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香港醫訊

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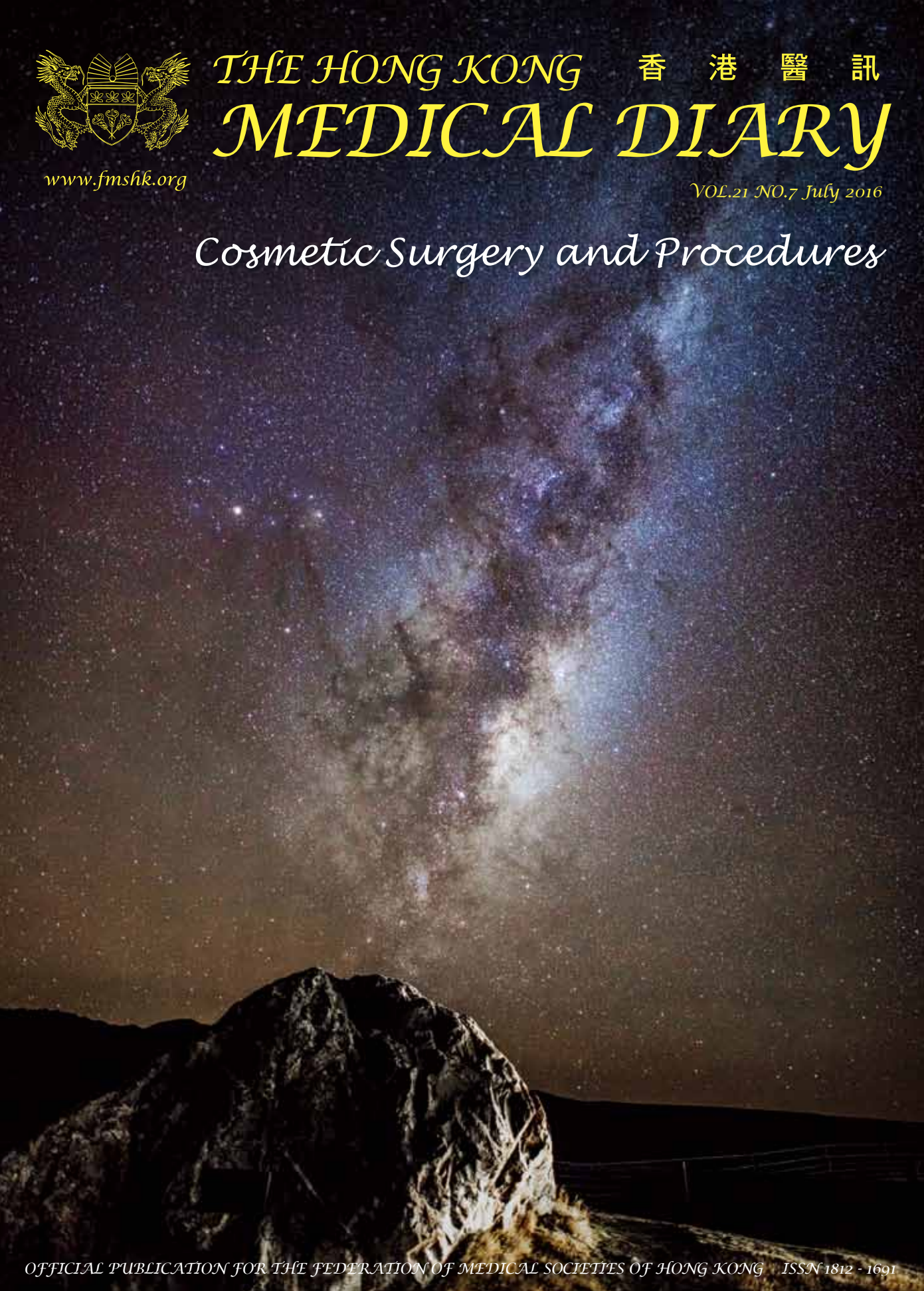
Cosmetic Surgery and Procedures



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The Cover Shot

This photo was taken in April this year in the area of Mount Cook, New Zealand with a full frame DSRL and a 20mm lens, F1.4, ISO 1600, 20s,

This area is renowned as one of the only few International Dark Sky Reserves (IDSR) worldwide. It is far from city lights and therefore has some of the darkest skies in the world – perfect for viewing the night sky!

Milky Way photography is much easier now than before because of the recent development in digital photography technology and the availability of large aperture wide angle lenses.

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Editorial

Dr Chun-on MOK

Specialist in Plastic Surgery
President of the Hong Kong Association of Cosmetic Surgery

Editor

Dr Chun-on MOK

Recently, a medical practitioner in Hong Kong has been cautioned by the Medical Council against his claim as a doctor in Aesthetic Medicine. To be eligible as a fellow in a specialty of medicine in Hong Kong, a medical practitioner has to go through a recognised structured post-registration training programme, passed an accredited exit examination under the relevant college and to carry out life-long continuing medical education.

The field of cosmetic surgery is an integral part of the Plastic Surgery Specialty. The training of the young plastic surgery trainees are mostly carried out within the public hospitals and the two universities where reconstructive plastic work are their main responsibility. Cosmetic surgery training, however, is also included in the programme with regular series of lectures and forums involving trainers from the private sector. Plastic surgery trainees are also welcome to extend their cosmetic surgery exposure from coaching with their mentors in the private sector (at their own spare time).

The Hong Kong Association of Cosmetic Surgery was founded in 2010 by a group of specialists in Plastic Surgery who practise cosmetic surgery in the private sector in Hong Kong. One of the objectives is to assist members and trainees in the safe, ethical and professional practice of cosmetic surgery and medicine through continuous professional development CPD, training, research and development of new procedures. Another important task is to disseminate professional information to the public and to promote awareness of the practice of cosmetic surgery and medicine.

I am privileged to be elected President of the Association. I am also grateful to the Federation of Medical Societies of Hong Kong, allowing us to contribute to the Hong Kong Medical Diary in this issue. The field of cosmetic surgery is changing and advancing rapidly due to breakthroughs in technology and material science. It is our duty to share our knowledge for training and for the advancement of our specialty, to disseminate information for awareness to the medical profession and to educate the public.

I have to thank the members of the Association who have devoted their time and knowledge to come up with this issue taken up by the Hong Kong Association of Cosmetic Surgery. In this issue, technological advancement in hair transplant procedures and non-invasive body slimming are updated by Dr Walter King and Dr Or respectively. The merits of the classical forehead lift are reinstated by Dr Elvis Lee in his article despite claims by other less invasive brow lifting procedures. Dr Vivian Lee has also furnished a concise summary of liposuction for everybody to share.

Lastly, I hope you would be inspired by Professor Michael Wong who is my dear classmate and is having his psychiatric career and wine hobby in Melbourne, Australia for some years. Do go out and get a bottle of good Australian wine while you read through the Medical Diary next time!

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Robotic Hair Transplant

Dr Walter KING
Specialist in Plastic Surgery

Dr Walter KING

This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 July 2016.

The usual scalp has about 100,000 hair follicles. Hair grows about half inch per month or 6 inches per year. The hair follicle sheds the hair usually in 5 years and can re-grow the hair 15 to 20 times. Therefore, an average person can enjoy a full head of hair for 75 years or longer. There are three phases of the hair growth cycle that regulates hair shedding and re-growth. The Anagen phase or active growth phase lasts 4 to 6 years. 89% of our hairs are in this active growth phase. The Catagen phase or shrinking phase lasts about 3 months and less than 10% of our own hairs are in this hair shedding phase. The Telogen phase or inactive phase lasts about 3 weeks and only 1% of our hairs are in this phase at any time. Hair is the thickest at age 20 and continues to shrink; by age 70, hair becomes very fine.

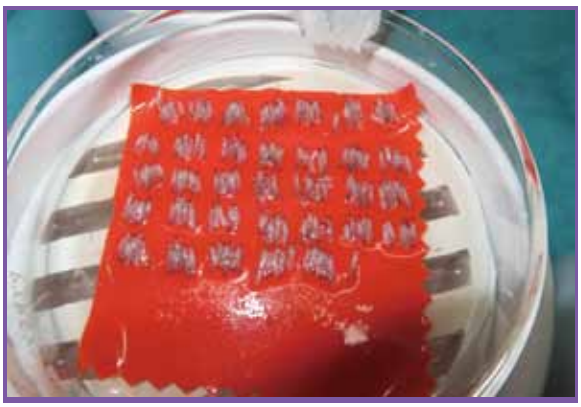
Premature hair loss in men is largely due to androgenetic alopecia. Both androgens and genetic factors work together to cause male pattern hair loss (MPHL). Current evidence implicates either an autosomal dominant and/or a polygenic inheritance pattern with variable penetrance. The androgen most closely implicated in MPHL is dihydrotestosterone (DHT). Finasteride, a competitive inhibitor of 5–∝ reductase can decrease levels of DHT and effectively treat MPHL. Candidates for hair transplant are males who are then reluctant to take long term Finasteride or who have failed to obtain a satisfactory result after a trial of oral Finasteride.

Surgical hair transplantation dates back to 1939 when Japanese dermatologist Shojui Okuda inserted small hair grafts with small needle-stick recipient sites. Dr Norman Orantreich popularised hair transplant in the 1960's. He described the "donor dominance" theory such that hair grafts transplanted from the occiput area to the frontal bald area keep their behaviour and graft longevity as the original occiput native hair follicles. In the 1970's and 1980's punch grafts were used for hair transplantation along with scalp reduction surgery to reduce bald scalps. In the 1990's strip scalp excision surgery was used by Dr Limmer to procure follicular units under magnification for hair transplant.

