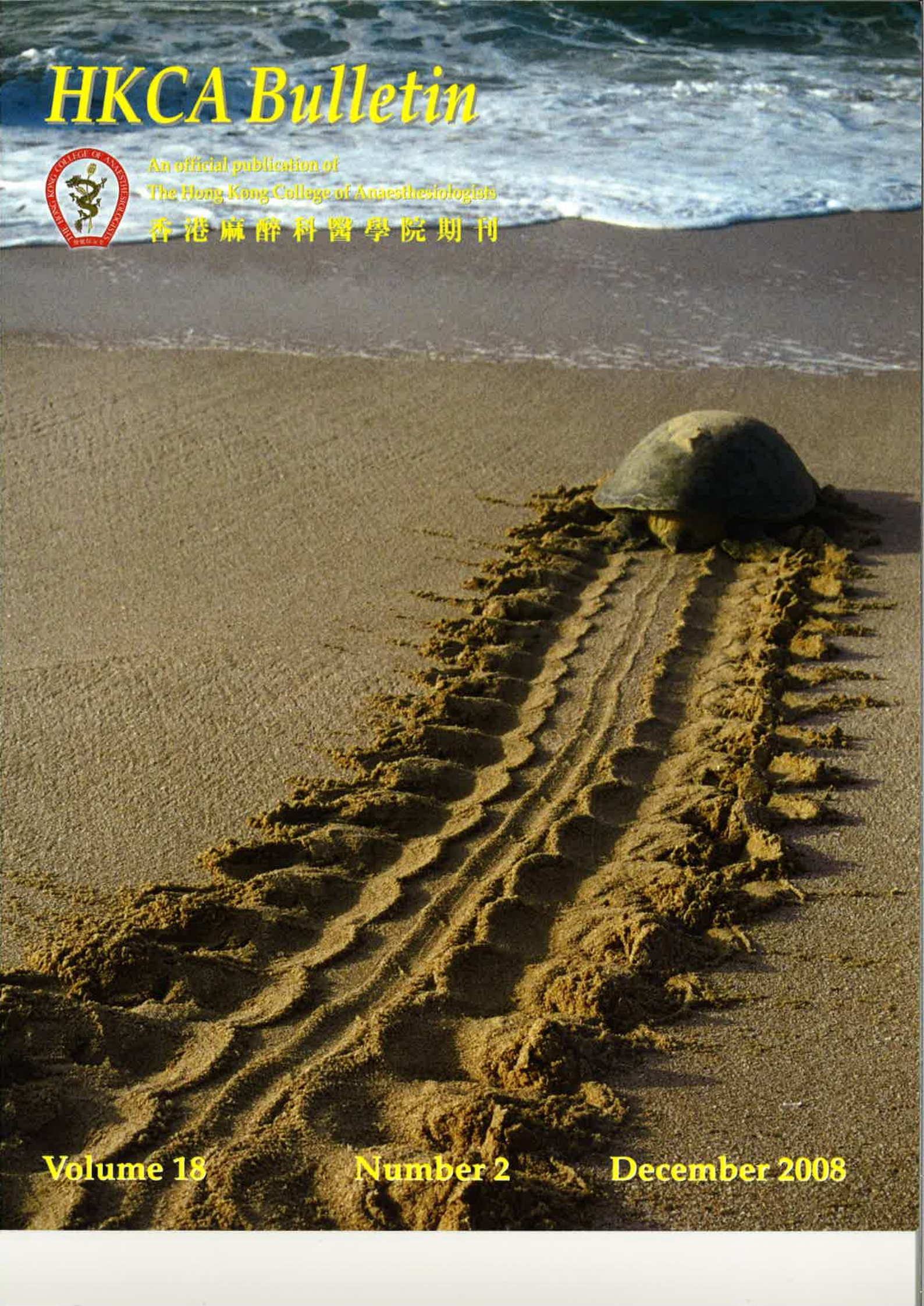


# HKCA Bulletin



An official publication of  
The Hong Kong College of Anaesthesiologists  
香港麻醉科醫學院期刊



**Volume 18**

**Number 2**

**December 2008**



## Contents

Pages

### Editor's Note

#### Know our Community

51 Daniel and Cherry

#### Special Articles

54 Robotic Surgery

#### Quality and Safety

61 Nice or Not?

#### Features : Step out from the Theatre

66 Annual Scientific Meeting 2008

71 Cross Word

#### Trainee Papers

72 Project Status

#### College Business

73 Meeting Calendar

74 Timetable of the Centrally Organised Training Program 2009

## The Editorial Board

|                 |              |              |              |
|-----------------|--------------|--------------|--------------|
| Editor-in-Chief | Libby LEE    |              |              |
| Editors         | Ming Chi CHU | Rebecca KWOK | Bassanio LAW |
|                 | Steven WONG  | Nicholas SUN | Michael POON |
|                 | Carina LI    | Vivian YUEN  |              |

Email: [leehyl@ha.org.hk](mailto:leehyl@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.

