	
Bleeding	None	Mucosal	Luminal, mild	Luminal, severe
Erosions & ulcers	None	Erosions	Superficial ulcers	Deep ulcers



With advances of medical treatment, mortality rates of ASUS has decreased to 0.84% in 3 months and 1.01% after 1 year. Toxic megacolon, colonic dilatation larger than 6cm, often associated with systemic symptom and should be refer to surgery as it carries a high risk of perforation. Patients should be monitored closely on the severity factors daily to avoid delaying surgery.



Severity factors of ASUC

NSAIDs intake	early clinical relapse of quiescent disease
Clostridioides difficile	higher mortality in hospitalized patients for IBD
CMV	In steroid-refractory patients, 50% of colectomy in patients with CMV reactivation versus 15% in patients without CMV.
Toxic megacolon	Small bowel distension is associated with steroids failure
Venous thromboembolism	Associated with higher mortality, longer length of hospital stays
Time to colectomy	Duration of in-hospitalization associated with higher postoperative complications

Medical management of ASUC

First line therapy:

IV 0.8-1mg/kg of methylprednisolone or equivalent for 5-7 days. Historical trial by Truelove and Witts reported a remission rate of 41% and a mortality rate of 7% in steroid treated group vs 16% and 24% in the placebo group. Optimal long-term maintenance therapy for immunomodulator (IMM)-native patients having a first episode of ASUC remained

unclear. A multi-center retrospective study including 141 patients with ASUC receiving amino salicylate vs IMM vs Infliximab and thiopurines have no difference in overall survival without relapse and without colectomy rates in all of the 3 maintenance regimen.

Second line therapy:

Calcineurin inhibitors (CNIs) or infliximab should be considered when no or suboptimal response to steroid by day3-5.

For steroid refractory UC receiving ciclosporin or tacrolimus as induction therapy followed by CNI then vedolizumab or vedolizumab as maintenance therapy, the colectomy free survival rate was 67% after 12 months. Infliximab has been shown in the index study in 2005 showing lower colectomy rate (29%) vs placebo arm (67%) in steroid refractory patients.

In patients of previous failure to anti TNF, ciclosporin is an alternative to surgery and a bridge to another biological maintenance therapy. A retrospective study of 71 patients with steroid-refractory ASUC were treated with a CNI followed by vedolizumab. The primary endpoint of colectomy-free survival rate was 93% at 3 months, 67% at 1 year and 55% at 2 years. The colectomy rate after a median of 25 months of follow-up was 42%

Emerging therapy for ASUC

Tofacitinib is an orally delivered, quick acting panJAK inhibitor recently approved in UC. In study with 55 patients with ASUC treated with tofacitinib reported, 49 had failed infliximab and 19 had been exposed to ciclosporin. Colectomy-free survival was 78.9% at 3 months and 73.6% at 6 months. Another retrospective study showing high dose tofacitinib three times daily seems protective with lower colectomy rate.

Tofacitinib use in retrospective cohort patients with ASUC

Berinstein et al., 2021	Standard induction doses of 10 mg twice daily or high-intensity regimen of 10 mg three times daily for 9 doses followed by twice daily.	Retrospective, case-controlled study, 40 patients matched with 113 controls. Prior long-term failure of infliximab (85%), adalimumab (40%), vedolizumab (52.5%)	Hazard ratio 0.28 at 90 days ($p = 0.018$)	Tofacitinib three times daily seemed protective (HR 0.11, $p = 0.008$) but not twice daily (HR 0.66, $p = 0.5$)
Uzzan et al., 2021	Treatment for current flare: Tofacitinib after steroids (52.7%), infliximab (3.6%), IV ciclosporin (14.5%). At week 6, all patients treated by a 10 mg twice daily regimen.	Retrospective and prospective, 55 patients. Previous exposure to a median of 2.5 lines of treatment: Anti-TNFs (98.1%) Ciclosporin (34.5%) Vedolizumab (69.1%)	15/55 (27.3%) at a median of 6.5 months	Colectomy-free survival: 85.2%, 78.9%, 73.6 at 1, 3 and 6 months Withdrawal linked to herpes zoster but not to cardio-vascular events.