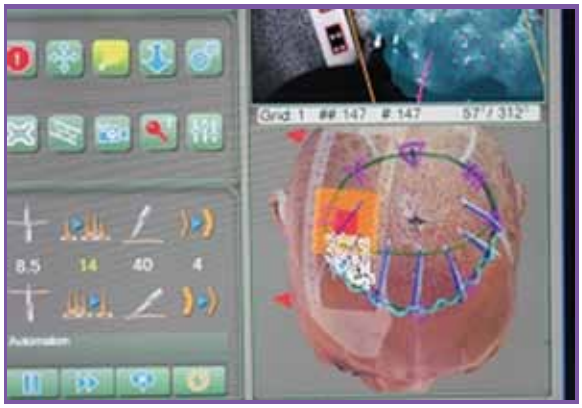
In the field of hair transplant, follicular unit extraction with micro-grafting has been popular since 1995. Follicular unit extraction is the manual or motorised harvesting of small units of occiput hair grafts containing 1 to 4 clusters of hairs commonly known as follicular units. A typical hair transplant session done under local anaesthesia lasts 6 hours or more and involves a team of 6 or more health care technicians or nursing staff.

Since 2011, a robotic hair transplant system is available from USA to assist in the labour intensive and delicate hair transplant surgery. Introduced to Asia including Hong Kong in 2015, this robotic hair restoration

system uses an interactive digital imaging to guide core needle extraction of hair follicles. The location and characteristics of each follicular unit are tracked in real time, updating 60 times per second. The high definition user interface provides multiple views of the dissection area, allowing the surgeon to adjust parameters as needed. The system can harvest 1,000 follicular unit hair grafts in 1.5 hours. The coring and perforating depth of the harvesting needle as well as the scalp entry angle can be adjusted as needed to allow a typical yield of approximately 90%. The punctured sites which are at the most 1mm in diameter will re-epithelise in about a week. For the best results, the hairs at the donor site and the recipient site are shaved down to 1mm length in order for the computerised system to accurately identify the features and characteristics of each hair graft and hair follicle.



The robotic system can also do site making of the recipient site with precision. The robot plans and creates recipient sites with computerised needle punctures with constant depth, angle and directions resulting in natural aesthetic patterns. Damage to adjacent pre-existing hair is also avoided. Roughly 800 hair grafts containing 2,000 hairs can be effectively transplanted within the usual 6 hours of hair transplant session. A second hair transplant session may be required for density. Partial shaving of hairs is required for the hair transplant procedure and new hair growth may require 6 months to develop completely.



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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Robotic Hair Transplant" by Dr Walter KING and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 July 2016. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please answer T (true) or F (false)

1. Lifespan of a hair follicle is 20 years.
2. Hair can only re-grow 10 times over 75 years.
3. Catagen phase is the growing phase of a hair follicle.
4. The culprit of androgenetic hair loss (male pattern baldness) is Dihydrotestosterone (DHT).
5. Hair transplant has over 50 years of progress and development.
6. Follicular unit hair grafts contain 1 to 4 clusters of hairs.
7. Robotic hair transplant is not available in Hong Kong.
8. Robotic hair transplant includes computerised image guided follicular unit graft extraction and recipient site making.
9. Robotic hair transplant can harvest 1,000 follicular unit hair grafts in 1.5 hours.
10. The yield for robotic assisted hair graft harvesting is approximately 90%.

ANSWER SHEET FOR JULY 2016

Please return the completed answer sheet to the Federation Secretariat on or before 31 July 2016 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Robotic Hair Transplant

Dr Walter KING

Specialist in Plastic Surgery

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

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Answers to June 2016 Issue

Intra-Oral Scanning: State of the Art in Dentistry?

1. T **2.** T **3.** T **4.** T **5.** T **6.** T **7.** T **8.** T **9.** F **10.** T

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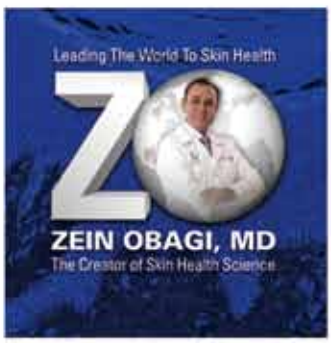

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Oh, It is really Brow Raising !

Dr Elvis Wai-ying LEE

Specialist in Plastic Surgery

Dr Elvis Wai-ying LEE

"For the last 24 years I have been impressed that the majority of improvement to be obtained in the aesthetics of the upper orbital region comes from proper brow positioning", as stated by Dr. Robert S. Flowers, a world renowned expert in upper blepharoplasty with ample experience in both Oriental and Caucasian patients.[1] In distinct contrary to his statement, operations for brow elevation may be one of the most underperformed cosmetic operations in Hong Kong, probably because patients are scared about the operations and doctors in general tend to neglect it since it seems a major undergoing.

Patients rarely go to the doctors complaining of problems with their eyebrows. They usually complain of long, drooping, heavy, or bulky upper eyelids or eyes becoming smaller (narrower) and demand upper eyelid surgery. Their concerns are that they look tired, sad or sometimes angry. Without a detailed examination and analysis, patients may be conveniently given the advice for upper blepharoplasty with skin excision for conditions which are caused by brow ptosis instead. On the other hand, patients will demand injection of botulinum toxin for the transverse forehead wrinkles which are the secondary effect of pseudoptosis caused by brow ptosis and the injection of botulinum toxin will further lower the brows, aggravating the problem.

The ageing forehead will cause cosmetic issues of vertical wrinkles over the glabella, transverse wrinkles across the forehead, horizontal wrinkles over the glabella-nasal root region and ptosis of the brow. The lowering of the brow will in turn lead to overactivity of the frontalis muscle further aggravating the transverse wrinkles; secondary dermatochalassis of the upper eyelid which may cause pseudoptosis; hooding of the lateral upper eyelid skin extending beyond the lateral canthus; transverse nasal wrinkles and medial bulging of the upper eyelid. The descended brows will turn the open, amiable and cheerful looking Y-shaped profile running from the nasal root to the glabella and medial brow to become a heavy and compressed T-shaped profile with a scowling look.

If the secondary dermatochalassis of the upper eyelid is treated with upper blepharoplasty and skin excision, the valuable thin pre-tarsal skin will be removed leaving the much thicker sub-brow skin to form the lid fold, making the eyelid looks swollen. Also since skin is removed mainly within the orbital region, the higher lid fold so created will cause the eyelid fold to look unnaturally rounded since the drooping skin lateral to the lateral canthus remains. If this area of skin is also excised a permanent scar will be exposed and the lateral end of the brow will be further pulled down. Very often following an upper eyelid skin excision to correct pseudoptosis the eyebrow will descend further with loss of reflex contraction of the frontalis muscle since visual obstruction has been resolved, further narrowing the brow-lid margin distance and results in a heavy look. So the more logical way is to raise the brow surgically rather than removing skin from beneath the brow.

The ideal position of the eyebrow differs between the two sexes. For ladies, the medial brow end should rest just above the supra-orbital rim, gently curving upwards to the peak of the arch at a vertical level between the lateral limbus and the lateral canthus well above the supra-orbital rim and then slowly descends to end at the extrapolation of an imaginary line extending from the nasal ala to the lateral canthus. For men, the brow should more or less lie flat all the way just at or slightly above the supra-orbital rim.[2]

The descent of the eyebrows with age is caused by degenerative changes and stretching out of tissues between the eyebrows and the top of the scalp superimposed on the dynamic interplay of muscles acting on the eyebrows. The muscles acting on the eyebrows consist of elevators and depressors. The frontalis muscle is the only brow elevator. It arises from the skin and subcutaneous tissue in the region of the eyebrows and root of the nose and inserts into the galea aponeurotica. It runs mainly vertically in a slightly oblique direction from inferomedially to superolaterally. Laterally it ends at the temporal crest. Its contraction elevates the eyebrows and forms transverse wrinkles. Its medial fibres are continuous with the procerus muscle at the nasion, its intermediate fibres blend with the corrugator supercillii muscle and its lateral fibres blend with the orbital portion of the orbicularis oculi muscle. These three muscles form the depressors of the eyebrows. The corrugator supercillii muscle is a small pyramidal muscle at the medial end of the eyebrow, deep to the frontalis and orbicularis oculi muscles. Its fibres arise from the medial portion of the supra-orbital rim and then fan out superolaterally, passing between those of the orbital portion of the orbicularis and then insert into the deep surface of the forehead skin. Its contraction draws the eyebrows inferomedially and causes vertical glabellar furrows.[3] The procerus muscle originates from the surface of the upper lateral cartilages of the nose and the nasal bones and inserts into the skin in the glabellar region. Its contraction pulls the forehead down causing transverse wrinkles at the root of the nose.[4] The orbicularis oculi muscle is the sphincter-like

muscle encircling the upper and lower eyelids and its primary action is to close the eyes. It is divided into the orbital, pre-septal and pre-tarsal portions. The orbital portion originates medially from the superomedial orbital margin, the maxillary process of the frontal bone, the medial canthal tendon, the frontal process of the maxilla and the inferomedial orbital margin. In the upper eyelid, the peripheral fibres sweep across the orbital margin and spread upwards onto the forehead, cover the frontalis and corrugator supercillii muscles and continue laterally over the temporoparietal fascia.[5] Its contraction closes the eyes, brings the eyebrows down and causes appearance of the Crow's feet.

The motor supply to the frontalis, corrugator supercillii and procerus is by the frontal (temporal) branch of the facial nerve. After exiting from the parotid gland, this nerve travels within the superficial musculoaponeurotic system (SMAS) upwards crossing the zygomatic arch and then enters the frontalis from its deep surface.[6]

The sensory supply of the forehead is by the supra-orbital nerve which exits from the supra-orbital notch and the supra-trochlear nerve which comes out from the superomedial aspect of the orbit.[5]

The blood supply to the forehead is by the supra-orbital and supra-trochlear arteries which accompany the sensory nerves with the same name. The temporal scalp is supplied by the superficial temporal artery which divides into the anterior and posterior branches.

There are many surgical operations described for dealing with the ageing forehead. These can be divided into direct brow lifting, limited incision brow lifting, endoscopic brow lifting and full forehead lifting. The full forehead lifting can in turn be divided into subcutaneous or subgaleal depending on the plane of dissection; or classified according to the site of incision into coronal or pre-trichial. In this article the subgaleal forehead lift with either coronal or pre-trichial incision is described.

