Editor's Note

By Editor-in-Chief

Happy New year of Oxt!

You might have noticed there were some changes in the last Bulletin. Thanks to our new members of the editorial board. We are able to bring in some new sessions. We do hope you find it a good read and continue your support to us!

We have conducted interviews to the renowned members of our anaesthetic community. In the last issue, we have invited our College President, Professor Michael Irwin to speak to us. It is a surprise to see the Mr. Anaesthesia in Glasgow 1991! We also have a sharing from Dr. Lett, who is our Cofounder, ex-President and ex-Chairman of the Society of Anaesthetists of Hong Kong.

In this issue, we are honored to have a good chat with our old friends, Daniel and Cherry, our College secretariat support. Probably you will remember meeting them during your examinations and congregation. They are also the one whom you have to submit everything before you can obtain your fellowship. Let’s meet them here!

Besides, we have introduced a session on Quality and Safety. Being an anaesthetist, we are trained to deliver judicious care to our patients. We should be proud of the safety design we have in our daily anaesthetic practice. In this issue, we talked about the use of ultrasound for regional block and venous cannulation, with reference to NICE guideline. We also have made notice of the new surgical gadgets in the section on Robotic Surgery. With the advancement of surgical technology, we, as anaesthetists have to know how it is going to affect our practice.

Last but not the least; we would like to extend our rapturous applause to Dr. Menon from the Caritas Medical Center, for his artistic photos, which you can find one in the cover of the last issue. Here is another capture and wish you a very good day!

Libby Lee
Editor-in-Chief

---

Email: jeehy@ha.org.hk
Address: Room 507S, HAHO Building, 147B Argyle Road, HK
Phone: 2300-6138

Disclaimer

Unless specifically stated otherwise, the opinions expressed in this publication are those of the author’s personal observation and do not necessarily reflect the official policies of the Hong Kong College of Anaesthesiologists.
Daniel and Cherry
By M C Chu

Figure 1. Mr. Daniel Tso (left) and Mrs. Cherry Wong (right)

What are you two doing here?

Room 807 means different things for different people. For many of us this is a reminder of the moments of stress: examinations, exit assessments, and so on. It is a well-lit yet gloomy place.

"Please enjoy the view of the Ocean Park." Daniel explained. "Members of the college might think otherwise, but this is quite a decent office. We have a reception area, desks, storage space, our own pantry, and even a chamber for the president."

"This did not come easy. The college back in 1989 did not even have an office. Secretarial support came from the staff of the anaesthetic department at the Prince of Wales Hospital, as well as the Academy of Medicine then at the Pamela Youde Hospital. The current setting only came into being for about 10 years." Daniel Tso 俊涛) was the longest serving Administrative Executive since 1998. "I am actually the second one. The first one left in one week, and I was summoned at very short notice!"

"Items of the college still bear witness to the humble beginnings and the generosity of our grandfathers. The college mace was commissioned by Dr. Chandra Rodrigo and was made in Sri Lanka, and the college mallet was donated by Dr. Jean Horton." (Figure 2)

Figure 2a. Mr. Daniel Tso with the college mace and the mallet

Figure 2b. Draft of college mace by Dr. Rodrigo, now in college archive
Trying the president's chair and holding the mallet did little to calm my nerves. One is surrounded by loads of documents, name badges, files and who knows what's inside.

"It is pretty busy looking after more than one hundred members and three fellow fellows, scattered all over the world." Cherry Wong said. She has been our Clerical Assistant for 5 years. "You can imagine the paperwork with all the CME and money matters. We mail everyone for announcements of all sorts. That might be meetings, bulletins, payment, reminder for payment (true!), etc. And then we would sort out their replies and come up with statistics and report to councils, boards and the Academy as well." (Figure 3)

"We monitor the progress of everyone trainee during their training period including their in-training assessments, workshops, projects, examinations and of course the exit assessments. Running five or six examinations (part one and two for anaesthesia, intensive care and diploma in pain) with visits each year is quite an undertaking," Daniel said. "There were only two occasions when only one single candidate participated, so we invited him here for the examination, in this very chamber." During another examination the battery of the official clock suddenly dropped dead. "We replaced the clock but there was a slight time difference between the clocks, and the examination finished a few minutes earlier. Fortunately we managed to get the consent from all the candidates to proceed with marking. Of course they are entitled to objections."

What about the better part of those events? "The best part is the announcement and reception after each examination. It's so happy watching these inspiring candidates turn into professionals. We are pleased to be involved throughout their development." Cherry said. (Figure 4)

So who is the boss? "We share instead of diversifying the work among ourselves and it works well for just two of us." That is even more remarkable for Cherry as she was a housewife for over 20 years before joining the college. "I started from scratch and Daniel is a great mentor. I never thought of staying for so long but I did."

"The college offers a very stable working environment for me too," Daniel said. Stability comes first when anaesthesiologists are in charge, even when the financial tsunami strikes. "We are not directly affected as we haven't invested on any of those 'tools', not even the Tracker Fund."

Next time when you pay your college fees, you know that they are in good hands.

---

**Special Articles**

**Robotic Surgery**

*By Nick Sun and Libby Lee*

The most famous robots we have ever encountered probably are C3PO and R2D2 in Star Wars. You will remember R2's "box of tricks", which was full of many apparatus and manipulators. Some of his gadgets include a laser, a gripping tool, a computer interface, and a periscope. There was nothing that R2D2 could not fix.

Now we have our C3PO and R2D2 in Medicine, fighting the wars against disease for us. Medicine has advanced with the progress of science. It is built on the best of the past. Robotic surgery is the new era of medicine. Besides precision, miniaturization, smaller incisions, decreased blood loss, less pain, and quicker healing time, robotic surgery also offers articulation beyond normal manipulation and three-dimensional magnification.