Conclusion

ASUC remains the most severe form of UC and still associated with 1% mortality rate. IV steroid and 2nd line therapy with IFX or ciclosporin should induce a quick response to avoid salvage colectomy. There is still no sufficient evidence to recommend the higher induction doses of IFX. There have been various proposed therapeutic strategies for patients who previously exposed to biologics and shall be considered awaiting further validation by controlled trials.

References:

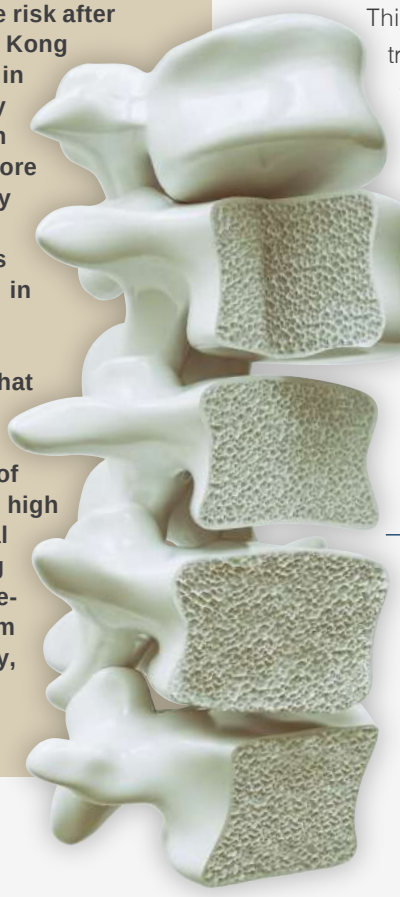
1. Narula N, Marshall JK, Colombel JF, Leontiadis GI, Williams JG, Muqtadir Z, et al. Systematic review and meta-analysis: infliximab or cyclosporine as rescue therapy in patients with severe ulcerative colitis refractory to steroids. Am J Gastroenterol. 2016; 111(4): 477–491
2. Spinelli. ECCO Guidelines of Therapeutics in Ulcerative colitis: surgical treatment. J of Crohns' and Colitis 2022; 16(2) 179-189
3. Travis SPL, Schnell D, Krzeski P, Abreu MT, Altman DG, Colombel J, et al. Reliability and initial validation of the ulcerative colitis endoscopic index of severity. Gastroenterology. 2013; 145(5): 987–995.
4. Admin S. European Crohn´s and colitis organisation - ECCO - DOP34 long-term outcome of acute severe ulcerative colitis responsive to intravenous steroid: a multicenter study of the Italian group for the study of inflammatory bowel disease
5. Järnerot G, Hertervig E, Friis-Liby I, Blomquist L, Karlén P, Grännö C, et al. Infliximab as rescue therapy in severe to moderately severe ulcerative colitis: a randomized, placebo-controlled study. Gastroenterology. 2005; 128(7): 1805–1811
6. Ollech JE, Dwadasi S, Rai V, Peleg N, Normatov I, Israel A, et al. Efficacy and safety of induction therapy with calcineurin inhibitors followed by vedolizumab maintenance in 71 patients with severe steroid-refractory ulcerative colitis. Aliment Pharmacol Ther. 2020; 51(6): 637–643..
7. Berinstein JA, Sheehan J, Dias M, Berinstein EM, Steiner CA, Johnson LA, et al. Tofacitinib for biologic-experienced hospitalized patients with acute severe ulcerative colitis: a retrospective case-control study. Clin Gastroenterol Hepatol. 2021; 19(10): 2112–2120.
8. Uzzan M, Bresteau C, Laharie D, Stefanescu C, Bellanger C, Carbonnel F, et al. Tofacitinib as salvage therapy for 55 patients hospitalised with refractory severe ulcerative colitis: a GETAID cohort. Aliment Pharmacol Ther. 2021; 54(3): 312–319

Breakthrough in Severe Postmenopausal Osteoporosis Care: Romosozumab

SPH Pharmacy Department
Chu Ho Leung (Ben), Pharmacy Intern

Postmenopausal osteoporosis is a condition characterized by declining bone mass and structural integrity, leading to increased bone fragility and a higher fracture risk after menopause.[1] An observational study in Hong Kong found a 60.4% prevalence of osteoporosis in treatment-naïve elderly women between May 2017 and April 2020.[1] The World Health Organization defines osteoporosis as a T-score ≤-2.5.[2] Osteoporotic fractures significantly increase mortality risk following the initial fracture.[3] Therefore, appropriate treatment is important to prevent disease progression in osteoporotic patients.