All rights reserved. The *HKCA Bulletin* and its electronic version are protected by the copyright and international treaties. Unauthorized reproduction or distribution, in whatever form or medium, is strictly prohibited. No part of the *HKCA Bulletin* may be reproduced, translated, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of The Hong Kong College of Anaesthesiologists.

Typeset and printed in Hong Kong by the *Best e-Publishing Group Limited*

## Editor's Note

By Editor-in-Chief

Happy New year of Ox!!

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



# 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 (曹澤港) 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

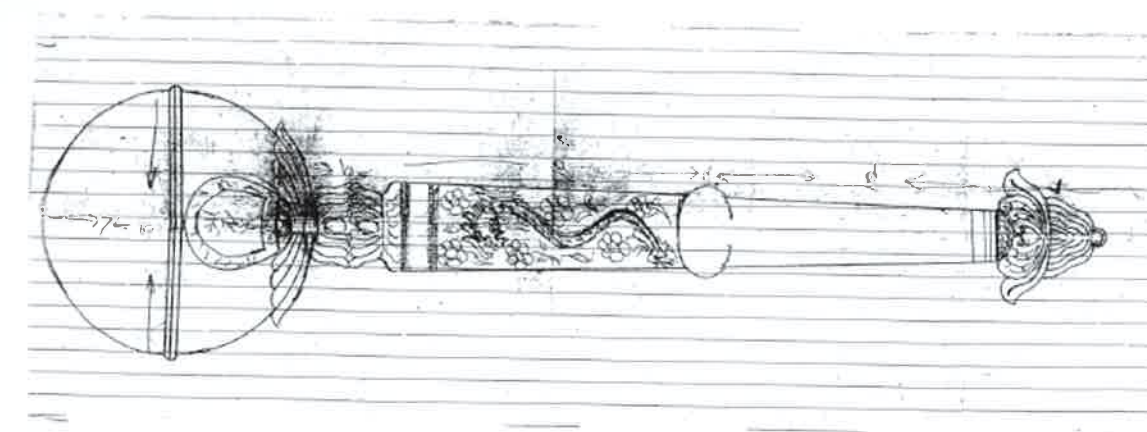


Figure 2b. Draft of college mace by Dr. Rodrigo, now in college archive



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 hundred fellows, scattered all over the world." Cherry Wong (施佩殊) 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 every 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 visitors each year is quite an undertaking." Daniel was reminiscing. "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 written 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 turning 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.



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



Figure 4. Academic dresses for the special occasions

## Robotic Surgery

By Nick Sun and Libby Lee

The most famous robots we have ever encountered probably are C3P0 and R2D2 in Star Wars. You will remember R2's "box of tricks", which was full of many apparatuses and manipulators. Some of his gadgets include a taser, a gripping tool, a computer interface, and a periscope. There was nothing that R2D2 could not fix.

Now we have our C3P0 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-Rossum'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 prostatic surgery. The ROBODOC 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.



Professor Tam sitting in front of the da Vinci Machine

A = Author

T = Dr. Tam Po Chor

**A: Dr. Tam, why do we need a new approach to the old operations?**

T: 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 unresolved 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 fulcrum 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 urethrovesical 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, valvular 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, HKD12-15,000 is required. The endowrist 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 torn 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 pneumo-peritoneum 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.





Patient having Robotic surgery



Professor Tam doing the surgery

### Time Line of Development of Robotic Surgery

1985: Kwoh et al performed aneurysmal 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: SOCRATES Robotic Telecollaboration System, created by Computer Motion, Inc, performed the first-ever transatlantic telesurgery.

## Nice or Not?

By Bassanio Law

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 ice-berg 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).<sup>1</sup> 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<sup>2,3</sup> that could occur during the insertion and removal<sup>3,4,5</sup> 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<sup>6</sup> 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,<sup>7, 8, 9, 10</sup> but also more cost-effective<sup>11</sup> and possibly decrease rate of line sepsis<sup>9</sup>. 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<sup>12, 13</sup> 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.<sup>14, 15</sup> There was also hot discussion among various organizations whether the guideline should/could be applicable to all age groups, e.g. paediatric population<sup>14</sup> of those < 1 year old and < 10kg. There were conflicting evidences found in this age group.<sup>8, 14, 16</sup> 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.<sup>10, 17</sup> 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 internal jugular vein could be felt easily;<sup>10</sup> 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<sup>18, 19</sup> and outside the country<sup>20, 21</sup>. 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<sup>22</sup>
- 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.<sup>23</sup> 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,<sup>7, 8, 9, 10, 20</sup> 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.<sup>24, 25</sup> We need criteria to assess competency and proficiency.<sup>26</sup> Inexperienced operator or the inappropriate use of equipment, particularly in the more challenging cases, may increase rather than decrease occurrence of the complications.<sup>14</sup> 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<sup>7, 27, 28, 29</sup> because it can provide visualisation of the aberrant anatomies, *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<sup>11</sup> Some argue that the cost effective model is inaccurate.<sup>22</sup> Other study even showed that the cost of ultrasound guidance was not mitigated by its reduction in the cost of treating pneumothoraces.<sup>30</sup>

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,<sup>31</sup> formulating contingency plan and risk management are all very important in safe management of our patients.