Robot, named by a Czech playwright Karel Capek in his play-Rossom's Universe Robots in 1921, means forced labour. Previously, being only able to perform simple task, robot now is capable to complete highly sophisticated, specific, precise and complicated tasks, like surgery. In 1985 a robot, the PUMA 560, was used to place a needle for a brain biopsy using CT guidance. In 1988, the PROBOT, developed at Imperial College London, was used to perform prostate surgery. The ROBODEC from Integrated Surgical Systems was introduced in 1992 to mill out precise fittings in the femur for hip replacement.

Currently, the use of robots in surgery is approved by United State Food and Drug Administration.

It is our great pleasure to discuss with Dr. Po Chor Tam, Division Chief of Urology, Department of Surgery, Queen Mary Hospital, on the practice and future of robotic surgery.

*Figure 3. Mrs. Cherry Wong introducing the college accounting system. See our debit notes?*

*Figure 4. Academic dresses for the special occasions*

*Professor Tam sitting in front of the da Vinci Machine*
A: The open surgery associates with a high morbidity. The situation improved after the introduction of minimally invasive laparoscopic surgery in 1987. It resulted in a potentially smaller incision, fewer complications, faster recovery, less postoperative pain and shorter hospital stay. However, laparoscopic operation has its own limitations such as small visible surgical field, difficulty in manipulation due to rigid instrumentation, hand-eye coordination and limited degree of movement. Robotic surgery is the new approach that can overcome many of the unsolved technical problems of laparoscopic surgery and enhance the performance of minimally invasive procedure.

A: What is the advantage of the robotic surgery compared to the conventional laparoscopic surgery?

T: I think one of the most obvious advantage of the robotic system is that it offers a better visualization. Theoretically the image can be magnified 10 times. With an improved image, the surgeons can perform the operation more precisely. An improved image implied a larger visual field, a higher resolution and a three-dimensional view with depth perception. The latter is particularly important for hand-eye coordination. There are 2 cameras at the end of the instruments so you can have a true 3-dimensional view. Another important advantage is the improvement in dexterity by the EndoWrist technology. Compared to the conventional laparoscopic instruments which only have four degree of movement, the instruments of robotic system have seven degrees of movement which greatly enhance the manipulation of instruments and tissues. The system can also filter the tremors and falcurn effect.

In addition, the system can scale the movements. The instrument can set the scaling into normal, fine and ultra-fine so that large movements of the control grips can be transformed into micro-motions inside the surgical field.

A: How popular is the robotic surgery worldwide?

T: There are more than 800 hospitals in the States and Europe equipped with robotic systems. According to the statistics in the States, about 80% of radical prostatectomy was done under robotic systems, which is by far the commonest operation that is being done by this approach. I think the trend is increasing as more operations will be done with robotic systems and less will be done in traditional way. It is getting more popular.

A: Apart from the United States, is robotic surgery common in other countries?

T: I think the other countries are catching up. It may be market-driven as well. For instance, in the States, some centers claim that if they do not offer robotic surgery, patients will go to other centers which equipped with the systems. It not only happens to the small medical centers but also to the well-established centers like John Hopkins. That is why they are under pressure to introduce the system. This happen to other countries as well.

A: Robotic system is commonly applied in urological surgery. Can you outline which urological operations are being done with Robotic?

T: So far the commonest operation being done under robotic system is radical prostatectomy. Other common robotic-assisted urological procedures include partial nephrectomy, pyeloplasty and cystectomy especially when you need to make a neo-bladder and perform urethrovexical anastomosis.

A: Apart from Urology, are there any surgical specialties using robotic systems as well?

T: Urology surely is not the only sub-specialty that benefits from the robotic systems. Robotic systems are also used in cardiothoracic procedure like coronary artery bypass, valvar repair, gastrointestinal procedures like fundoplication, hepatobiliary operation like Whipple’s operation and pancreatectomy. Another field with great potential is gynaecology. The robotic system is very useful when the operation involves pelvic structure or lymph node dissection.

A: One simple question, is it safe?

T: It is reasonably safe. The important thing is that you have to know your limitation and you have to familiarize with the system before using it. There is always a learning curve for every procedure. That is why the operating surgeons need to attend the skill course and be supervised by trainers at the early stage. One safety concern is the position of the machine arms which stay in the body of the patient. It may hinder intra-operative resuscitation, if required. However, it takes less than 30 seconds to stop the procedure and remove the system if necessary.

A: There are numbers of robotic models in the market. The one we are using in Hong Kong is the Da Vinci surgical system. Why it is called Da Vinci?

T: It is because Da Vinci was a very famous scientist and he was the one who invented the concept of robot. He was also famous for the detail description of human anatomy. I think that is why the system named after him.

A: What are the components of the robotic system?

T: It varies with the manufacturer. For the Da Vinci surgical system, it adopts a master-slave system which evolved from the telepresence machines in NASA. Basically it consists of 3 components: A master console where the operating surgeon sits, a vision part that holds the cameras and light source and a movable part that mounts with the robotic arms and camera arm. All these 3 parts are linked together.

A: I was told that when you operate from the master console, you lose the tactile sensation. Is it a problem?

T: Yes, that is why when we start doing it, we go very slowly. Normally in traditional open operation, we do feel the texture of the tissue. In robotic system, you don’t even feel the resistance from the machine arms. Because of this you may break the suture quite easily during suturing.

A: How do surgeons overcome this loss of tactile feedback?

T: Practice makes perfect. Besides experience, one can get the clue from the colour and texture change of the tissue during surgical manipulation.
A: Which type of operations you think will benefit most from it?

T: I think those operations which require precise reconstruction and suturing will benefit most from it. For operations like total nephrectomy or cholecystectomy, the benefit may not be obvious in robotic approach when compared to laparoscopic ones. It is best for the procedure which involves a small and restricted surgical field and requires lots of reconstruction and suturing.

A: Are there any disadvantages or limitations of the robotic system?

T: The major disadvantage is the financial implication of the service. The capital cost is almost 2 millions dollar and the maintenance cost is about 1.5 million per year. The consumables are very expensive too. e.g. for a single procedure, HRD12-15,000 is required. The endorist instruments can only be re-used for a limited number of times. Most of them can only be used for 10 times and they will then be discarded. It all adds up the cost.