The coronal or pre-trichial forehead lift

Pre-operative Consultation

During the pre-operative consultation, the surgeon needs to attend to the patient's concerns and analyse the conditions that cause the concerns. The brow positions are noted and the upper eyelid and periorbital skin and the formation of a double fold if any is assessed. The brows should then be placed back to the ideal position and whether the patient's complaint can be resolved with this act is checked. If true dermatochalassis of the upper eyelid or dehiscence of the levator is present, then upper blepharoplasty should be considered but should follow a forehead lift if brow ptosis is present because this will let the surgeon better judge the amount of upper eyelid skin to be removed. The presence of transverse forehead wrinkles, transverse nasal lines, vertical glabellar lines and Crow's feet should also be noted. The level of the hairline and the presence of alopecia would influence the choice of incision. Usually if the hairline is more than 7 cm above the brow level, it signifies a high forehead and coronal incision may not be appropriate. Alternatively, the surgeon may use the ratio of the upper, middle and lower face for the choice of incision since the ideal ratio would be 1:1:1. The placement of the incision should be demonstrated to the patient.

Pre-operative Preparation

For two weeks prior to the operation, the patient should quit smoking. Any DM or hypertension should be well controlled. Medications that would compromise haemostasis like aspirin should be stopped in consultation with the physician. Any health supplements which may affect bleeding tendency should also be stopped like vitamin E, Gingko Biloba.

On the evening before and in the morning of operation, the patient should shampoo his or her hair with antiseptic soap.
No shaving is necessary.

The operation

The operation can be performed under local anaesthesia with intravenous sedation although general anaesthesia is preferred for patient comfort. For the coronal approach the incision extends from above the helix of the ear on one side going upwards well behind the temporal hairline and avoiding the anterior superficial temporal vessels, then slightly curves anteriorly but remains at least four to five centimetres behind the frontal hairline over the central portion and then back towards the temple and then downwards ending above the opposite helix. For the pre-trichial incision, the temporal parts of the incision are the same but the incision goes anteriorly over the central portion to lie just within the tufts of thin hair along the frontal hairline. Throughout the incisions in either situation the blade should be bevelled according to the direction of hair follicles to avoid damaging them and causing extra alopecia along both sides of the scar.

The incision is deepened to the subgaleal plane and the dissection proceeds anteriorly and caudally in the central portion until the supra-orbital rim is almost reached. Laterally at the temporal crest the fused fascia is divided at a plane deep to the temporoparietal fascia (part of SMAS) within which the frontal branch of the facial nerve travels. Then the supra-orbital neurovascular bundles should be identified and fascial attachments over the lateral part of the supra-orbital rim are freed down the upper halves of the lateral orbital wall. Medial to the supra-orbital nerves the corrugator supercillii muscles will be identified with branches of the supra-trochlear nerves running within the muscle. This muscle is then carefully dissected from the nerve and then a segment of it removed. Then medially over the glabellar region the procerus muscle can be identified. A transverse myotomy can then be performed. At the level of the most prominent transverse forehead wrinkle a transverse myotomy of the frontalis between the two supra-orbital nerves is made. After these manoeuvres the forehead flap can be slided upwards and posteriorly easily and the amount of skin to be resected is then determined, which is then marked and cut. Undue tension or excessive elevation

of the brows is to be avoided. After careful haemostasis and irrigating the wound with antiseptic or antibiotic solutions, a small suction drain is put into place and the wound sutured in two layers. Padded dressings under light pressure are then put on.

Post-operative course and complications

The drain can be removed on the following day and the bulky dressing changed to light dressing. The patient can resume hair shampooing with antiseptic soap on post-operative day 2. The skin clips or the stitches can be removed on day 7.

Usually there will be swelling and mild bruisings over the forehead and the peri-orbital region which normally resolve within the first week. There will be temporary hypoaesthesia of the scalp and sometimes paraesthesia including itchiness which usually resolves after a few months. In the first few weeks after operation the patient is advised not to use a hot hair dryer.

Complications are uncommon but include haematoma, nerve injury causing motor or sensory impairment and skin necrosis. A large and expanding haematoma is an emergency and should be opened and drained to avoid disastrous skin necrosis or alopecia. Small haematomata may be treated conservatively but can result in irregularities. Nerve injury is usually due to traction and usually recovers in several months. Skin necrosis is much less likely if the subgaleal rather than the subcutaneous plane of dissection is taken.

Conclusion

Traditional open forehead lift operations are safe and reliable with durable results. Post-operative recovery is also reasonably quick. The scar is well hidden within the hair and even for pre-trichial incisions is usually acceptable unless in patients with keloid or hypertrophic scar tendencies. The opportunity to remove redundant skin makes it the operation of choice in patients with loose and lax skin since the endoscopic approach precludes skin resection and unlike the limited points of suspension in the latter approach, the whole forehead is resuspended, making the brow elevation more even. Different issues of cosmetic concern due to forehead ageing can be dealt with in one go.[7]

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1. Introduction

a. Body slimming is one of the common requests in aesthetic medicine. People are looking for all sorts of measures to become thinner, including diets, exercises, massages, acupunctures, or even surgeries.

b. Abdominoplasty and liposuction are the two commonly adopted plastic surgeries for body contouring. Both abdominoplasty and liposuction are effective. However, people still have reservations on the associated use of anaesthesia, post-operative pain, scars and downtime. Therefore, non-surgical means such as the use of energy-based devices, which involves the processes of subcutaneous fat reduction, skin tightening, cellulite reduction, are often used to provide alternative solutions for body slimming and contouring.

c. With the invention of less invasive energy-based devices, the number of non-surgical cosmetic procedures have surpassed the number of surgical procedures significantly. According to a recent medical research, the number of non-surgical cosmetic procedures have increased 920% when compared to the increase of surgical procedures of only 74% from 1997 to 2011.

2. Energy-based Devices

Energy-based devices are one of the common tools for non-surgical body slimming. There are different types of energy-based devices. They include ultrasound, radiofrequency, laser, low temperature and mechanical devices. Each of these tools will be examined below.

3. Ultrasound

a. Ultrasound technology has been utilised to decrease subcutaneous fat and to tighten the skin. Transcutaneous ultrasound devices involve suitable frequency of ultrasound energy. It penetrates the skin without making any wound.

b. The ultrasound waves produced in this technology will propagate in the medium and the energy will be absorbed by the target tissue. It will induce the fat cells to vibrate and generate heat. Both the mechanical and thermal energy will lyse the fat cells.

c. The ultrasound technology has two means to remove fat: mechanical and thermal.

d. Low-intensity, low frequency focused ultrasound produces mechanical disruption of fat cells; high-intensity focused ultrasound produces thermal effect on target cells.

e. Ultrasound operates with frequencies from 20 kHz up to several gigahertz. The increase in the frequency will decrease the depth of penetration. In addition, a lower frequency is associated with cavitation of fat cells (mechanical effect)

f. Low-intensity low frequency ultrasound

   i. UltraShape Contour I Version 3 (Syneron Medical Ltd. US) (Fig 1) is one of the devices using low frequency ultrasound. The pulse waves of focused ultrasound with low frequency (200 +/- 30kHz) low intensity (17.5W/cm2) causes mechanical stress to adipocytes and results in cell cavitation. It can penetrate deep to 30mm.

   ii. The console of the UltraShape Contour I Version 3 is equipped with a video camera and a computer navigation system. Focused ultrasound is delivered evenly to the subcutaneous fat layer from the transducer with a stamping technique.

   iii. With the aid of a built-in video camera and navigation software, the ultrasound transducer is placed over the patient's skin. The ultrasound is fired to the subcutaneous layer.

   iv. It is recommended that a minimum of three bi-weekly treatments are to be carried out in order to attain some obvious results.

Fig. 1 Low frequency low intensity focused ultrasound device

g. High Intensity Focused Ultrasound

i. High-intensity focused ultrasound (HIFU) operates at high frequency (2 MHz) and high intensity (>1000W/cm2). The treatment temperate will be above 58C. The high temperate results in coagulation necrosis of fat (burn injury). The injured adipocytes will die and attract macrophages to ingest them, which results in reduction in fat volume in the subcutaneous layer.

ii. Liposonix (Solta Medical. US) (Fig 2) is a device which uses high intensity focused ultrasound. It makes use of the fractional principle to reduce the recovery duration, whereby the treatment zone is surrounded by a normal untreated area.

Fig. 2 High intensity focused ultrasound device

4. Radiofrequency

a. Radiofrequency (RF) is an electromagnetic energy. When the energy passes through tissues with resistance, it converts to thermal energy.

b. The RF energy targets the subcutaneous fat. The thermal stress causes damages in the fat cells. Moreover, the thermal energy that goes to the dermis causes skin tightening by contraction and neocollagenesis

c. Bipolar Radiofrequency

i. VelaShape III (Syneron Medical Ltd. US) (Fig 3) is a device which uses bipolar radiofrequency. It incorporates bipolar RF energy, controlled infrared IR light and pulsed vacuum. The device can deliver bipolar RF energy of 1MHz up to 150W.

ii. During the VelaShape III treatment, the suction applied will draw the skin into the vacuum chamber. Two metal electrodes inside the chamber will deliver the bipolar RF energy to increase the temperate of the tissue. The temperature is checked by a real time monitor. The treatment time should last for about 30 to 60 mins. The treatment interval should be increased gradually from weekly to biweekly, then from biweekly to monthly, depending on results.

iii. The patient will experience a vacuum suction feeling and a warm sensation. Burn injury could be a potential complication which may be associated with the VelaShape III treatment. However, no such complication has been reported so far.

iv. Legacy (VenusConcept. Israel) (Fig 4) also has a suction applicator which can deliver radiofrequency of 1MHz up to 150W. It is also equipped with a technology with pulsed electromagnetic field (PEMF) to stimulate the dermis collagen synthesis.