#### References

- 1) The National Institute for Health and Clinical Excellence. 2002, TA49 Central venous catheters - ultrasound locating devices: Guidance, <http://www.nice.org.uk/Guidance/TA49/Guidance/pdf/English>, [http://www.nice.org.uk/nicemedia/pdf/Ultrasonnd\\_49\\_GUIDANCE.pdf](http://www.nice.org.uk/nicemedia/pdf/Ultrasonnd_49_GUIDANCE.pdf)
- 2) Bowdle TA. 2002, ASA Newsletter (June 2002 vol 66): Central Line Complications From the ASA Closed Claims Project: An Update, *American Society of Anesthesiologists*, [http://www.asahq.org/Newsletters/2002/6\\_02/bowdle.html](http://www.asahq.org/Newsletters/2002/6_02/bowdle.html), [http://depts.washington.edu/asaccp/ASA/Newsletters/asa66\\_6\\_11\\_12\\_25.pdf](http://depts.washington.edu/asaccp/ASA/Newsletters/asa66_6_11_12_25.pdf)
- 3) McGee DC, Gould MK. (2003). Preventing complications of central venous catheterization. *The New England Journal of Medicine*, 348(12):1123-1133
- 4) Jones SA, Giacomantonio M. (2003). A complication associated with central line removal in the pediatric population: Retained fixed catheter fragments. *Journal of Pediatric Surgery*, 38(4):594-596
- 5) Holubar S. Central Line Caveats, <http://www.anastomosis.net/Interns%20Survival%20Guide/Central%20Line%20Caveats%20v1.htm>
- 6) Reason J. (2000). Human error: models and management, *British Medical Journal*, 320(7237):768-770
- 7) Hind D, Calvert N, McWilliams R, Davidson A, Paisley S, et al. (2003). Ultrasonic locating devices for central venous cannulation: meta-analysis. *British Medical Journal*, 327(7411):361-367
- 8) Verghese ST, McGill WA, Patel RI, Sell JE, Midgley FM, Ruttimann UE. (1999). Ultrasound-guided internal jugular venous cannulation in infants: a prospective comparison with the traditional palpation method. *Anesthesiology*, 91(1):71-77
- 9) Karakitsos D, Labropoulos N, De Groot E, Patrianakos AP, Kouraklis G, et al. (2006). Real-time ultrasound-guided catheterisation of the internal jugular vein: a prospective comparison with the landmark technique in critical care patients. *Critical Care*, 10(6):R162
- 10) Wigmore TJ, Smythe JF, Hacking MB, Raobaikady R, MacCallum NS. (2007). Effect of the implementation of NICE guidelines for ultrasound guidance on the complication rates associated with central venous catheter placement in patients presenting for routine surgery in a tertiary referral centre. *British Journal of Anaesthesia*, 99(5):662-665
- 11) Calvert N, Hind D, McWilliams R, Davidson A, Beverley CA, Thomas SM. (2004). Ultrasound for central venous cannulation: economic evaluation of cost-effectiveness. *Anaesthesia*, 59(11):1116-1120
- 12) Samanta A, Samanta J, Gunn M. (2003). Legal considerations of clinical guidelines: Will NICE make a difference? *Journal of the Royal Society of Medicine*, 96(3):133-138
- 13) Samanta A, Samanta J. (2004). NICE guidelines and law: clinical governance implications for trusts. *Clinical Governance: An International Journal*, 9(4): 212-215
- 14) Grebenik CR, Boyce A, Sinclair ME, Evans RD, Mason DG, et al. (2004). NICE guidelines for central venous catheterization in children. Is the evidence base sufficient? *British Journal of Anaesthesia*, 92(6):827-830
- 15) Muhm M. (2002). Editorials: Ultrasound guided central venous access - Is useful for beginners, in children, and when blind cannulation fails. *British Medical Journal*, 325(7377):1373-1374
- 16) Leyvi G, Taylor DG, Reith E, Wasnick JD. (2005). Utility of ultrasound-guided central venous cannulation in pediatric surgical