The huge size of the system also imposes an accommodation problem. The size of the instruments is too big when used on paediatric patients. I think in a very near future, there will be a more handy system and instruments available.

Like most of the latest technology, figure or data to supporting its uses and efficacy is still lacking. Its long term effect on patient outcome is still uncertain. More studies are essential to consolidate its safety and cost-effectiveness.

Other disadvantages include the learning curve of operator & the long preparation time before operation.

A: Robotic surgery seems to be a long operation, which is most likely associated with the learning curve. What is the learning curve for the robotic system?

T: For radical prostatectomy, an operator might require to operate on 40 patients before establishing the necessary skills. An expert once said he has done 400 cases but he is still in his learning phase. But normally after 30 or 40 operations, the surgeon will feel confident to the system and the surgical procedure. Of course, in order to improve the efficacy, say finish an operation in 3-4 hours, the surgeons need to do more. However, when compared to the learning phase for laparoscopic surgeries, which involved several hundred operations, it is easier to master the skills in robotic surgery. This is one of the reasons why many centers in the States shifted their operation from laparoscopic to robotic approach.

A: What are the common surgical complications associated with robotic surgery?

T: Basically the common complications are similar to the laparoscopic surgery such as injury to internal organs: puncture unrecognized blood vessels, gas embolism, & surgical emphysema. In addition, bending the instrument arms can turn the internal organs because of lack of tactile sensation.

A: What do you think of the cost-effectiveness?

T: It depends on the type of operations. I think radical prostatectomy is cost effective. The hospital stay is certainly shorter. It also allows a smoother patient recovery from the operation and an earlier return to normal daily activities. The early returns of continence and potency are the added values. The overall functional outcome is better.

A: You mentioned about a smoother recovery. How about the postoperative pain?

T: Most of the patients do not experience much pain after the operation compare with the open surgery approach. Indeed most of them can sit out or are even ambulatory in post-op day one. In fact in the States, patients are discharged on the first day after prostatectomy.

A: Another concern from anaesthetic point of view. How about the intra-operative blood loss?

T: The blood loss, like that in laparoscopic approach, is usually less than that of open surgery. Again, using radical prostatectomy as an example, the average blood loss by robotic approach is about 200-300ml. But in the traditional open approach, the intra-operative blood loss is about 1-2 liters, mainly coming from the dorsal venous complex. The reduction in blood loss is mainly due to the pressure effect of prostatic-rectum as well as precise and concise dissection. As expected the transfusion rate and the complications associated with the transfusion are reduced.

A: What is the future role of robotic surgery?

T: Although robotic surgery is still in its developing stage, the initial outcome is quite promising. I think it has a great value in complicated operations. However its role in simple procedures might not be cost-effective. For well-established procedures like radical prostatectomy, it will stay.

A: Is there any training requirement for robotic surgery?

T: It varies from place to place. In general the manufacturing companies recommend surgeons attending skill course before operating with the system. For Da Vinci system, the company organizes a two-day skill course for the surgeons. The course initially was only available in the States but now surgeons can attend the course locally in Hong Kong. It consists of background knowledge and theory of the system. Technical aspect like suturing and dissection are taught in a pig model. After one get familiarized with the machine and instruments, one still need to observe adequate numbers of procedures on patients before becoming a surgical assistant. For some hospitals one needs to assist 5-10 times before he / she can be the chief surgeon. He / she needs to have a certified mentor in the operating theater supervising the initial few operations. In general, the surgeon has to be competent in both open and laparoscopic approach before embarking on robotic surgery.

A: What do you think about the future development of the robotic surgery in Hong Kong?

P: Currently there are two Da Vinci systems in public sector and one in private hospital. There will be another two in public hospitals later this year.

For every development of service, there should be a balance of demand and supply, and the latter is limited by the cost required to bring in the system.

Cost is an issue here, which might have a negative impact on the development of the system. Demand is another consideration. One to two systems can already comfortably support three to four hundred radical prostatectomies per year. In view of limited resources every medical healthcare system is facing now, careful planning for technology development is essential.
**Time Line of Development of Robotic Surgery**

1985: Kwoh et al performed aneurological biopsies with greater precision using PUMA 560.

1988: Davies et al performed a transurethral resection of the prostate using PUMA 560 which further development into PROBOT.

1993: AESOP® Endoscope Positioner, a voice-activated robotic system for endoscopic surgery developed by Computer Motion, Inc.

1998: ZEUS® Surgical system was introduced to the market. Zeus was the system used to perform the first fully endoscopic robotic surgery and the initial beating-heart, totally endoscopic coronary bypass procedure.

1999: The world’s first surgical robotics beating heart coronary artery bypass graft (CABG) was performed in Canada using the ZEUS surgical robot.

2000: Da Vinci Surgical System, made by Intuitive Surgical, Inc is the first completely robotic surgery device approved by FDA.

2001: SOCRA TE Robotic Telecollaboration System, created by Computer Motion, Inc, performed the first-ever transatlantic telesurgery.
Hospital Authority Risk Alert published a series of local sentinel events of retained guidewires after central venous (CV) catheterization in March 2008. As a frequent performer of CV cannulation, we, anaesthetist and intensivist, know that retaining guidewire is likely the tip of the iceberg amongst all other complications associated with the process of the CV catheterization. We should act proactively. Besides just looking into the prevention of retaining guidewires, it might be more important to evaluate the whole system in order to improve our patient safety.

**LOCAL SENTINEL EVENT (1)**

**RETAINED GUIDEWIRES AFTER CENTRAL VENOUS CATHETERIZATION**

Same concern has been addressed by the NICE guideline on 04 October 2002 (TA49 Central venous catheters - ultrasound locating devices: Guidance). Ultrasound is a mandatory tool to use when CV catheterization is done.

i. Two-dimensional (2-D) imaging ultrasound guidance is recommended as the preferred method for insertion of central venous catheters (CVCs) into the internal jugular vein (IJV) in adults & children in elective situations.

ii. The use of 2-D imaging ultrasound guidance should be considered in most clinical circumstances where CVC insertion is necessary either electively or in an emergency situation.

iii. It is recommended that all those involved in placing CVCs using 2-D imaging ultrasound guidance should undertake appropriate training to achieve competence.

iv. Audio-guided Doppler ultrasound guidance is not recommended for CVC insertion.