Fig. 3 Bipolar radiofrequency device - VelaShape

Fig. 4 Bipolar radiofrequency device – Legacy

d. Monopolar Radiofrequency

i. Besides the bipolar RF, there are some devices that employ monopolar radiofrequency. Examples of such devices are Vanquish, Exilis Elite and Thermage.

ii. Vanquish (BTL Industrial, MA, USA) (Fig 5) consists of a non-contact high frequency broad RF field device. The deep subcutaneous tissue converts the RF energy into thermal energy. This device increases the temperature of fat to 44-45C to cause fat cells apoptosis.

iii. During the treatment, the patient will lie on the treatment bed and the RF applicator is positioned above the treatment area without contacting the patient's skin surface. The treatment duration is 30 minutes per session with multiple sessions required.

Fig. 5 Monopolar radiofrequency device - Vanquish

iv. Exilis Elite (BTL Industrial, MA, USA) (Fig 6) is a monopolar RF device with 90W power. It consists of a grounding plate and an applicator. The alternate electric current flows between the applicator and the grounding electrode. Heat is generated adjacent to the applicator.

Fig. 6 Monopolar radiofrequency device – Exilis Elite

v. The temperature is raised to 39-43C and is closely monitored and controlled. During the treatment, skin tightening and adipocytes apoptosis are observed.

vi. Thermage (Solta Medical. US) (Fig 7) is another device using monopolar radiofrequency. Initially it is designed for facial wrinkle reduction by skin tightening. With the development of newer and larger treatment tips, the energy penetrates deeper into the fat layer. Both skin tightening and fat reduction are observed as a result of the treatment.

Fig. 7 Monopolar radiofrequency device - Thermage

5. Low Temperature Devices

a. One of the low temperature devices is called Zeltiq (Zeltiq Aesthetics, Pleasanton, CA) (Fig 8). It employs another side of fat reduction technology called cryoliplolysis.

b. The principle of the cryolipolysis is believed to be cold-induced inflammation of the adipose tissue. The low temperature results in adipocyte apoptosis, stimulates inflammatory response. The dead adipocytes are engulfed and digested by macrophages with the response results in reduction in the fat volume.

c. The device has an applicator that has vacuum to draw the tissue into a cup-shaped applicator. The tissue is positioned between two cooling panels. Heat is extracted from the tissue and the rate is modulated by the control unit. The treatment duration lasts for 60 mins.

d. Post-operatively the patient may experience erythema, bruise or dysaesthesia. The associated rare side effects may include vasovagal reaction and paradoxical adipose hyperplasia.

Fig. 8 Low temperate device - Zeltiq

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6. Low Level Laser Therapy

a. Laser energy has been used for minimally invasive lipolysis through a small puncture wound under tumescent anaesthesia. However external transcutaneous laser energy for fat reduction has different working principles.

b. Zerona (Erchonia Medical Inc.) (Fig 9) is a device which employs low level laser therapy (LLLT) using 635nm wavelength laser at 17.5W power. It reaches the subcutaneous fat layer and executes its photobiomodulatory effect to adipocytes. The laser energy causes the formation of transitory pores on the cell membrane, releases the stored fat content of the cells and collapses the adipocytes. The released fatty content is drained away by the lymphatic and circulation system. The deflation of the cell results in decrease in the subcutaneous fat volume.

c. The procedure protocol consists of a two weeks' treatment with three procedures per week, and each procedure should be two days apart. The patient is lies on the bed in the supine position. The treatment scanning device is positioned 6 inches above the body surface. The device is activated for 20 mins. Then the procedure is repeated with the patient now lying in the prone position.

d. Since there is no photothermal or photoacoustic mechanisms employed, the patient will not experience any major heating or pain.

e. Besides Zerona, ILipo (Chromogenex Technologies Ltd, UK)(Fig 10) also makes use of the low level laser energy of 650-660nm wavelength. It also combines infrared vacuum massage for lymphatic drainage and multi-polar radiofrequency to tighten the skin.

Fig. 9 Low level laser device – Zerona

Fig. 10 Low level laser device - iLipo

7. Mechanical

a. Endermologie M6 (LPG. France) (Fig 11) is a body slimming device using suction and massage. The device uses a mechanical suction and a roller applicator to treat the fatty region of the body. It mainly acts on the oedematous fatty tissue and for cellulite treatment.

Fig. 11 Mechanical device – M6

8. Personal preference

a. When using non-surgical energy-based devices, I will consider the following criteria:
   i. Effectiveness
   ii. Treatment duration of each session and the whole course
   iii. Anaesthesia requirement
   iv. Patient's experience during treatment, such as pain
   v. Safety
   vi. Downtime
   vii. Adjunctive therapy requirement, such as pressure garment
   viii. Patient's expectation

b. My personal preference of devices are low-intensity low frequency ultrasound and bipolar radiofrequency with suction applicator.

c. If the fat layer is thicker than 3cm, I will use the low intensity and low energy ultrasound to scale down the fat thickness. If the skin laxity is more problematic, the use of bipolar radiofrequency will have an additional benefit on skin tightening. Sometime using a combination approach of these two devices will be required. (Fig 12)

Fig. 12 Patient received 10 sessions of bipolar radiofrequency treatment

d. Most patients will experience improvement after 1-3 treatments, with each session lasts for about 30-60 mins. If the treatment duration is too long, the patients will find it hard to keep in position, even if they are in the supine position. If the patients do not get the results as they expected, regardless if their opinion is subjective or objective, their willingness to comply for further treatments will be compromised.

e. When non-surgical energy-based treatments are provided, patients do not require anaesthesia, whether it is topically, inhalationally or intravenously. Non-surgical energy-based treatments are mostly carried out in the clinic with repeated sessions required. I do not want my patients to expose to strong, high dosage of anaesthetic drugs, as this may increase the chance of unpredicted complications.

f. Mild degree of discomfort or pain is expected to be normal when low-intensity low frequency ultrasound and bipolar radiofrequency devices are used. If the patients cannot tolerate the pain even when the device is tuned with the lowest energy level, I will exclude them from the treatment.

g. Most of the energy devices will increase the temperature of the skin tissues. Thus, temperate monitoring plays an important part in the safety measure. Occasionally a mild degree of bruise is observed, however, burn injury is unacceptable.

h. After a non-surgical energy-based treatment is provided, a short period of erythema, swelling or dysaesthesia may be experienced. No burn injury or wounds should be considered normal.

i. No adjuvant therapy except diet and exercise advices should be considered. I do not use any form of pressure garment.

j. Given the results of the non-surgical slimming therapies are not compatible to the results of the surgical operations, patients should have a reasonable expectation on what results the non-surgical slimming therapies could produce. I believe that diet control and adequate amount of exercise are also key contributing factors to the success of body slimming.

9. Conclusion

a. When choosing a body contouring therapy, either surgical or non-surgical modality can be adopted. Surgeries such as abdominoplasty and liposuction are considered to be effective, single treatment with long-lasting therapies. However their associated anaesthetic and surgical risks, as well as long downtime are often seen as the major drawbacks for many patients. Non-surgical energy-based therapies are mainly clinic-based treatments, which do not require anaesthesia or wound management. The downtime are considerably short. No specific post-therapy care is needed. However, multiple sessions of treatments are often required, with results usually not immediate and are more subtle.

b. No matter which type of treatment option is adopted, dietary control and exercise are inevitable in order to achieve the best body slimming outcome. Pre-treatment consultation and physical examination can offer better treatment choices to different patients. Finally, managing patients' expectations is the key to success for non-surgical slimming treatment.

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Liposuction

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Introduction

Liposuction removes areas of unwanted fat with a tube and a vacuum device through a small skin incision. It has become the most frequently performed cosmetic surgical procedure, with over 300,000 cases in 2011 according to the American Society for Aesthetic Plastic Surgery (ASAPS). The technology of liposuction has been constantly improved since the first description in 1975. Nowadays, the trend moves toward lipoplasty or lipotransfer, namely transferring the unwanted fat to desired areas such as breast, depressed scar, soft tissue defect etc. Indications have been extended to gynaecomastia, facelift, neck lift and skin rejuvenation of face and hand.

Anatomy of Subcutaneous Fat

In the subcutaneous layer, the fat lobules are separated from each other by fibrous septae. There are blood vessels, nerves and lymphatics in this fibrous structure. In the fat lobule it contains fat cells. It has been shown that during initial weight gain, the size of fat cells increases. With further weight gain, there is an increase in the fat cell number because the mesenchymal stem cells would become fat cells. Diet and exercise have been shown to decrease the fat cell size rather than the fat cell number. That is the so-called "resistant fat".

Liposuction is a method to reduce the resistant fat by two mechanisms:
1 – Removal of fat cells with suction
2 – Damaging the fat cells by to-and-fro motion of the cannula. The damaged fat cells would get reabsorbed slowly over 6-12 weeks.

History of liposuction

Traditionally, the "dry technique" worked by manual suction with a syringe and mechanical avulsion of the fat lobules. However, it was associated with significant blood loss due to forceful injury to blood vessels and nerves in the subcutaneous layers and perioperative pain. Later, a small amount of fluid was introduced into the fat, also known as the "wet technique". It was also associated with much blood loss and patients frequently required blood transfusions. In 1985, Dr Jeffrey A. Klein developed the tumescent (meaning "swelling" and "firm") technique, which resulted in significant reduced blood loss and less pain. The techniques of liposuction have evolved rapidly over the past decades. The suction technique has been modified to reduce the manual effort, cause less trauma to the fat lobules aspirated and produce better survival of the fat graft for fat transfer.