Romosozumab is a novel medication that possesses both osteoanabolic and antiresorptive effects, approved by the U.S. Food and Drug Administration in 2019 for the treatment of osteoporosis in postmenopausal women at high risk for fractures.[4] Although there are several anti-osteoporotic agents available in Hong Kong, most are either osteoanabolic or antiresorptive. This article will explore the mechanism of action, clinical effects, place in therapy, limitation of use and safety concerns of romosozumab.



Dual effects in the treatment of postmenopausal osteoporosis

Romosozumab is a monoclonal antibody that inhibits the action of sclerostin, a regulatory factor in bone metabolism. This inhibition activates modeling-based bone formation via osteoblasts, remodeling-based bone formation via osteoclasts and osteoblasts, while inhibiting osteoclast-mediated bone resorption at remodeling surfaces.[4-5] As a result, romosozumab exhibits dual effects by increasing bone formation and, to a lesser extent, decreasing bone resorption (Figure 1). This distinguishes it from other osteoporosis treatments like bisphosphonates and denosumab, which mainly reduce bone resorption, or teriparatide, which primarily stimulates bone formation.[5]

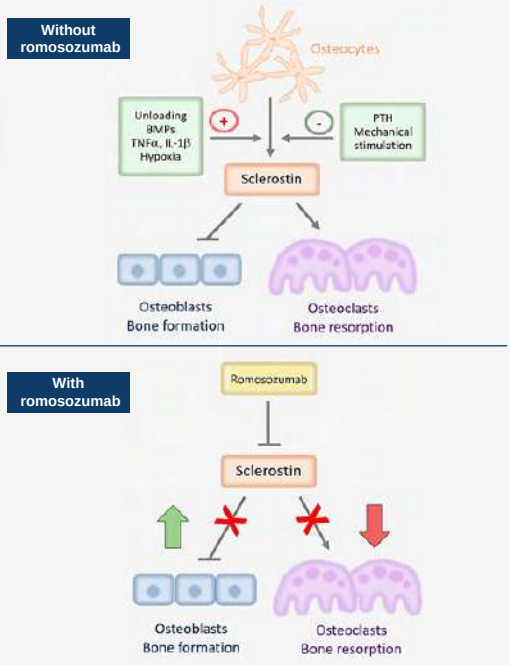


Figure 1. Dual effects of romosozumab on bone surfaces

Clinical effects

Effects on fracture risk

The FRAME study, a landmark phase 3 trial, evaluated the efficacy of romosozumab in postmenopausal women with osteoporosis. Patients receiving romosozumab experienced a significant reduction in the incidence of vertebral fractures at month 12 of therapy compared to those receiving placebo. Specifically, the risk of new vertebral fractures was reduced by 73%.[6]

The ARCH trial further compared romosozumab followed by alendronate against alendronate alone in reducing fracture risk. 12 months of romosozumab followed by alendronate resulted in a 37% and 48% lower risk of new vertebral fractures than alendronate alone at months 12 and 24, respectively.[7] Patients on romosozumab followed by alendronate showed a 27% lower risk of clinical fractures than those on alendronate alone.

Effects on bone mineral density (BMD)

Several clinical trials have demonstrated the effectiveness of romosozumab in improving BMD, due to its dual action on increasing bone formation and decreasing bone resorption. A meta-analysis and the STRUCTURE trial found that the romosozumab group showed superior clinical efficacy in terms of BMD of the lumbar spine, total hip, and femoral neck after 6 and 12 months of treatment compared to denosumab and teriparatide.8 Similar results were observed in the ARCH trial, which demonstrated that romosozumab led to greater gains in BMD from baseline at all measured sites.[6]

Regarding its long-term effect on maintaining BMD, studies including FRAME (at month 24) and ARCH (at month 36) showed that the BMD gains achieved during the 12 months of romosozumab treatment were largely maintained or even further increased after transiting to an antiresorptive agent.[6-7]

When comparing to denosumab, romosozumab was able to establish a faster and more pronounced increase in BMD at key skeletal sites.[6] For patients who require a rapid improvement in BMD, such as those with history of recent fractures, severe osteoporosis, and high fall risk, romosozumab may be preferred over denosumab.