However before committing to the use of this equipment and follow what has been recommended in the guideline, we need to address some of the core issues:

1) We need to aware of the complications that could occur during the insertion and removal of central line

2) We should have adequate training, supervision and competency assessment in order to make full advantage of ultrasound guided CV access technique.

3) Ultrasound is an adjunct in improving patient safety during CV catheterization but should not replace our knowledge of surface anatomy in the landmark approach

**Training and Supervision**

Knowing the technical skills of inserting a central line is not good enough to ensure a safe practice. By knowing what complications are associated with the insertion and removal of a central line & preparing to handle such complications when arise, we could then decide the risk-benefit ratio, find ways to perfect our technique so as to avoid complications & limit damage once complications occur.

We all learn from our / others’ mistakes and that is why it is important to look at the reasons for such mistakes occurred in our daily practice. These may include:

- Inattention, poor motivation, carelessness, negligence, & recklessness.

- Tiredness, time pressure

- Deficiency in knowledge: not knowing the complications that might occur. It happens to the staff at all level. Staff who are too keen to try out new gadgets / technique without acquiring a good understanding of the possible complications, actually might do more harms to patients than goods. Without a thorough understanding of the anatomy, central venous cannulation can impose a great risk to patients.

- Organisational deficiency includes a lack of organised, standardised training and supervision, a lack of safety guideline or protocol and a non-compliance to the well set guideline and protocol.

There are a lot of confirmative evidences of improving safety with the use of ultrasound during central line insertion. It is not only proved to be safer, but also more cost-effective and possibly decrease rate of line sepsis. NICE (UK National Institution for Health and Clinical Excellence of the United Kingdom) guideline aligned with all the above findings. It was then introduced as a national guideline based on evidences. It might carry significant legal implications and thus raises a lot of criticisms.

The criticisms mainly lied on the clinical significance of the randomised controlled trials (RCTs) the guideline was based on. For instance, the sample size was considered to be too small in some of the trials. There was also hot discussion among various organizations whether the guideline should/could be applicable to all age groups, e.g. paediatric population of those < 1 year old and < 10kg. There were conflicting evidences found in this age group. The contrasting result maybe accounted by the small neck size of the said patients when compared to the ultrasound probe, that may then increase the margin of error during the procedure. Besides the application of ultrasound, the confounding factors for safe and accurate cannulation like experience of staff in performing central line insertion and using ultrasound as a guide could hardly be controlled in the studies. Ultrasound conferred the greatest benefit for the less experienced operators. To the experienced physician, an internal jugular venous central line insertion is rarely a problem especially when the patient is well positioned with the head down. The central jugular vein could be felt easily such that there may be grounds to believe that ultrasound may not be needed in those situations, whereas a subclavian line insertion is more difficult whether ultrasound or landmark technique is being used.

The guideline was not widely adopted both in the UK and outside the country. Other possible reasons would be:

- Human factors - new learning curve, time to learn and adjust to new technique, inertia in acquiring new technologies
A general lack of consultation with anaesthetists in formulation of the NICE guideline.22

No legal obligation to follow the guideline

Financial factor - Budget in supporting ultrasound guided central venous cannulation was not secured with the initial implementation of the guideline in 2002. By 2006, it was found that 95% of hospitals in UK had ultrasound machines readily available for inserting CVCs.23 However it is not yet the situation in Hong Kong.

Standardised training for using the equipment was not provided with the implementation of the guidelines.

Despite the seemingly superiority of ultrasound guided insertion technique,7 8 9 10 18 20 there is always a learning curve to go through, for both the individual performer or an organization. In order to make ultrasound guided technique a real safe technique, we do need organised training and supervision.24 25 We need criteria to assess competency and proficiency.26 Inexperienced operator or the inappropriate use of equipment, particularly in the more challenging cases, may increase rather than decrease occurrence of the complications.31 We do more harm than good if we try the new technique on patients without having gone through any organised training.

Ultrasound as an adjunct
Can ultrasound guided approach replace landmark approach? Despite studies showing that ultrasound guided procedure improves safety, it does not mean we can perform the ultrasound guided procedures without any knowledge of the anatomy and the preferred entry point of the central venous catheter. Ultrasound is most useful in difficult cases,7 8 18 29 because it can provide visualisation of the aberrant anatomy, only if we know what to look for and what the imaging anatomy is.

Ultrasound is helpful in difficult cases does not mean ultrasound guided insertion is easy when performing the procedure in difficult cases e.g. obese patient with short thick neck for internal jugular line insertion. An analogy to this being that regional anaesthesia may not be easy to perform in obese patients when intubation could be difficult in this group

Cost-effectiveness
It has been said that ultrasound guidance in central venous cannulation procedures saves NHS resources even with conservative modelling assumptions.11 Some argue that the cost effective model is inaccurate.32 Other study even showed that the cost of ultrasound guidance was not mitigated by its reduction in the cost of treating pneumothoraces.30

Yet, the ultrasound guided technique remains as a useful teaching tool to visualise the anatomy related to the CV insertion. One can view it as an educational imperative, or a desirable practice alternative.

Conclusion
Being vigilant, having adequate training and supervision, early planning and anticipation of what we need to do,31 formulating contingency plan and risk management are all very important in safe management of our patients.

References

**Annual Scientific Meeting 2008**

*By Libby Lee*

The Annual Scientific Meeting 2009 with the theme of "Mother, Baby and Anaesthesia" was concluded after a memorable sake wine tasting on 23 November 2008. The meeting broke the records of attendance. Here let’s share some precious moments in the conference.

We would also like to take this opportunity to express our sincere appreciation to our invited speakers, not to say the organizing committee members and all the voluntary helpers in the workshops and symposium. Without your precious time and effort, we won’t be able to enjoy so much in the meeting.