- patients: a clinical series. *Pediatric Anesthesia*, 15(11):953-958
- 17) Keenan SP. (2002). Use of ultrasound to place central lines. *Journal of Critical Care*, 17(2): 126 - 137
  - 18) Tovey G, Stokes M. (2007). A survey of the use of 2D ultrasound guidance for insertion of central venous catheters by UK consultant paediatric anaesthetists. *European Journal of Anaesthesiology*, 24(1):71-75
  - 19) McGrattan T, Duffy J, Green JS, O'Donnell N. (2008). A survey of the use of ultrasound guidance in internal jugular venous cannulation. *Anaesthesia*, 63(11):1222-1225
  - 20) Bailey PL, Glance LG, Eaton MP, Parshall B, McIntosh S. (2007). A survey of the use of ultrasound during central venous catheterization. *Anesthesia & Analgesia*, 104(3):491-497
  - 21) Girard TD, Schectman JM. (2005). Ultrasound guidance during central venous catheterization: A survey of use by house staff physicians. *Journal of Critical Care*, 20(3):224-229
  - 22) White SM. (2003). Not NICE advice. *Anaesthesia*, 58(3):295-296
  - 23) McGregor M, Rashid A, Sable N, Kurian J. (2006). Impact of NICE guidance on the provision of ultrasound machines for central venous catheterization. *British Journal of Anaesthesia*, 97(1):117-118
  - 24) Wise J. (2008). Everyone's a radiologist now, *British Medical Journal*, 336(7652):1041-1043
  - 25) Bodenham AR. (2006). Editorial II: Ultrasound imaging by anaesthetists: training and accreditation issues. *British Journal of Anaesthesia*, 96(4):414-417
  - 26) Feller-Kopman D. (2007). Ultrasound-guided internal jugular access: a proposed standardized approach and implications for training and practice. *Chest*, 132(1):302-309
  - 27) Hatfield A, Bodenham A. (1999). Portable Portable ultrasound for difficult central venous access. *British Journal of Anaesthesia*, 82(6):822-826
  - 28) Jefferson P, Ogbue MN, Hamilton KE, Ball DR. (2002). A survey of the use of portable ultrasound for central vein cannulation on critical care units in the UK. *Anaesthesia*, 57(4):365-368
  - 29) Šustić A, Cerović R, Juretić M (2001). Ultrasound-guided central venous cannulation in patient with radical dissection on both sides of neck: case report. *Radiology and Oncology*, 35(3): 175-177
  - 30) Kinsella S, Young N. (2008). Ultrasound-Guided Central Line Placement as Compared with Standard Landmark Technique: Some Unpleasant Arithmetic for the Economics of Medical Innovation. *Value in Health*, Jul 18. [Epub ahead of print]
  - 31) Hall AP, Russell WC. (2005). Toward safer central venous access: ultrasound guidance and sound advice *Anaesthesia*, 60(1):1-4

## Feature : Step Out from the Theatre

### 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. Walid Habre, Professor Gregory Hammer, Professor Mike James, Professor Gavin Kenny, Professor Peter Kam, Dr. Rob McDougall, Dr. Alan McLintic, Professor Frederic Mercoer, Professor Michael O'Reilly, Dr. Sng Ban Leong, Professor Lawrence Tsen and Professor Zhu Yesen.



Professor Lawrence Tsen, Professor Mike James, Professor Michael Irwin and Dr. David Bogod







Workshops



Fiberoptic Intubation



Difficult airway workshop



Professor Gregory Hammer



Nursing symposium

Meeting old friends



Sake Tasting



Answer to the Cross Word

Answers:

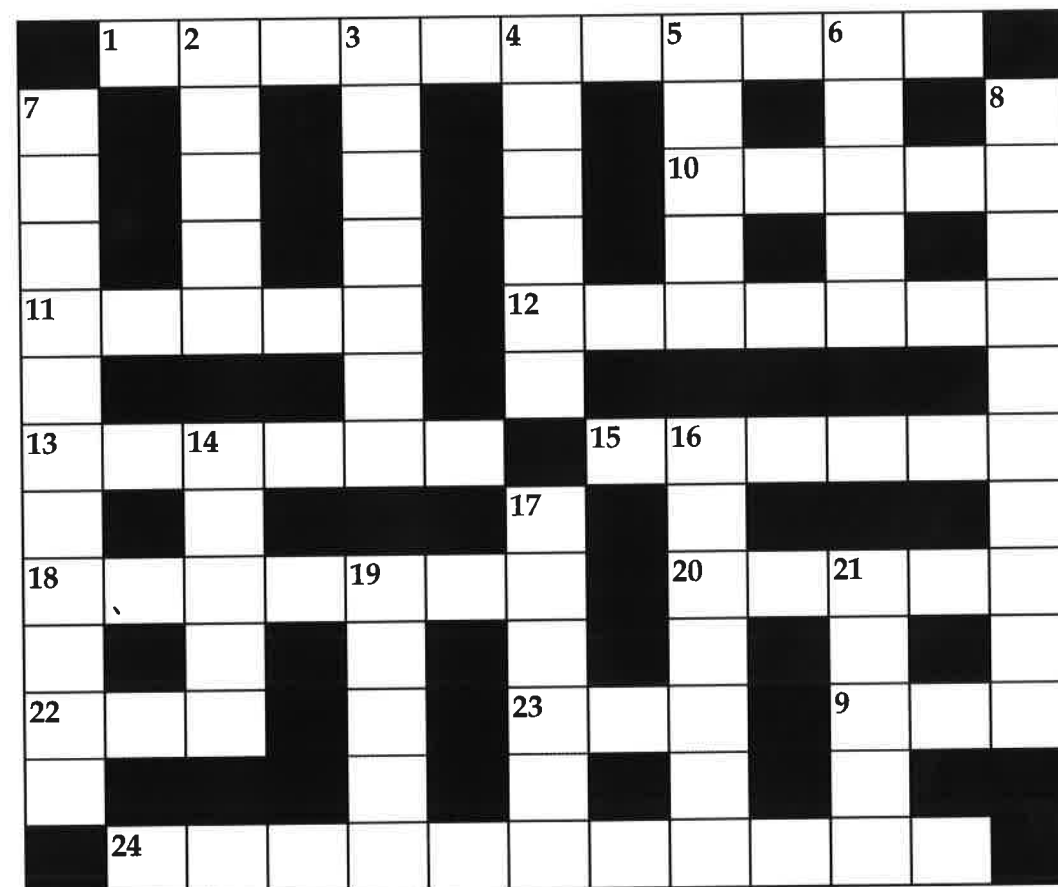
|        |                 |
|--------|-----------------|
| Across | 1. neuropathic  |
|        | 9. dis          |
|        | 10. enter       |
|        | 11. medic       |
|        | 12. icteric     |
|        | 13. double      |
|        | 15. opioid      |
|        | 18. Chinese     |
|        | 20. rarer       |
|        | 22. toe         |
|        | 23. era         |
|        | 24. anaesthesia |
| Down   | 2. ended        |
|        | 3. radical      |
|        | 4. pelvic       |
|        | 5. treat        |
|        | 6. inter        |
|        | 7. premedicate  |
|        | 8. procedures   |
|        | 14. urine       |
|        | 16. parnate     |
|        | 17. recent      |
|        | 19. eagle       |
|        | 21. radii       |



## 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  
"\_\_\_\_\_ lumen"
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 transcyllpromine
17. Happened in a time shortly before the present
19. Type of bird. Also Name of rare disorder as in \_\_\_\_\_barrett syndrome
21. Pleural of straight line that runs from center to edge of circle