Place in therapy

According to the 2020 Guideline of Pharmacological Management of Osteoporosis in Postmenopausal Women, romosozumab is considered a first-line therapy in postmenopausal women with osteoporosis and multiple vertebral or hip fractures, and those who have failed antiresorptive therapies. Treatment duration is up to 1 year for the reduction of vertebral, hip, and non-vertebral fractures. After completion of the whole course, treatment with other antiresorptive osteoporosis therapies is advised to maintain BMD gains and reduce fracture risk.[9]

Moreover, romosozumab is also viewed as an alternative by 2020 American Association of Clinical Endocrinologists/American College of Endocrinology Clinical Practice Guidelines for patients at very high fracture risk (e.g. patients with multiple vertebral or hip fractures, or with very low T-scores) and an option for patients previously treated with teriparatide.[2]

Prescribing information of romosozumab[2,4,9]

	Romosozumab (EVENITY)
Route	Subcutaneous injection
Dose and frequency	210 mg once monthly (2 separate 105 mg injections administered immediately one after the other)
Renal and hepatic dose adjustment	No adjustment
Optimal duration	Up to 1 year
Contraindication	• History of myocardial infarction (MI) or stroke • Hypocalcemia

Limitation of use

Treatment duration of romosozumab is limited to 12 months as the anabolic effect of romosozumab wanes after 12 monthly doses of therapy. If continued osteoporosis therapy remains warranted after this initial 12-month course, continued therapy with other antiresorptive agents, such as bisphosphonates and denosumab should be considered.[2,4,9]

Safety concerns

Romosozumab is generally well tolerated, with a safety profile similar to other osteoporosis treatments. According to the ARCH study, 3.4% of patients receiving romosozumab discontinued treatment due to adverse events, compared to 3.2% in the alendronate group.[7] Additionally, romosozumab demonstrated a better safety profile compared to teriparatide; only 3% of patients in the romosozumab group discontinued treatment due to adverse events, compared to 6% in the teriparatide group.[10]

The common adverse effects of romosozumab are arthralgia and nasopharyngitis, which were occurring in ≥9% of romosozumab-patients in both ARCH and STRUCTURE trials.[7,10] Additionally, a higher rate of major adverse cardiac events, yielding a hazard ratio of 1.87, was reported in patients receiving romosozumab treatment compared to those

treated with alendronate.[4,7] Therefore, romosozumab carries a black box warning, indicating that it should not be initiated in patients who have had a MI or stroke within the preceding year. Patients with other cardiovascular risk factors, signs and symptoms related to MI and stroke should be closely monitored throughout the treatment period. In the event of a MI or stroke, romosozumab should be discontinued.[4]

Osteonecrosis of the jaw (ONJ) and atypical femoral fractures have also been reported in patients receiving romosozumab.[4-7] ONJ is a very rare side effect linked with romosozumab. Patients should be recommended on the importance of maintaining good oral hygiene and to perform routine dental check-ups.[4] Furthermore, atypical femoral fractures are infrequent but catastrophic. Patients should be advised to report any new or unusual pain in the thigh, hip, or groin while receiving romosozumab treatment.[4]

Hypocalcemia is more common in those with severe renal impairment or undergoing dialysis. Pre-existing hypocalcemia must be corrected prior to initiating therapy with romosozumab. Regular monitoring of serum calcium levels is advised, and appropriate supplementation of calcium and vitamin D during romosozumab treatment is recommended.[4]

Conclusion

Romosozumab has revolutionized the management of severe postmenopausal osteoporosis by combining antiresorptive and osteoanabolic effects. It is recommended as a first-line therapy for high-risk patients, though its use is limited to 12 months. Close monitoring and adherence to guidelines are crucial for optimizing patient outcomes. Further research is needed to explore its efficacy and safety in the long run.