In this conference, it was our pleasure to have lectures from various international speakers like Dr. David Bogod, Dr. George Chalkiadis, Professor Chen Yu, Dr. John Colvin, Dr. Andreas Gerber, Dr. Keith Greenland, Dr. Wafid Hareb, Professor Gregory Hammer, Professor Mike James, Professor Gavin Kenny, Professor Peter Kain, Dr. Rob McDougall, Dr. Alan McLintic, Professor Frederic Mercocier, Professor Michael O’Reilly, Dr. Sng Ban Leong, Professor Lawrence Tsen and Professor Zhu Yesen.
Workshops

Fiberoptic Intubation

Difficult airway workshop

Professor Gregory Hammer

Nursing symposium

Meeting old friends

Sake Tasting

Answer to the Cross Word

Answer:

Across

2. Cardiac
3. Needle
4. Splice
5. Needle

6. Intens
7. Procedures
8. Intensive
9. Diaz
10. Nurse
11. Needle
12. Lecture
13. Speaker
14. Nurse
15. Institute
16. Patient
17. Clinic
18. Chinese
19. Eater
20. Enter
21. Table
22. Men
23. The
24. Anesthesiologist

Down

1. Neuroplastic
Cross Word
By S K Kong

Do you want to test your anaesthetic knowledge? Come and challenge yourself!!
You can find the answer on page 70.

Across
1. Pain pertaining to nerves
9. Prefix meaning “not, away from, apart”
10. To go in
11. Colloquial term for medical profession
12. Feverish
13. Tracheal tube used for lung isolation
15. Strong analgesia with abuse potential
18. Asian race
20. The more unusual
22. Acronym for transoesophageal echo
23. Period of time
24. Your specialty

Down
2. Finished
3. Extreme/thorough. Type of prostate removal operation
4. Pertaining to bony frame at base of spine
5. To heal
6. To bury
7. The act of administering a drug before a procedure. Common orders include sedatives/H2 antagonists
8. Series of action done to accomplish something
14. Natural human waste, collects in bladder
16. Trade name for transylpronine
17. Happened in a time shortly before the present
19. Type of bird. Also Name of rare disorder as in ________ barrett syndrome
21. Fleural of straight line that runs from center to edge of circle

Project Status

<table>
<thead>
<tr>
<th>Project number</th>
<th>Name of Trainee</th>
<th>Project title</th>
<th>Date of manuscript approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN0075</td>
<td>Catherine Lo</td>
<td>Assessment of circid pressure application on real human and knowledge about circid pressure in Hong Kong</td>
<td>27-May-08</td>
</tr>
<tr>
<td>PN0089</td>
<td>Lam Tat Shin</td>
<td>Palatopharyngeal injuries associated with the GlideScopeR video laryngoscope system: 3 case reports and literature</td>
<td>30-May-08</td>
</tr>
<tr>
<td>PN0096</td>
<td>Li Luk Sing</td>
<td>Prospective randomized control trial to investigate the effectiveness of haloperidol in prevention of postoperative nausea and vomiting associated with patients using patient-controlled analgesia</td>
<td>14-Apr-08</td>
</tr>
<tr>
<td>PN0097</td>
<td>Viki Yung</td>
<td>A retrospective review of the decision-to-delivery intervals for emergency Cesarean sections and perinatal outcomes in a major general hospital in Hong Kong</td>
<td>7-Jul-08</td>
</tr>
<tr>
<td>PN0098</td>
<td>Lam Kit Ying</td>
<td>A case report on the use of dexmedetomidine and remifentanil in a patient with mitochondrial myopathy</td>
<td>27-May-06</td>
</tr>
<tr>
<td>PN0100</td>
<td>Kam Hau Chi</td>
<td>Survey of epidural Practice of Hong Kong Anaesthesia</td>
<td>4-Feb-08</td>
</tr>
<tr>
<td>PN0126</td>
<td>Lam Chi Shan</td>
<td>Effectiveness of airway management workshop in improving nurses' knowledge and confidence in assisting airway management</td>
<td>31-Mar-08</td>
</tr>
<tr>
<td>PN0129</td>
<td>Lau Chung Wai</td>
<td>Effect of Nitrous Oxide Anaesthesia on Plasma Homocysteine and endothelial dysfunction</td>
<td>21-Jan-08</td>
</tr>
<tr>
<td>PN0132</td>
<td>Njo Kui Hung</td>
<td>Case report: Delay recovery from spinal anesthesia</td>
<td>8-Apr-08</td>
</tr>
<tr>
<td>PN0134</td>
<td>Cheung Suk Kwan</td>
<td>In vitro evaluation of the lowest cuff pressures that prevent fluid leakage for lubricated endotracheal tubes</td>
<td>2-Apr-08</td>
</tr>
<tr>
<td>PN0136</td>
<td>Wong Ho Kay</td>
<td>Pre-induction fentanyl co-administered with propofol dose-response curves when inserting the classic laryngeal mask airway</td>
<td>17-Jul-08</td>
</tr>
<tr>
<td>PN0146</td>
<td>Tam Tak King</td>
<td>Analogic efficacy of intra-articular magnesium after arthroscopic anterior cruciate ligament reconstruction</td>
<td>13-Feb-08</td>
</tr>
</tbody>
</table>
## Meetings Calendar