## Trainee Papers

### Project Status

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

## Meetings Calendar

|     | Date (2009)    | Title   | Location                     |
|-----|----------------|---|------------------------------|
| 1.  | 14-16 Jan      | WSM (Winter Scientific Meeting) London 2009   | London, UK                   |
| 2.  | 19-23 Jan      | California Society of Anesthesiologists Winter Hawaiian Seminar                                     | Maui, Hawaii, USA            |
| 3.  | 26-30 Jan      | 3rd International Hokkaido Trauma Conference  | Hokkaido, Japan              |
| 4.  | 28-31 Jan      | 2009 AAPM Meeting (25th Annual meeting of the American Academy of Pain Medicine)                    | Honolulu, Hawaii, USA        |
| 5.  | 6-8 Feb        | 3rd Pan-Asian NYSORA Symposium on Regional Anesthesia and Pain Medicine                             | Kuala Lumpur, Malaysia       |
| 6.  | 13-16 Mar      | 5th World Congress World Institute of Pain - WIP 2009   | New York, USA                |
| 7.  | 14-17 Mar      | 2009 IARS (International Anesthesia Research Society) Annual Meeting                                | San Diego CA, USA            |
| 8.  | 26-28 Mar      | Risk Management Seminar for Health and Safety 2009  | Tokyo, Japan                 |
| 9.  | 9 Apr          | 1st International Symposium on Spine and Paravertebral Sonography for Anaesthesia and Pain Medicine | Shatin, Hong Kong            |
| 10. | 23-24 Apr      | 6th Annual Critical Care Symposium  | Manchester, UK               |
| 11. | 23-25 Apr      | 2nd World Congress of Total Intravenous Anaesthesia - TIVA/TCI 2009                                 | Berlin, Germany              |
| 12. | 29 Apr - 1 May | ANZCA New Fellow's Conference 2009  | Port Douglas, QLD, Australia |
| 13. | 2-6 May        | 2009 ANZCA Annual Scientific Meeting  | Melbourne, Australia         |
| 14. | 15-17 May      | California Society of Anesthesiologists 2009 Annual Meeting and Clinical Anesthesia Update          | Monterey, California, USA    |
| 15. | 20-22 May      | OBSTETRIC ANAESTHESIA 2009  | Jersey, UK                   |
| 16. | 6-9 Jun        | EUROANAESTHESIA 2009 Annual Meeting of the European Society of Anaesthesiology (ESA)                | Milan, Italy                 |
| 17. | 8-12 Jun       | 8th International Symposium on Pediatric Pain   | Acapulco, Mexico             |
| 18. | 25-26 Jun      | First Signa Vitae International Conference in Pediatric/Neonatal Intensive Care and Anesthesiology  | Split, Croatia               |
| 19. | 26-30 Jun      | 65th Annual Meeting Canadian Anesthesiologists' Society   | Vancouver, Canada            |
| 20. | 3-6 Jul        | I.A.A.S. 8th International Congress on Ambulatory Surgery   | Brisbane QLD, Australia      |
| 21. | 5-8 Sep        | 68th National Scientific Congress of the Australian Society of Anaesthetists                        | Darwin, Australia            |
| 22. | 9-12 Sep       | XXVIII Annual ESRA Congress - European Society of Regional Anaesthesia & Pain Therapy               | Salzburg, Austria            |
| 23. | 9-12 Sep       | 6th Congress of the European Federation of IASP Chapters - EFIC 2009                                | Lisboa, Portugal             |
| 24. | 23-25 Sep      | AAGBI (The Association of Anaesthetists of Great Britain & Ireland) Annual Congress 2009            | Liverpool, UK                |
| 25. | 11-14 Oct      | 22nd Annual Congress European Society of Intensive Care Medicine                                    | Vienna, Austria              |
| 26. | 17-21 Oct      | ASA (American Society of Anesthesiologists) Annual Scientific Meeting 2009                          | New Orleans - USA            |
| 27. | 26-30 Oct      | California Society of Anesthesiologists Fall Hawaiian Seminar 2009                                  | Kauai, Hawaii                |
| 28. | 4-7 Nov        | New Zealand Anaesthesia ASM 2009  | Rotorua, New Zealand         |
| 29. | 14-15 Nov      | 3rd Annual NYSORA Europe Symposium  | London, UK                   |
| 30. | 11-15 Dec      | 63rd PostGraduate Assembly in Anesthesiology (PGA)  | New York, USA                |

## Meetings Calendar

|     | Date (2010)    | Title  | Location                    |
|-----|----------------|--|-----------------------------|
| 31. | 7-12 Mar       | The First NYSORA World Congress of Regional Anesthesia and Pain Medicine   | Dubai, United Arab Emirates |
| 32. | 1-5 May        | 2010 ANZCA Annual Scientific Meeting                                       | New Zealand                 |
| 33. | 25-29 Jun      | Canadian Anesthesiologists' Society Annual Meeting                         | Montreal, Canada            |
| 34. | 29 Aug - 3 Sep | 13th WORLD CONGRESS ON PAIN  | Montreal, Canada            |
| 35. | 16-20 Oct      | ASA (American Society of Anesthesiologists) Annual Scientific Meeting 2010 | San Diego - USA             |

## Timetable of the Centrally Organised Training Program 2009

| Date              | Hospital              | Tutor             | Topics   |
|-------------------|-----------------------|-------------------|--|
| 7 January, 2009   | PMH                   | Dr T Buckley      | Acute renal failure and rhabdomyolysis                                   |
| 14 January, 2009  | NDH                   | Dr C C Tsang      | Acute abdominal compartment syndrome                                     |
| 21 January, 2009  | QMH                   | Dr R Kwok         | Management of Burn   |
| 28 January, 2009  | Chinese New Year      |                   | No tutorial  |
| 4 February, 2009  | TMH                   | Dr HM Lee         | Management of hyperthermia   |
| 11 February, 2009 | QEH/CMC               | Dr YF Chan        | Nutrition  |
| 18 February, 2009 | PWH                   | Dr HY So          | Use of USG in ICU  |
| 25 February, 2009 | NDH                   | Dr Claudia Cheng  | Infection in immunocompromised patient                                   |
| 4 March, 2009     | QMH                   | Dr Alexander Chiu | New mode of mechanical ventilation                                       |
| 11 March, 2009    | PYNEH                 | Dr WW Yan         | Statistics   |
| 18 March, 2009    | PMH                   | Dr T Buckley      | Lab Data analysis/ECG/equipment  |
| 25 March, 2009    | (Brussels meeting)    |                   | No tutorial  |
| 1 April, 2009     | QEH/CMC               | Dr YF Chan        | Poison management II: causative injury, OP, CVS toxidrome, snake bite    |
| 3 April, 2009     | JFICM written         |                   |  |
| 8 April, 2009     | HKCA(IC) Written Exam |                   |  |
| 15 April, 2009    | PWH                   | Prof G Joynt      | Evidence-base medicine and how to critically appraise a scientific paper |
| 22 April, 2009    | PWH                   | Dr HY So          | Emergency airway management  |
| 29 April, 2009    | TMH                   | Dr Judith Shen    | Mechanical Ventilation-General Principle                                 |
| 6 May, 2009       | TMH                   | Dr Judith Shen    | Bedside teaching   |
| 13 May, 2009      | PYNEH                 | Dr KC Chan        | Viva   |
| 20 May, 2009      | PWH                   | Dr Thomas Li      | Bedside teaching   |
| 27 May, 2009      | QEH                   | Dr Anne Leung     | X-ray interpretation   |
| 28-29 May 2009    | JFICM Clinical        |                   |  |