References:

1. Lo, S. S. T. (2021). Prevalence of osteoporosis in elderly women in Hong Kong. Osteoporosis and Sarcopenia, 7(3), 92-97.
2. Camacho, P. M., Petak, S. M., Binkley, N., Diab, D. L., Eldeiry, L. S., Farooki, A., ... & Watts, N. B. (2020). American Association of Clinical Endocrinologists/American College of Endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis—2020 update. Endocrine Practice, 26, 1-46.
3. Cauley, J. A. (2013). Public health impact of osteoporosis. Journals of Gerontology Series A: Biomedical Sciences and Medical Sciences, 68(10), 1243-1251.
4. FDA. (2019). EVENITY™ (romosozumab-aqqg) injection, for subcutaneous use. Retrieved May 28, 2024, from https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/761062s000lbl.pdf
5. Ferrari, S. L. (2018). Romosozumab to rebuild the foundations of bone strength. Nature Reviews Rheumatology, 14(3), 128-128.
6. Cosman, F., Crittenden, D. B., Ferrari, S., Khan, A., Lane, N. E., Lippuner, K., ... & Lewiecki, E. M. (2018). FRAME study: The foundation effect of building bone with 1 year of romosozumab leads to continued lower fracture risk after transition to denosumab. Journal of Bone and Mineral Research, 33(7), 1219-1226.
7. Saag, K. G., Petersen, J., Brandi, M. L., Karaplis, A. C., Lorentzon, M., Thomas, T., ... & Grauer, A. (2017). Romosozumab or alendronate for fracture prevention in women with osteoporosis. New England Journal of Medicine, 377(15), 1417-1427.
8. Hu, M., Zhang, Y., Guo, J., Guo, C., Yang, X., Ma, X., ... & Xiang, S. (2023). Meta-analysis of the effects of denosumab and romosozumab on bone mineral density and turnover markers in patients with osteoporosis. Frontiers in Endocrinology, 14, 1188969.
9. Shoback, D., Rosen, C. J., Black, D. M., Cheung, A. M., Murad, M. H., & Eastell, R. (2020). Pharmacological management of osteoporosis in postmenopausal women: an Endocrine Society guideline update. The Journal of Clinical Endocrinology & Metabolism, 105(3), 587-594.
10. Langdahl, B. L., Libanati, C., Crittenden, D. B., Bolognese, M. A., Brown, J. P., Daizadeh, N. S., ... & Grauer, A. (2017). Romosozumab (sclerostin monoclonal antibody) versus teriparatide in postmenopausal women with osteoporosis transitioning from oral bisphosphonate therapy: a randomised, open-label, phase 3 trial. The Lancet, 390(10102), 1585-1594.

Following the Drug and Therapeutics Committee (DTC) meeting in March 2024, the SPH Drug Formulary has been updated as follows:

Drugs	Indication(s)	Usual dosage	Remarks
New Drug Approval			
Acarizax oral lyophilizate 12SQ-HDM	Persistent moderate to severe house dust mite (HDM) allergic rhinitis despite use of symptom-relieving medication in patients aged 12 to 65 years; or in patients aged 18 to 65 years with HDM allergic asthma not well controlled by inhaled corticosteroids and associated to severe HDM rhinitis.	One oral lyophilizate sublingual once daily	Available on request.
Omarcor capsule 1000mg	Adjunct to diet when dietary measures alone are insufficient to produce an adequate response in type IV in monotherapy or type IIb/III in combination with statins for endogenous hypertriglyceridemia.	Two capsules orally once daily	N/A
Deletion of Drug			
Tractocile (Atosiban)	Second line option for tocolysis.	N/A	Removed from the SPH Drug Formulary as endorsed by O&G Advisory Committee.

St. Paul's Hospital
Pathology Department

Implementation of new Laboratory Automation Track System

The fully automated new Roche Cobas Chemistry Analyzer with connection to track system will come into service from September 2024.

The main CONSIDERATIONS for a new system?

1. Broad assay menu

The new automation system allows us to establish new in-house tests.