<table>
<thead>
<tr>
<th>Date (2009)</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 14-16 Jan</td>
<td>WSM (Winter Scientific Meeting) London 2009</td>
<td>London, UK</td>
</tr>
<tr>
<td>2. 19-23 Jan</td>
<td>California Society of Anesthesiologists Winter Hawaiian Seminar</td>
<td>Maui, Hawaii, USA</td>
</tr>
<tr>
<td>3. 26-30 Jan</td>
<td>3rd International Hokkaido Trauma Conference</td>
<td>Hokkaido, Japan</td>
</tr>
<tr>
<td>4. 28-31 Jan</td>
<td>2009 AAPM Meeting (25th Annual meeting of the American Academy of Pain Medicine)</td>
<td>Honolulu, Hawaii, USA</td>
</tr>
<tr>
<td>5. 6-8 Feb</td>
<td>3rd Pan-Asian NYSORA Symposium on Regional Anaesthesia and Pain Medicine</td>
<td>Kuala Lumpur, Malaysia</td>
</tr>
<tr>
<td>6. 13-16 Mar</td>
<td>5th World Congress-World Institute of Pain - WIP 2009</td>
<td>New York, USA</td>
</tr>
<tr>
<td>7. 14-17 Mar</td>
<td>2009 IARAS (International Anesthesia Research Society) Annual Meeting</td>
<td>San Diego CA, USA</td>
</tr>
<tr>
<td>8. 26-28 Mar</td>
<td>Risk Management Seminar for Health and Safety 2009</td>
<td>Tokyo, Japan</td>
</tr>
<tr>
<td>9. 9 Apr</td>
<td>1st International Symposium on Spine and Paravertebral Somnography for Anaesthesia and Pain Medicine</td>
<td>Shatin, Hong Kong</td>
</tr>
<tr>
<td>10. 23-24 Apr</td>
<td>6th Annual Critical Care Symposium</td>
<td>Manchester, UK</td>
</tr>
<tr>
<td>11. 22-25 Apr</td>
<td>2nd World Congress of Total Intravenous Anaesthesia – TIVA/TCI 2009</td>
<td>Berlin, Germany</td>
</tr>
<tr>
<td>12. 29 Apr - 1 May</td>
<td>ANZCA A New Fellow’s Conference 2009</td>
<td>Port Douglas, QLD, Australia</td>
</tr>
<tr>
<td>13. 2-6 May</td>
<td>2009 ANZCA Annual Scientific Meeting</td>
<td>Melbourne, Australia</td>
</tr>
<tr>
<td>14. 15-17 May</td>
<td>California Society of Anesthesiologists 2009 Annual Meeting and Clinical Anesthesia Update</td>
<td>Monterey, California, USA</td>
</tr>
<tr>
<td>15. 20-22 May</td>
<td>Obstetric Anaesthesia 2009 Annual Meeting of the European Society of Anaesthesiology (ESA)</td>
<td>Jerse, UK</td>
</tr>
<tr>
<td>16. 6-9 Jun</td>
<td>EUROANAESTHESIA 2009 Annual Meeting of the European Society of Anaesthesiology (ESA)</td>
<td>Milan, Italy</td>
</tr>
<tr>
<td>17. 8-12 Jun</td>
<td>5th International Symposium on Pediatric Pain</td>
<td>Acapulco, Mexico</td>
</tr>
<tr>
<td>18. 25-26 Jun</td>
<td>First Sigma Vite International Conference in Pediatric/Neonatal Intensive Care and Anaesthesiology</td>
<td>Split, Croatia</td>
</tr>
<tr>
<td>19. 26-30 Jun</td>
<td>6th Annual Meeting Canadian Anaesthesiologists’ Society</td>
<td>Vancouver, Canada</td>
</tr>
<tr>
<td>20. 3-6 Jul</td>
<td>L.A.S. 8th International Congress on Ambulatory Surgery</td>
<td>Brisbane QLD, Australia</td>
</tr>
<tr>
<td>21. 5-8 Sep</td>
<td>68th National Scientific Congress of the Australian Society of Anaesthetists</td>
<td>Darwin, Australia</td>
</tr>
<tr>
<td>22. 9-12 Sep</td>
<td>XXVIII Annual ESRA Congress - European Society of Regional Anaesthesia &amp; Pain Therapy</td>
<td>Salzburg, Austria</td>
</tr>
<tr>
<td>23. 9-12 Sep</td>
<td>6th Congress of the European Federation of IASP Chapters – EFIC 2009</td>
<td>Lisbon, Portugal</td>
</tr>
<tr>
<td>24. 23-25 Sep</td>
<td>AAGBI (The Association of Anaesthetists of Great Britain &amp; Ireland) Annual Congress 2009</td>
<td>Liverpool, UK</td>
</tr>
<tr>
<td>25. 11-14 Oct</td>
<td>22nd Annual Congress European Society of Intensive Care Medicine</td>
<td>Vienna, Austria</td>
</tr>
<tr>
<td>26. 17-21 Oct</td>
<td>ASA (American Society of Anesthesiologists) Annual Scientific Meeting 2009</td>
<td>New Orleans - USA</td>
</tr>
<tr>
<td>27. 26-30 Oct</td>
<td>California Society of Anesthesiologists Fall Hawaiian Seminar 2009</td>
<td>Kauai, Hawaii</td>
</tr>
<tr>
<td>28. 4-7 Nov</td>
<td>New Zealand Anaesthesia ASM 2009</td>
<td>Rotora, New Zealand</td>
</tr>
<tr>
<td>29. 14-15 Nov</td>
<td>3rd Annual NYSORA Europe Symposium</td>
<td>London, UK</td>
</tr>
<tr>
<td>30. 11-15 Dec</td>
<td>63rd PostGraduate Assembly in Anaesthesia (PGA)</td>
<td>New York, USA</td>
</tr>
</tbody>
</table>