Tumescent Anaesthesia

The tumescent solution has no standard or official recipe[1]. It consists of a few main components, namely isotonic normal saline, lidocaine, adrenaline solution and/ or Sodium Bicarbonate. Conventionally, the safety dosage of 1% lignocaine and adrenaline solution local anaesthetic is up to 7mg/kg. Klein showed that much higher doses, even up to 45-55mg/kg could safely be administrated.[1-3] This is because of the low blood flow in the subcutaneous fat. Adrenaline acts as a vasoconstrictor, minimising systemic absorption and bleeding. The duration of the anaesthetic effect may last as long as 24 hours due to the low absorption rate. Furthermore, most of the solution is removed during the aspiration, so the risk of overdose and toxicity would be lower.

Ultrasound-assisted liposuction (UAL)

This technique aims to liquefy the fat cells with the ultrasound energy emitted from the probe without traumatising the blood vessels and nerves in the subcutaneous layers. The liquefied fat is removed in a similar fashion to tradition liposuction. UAL is associated with prolonged swelling and seroma formation. Cases of skin burn have been reported. The ultrasound machines are expensive, resulting in a higher cost of the procedure.

Power-assisted liposuction (PAL)

In powered liposuction, there is reciprocating motion of the cannula, which mimics the movements of surgeons during liposuction. This technology saves the manual work of the operating surgeon, especially when a large amount of liposuction is being done. In addition, it is useful in "tight areas", where the physical space is limited (e.g. per umbilical and waist areas).

Other methods of liposuction

Water jet-assisted liposuction (WAL) uses the pressurised influx of tumescent solution to exert hydro-dissection of the fat. The fat is gently detached from the fibrous septae, and then aspirated with a cannula. Theoretically, the surrounding lymphatic, connective tissue, blood vessels and nerves are less traumatised during this procedure. The advantages include saving energy for surgeons, less traumatised fat lobules and

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better quality of structural fat cells for fat transfer. Immunohistological analyses of the aspirate showed relatively specific removal of primarily intact lipocytes with the minimal lymphatic structure and low vascular amount.[5]

Patient selection and counselling

Ideal patients are not grossly obese, with localised fat, without significant medical co-morbidity and have realistic expectations. It should be emphasised that liposuction is not a treatment for weight reduction, but improving the body shape. There is no age or weight limit for liposuction per se. The maximum amount of fat removed in each procedure is probably about 4-5 litres.[6] But megaliposuction should be avoided to minimise the associated complications. A thorough medical history and a detailed physical examination are paramount to rule out those risk factors such as severe cardiovascular disease, coagulation disorders, pregnancy, lidocaine allergy, keloid, hernia etc. Detailed counselling is mandatory to prevent miscommunication and unrealistic expectations.

Procedure

Pre-operative planning with the patient standing up should be done. Mark and illustrate the pre-existing deformity, incision placement, striae, surgical scars, redundant skin and hernia. Blood pressure, heart rate and pulse oximetry should be recorded throughout the procedure. An anaesthetist should be available in the theatre.

Infiltration of the tumescent fluid with a cannula is done through a small skin incision. Avoid overdose of the tumescent fluid infiltration. One should wait long enough for the tumescent fluid to percolate and its full pharmacological effect to take place.

Proper aspiration should be slow, gentle and to-and-fro movements of the cannula. There are different sizes of cannulae. A smaller cannula is used first to create tunnels in the fat, and then a larger cannula is used to aspirate the fat. It is better to perform the deep layers before the superficial layers. Avoid too superficial liposuction to minimise the risk of irregularity, skin injury etc. Non-operating hand can help assessment, guidance of liposuction during the procedure. One should aim for symmetry. Some surgeons would do liposuction with the patient standing up or sitting up for better results.

Post-operative pressure dressing is paramount in liposuction. There must be some tumescent fluid left behind. Surgical drain(s) can help to drain out the remaining fluid in 3-5 days. And pressure dressing can help to minimise the potential space after liposuction. Improper dressing increases the chance of irregularity, panniculitis and secondary infection. There are no strict rules for the duration of the pressure dressing. It is subject to the surgeon's preference, patient activity and degree of the liposuction. Post-op analgesics and antibiotics should be given. After the liposuction, the residual fluid would be drained out or reabsorbed in the next 3 days. And the damaged fat would be continuously absorbed over 4-6 weeks. The best result would be expected 6 weeks after the procedure.

Complication and Safety

Liposuction is a safe procedure but not without risks. Complications include:
- Post-operative tenderness or numbness
- Post-operative oedema or seroma
- Ecchymosis
- Panniculitis or wound infection
- Skin necrosis
- Fat embolism
- Irregularity or asymmetry
- Scarring/ keloid/ hyperpigmentation
- Bleeding

In a survey of 9,478 liposuction cases done by dermatologic surgeons, the risk of systemic complications was as low as 0.07%.[7] Five patients had excessive blood loss intra- or post-operatively, and two patients had infection. The commonest complications were irregularity (2.1%), haematoma (0.47%), and persistent oedema (46%). In 2002, a national survey of more than 66,000 liposuction cases performed with the tumescent technique found that the rate of serious adverse events was 0.68 per 100 cases. No death was reported.[8]

Conclusion

Liposuction is a safe and effective procedure when all essential steps and proper techniques are implemented. Proper patient selection, aseptic technique, anaesthesia, aspiration technique and post-operative care are all important to achieve optimal results for patients.

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Australian Wines – To Drink Or Not to Drink?

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When the Editor of the Hong Kong Medical Diary (HKMD) invited me to share some of my experience on Australian wines I had a couple of observations and thoughts in mind.

First, I know some of my colleagues who read HKMD empty bottles from Bordeaux, Burgundy, Champagne, Alsace, Rhone and Loire Valley at their dinner table on a regular basis. While I am now based "down under" I do commute to Hong Kong quite regularly and very often have the opportunity to taste wines over a meal with classmates and friends whose "house wines" are nothing but *Grand Cru* or *DRC*. The distinction between Old World and New World wine continues to be a focus of discussion and debate.

Second, there are those of us who are yet to be convinced about the health promoting effect of red wine or remain quite weary of the morbidity and mortality associated with imbibing alcohol. I am not a wine writer or master of wine but a psychiatrist who happens to have been enjoying wine all these years and is too aware of what alcohol can do to the body mind and soul of a person. I would like to highlight from the start that enjoying wines means drinking responsibly and in moderation.

People may not realise that Australia is so big with every type of climate and terroir that she produces a wine in every style that we are familiar with. Her European background also allows her to blend Old World specialties with New World techniques to produce wines packed full of flavour. While there are more than sixty distinct wine regions around Australia there are six key areas that continuously produce the best of the best – Barossa Valley (Shiraz), Clare Valley (Riesling), Hunter Valley (Semillon), McLaren Vale (Shiraz), Yarra Valley (Chardonnay, Pinot Noir and Sparkling) and last but not least Margaret River (Carbernet Sauvignon). Australian winemakers are steep in tradition – Australia still has one of the oldest vines in the world as she has never been affected by Phylloxera aphids which nearly killed all the vines in Europe in the 1800s and again in 1900s – but they are also very forward thinking in their unhesitating adoption of the screwcap (more than 95% of wine made in Australia nowadays are no longer sealed with cork) which I think is a game changer for those of us who want to keep wine a bit longer but without the perfect private cellar. The adoption of either organic or biodynamic regimes focusing on healthy soil with maximum bacterial and earthworm population and minimum herbicides and insecticides, the so called back to the good old day holistic approach to viniculture, may appeal to those of us who care about the environment and health. For those technically minded among us you may also like to know new and environmentally friendly winery equipment and technology are being developed and promoted by the Australian Wine Research Institute.

Having said all these, how do Australian Wines actually taste?

Australia's red grapes are among the greatest. The world is not the same without the classic Australian Shiraz (the same grape as Syrah in France's Rhone Valley; it arrived at the southern continent in 1832 and went on to liberate her unique complexity of mulberry, spicy and slightly wild flavour here). Australia is blessed with abundant sunshine which enables her grapes to ripen to perfection. If you are not prepared to pay up to four figures for a good bottle of Penfolds Grange, you will be glad to know that AUD20 or even less can get you a rather decent gratifying and ready to drink Shiraz. Please do not forget also to try the eccentric and yet wonderful Australian specialty wine, sparkling Shiraz, especially as part of your Christmas celebration (e.g. Seppelt). If you prefer a Carbernet Sauvignon a classic bottle from the South Australia Coonawarra *terra rossa* (red earth) soils or a stylishly crafted one from Western Australia's Margaret River (e.g. Leeuwin Estate) will not disappoint you. As for a good Pinot Noir, make sure you secure a bottle from the coolest regions in Tasmania or in Victoria (Mornington Peninsula, Geelong and the Yarra Valley) – diehard fans of those boutique winemakers like Bass Philip, Mount Mary or Giaconda may even dare you to a blind tasting against a Burgundy! Fortunately for the Merlot fans you can continue to live in peace indulging in your top drops from the Bordeaux Right Bank, but probably not for too long.

The white wine connoisseurs among us may already know that the Chardonnay grape did not really establish herself in Australia till the late 1920s. If you like vanilla and oak with plenty of ripe melon grapefruit and peach you will not be disappointed. Some argue the Leeuwin Estate Art Series Chardonnay is probably the best while others swear by Penfolds Yattarna though I have been told the sub-AUD10 Lindemans Bin 65 was for a while and probably still is one of the most consumed Australian Chardonnay in the USA if not the world. If you are into cellaring white wines you cannot afford to overlook the Semillon grape from the Hunter Valley which can continue to improve even beyond a decade.

DCH (Diploma in Child Health Examination) Written Examination (MRCPCH Foundation of Practice) 2016

The Hong Kong College of Paediatricians (HKCPaed) and the Royal College of Paediatrics and Child Health (RCPCH) will hold a Joint Diploma in Child Health Examination in Hong Kong in 2016 awarding DCH (HK) and DCH (International) to successful candidates.

The DCH Examination is divided into two parts, written (MRCPCH Foundation of Practice (formerly known as Part IA) and clinical. The written examination is the same as the MRCPCH Foundation of Practice Examination, which is held two times a year in Hong Kong. The next DCH written examination will be held on **Tuesday, 11 October 2016.** The examination fee is **HK$4,500** for Foundation of Practice. Candidates who wish to enter the examination must hold a recognized medical qualification in Hong Kong.