2. Shortened turnaround time

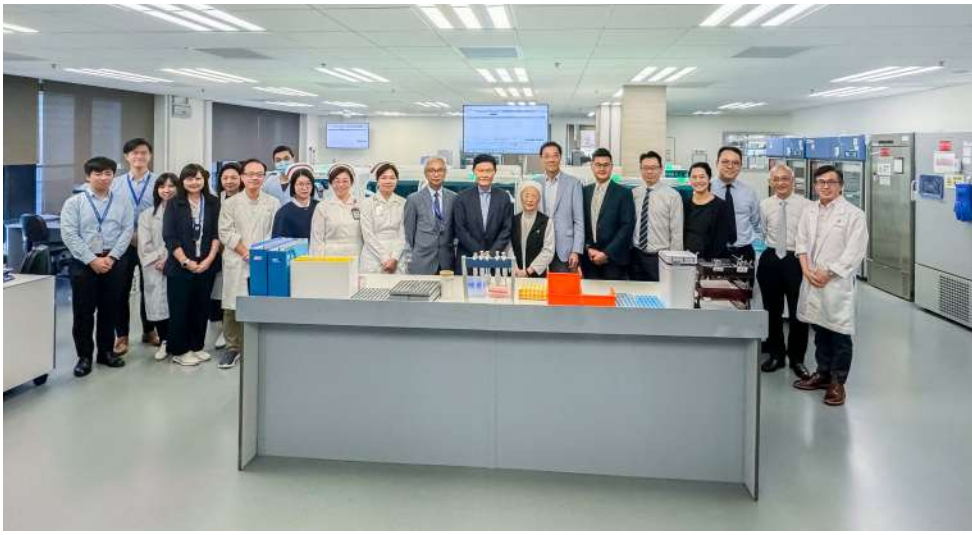
The system is able to streamline our workflow to shorten the turnaround time, especially for Endocrinology and Cardiac tests.

3. Local Reference

This New automation system has more stable performance and is supported by local technical team, which is important to the laboratory operation.

4. Consolidation

The new automation system consolidates existing tests in a high throughput platform.



What is NEXT? Goals to achieve

- *Streamline workflow*
- *Keep pace with increasing demands*
- *Laboratory accreditation*

Dr. Au Hon Da, Kenneth
Resident Consultant Gastroenterologist & Hepatologist

Hi, I am Kenneth Au, newly joined gastroenterologist. I am a HKU 04 graduate and completed my residency in TMH 2011 before moving to AHNH in 2014 as an associate consultant.
I underwent overseas endoscopy training in EUS & ERCP in Erasmus Medical Centre, Rotterdam, the Netherlands in 2017.
I enjoy playing table tennis and I have recently started taking pilates classes. I love watching soccer every weekends and I am a Tottenham Hotspur fan.
I look forward to working with all of your in the future.

Hello every one, I am Michael. It's my pleasure to join the St. Paul's family. I graduated from Ji Nan University in China and pass the licentiate exam of Hong Kong in 2014.I started my career in acute and emergency department of Yan Chai Hospital. I worked in Yan Chai hospital for 3 years, then I started my private practice as general practitioner since 2018, now I continue my career in St. Paul's Hospital. I wish I could try my best to provide good quality of service to our patient and staff. I look forward to working with all of you in the future.

Dr. Cheong Tsz King
Resident Medical Officer

Dr. Lam Wing Sun
Resident Consultant Pathologist

I am Angus Lam Wing Sun, a newly-joined pathologist. It is my great pleasure to join St. Paul's Hospital. I graduated from The University of Hong Kong in 1994 and completed my pathology training in Princess Margaret Hospital. I had been serving in Princess Margaret Hospital and Tseung Kwan O Hospital for over twenty years when I joined St. Paul's Hospital in March this year. My special interest is in soft tissue pathology. I am looking forward to working with you all.