## Timetable of the Centrally Organised Training Program 2009

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital</th>
<th>Tutor</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 January, 2009</td>
<td>IMH</td>
<td>Dr T Buckley</td>
<td>Acute renal failure and rhabdomyolysis</td>
</tr>
<tr>
<td>11 January, 2009</td>
<td>NDH</td>
<td>Dr C Tsang</td>
<td>Acute abdominal compartment syndrome</td>
</tr>
<tr>
<td>26 January, 2009</td>
<td>QMH</td>
<td>Dr K Kwok</td>
<td>Management of Burn</td>
</tr>
<tr>
<td>28 January, 2009</td>
<td>Chinese New Year</td>
<td>No tutorial</td>
<td></td>
</tr>
<tr>
<td>11 February, 2009</td>
<td>QEH</td>
<td>Dr IF Chan</td>
<td>Management of hyperthermia</td>
</tr>
<tr>
<td>11 February, 2009</td>
<td>CMC</td>
<td>Dr TF Chan</td>
<td>Nutrition</td>
</tr>
<tr>
<td>11 February, 2009</td>
<td>CMC</td>
<td>Dr HW So</td>
<td>Use of USG in ICU</td>
</tr>
<tr>
<td>25 February, 2009</td>
<td>NDH</td>
<td>Dr Claudia Cheng</td>
<td>Infection in immuno-compromised patient</td>
</tr>
<tr>
<td>4 March, 2009</td>
<td>QMH</td>
<td>Dr Alexander Chiu</td>
<td>New mode of mechanical ventilation</td>
</tr>
<tr>
<td>11 March, 2009</td>
<td>QEH</td>
<td>Dr WW Yan</td>
<td>Statistics</td>
</tr>
<tr>
<td>18 March, 2009</td>
<td>CMR</td>
<td>Dr T Buckley</td>
<td>Lab Data analysis/ ECG/equipment</td>
</tr>
<tr>
<td>1 April, 2009</td>
<td>CMR</td>
<td>Dr TF Chan</td>
<td>Poison management II: causative injury, OP, CVS, snake bite</td>
</tr>
<tr>
<td>3 April, 2009</td>
<td>FICM</td>
<td>Written</td>
<td>Evidence-based medicine and how to critically appraise a scientific paper</td>
</tr>
<tr>
<td>8 April, 2009</td>
<td>KICA(FC)</td>
<td>Written Exam</td>
<td>Evidence-based medicine and how to critically appraise a scientific paper</td>
</tr>
<tr>
<td>15 April, 2009</td>
<td>PWI</td>
<td>Prof G Jayne</td>
<td>Evidence-based medicine and how to critically appraise a scientific paper</td>
</tr>
<tr>
<td>22 April, 2009</td>
<td>PWI</td>
<td>Dr HW So</td>
<td>Emergency airway management</td>
</tr>
<tr>
<td>29 April, 2009</td>
<td>PWI</td>
<td>Dr Judith Shen</td>
<td>Mechanical Ventilation-General Principle</td>
</tr>
<tr>
<td>6 May, 2009</td>
<td>PWI</td>
<td>Dr Judith Shen</td>
<td>Bedside teaching</td>
</tr>
<tr>
<td>13 May, 2009</td>
<td>QEH</td>
<td>Dr KC Chan</td>
<td>Viva</td>
</tr>
<tr>
<td>20 May, 2009</td>
<td>PWI</td>
<td>Dr Thomas Li</td>
<td>Bedside teaching</td>
</tr>
<tr>
<td>27 May, 2009</td>
<td>QEH</td>
<td>Dr Anne Leung</td>
<td>X-ray interpretation</td>
</tr>
<tr>
<td>28-29 May, 2009</td>
<td>IFCM</td>
<td>Clinical</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Topics</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>5 June, 2009</td>
<td>PWH</td>
<td>Dr G Choi</td>
<td></td>
</tr>
<tr>
<td>10 June, 2009</td>
<td>PMH</td>
<td>Dr Dominic So</td>
<td></td>
</tr>
<tr>
<td>17 June, 2009</td>
<td></td>
<td>Viva</td>
<td></td>
</tr>
<tr>
<td>20 June, 2009</td>
<td>HKCA(FC) Clinical Exam.</td>
<td>No tutorial</td>
<td></td>
</tr>
<tr>
<td>24 June, 2009</td>
<td>NDH</td>
<td>Dr CC Tsang</td>
<td></td>
</tr>
<tr>
<td>1 July, 2009</td>
<td>Public Holiday</td>
<td>Mechanical Ventilation-Asthma/COAD</td>
<td></td>
</tr>
<tr>
<td>8 July, 2009</td>
<td>TMH</td>
<td>Dr Judith Shen</td>
<td></td>
</tr>
<tr>
<td>13 July, 2009</td>
<td>PYNH</td>
<td>Dr KW Chan</td>
<td></td>
</tr>
<tr>
<td>22 July, 2009</td>
<td>PWH</td>
<td>Prof Gavin Joynt</td>
<td></td>
</tr>
<tr>
<td>29 July, 2009</td>
<td>PYNH</td>
<td>Dr CW Lau</td>
<td></td>
</tr>
<tr>
<td>5 August, 2009</td>
<td>QMH</td>
<td>Dr Karl Young</td>
<td></td>
</tr>
<tr>
<td>12 August, 2009</td>
<td>PWH</td>
<td>Dr Anna Lee</td>
<td></td>
</tr>
<tr>
<td>19 August, 2009</td>
<td>TMH</td>
<td>Dr Gladys Kwan</td>
<td></td>
</tr>
<tr>
<td>26 August, 2009</td>
<td>NDH</td>
<td>Dr W Wong</td>
<td></td>
</tr>
<tr>
<td>20 August, 2009</td>
<td>JFCIM Witten</td>
<td>Diagnosis and general management principle of shock</td>
<td></td>
</tr>
<tr>
<td>2 September, 2009</td>
<td>QEH</td>
<td>Dr K W Lam</td>
<td></td>
</tr>
<tr>
<td>9 September, 2009</td>
<td>PYNH</td>
<td>Dr NS Mok</td>
<td></td>
</tr>
<tr>
<td>16 September, 2009</td>
<td>QMH</td>
<td>Dr Victor Yeo</td>
<td></td>
</tr>
<tr>
<td>23 September, 2009</td>
<td>PWH</td>
<td>Dr Philip Lam</td>
<td></td>
</tr>
<tr>
<td>30 September, 2009</td>
<td>PYNH</td>
<td>Dr Eunice Fio</td>
<td></td>
</tr>
<tr>
<td>7 October, 2009</td>
<td>NDH</td>
<td>Dr Claudia Cheng/CM Chau</td>
<td></td>
</tr>
<tr>
<td>14 October, 2009</td>
<td>PYNH</td>
<td>Dr KW Chan</td>
<td></td>
</tr>
<tr>
<td>21 October, 2009</td>
<td>QMH</td>
<td>Dr KM Kwok</td>
<td></td>
</tr>
<tr>
<td>22-23 October, 2009</td>
<td>JFCIM Clinical</td>
<td>Management of heart failure</td>
<td></td>
</tr>
<tr>
<td>28 October, 2009</td>
<td>QEH</td>
<td>Management of arrhythmia and Cardiac pacing</td>
<td></td>
</tr>
<tr>
<td>4 November, 2009</td>
<td>PYNH</td>
<td>Viva</td>
<td></td>
</tr>
<tr>
<td>11 November, 2009</td>
<td>NDH</td>
<td>Bedside teaching</td>
<td></td>
</tr>
<tr>
<td>18 November, 2009</td>
<td>QME</td>
<td>Viva</td>
<td></td>
</tr>
<tr>
<td>25 November, 2009</td>
<td>TMH</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>2 December, 2009</td>
<td>PYNH</td>
<td>Dr Alexander Chiu</td>
<td></td>
</tr>
<tr>
<td>9 December, 2009</td>
<td>QEH</td>
<td>Dr CK Koo</td>
<td></td>
</tr>
<tr>
<td>2 December, 2009</td>
<td>QEH</td>
<td>Management of delirium in ICU</td>
<td></td>
</tr>
<tr>
<td>2 December, 2009</td>
<td>QEH</td>
<td>Management of status epileptic</td>
<td></td>
</tr>
<tr>
<td>9 December, 2009</td>
<td>QEH</td>
<td>Neurorocular disease causing acute respiratory failure</td>
<td></td>
</tr>
<tr>
<td>16 December, 2009</td>
<td>NDH</td>
<td>GBS, MG, Critical illness polyneuropathy, tetanus</td>
<td></td>
</tr>
<tr>
<td>23 December, 2009</td>
<td>NDH</td>
<td>Management of cerebrovascular disease</td>
<td></td>
</tr>
<tr>
<td>30 December, 2009</td>
<td></td>
<td>No tutorial</td>
<td></td>
</tr>
<tr>
<td>6 January, 2010</td>
<td>TMH</td>
<td>Dr Judith Shen</td>
<td></td>
</tr>
<tr>
<td>13 January, 2010</td>
<td>QEH</td>
<td>Dr Anne Leung</td>
<td></td>
</tr>
</tbody>
</table>