|                     |                        |                              |   |
|---------------------|------------------------|------------------------------|---|
| 3 June, 2009        | PWH                    | Dr G Choi                    | Viva  |
| 10 June, 2009       | PMH                    | Dr Dominic So                | Bedside teaching  |
| 17 June, 2009       |                        |                              | No tutorial   |
| 20 June, 2009       | HKCA(IC) Clinical Exam |                              |   |
| 24 June, 2009       | NDH                    | Dr CC Tsang                  | Mechanical Ventilation-Asthma/COAD  |
| 1 July, 2009        | Public Holiday         |                              |   |
| 8 July, 2009        | TMH                    | Dr Judith Shen               | Assessment of critically ill patient  |
| 15 July, 2009       | PYNEH                  | Dr KW Chan                   | ARDS  |
| 22 July, 2009       | PWH                    | Prof Gavin Joynt             | Weaning of mechanical ventilation   |
| 29 July, 2009       | PYNEH                  | Dr CW Lau                    | Management of pneumothorax, pleural effusion and chest drain in ICU   |
| 5 August, 2009      | QMH                    | Dr Karl Young                | Diagnosis and general management principle of shock   |
| 12 August, 2009     | PWH                    | Dr Anna Lee                  | Cardiovascular monitoring in Shock  |
| 19 August, 2009     | TMH                    | Dr Gladys Kwan               | Novel treatment of Septic shock   |
| 26 August, 2009     | NDH                    | Dr W Wong                    | Myocardial ischaemia  |
| 28 August, 2009     | JFICM Written          |                              |   |
| 2 September, 2009   | QEH                    | Dr K W Lam                   | Management of heart failure   |
| 9 September, 2009   | PMH                    | Dr NS Mok                    | Management of arrhythmia and Cardiac pacing   |
| 16 September, 2009  | QMH                    | Dr Victor Yeo                | Viva  |
| 23 September, 2009  | PWH                    | Dr Philip Lam                | Bedside teaching  |
| 30 September, 2009  | PMH                    | Dr Eunice Ho                 | Viva  |
| 7 October, 2009     | NDH                    | Dr Claudia Cheng/<br>CM Chau | Bedside teaching  |
| 14 October, 2009    | PYNEH                  | Dr KW Chan                   | Bedside teaching  |
| 21 October, 2009    | QMH                    | Dr KM Kwok                   | Pulmonary thromboembolism   |
| 22-23 October, 2009 | JFICM Clinical         |                              |   |
| 28 October, 2009    | QEH                    | Dr Anne Leung                | Management of community acquired infections - CAP/Meningitis/Viral infections/sepsis of unknown origin Antimicrobial therapy in ICU |
| 4 November, 2009    | PMH                    | Dr Dominic So                | Nosocomial infections including VAP/line sepsis/Catheter related UTI/Wound sepsis etc.  |
| 11 November, 2009   | NDH                    | Pending                      | Use of Sedation and muscle relaxant in ICU  |
| 18 November, 2009   | QMH                    | Dr Alexander Chiu            | Approach to fever in ICU  |
| 25 November, 2009   | TMH                    | Dr CK Koo                    | Management of delirium in ICU   |
| 2 December, 2009    | PYNEH                  | Dr KC Chan                   | Management of status epilepticus  |
| 9 December, 2009    | QEH                    | Dr KY Lai                    | Neuromuscular disease causing acute respiratory failure: GBS, MG, Critical illness polyneuropathy, tetanus                          |
| 16 December, 2009   | NDH                    | Dr CM Chau                   | Management of cerebralvascular disease  |
| 23 December, 2009   |                        |                              | No tutorial   |
| 30 December, 2009   |                        |                              | No tutorial   |
| 6 January, 2010     | TMH                    | Dr Judith Shen               | Infection control, mechanisms of antibiotic resistance & antibiotic modifications for resistant organisms                           |
| 13 January, 2010    | QEH                    | Dr Anne Leung                | Terrorist attack  |

## 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 [ipy530@ha.org.hk](mailto:ipy530@ha.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](mailto:office@hkca.edu.hk), website: [www.hkca.edu.hk](http://www.hkca.edu.hk)