CME/CPD/CNE Programme 2024

Axillary management in post neoadjuvant therapy breast cancer patients

Speakers: **Dr. Chan Man Yi**
Staff Consultant, Specialist in General Surgery, St. Pauls' Hospital

Dr. Lam Wing Sun
Specialist in Pathology, St. Paul's Hospital

Dr. Chan Sum Yin, Ann
Specialist in Clinical Oncology

Chairman: **Dr. Lo Hak Keung, Alex**
Deputy Medical Superintendent, St. Paul's Hospital

Date: **29 November 2024 (Friday)**

Time:

7:00 pm – 7:30 pm	Reception (light refreshment provided)
7:30 pm – 8:30 pm	"Axillary management in post neoadjuvant therapy breast cancer patients" by Dr. Chan Man Yi & Dr. Lam Wing Sun & Dr. Chan Sum Yin, Ann
8:30 pm – 9:00 pm	Q & A Session

Venue: **Auditorium, 18/F, Block A, St. Paul's Hospital**

Registration & Enquiry:
(First-come-first-serve)

Contact Person: Ms. Merrillin Leung
Tel: 2830 8857 , Fax: 2837 5271 , E-mail: sph.sdd@stpaul.org.hk

CME / CPD / CNE Accreditation for all Colleges (Pending approval)

Sponsored by: Roche

聖保祿醫院
保健同樂日

聖保祿醫院於二零二四年四月十四日舉行健康同樂日，旨在為本院職員及其家屬提供免費身體檢查和健康資訊。透過同事與家人共同參與，希望能及早發現健康問題並尋求適切的醫療照護，同時也能改善整體的健康習慣，推廣職業安全和提升健康指數，讓大家一同分享健康的快樂。

當日共有超過一百名義工參與，包括修女、醫護人員和各部門同事，全力為參加者提供多項免費身體檢查。現場並設有各類主題展覽、攤位活動和健康技巧工作坊，深受同事及家人歡迎，活動參與總人數近八百人次。能夠在熟悉的工作環境中與家人一起接受健康檢查，大家都感到十分欣慰。同事們亦表示今次活動受益良多，對自身健康有更深入的了解。

保健同樂日的高潮是寶寶爬行和生活技能競技比賽，見到參賽者和可愛的寶寶及家長們團結合作及努力拼搏，現場掌聲和歡笑聲此起彼落。

今次活動得以順利舉辦，有賴各部門同事的精心策劃和積極參與，在繁忙工作之餘抽出時間協助，在此表示衷心感謝。

聖保祿醫院主保瞻禮日

聖保祿醫院每年均以主保聖保祿宗徒瞻禮日作為院慶，同時亦是沙爾德聖保祿女修會修女進會週年紀念及「聖保祿之友」取錄禮。為慶祝這個特別日子，沙爾德聖保祿女修會聯同聖保祿醫院於二零二四年六月二十九日於基督君王小堂舉行感恩聖祭，由薛君浩神父主祭。

是次感恩聖祭是為陳婉如修女進會金禧，感謝她多年獻身修會，為社會服務。隨後舉行的「聖保祿之友」取錄禮，讓新成員在眾多嘉賓見證下，許諾成為「聖保祿之友」，追隨聖保祿宗徒「對一切人，我就成為一切」的服務精神。

當天，陳修女送贈自己編著的書籍 -「鴻雁傳情」予每位蒞臨的嘉賓，好讓嘉賓們可以從字裏行間細味她的人生點滴及心聲。院方亦安排了免費午餐及晚餐，與全院同事一起分享瞻禮日歡樂的氣氛。

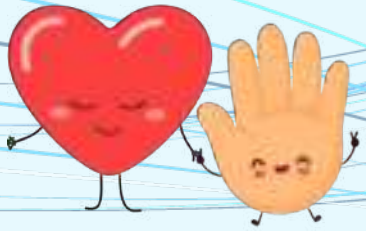
台灣聖保祿醫院代表到訪

本院於二零二四年七月十六日接待阮璇修女(Sr. Mary Nguyen)及四位台灣聖保祿醫院管理層的嘉賓到訪本院參觀及作交流。當天本院分享了聖保祿醫院的管治和經營理念以及未來發展方向。之後，更一同參觀本院部分主要的部門，了解其日常運作及設施。倆院異地同心，期望將來有更多機會就兩地醫療資訊作相互交流，藉著實踐醫療護理服務，傳揚天主美善，造福市民。