Application: Candidates **must apply online** using the RCPCH website via the **member sign in** area https://www.rcpch.ac.uk/user. In order to access the online application form, you need to be a registered user. If you do not have an RCPCH online account, you will be required to create one using the following link: https://www.rcpch.ac.uk/user/signup Applications for all exams will open at 9.00am UK local time on the first day of the advertised application period and close at 4.30pm UK local time on the last day.

Please note that application is NOT confirmed until payment of examination fees is received in Hong Kong.

Candidates who wish to sit the examination in Hong Kong **MUST ALSO** submit paper application to the Hong Kong College of Paediatricians (HKCPaed) by completing Form B (Application for entry to the MRCPCH Foundation of Practice & Theory and Science Examinations-Overseas Centres). For application details, please visit the HKCPaed website at http://www.paediatrician.org.hk/index.php?option=com_content&view=article&id=45&Itemid=46 or call the College Secretariat at 28718773.

Application Period: 25 July 2016 (Monday) – 10 Aug 2016 (Wednesday)

Important Notice
Clinical Examination format for DCH from April 2011

Details of the DCH Clinical examination format and other relevant information can be viewed on the RCPCH website at:
http://www.rcpch.ac.uk/training-examinations-professional-development/assessment-and-examinations/examinations/clinical-e-3

The Hong Kong College of Paediatricians (HKCPaed) and the Royal College of Paediatrics and Child Health (RCPCH) will be holding a Joint Diploma in Child Health Clinical Examination in Hong Kong in October 2016, awarding DCH (HK) and DCH (International) to successful candidates.

The DCH Clinical Examination will be held on **27th October 2016 (Thursday).**

The DCH Clinical Examination is open to registered medical practitioners in Hong Kong. Candidates who have already successfully passed the DCH written examination, namely Part IA since January 2004 or Foundation of Practice since February 2013, are eligible to apply. In addition, candidates who passed the Part IA examination in May 2005 or thereafter should have at least 6 months of Paediatric practice (resident medical officer or intern within 5 years prior to the date of the DCH Clinical Examination) in a recognized institution with acute hospital admissions. There are no exemptions from the Part 1A or Foundation of Practice examination.

The DCH Syllabus, which has been introduced since November 2009, will serve as the basis for assessments for the DCH Clinical Examination to be held in Hong Kong in October 2016. The Syllabus is available for viewing at the following link on the RCPCH Website:
http://www.rcpch.ac.uk/training-examinations-professional-development/assessment-and-examinations/examinations/syllabus-and

Application:
Candidates who wish to sit the DCH Clinical Examination in Hong Kong MUST apply through the Hong Kong College of Paediatricians. Application form, details of application and the format of examination can be found on the HKCPaed website at http://www.paediatrician.org.hk/index.php?option=com_content&view=article&id=45&Itemid=46 . Examination Fee is HK$ 8,500. Available places are limited and will be allocated on *a 'first come first served' basis.*

Opening date: 20 June 2016 ***Closing date: 18 July 2016***

Those who have sweet tooth will be offended if I do not mention De Bortoli Noble One. This fine Botrytis Semillon is arguably an Australian icon, kind of a *d'Yquem* not from Sauternes but less than an hour's drive from my home. Her cellar door restaurant used to have a dessert that comes with a half-bottle of Black Noble One for you to mix with the sweet which I always manage to "fully utilise" while forgetting about the actual dessert altogether!

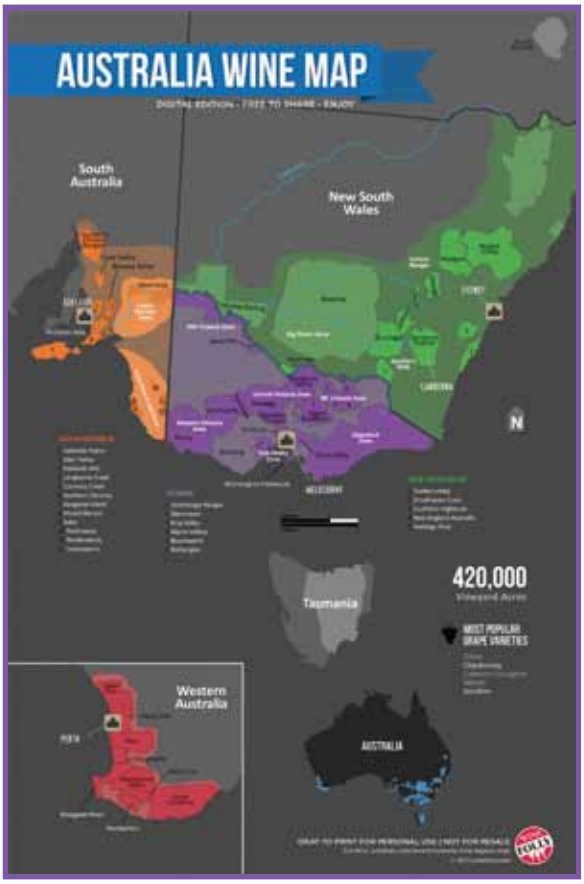
So what should you drink? If you have around AUD50000 to 70000 to spare a 1951 Penfolds Grange is one to go for. This is "cheap" compared to the most expensive Australian wine ever changed hands in the world – the Penfolds 2004 Kalimna Block 4 Cabernet Sauvignon was sold for AUD168000 a bottle in 2012 (just 12 individually numbered vessels have been made, with one reserved for Penfolds' own museum). Otherwise any good bottles from the following wineries – Penfolds, Wolf Bass, Wynns, Lindemans, Rosemount, Hardy, Jacob's Creek, De Bortoli, Yalumba, Yellowglen and many more – will provide you and your family or friends lots of quality time over a meal coupled with classic Australian dishes such as lamb roast or pan-fired Barramundi or indeed any well matched cuisine. For those who do not like Penfolds for the right or wrong reasons there is always Henschke's own Shiraz top drop "Hill of Grace" and her various "lesser" siblings. As a *very* generalised guide for great wines which are ready to drink or still drinkable now (you probably will get a different list from each "expert" you consult) 1990, 1992, 1996, 1999, 2005 and 2009 are excellent vintages while 1998, 2001, 2002 and 2004 can be spectacular. For specific advice on a particular region, grape, winery or wine and which ones to cellar now one really has to refer to the particular wineries (e.g. Clonakilla, Cullen, Moss Wood), respectable wine writers (e.g. James Halliday, Robert Geddes), professional magazines (e.g. Decanter, Winestate) and auction houses (e.g. Langton's) through their publications or websites. Those who are into wine maps will find the following website very informative too. (http://www.wineweb.com/mapaustr.cfm)

In short, in this year of Shakespeare 400th Anniversary when everyone still ponders over Hamlet's soliloquy "to be or not to be - that is the question" those of us who are here asking ourselves "Australian Wines – to drink or not to drink?" probably have a more forthcoming answer at hand. If you nevertheless still cannot make up your mind may I humbly and sincerely yet firmly suggest you to go to a nearby shop which sells wine and acquire a bottle from Australia with the amount that you would otherwise be prepared to pay for one from France and, of course, drink it please? I am sure you would not hesitate from then on to embark on your personal journey of exploring Australian wines in an informed and responsible manner, and will have no regrets.

All the best with your wine collecting and cellaring but please do not forget you need to drink and enjoy them with your beloved, family and friends too!

Penfolds 2004 Kalimna Block 4 Cabernet Sauvignon

Penfolds Grange 1951



HONG KONG SANATORIUM & HOSPITAL

LI SHU PUI SYMPOSIUM 2016

AMBULATORY MEDICAL PRACTICE

Date : Sunday, 4 September 2016
Venue : Ballroom, JW Marriott Hotel Hong Kong

08:50 – 09:00	Welcome		Dr. Walton LI
09:00 – 09:30	**Keynote Lecture 1: What the Plastic Surgeon Can Do Nowadays**		Dr. Gordon MA
Symposium 1	**Surgery & Related Disciplines**	Chairperson	Dr. Michael LI | Dr. TANG Wai Man
09:30 – 09:45	Anaesthesia Service in Ambulatory Setting		Dr. Henry TONG
09:45 – 10:00	ENT Service in the Clinic		Dr. Ambrose HO
10:00 – 10:15	Ambulatory Breast Surgery		Dr. Ava KWONG (HKU)
10:15 – 10:30	Neck Pain / Back Pain		Dr. Joshua KO
10:30 – 10:40	Q & A		
10:40 – 11:00	Coffee Break		
Symposium 2	**General Medicine**	Chairperson	Dr. Gavin LEE | Dr. KWAN Wing Hong
11:00 – 11:15	Advances in Gastrointestinal Endoscopy		Dr. Axel HSU
11:15 – 11:30	Chemotherapy in the Oncology Clinic		Dr. YAU Chun Chung
11:30 – 11:45	Rheumatology and Ultrasound		Dr. Helen CHAN
11:45 – 12:00	Cough, Dyspnea and Bronchoscopy		Dr. Jamie LAM
12:00 – 12:10	Q & A		
12:10 – 13:00	**Li Shu Pui Lecture Ambulatory Medical Practice – Safe & Efficient**	Chairperson	Dr. Gordon MA **Dr. Foad NAHAI**
13:00 – 14:00	Lunch		
Symposium 3	**Plastic & Reconstructive Surgery**	Chairperson	Dr. Daniel LEE | Dr. HO Chiu Ming
14:00 – 14:15	The Role of Modern Machines in Plastic Surgery		Dr. TUNG Man Kwong
14:15 – 14:30	Body Reshaping: Trash or Recycle		Dr. Vincent KWAN
14:30 – 14:45	Facial Contouring by Non-Surgical & Minimal Invasive Means		Dr. CHENG Ming Shiaw
14:45 – 15:00	Facial Contouring by Surgical Means		Dr. LAM Lai Kun
15:00 – 15:10	Q & A		
15:10 – 15:40	**Keynote Lecture 2 : PET/MR Current Applications**		Dr. Gladys LO | Dr. William CHEUNG
15:40 – 16:00	Coffee Break		
Symposium 4	**GP Forum**	Chairperson	Dr. YUEN Shiu Man | Dr. CHAN Wan Pang
16:00 – 16:15	Tearing - Diagnosis and Treatments		Dr. Andy CHENG
16:15 – 16:30	Management of Common Dermatological Conditions: General Pratitioners' Perspectives		Dr. Johnny CHAN
16:30 – 16:45	Gynaecologic Oncology in a Nutshell		Dr. TAM Kar Fai
16:45 – 17:00	Dental Implants in Severely Resorbed Alveolar Ridge		Dr. LAU Sze Lok