## Office Bearers and Council (2005-2007)

|                          |  |
|--------------------------|--|
| President                | Mike IRWIN   |
| 1st 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<br>Phoon Ping CHEN<br>Desmond W L LAM<br>Tsun Woon LEE<br>Gavin JOYNT<br>Matthew Tak Vai CHAN<br>David Y C CHONG<br>Po Tong CHUI |

## Staff

|                          |             |
|--------------------------|-------------|
| Administrative Executive | Daniel TSO  |
| Assistant                | Cherry WONG |

## Board of Censor

|  |              |
|--|--------------|
| Mike IRWIN ( <i>Censor-in-Chief</i> )      |              |
| T W LEE ( <i>Examination</i> )             |              |
| Y F CHOW ( <i>Deputy Censor-in-Chief</i> ) |              |
| Simon CHAN                                 | P T CHUI     |
| Gavin JOYNT                                | Lilian LAU   |
| T W LEE                                    | K C LI       |
| John LIU                                   | D A SUDHAMAN |

## Board of Education

|                                  |                                     |
|----------------------------------|-------------------------------------|
| Y F CHOW ( <i>Chairman</i> )     | C H KOO ( <i>Training Officer</i> ) |
| Simon CHAN ( <i>Ex-officio</i> ) | Mike IRWIN                          |
| P W CHEUNG                       | C K KOO                             |
| T W LEE                          | Joseph LUI                          |
| Gavin JOYNT                      | Anne KWAN                           |
| Andrew CHAN                      | C T HUNG                            |
| Andrew O'REGAN                   | P T CHUI                            |
| M C CHU                          | Anne LEUNG                          |

## Formal Project Officer:

|  |
|--|
| K F NG                                   |
| Jacqueline YAP ( <i>Deputy Officer</i> ) |

## Manpower Committee

|                              |          |
|------------------------------|----------|
| John LOW ( <i>Chairman</i> ) | C T HUNG |
|------------------------------|----------|

## Board of Examination

|                                       |   |
|---------------------------------------|---|
| P T CHUI ( <i>Chairman</i> )          | Tony GIN                                |
| Mike IRWIN ( <i>Ex-officio</i> )      | Simon CHAN ( <i>Ex-officio</i> )        |
| S L TSUI ( <i>representing BoPM</i> ) | Peggy TAN ( <i>representing BoICM</i> ) |
| Cindy AUN                             | Theresa HUI                             |
| C T HUNG                              | T W LEE                                 |
| S K NG                                | Andrea O'REGAN                          |
| Steven WONG                           | M T V CHAN                              |

## Board of Accreditation

|                                |              |
|--------------------------------|--------------|
| Lilian LAU ( <i>Chairman</i> ) | Amy CHO      |
| Andrea O'REGAN                 | Anne KWAN    |
| C T HUNG                       | John LIU     |
| Joseph LUI                     | H Y SO       |
| Mike IRWIN                     | P P CHEN     |
| Simon CHAN                     | Tom BUCKLEY  |
| T S SZE                        | Wallace CHIU |
| Y F CHOW                       |              |

## Board of Pain Medicine

|                                     |   |
|-------------------------------------|---|
| P P CHEN ( <i>Chairman</i> )        | Steven WONG ( <i>Secretary</i> )          |
| T W LEE ( <i>Examination</i> )      | Anne KWAN ( <i>Accreditation</i> )        |
| M C CHU ( <i>Training Officer</i> ) | Jacqueline YAP ( <i>Project Officer</i> ) |
| W S CHAN                            | C T HUNG                                  |
| Libby LEE                           | S L TSUI                                  |
| Theresa LI                          | Simon CHAN ( <i>Ex-officio</i> )          |
| Mike IRWIN ( <i>Ex-officio</i> )    |   |

## Board of Intensive Care Medicine

|                                  |  |
|----------------------------------|--|
| Gavin JOYNT ( <i>Chairman</i> )  | H Y SO ( <i>Secretary</i> )            |
| Karl YOUNG                       | Anne LEUNG ( <i>Training Officer</i> ) |
| Simon CHAN                       | P W CHEUNG                             |
| Peggy TAN ( <i>Examination</i> ) | K W AU YUENG                           |
| K C CHAN                         | Claudia CHENG                          |
| Judith SHEN                      |  |

## Resuscitation Committee

|                            |        |
|----------------------------|--------|
| H Y SO ( <i>Chairman</i> ) | K M HO |
| T Y CHAN                   |        |

## Guidelines Committee

|                               |             |
|-------------------------------|-------------|
| Anne KWAN ( <i>Chairman</i> ) | P P CHEN    |
| Joseph LUI                    | Theresa HUI |
| Agnes CHENG                   | K K LEUNG   |
| Samantha LEE                  | 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