聖保祿醫院 捐血日

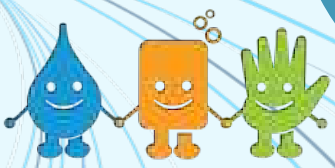
聖保祿醫院全力支持香港紅十字會輸血服務中心，在九月二十六日於本院順利舉辦了捐血活動。是次活動獲得一百零七位同事熱烈響應，當中七十九位同事成功完成捐血，所捐贈的每一包全血可救治三個或以上病人。感謝各同事的無私奉獻及各部門鼎力的協助，令有需要的病人生命得以延續，亦繼續為公眾健康盡一份力。

手部衛生日
Hand Hygiene Day



本院今年繼續響應世界手部衛生日，於二零二四年五月六日舉辦網上有獎問答遊戲，從日常工作片段中找出正確潔手五時刻，藉此推動醫護人員建立互相促進正確履行潔手五時刻的文化，在工作氛圍宣揚手部衛生的重要性。

是次活動共有三百六十一位同事參與，當中一百七十一位獲得優異成績，而B13, B14, B09及B20更取得部門最佳成績獎項，值得鼓勵！此活動得以成功舉辦，除了感謝醫院管理層及各同事的支持和參與，也衷心感謝為活動拍攝短片的部門同事在百忙中踴躍為推廣手部衛生出一分力！



2024國際護士節

為表揚一眾為社會及醫院服務的護士，國際間將每年五月十二日訂為「國際護士節」。今年的護士節，醫院管理層為護士們送上小禮品，感謝他們一年來的辛勞，不辭勞苦為病人提供護理服務。

我們感謝每位前線護理人員一直堅守崗位及無私的付出，陪伴病人走過治療和康復的路。

2024 馬鞍山 社區保健同樂日

聖保祿醫院聯同明愛馬鞍山中學、明愛蘇沙伉儷綜合家庭中心、明愛YCS青年中心及聖公會馬鞍山青少年綜合中心，於二零二四年九月二十九日在明愛馬鞍山中學舉辦了社區保健同樂日。此次活動以「關愛社區」為主題，並慶祝中華人民共和國成立七十五周年，透過健康檢查、健康技巧指導、攤位活動及講座展覽等多元化項目，期望市民能及早察覺健康狀況，在疾病早期尋求醫護照料。

當日活動共有一百二十六名義工參與，包括修女、醫生及來自不同專業的醫護人員、非臨床部門同事及聖保祿之友義工隊。大家齊心協力，為市民提供多項免費身體檢查，包括骨質密度測試、心電圖、膽固醇及血糖測試、肝膽超聲波檢查及眼睛健康普查。

此外，活動當天大會還舉辦了多場健康教育講座、健康技巧工作坊、展覽及攤位遊戲，吸引了居民積極參與，當日受惠的服務人次達八百人。市民對不同病症的認識、治療方案、營養運動健康資訊、手部及口腔衛生、急救技巧、藥劑及生活知識等方面的了解均有顯著提升。

感謝各部門同事和義工的對今次外展服務全力支持，大家秉持聖保祿宗徒「對一切人，我就成為一切」的精神，不辭勞苦地關心和幫助他人。

聖保祿醫院
St. Paul's Hospital

2024春季順德美食兩天團

本院於今年五、六月期間舉辦了五團「順德美食兩天團」，各部門同事鼎力支持、積極參與。大家可以暫時放下工作，一同享受輕鬆寫意的旅程。

行程的第一天，大家興高采烈地來到有「順德新十景」之稱的順峰山公園及牌坊打卡。之後，更遊覽順德華僑城歡樂口岸，盡玩景區的遊樂設施，又品嘗當地小食及到處拍照留念。同事們於名店「黃但記食府」享用午餐，品嘗順德名菜，晚上則享用「生炒黃鱔飯包燒雞宴」美食，當晚更入住五星級酒店休息。

第二天，一行人先遊覽詩情畫意的順德逢簡水鄉，體驗古代水鄉的風情，更一嘗知名的順德雙皮奶及其他甜品。午餐品嘗順德地道美食，大家吃過當地的燒鵝，都不禁垂涎三尺。

這次的旅程，大家都感到「玩得開心、吃得高興、住得舒適」。同事們感謝院方的悉心安排，令他們可以享受高質素旅行的同時，給予他們認識彼此的機會及增進友誼。大家均表示十分期待醫院每年舉辦的旅行。