**Content is subject to change without prior notice*

REGISTRATION IS ON A FIRST COME, FIRST SERVED BASIS

Reserve your place by phone: 2835 8800 or at www.hksh.com/lsp-registration

CME Accreditation Pending | CNE 5.5 Points | CPD (Allied Health) 6 Points

Registration Deadline: Friday, 19 August 2016 | For Medical Professionals Only

Dermatological Quiz

Dr Chi-keung KWAN
MBBS(HK), MRCP(UK), FHKCP, FHKAM(Medicine)
Specialist in Dermatology and Venereology

Dr Chi-keung KWAN

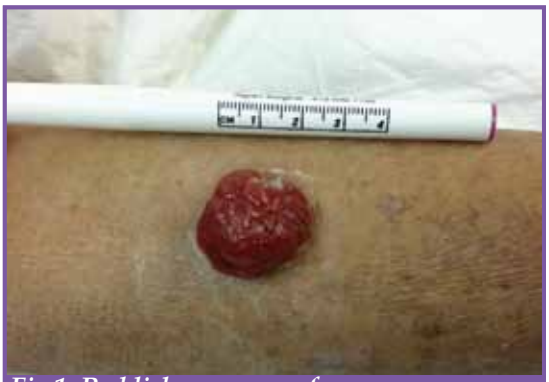


Fig.1: Reddish mass over forearm

This 56-year-old gentleman complained of a solitary and relative rapid growing mass protruding out at the right forearm for around 5 months. He did not remember any history of injury or any precipitating cause. The lesion was asymptomatic without any itchiness or pain. It was around 3cm in diameter and the surface was smooth and reddish (Fig. 1).

Questions

1. What are the differential diagnoses of his skin lesion?
2. What investigations are you going to order?
3. How do you treat this patient?

(See P.33 for answers)

Certificate Course on
Occupational Hygiene Practice 2016



Objectives:

This training course is intended to promote occupational hygiene among people working in healthcare sectors. The basic principles of occupational hygiene include recognition, identification, evaluation and control of health hazards in the workplace environment. In a series of six talks, some common health and safety issues will be discussed, including risk assessment and OSH management for health care facilities. Through simple languages with illustrative examples, measures are recommended to raise the awareness and to enhance the understanding on safe work practices in order to protect their own health and wellbeing at work.

Jointly organised by

The Federation of Medical Societies of Hong Kong

Hong Kong Institute of Occupational and Environmental Hygiene

Date	Topics	Speakers
4 Jul	OSH management for health care facilities	Mr. Hok-kwan TSUI
11 Jul	Handling of medical and chemical waste in health care services	Mr. Siu-lun WONG
18 Jul	Night shift works and health effect	Prof. Shelly Lap-ah TSE
25 Jul	Radiation hazards and controls	Mr. Sung-tat YIP
1 Aug	Infection control and ventilation	Mr. Tai-wa TSIN
8 Aug	Exposure risk assessment and ventilation controls of chemicals in health care	Mr. Mo-tsun TO

Date : 4, 11, 18, 25 July and 1, 8 August, 2016 (Every Monday)
Time : 7:00 p.m. – 8:30 p.m.
Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong
Language Media : Cantonese (Supplemented with English)
Course Fee : HK$750 (6 sessions)
Certificate : Awarded to participants with a minimum attendance of 70%
Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong
Tel.: 2527 8898 Fax: 2865 0345 Email: info@fmshk.org

CME / CPD Accreditation in application
A total of 9 CNE points for the whole course and the points will be awarded according to the number of hours attended
Application form can be downloaded from website: http://www.fmshk.org

Certificate Course for All Healthcare Professionals | CME/CNE Course | Course No. C284



Certificate Course on
Practical Applications of Quality of Life Measures

Objectives:

This course equips participants the know-how of assessing quality of life (QoL) in both healthy and ill individuals. The development of health-related quality of life dates back to the sixties when a group psychophysicists and econometricians developed a group of generic indices for assessing the changes in the state of well-being of patients, some of which were later developed as Index of Health-related Quality of Life. Since then, the measurement of health-related quality of life has made a major impact on the evaluation of health care and medical interventions. Nowadays, numerous measures have been developed across a wide range of clinical areas, including but not limited to neurology, oncology, cardiology, and palliative care. The best use of these tools is hinged on a good understanding of their developmental framework, extent of evaluation, and use in practice. In the sequel, this course provides the necessities for healthcare professionals to conduct QoL assessment in practice.

Jointly organised by

The Federation of Medical Societies of Hong Kong

ACQO 世界華人生活質素學會
World Association for Chinese Quality of Life

Date	Topics	Speakers
8 Jul	Principles and Concepts of Quality of Life (QoL) Assessment – Implication to the Integrative Medicine	Dr Wendy Wong Assistant Professor, Hong Kong Institute of Integrative Medicine, School of Chinese Medicine, The Chinese University of Hong Kong
15 Jul	QoL Assessment: A Chinese Medicinal Approach	Dr Zhao Li Chief of Chinese Medicine Service The Hong Kong Tuberculosis Association Chinese Medicine Clinic cum Training Centre of the University of Hong Kong
22 Jul	Assessments of sleep and related dimensions in clinical practice	Dr Wing Fai Yeung Assistant Professor, School of Nursing, Hong Kong Polytechnic University
29 Jul	Challenges of patients reported outcome for cardiovascular diseases patients	Prof Vivian Lee Assistant Dean (Student Development), Faculty of Medicine Associate Professor, School of Pharmacy
5 Aug	Best Practice in Selecting a QoL Measure: measurement of the quality of life in cancer patients	Dr Winnie So Associate Professor, The Nethersole School of Nursing, The Chinese University of Hong Kong
12 Aug	Best Practice of using QoL in health economic evaluation	Dr. Carlos Wong Research Assistant Professor, Department of Family Medicine and Primary Care, the University of Hong Kong

Dates : 8, 15, 22, 29 July 2016 and 5, 12 August 2016 (Every Friday)
Time : 7:00 pm – 8:30 pm
Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong
Language Media : Cantonese (Supplemented with English)
Course Fee : HK$750 (6 sessions)
Certificate : Awarded to participants with a minimum attendance of 70%
Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong
Tel: 2527 8898 Fax: 2865 0345 Email: info@fmshk.org

CME/CNE/CPD Accreditation in application
Application from can be downloaded from website : http://www.fmshk.org

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					★ 2016 AIRP Course in Hong Kong 1	★ 2016 AIRP Course in Hong Kong 2
★ 2016 AIRP Course in Hong Kong 3	4	★ HKMA Yau Tsim Mong Community Network - Current Trends on Viscosupplementation in Osteoarthritis Joint Management ★ HKMA Kowloon West Community Network - Certificate Course on Dermatology (Session 3): Updated Management of Atopic Dermatitis ★ FMSHK Officers' Meeting ★ HKMA Council Meeting 5	6	7	8	9
10	11	★ HKMA Kowloon West Community Network - Training Course on Dementia for Primary Care Doctors (Session 1) - Early Clinical Diagnosis of Dementia – Core Clinical Features and Diagnostic Criteria 12	★ Hong Kong Neurosurgical Society Monthly Academic Meeting – AVM treatment in the post-ARUBA era ★ HKMA Shatin Doctors Network - Role of HMB on Healthy Aging ★ HKMA Central, Western & Southern Community Network - Modern GOUT Management Perspective 13	★ HKMA Structured CME Programme with HKS&H Session 6: Update Management on Non-alcoholic Fatty Liver Disease ★ FMSHK Executive Committee Meeting 14	15	16
17	18	★ HKMA Kowloon West Community Network - Fragility Fracture: Medical and Surgical Treatment ★ HKMA CME: Emotional Disorders in Professionals and Managers: Management in General Practice ★ Annual General Meeting 19	20	★ HKMA KECN, HKCFP & UCH - Certificate Course for GPs 2016 (Session 3): Update on Depression Management ★ FMSHK Foundation Meeting 21	22	★ Hong Kong College of Health Service Executives Annual Conference 2016 - People, Technology and Innovation 23
24 31	25	★ HKMA Kowloon West Community Network - Training Course on Dementia for Primary Care Doctors (Session 2) - Drug Treatment – Strategic Pharmacological Intervention for Dementia 26	27	★ HKMA New Territories West Community Network - First 1000 Days of Allergy Prevention 28	★ Joint Surgical Symposium - Robotic Prostatectomy 29	30

IMMEDIATE

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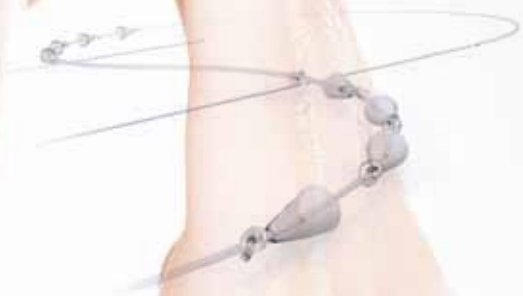

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"SILHOUETTE ENHANCED THE CONTOURS OF MY FACE AND PUT A SMILE UPON IT"