**EMAC Course**

**EMAC Instructors Course**
11 - 12 June, 2009
HKCA Fellows who have previously been a participant at an EMAC Course and have an interest in becoming instructors, and are willing to commit to teaching in 2-3 EMAC courses per year.
Successful candidates of the Instructors Course will then buddy with experienced instructors during the Participants Course.

**EMAC Participants Course**
13 - 15 June, 2009
Reply to Pik Ying IP, NDHANA M(ANA), ICS Manager at ipy@ndh.org.hk by 4 May, 2009.

---

**Annual Scientific Meeting In Anaesthesiology**

**Challenge the Status Quo**
24-25 October 2009
Hong Kong Academy of Medicine Building

**Pre-conference workshops**
23 October 2009
Queen Elizabeth Hospital - Pain Interventional Workshop
Prince of Wales Hospital - Echocardiography Workshop
The Hong Kong College of Anaesthesiologists

Room 807, Hong Kong Academy of Medicine Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong
Phone: (852) 2871 8833, Fax: (852) 2814 1029, Email: office@hkca.edu.hk, website: www.hkca.edu.hk

Office Bearers and Council (2005-2007)

President
Mike IRWIN
1s: Vice President
Yu Fat CHOW
2nd Vice President
John Tak Chiu LIU
Honorary Secretary
Simon K C CHAN
Honorary Treasurer
Chi Hung KOO
Assistant Secretary
Libby H Y LEE
Assistant Treasurer
Samantha Y Y LEE
Immediate Past President
Tony GIN
Council Members
Anne S K KWAN
Phoon Ping CHEN
Desmond W L LAM
Tsun Woon LEE
Gavin JOYNT
Matthew Tak Vai CHAN
David Y C CHONG
Po Tong CHUI

Board of Examination
P T CHUI (Chairman)
Mike IRWIN (Ex-officio)
S L TSUI (representing BoPM)
Cindy AUN
S K NG
Steven WONG
Tony GIN
Mike IRWIN (Ex-officio)
Peggy TAN (representing BoICM)
C T HUNG
Andrea O'REGAN
M T V CHAN
Simone HUI
T W LEI

Board of Accreditation
Lilian LAU (Chairman)
Andrea O'REGAN
C T HUNG
Joseph LUI
Mike IRWIN
T S SZE
Amy CHO
Anne KWAN
John LIU
H Y SO
P P CHEN
Y F CHOW
Tom BUCKLEY
Wallace CHIU

Board of Pain Medicine
P P CHEN (Chairman)
T W LEE (Examination)
W S CHAN (Training Officer)
Libby LEE
Theresa LI
Mike IRWIN (Ex-officio)
Steven WONG (Secretary)
Anne KWAN (Accreditation)
Jacqueline YAP (Project Officer)
S L TSUI
Simon CHAN

Board of Intensive Care Medicine
Gavin JOYNT (Chairman)
Karl YOUNG
Simon CHAN
Peggy TAN (Examination)
K C CHAN
Judith SHEN
H Y SO (Secretary)
Anne LEUNG (Training Officer)
P W CHEUNG
K W AU YUENG
Claudia CHENG

Resuscitation Committee
H Y SO (Chairman)
K M HO
T Y CHAN

Guidelines Committee
Anne KWAN (Chairman)
Joseph LUI
Agnes CHENG
Samantha LEE
P P CHEN
Theresa HUI
K K LEUNG
Libby LEE

Organizer, Basic Science Course: CH Koo, Vincent Ng
Organizers, Clinical Anaesthesiology Courses (Informative course and Crash Course): Douglas Fok and Eric So Chairman, The Institute of Clinical Simulation: PP Chen