Date / Time	Function	Enquiry / Remarks
1 FRI 8:00AM (2,3)	**2016 AIRP Course in Hong Kong** Organiser: American Institute for Radiologic Pathology (AIRP) and Hong Kong College of Radiologists (HKCR); Speakers: Dr Mark D. MURPHEY; Dr Marilyn J. SIEGAL, MD; Dr Kelly K KOELLER, MD; Venue: Hong Kong Academy of Medicine Jockey Club Building 99 Wong Chuk Hang Road, Aberdeen, Hong Kong SAR	Ms. Jana LAM Tel: 2871 8790 Fax: 2554 0739 7 CME Point
5 TUE 1:00 PM	**HKMA Yau Tsim Mong Community Network - Current Trends on Viscosupplementation in Osteoarthritis Joint Management** Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. HO Fung; Speaker: Dr. HO Hok Ming; Venue: Pearl Ballroom, Level 2, Eaton, Hong Kong, 380 Nathan Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA Kowloon West Community Network - Certificate Course on Dermatology (Session 3): Updated Management of Atopic Dermatitis** Organiser: HKMA Kowloon West Community Network; Chairman: Dr. LAM Ngam, Raymond; Speaker: Dr. CHUNG Chun Kin, Alex; Venue: Crystal Room IV-V, 3/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, N.T.	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
8:00PM	**FMSHK Officers' Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Gallop, 2/F, Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
8:00PM	**HKMA Council Meeting** Organiser: The Hong Kong Medical Association; Chairman: Dr. CHAN Yee Shing, Alvin; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Christine WONG Tel: 2527 8285
12 TUE 1:00 PM	**HKMA Kowloon West Community Network - Training Course on Dementia for Primary Care Doctors (Session 1) - Early Clinical Diagnosis of Dementia – Core Clinical Features and Diagnostic Criteria** Organiser: HKMA Kowloon West Community Network and Institute of Alzheimer's Education of Hong Kong Alzheimer's Disease Association; Chairman: Dr. LEE Fook Kay, Aaron; Speaker: Dr. CHAN Chun Chung, Ray; Venue: Gingko House, G/F, Cheerful Court, 55 Choi Ha Road, Ngau Tau Kok, Kowloon (牛頭角彩霞道55號彩頤居地下銀杏館)	Miss Hana YEUNG Tel: 2527 8285 1.5 CME Point
13 WED 7:30 AM	**Hong Kong Neurosurgical Society Monthly Academic Meeting – AVM treatment in the post-ARUBA era** Organizer: Hong Kong Neurosurgical Society; Chairman: Dr WONG Kai Sing, Alain; Speaker: Dr HO Wing Kiu, Joanna; Venue: Seminar Room, G/F, Block A, Queen Elizabeth Hospital	Dr. LEE Wing Yan, Michael Tel: 2595 6456 1.5 CME points
1:00 PM	**HKMA Shatin Doctors Network - Role of HMB on Healthy Aging** Organiser: HKMA Shatin Doctors Network; Chairman: Dr. MAK Wing Kin; Speaker: Dr. YIP Wai Man; Venue: Jasmine Room II, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin, Hong Kong	Ms. Connie NG Tel: 2806 4287 1 CME Point
1:00 PM	**HKMA Central, Western & Southern Community Network - Modern GOUT Management Perspective** Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. YIK Ping Yin; Speaker: Dr. YU Ka Lung, Carrel; Venue: HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road, Central, Hong Kong	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
14 THU 1:15 PM	**HKMA Structured CME Programme with HKS&H Session 6: Update Management on Non-alcoholic Fatty Liver Disease** Organiser: The Hong Kong Medical Association & Hong Kong Sanatorium & Hospital; Chairman: Dr. NG Fook Hong; Speaker: Dr. Hsu Shing Jih, Axel; Venue: Function Room A, HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point
8:00 PM	**FMSHK Executive Committee Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
19 TUE 1:00 PM	**HKMA Kowloon West Community Network - Fragility Fracture: Medical and Surgical Treatment** Organiser: HKMA Kowloon West Community Network; Speaker: Dr. TSE Lung Fung; Venue: Crystal Room IV-V, 3/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, N.T.	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
7:00 PM	**HKMA CME: Emotional Disorders in Professionals and Managers: Management in General Practice** Organiser: The Hong Kong Medical Association; Chairman: Dr. CHOI Kin; Speaker: Prof. TANG Siu Wa; Venue: Jade Ballroom, 2nd Floor, Eaton, 380 Nathan Road, Jordan, Kowloon, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point
9:00 PM	**Annual General Meeting** Organiser: The Hong Kong Medical Association; Chairman: Dr. LAM Tzit Yuen, David; Venue: Jade Ballroom, 2/F, Eaton HK, 380 Nathan Road, Kowloon	Ms. Christine WONG Tel: 2527 8285
21 THU 1:00 PM	**HKMA KECN, HKCFP & UCH - Certificate Course for GPs 2016 (Session 3): Update on Depression Management** Organiser: HKMA Kowloon East Community Network & Hong Kong College of Family Physicians & United Christian Hospital; Chairman: Dr. MA Ping Kwan, Danny; Speaker: Dr. LEUNG Man Wai, Meranda; Venue: Conference Room, G/F, Block K, United Christian Hospital, 130 Hip Wo Street, Kwun Tong, Kowloon	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
8:00PM	**FMSHK Foundation Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
23 SAT 12:00PM - 5PM	**Hong Kong College of Health Service Executives Annual Conference 2016 - People, Technology and Innovation** Organiser: HKCHSE Venue: Shanghai room, Level 8, Cordis Hong Kong, 555 Shanghai Street, Mongkok	Ms Eva TSANG Tel: 2821 3514 Fax: 2865 0345
26 TUE 1:00 PM	**HKMA Kowloon West Community Network - Training Course on Dementia for Primary Care Doctors (Session 2) - Drug Treatment – Strategic Pharmacological Intervention for Dementia** Organiser: HKMA Kowloon West Community Network and Institute of Alzheimer's Education of Hong Kong Alzheimer's Disease Association; Chairman: Dr. LEE Fook Kay, Aaron; Speaker: Dr. SHEA Tat Ming, Paul; Venue: Gingko House, G/F, Cheerful Court, 55 Choi Ha Road, Ngau Tau Kok, Kowloon (牛頭角彩霞道55號彩頤居地下銀杏館)	Miss Hana YEUNG Tel: 2527 8285 1.5 CME Point
28 THU 1:00 PM	**HKMA New Territories West Community Network - First 1000 Days of Allergy Prevention** Organiser: HKMA New Territories West Community Network; Chairman: Dr. TSANG Yat Fai; Speaker: Dr. CHENG Man Yung; Venue: Pearl Ocean, 1/F., Gold Coast Yacht and Country Club, 1 Castle Peak Road, Castle Peak Bay, Hong Kong (黃金海岸鄉村俱樂部 - 遊艇會一樓金霞殿)	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
29 FRI 8:00AM - 9:00AM	**Joint Surgical Symposium - Robotic Prostatectomy** Organizers: Department of Surgery, The University of Hong Kong & Hong Kong Sanatorium & Hospital; Venue: Hong Kong Sanatorium & Hospital; Chairman: Dr. WONG Wai-Sang; Speakers: Dr. CHAN Wai-Hee, Steve, Dr. YIU Ming-Kwong	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 Fax: 2892 7511 1 CME Point (Active)

Upcoming Meeting

4/9/2016 8:50AM-5:00PM	**Li Shu Pui Symposium 2016 – Ambulatory Medical Practice** Organiser: Hong Kong Sanatorium & Hospital Venue: Ballroom, JW Marriott Hotel Hong Kong, Pacific Place, 88 Queensway, Hong Kong	Tel: 2835 8800 Website: www.hksh.com/lsp-registration
8-9/10/2016	**The 9th Hong Kong Allergy Convention - Novel Strategies for Prevention and Treatment of Allergic Disorders** Organiser: Hong Kong Institute of Allergy; Venue: Hong Kong Convention and Exhibition Centre	HKAC 2016 Secretariat Tel: 2559 9973

Answers to Dermatological Quiz

Answer:

1. Pyogenic granuloma, Squamous cell carcinoma(SCC), Secondary cutaneous metastasis, Tufted Haemangioma, Angiosarcoma and Amelanotic melanoma.
   Pyogenic granuloma is a relatively common benign vascular lesion and can present as a rapidly growing tumour. Secondary cutaneous metastasis is likely presented with multiple cutaneous papules or nodules. Tufted haemangioma is often seen in paediatric patients but teenage and adult reports are sometimes encountered. Angiosarcoma can be one of the differential diagnoses but likely presents in the head and neck region with more advanced in age. SCC and Amelanotic melanoma is very difficult to be ruled out clinically.

2. Skin biopsy either incisional or excisional may be necessary to differentiate the above mentioned differential diagnoses. It is also named lobular capillary haemangioma and pyogenic granuloma but these are misnamed as they are neither infectious nor granulomatous. Histology reveals early lesions will have numerous capillaries and venules with plump endothelial cells arrayed radially towards the skin surface and late lesions showing polypoid lesions exhibited a fibromyxoid stroma separating the lesion into lobules.

3. Surgical removal by complete excision with suturing or shave excision followed by electrocautery of the base are feasible treatments. Pulsed dye laser is safe and effective treatment for small lesions particularly in paediatric patients. Injectable sclerotherapy, chemical cauterisation with silver nitrate and topical phenol are occasionally used. Topical imiquimod cream has also been reported to be useful in the treatment of pyogenic granuloma. The triggering factors or irritations must be removed if present.

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Reference:
1. Becker MA et al. N Engl J Med 2005;353(23):2450-2641. 2. Schumacher HR Jr. et al. Rheumatology 2009;48:188-194.
3. FEBURIC® HK packaging insert May 2014. 4. Sezai A et al. Circ J 2013; 77 (8):2043-2049. 5. Tanaka K et al. Clin Exp Nephrol. 2015 Dec; 19(6):1044-53.

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