In the past decades, treatment of non–small-cell lung cancer (NSCLC) had posed an immense challenge for oncologists due to the nature of this tumour with its marginal response to treatment and early propensity for metastasis. The survival rates have been dismal, especially with advanced-stage disease. However, in the past few years, we seem to have reached an inflection point with therapeutic advances focusing on tailored treatment for individual patients through improvements in radiotherapy techniques, identification of driver mutations and development of targeted anticancer treatment.

**Advances in Radiotherapy**

Recently, a wealth of clinical trials has shown that radiotherapy is becoming an important component in treatment with curative intent for NSCLC. Stereotactic body radiotherapy (SBRT) is a viable and attractive treatment option for patients with early-stage lung cancers, especially those who are medically inoperable. SBRT delivers very high doses of radiation precisely to tumour sites within the body with the purpose of improving local control and limiting side effects. A recent review of 87 patients with operable Stage I NSCLC who received SBRT showed 5-year overall survival rates of 62%–72%, which is potentially comparable to that of surgery.¹
With the technological advances in thoracic radiotherapy including intensity-modulated radiation therapy (IMRT) and dose escalation combined with concurrent chemotherapy, median overall survival often exceeding 20 months may be attained even for locally advanced NSCLC.  

**Molecularly Targeted Therapy**

Targeted therapy refers to using drugs specifically designed to selectively target molecular pathways responsible for, or that substantially drive, the malignant phenotype of cancer cells. The result is higher tumour response and fewer toxic effects on normal cells. The first driver mutation identified in NSCLC was epidermal growth factor receptor (EGFR) mutation, which was found to be related to a dramatic treatment response to EGFR tyrosine kinase inhibitors (TKI). This mutation can be found in around 50% of Asian patients with adenocarcinoma of the lung. In a large randomised trial of 1,217 Asian patients with advanced-stage EGFR-mutated adenocarcinoma, progression-free survival, tumour response and quality of life were significantly improved in patients receiving gefitinib/TKI compared with those receiving chemotherapy. Another recent trial using erlotinib/TKI in the first-line setting in Asian patients with advanced NSCLC with EGFR mutations showed a striking improvement in progression-free survival to 13.1 months compared with 4.6 months achieved with chemotherapy.

A more recently identified driver mutation is the rearrangement of anaplastic lymphoma kinase (ALK) occurring in 2%—7% of patients with NSCLC. Crizotinib is a potent and selective ALK inhibitor. Its efficacy was demonstrated in a phase I/II trial in patients with ALK-positive advanced NSCLC, which demonstrated a remarkable disease control rate of 90% and a good safety profile.

**Palliative Care**

Patients with NSCLC suffer from a vast array of disease- and treatment-related symptoms, both physical and psychological, during the course of their illness. Awareness and palliation of these symptoms are of prime importance in the optimisation of care for these patients. A study published in 2010 reported that introducing palliative care early after diagnosis significantly improved quality of life, mood and even median survival of patients with advanced NSCLC. Palliative medicine specialists and multidisciplinary input form the basis of integrated palliative care.

In conclusion, the management of NSCLC has progressed considerably in light of advances in radiotherapy techniques, development of personalised medicine and the recognition of palliative care as a therapeutic modality in its own right. Hopefully, these will translate into continuing improvement in survival and quality of life for our lung cancer patients.
Proper documentation of surgical operation records is essential to safeguard patient safety. In HKBH, reviews of documentation are regularly conducted. In 2008 and 2009, two audits concerning surgical operation records were carried out. In 2010, a revised surgical operation record was introduced. More information, such as anaesthesia, operative findings, specimens, blood loss, and doctor codes, was collected in the revised record.

With the introduction of the revised operation record, an audit was subsequently performed to examine the completeness and quality of operation records.

From January 1 to June 30, 2011, 100 sets of operation records were selected randomly for auditing from a computerised list of patients who had undergone general operations (excluding Obstetrics & Gynaecology, ENT, Eye, Oral & Maxillofacial surgery, Neurosurgery, Cardiothoracic and Orthopaedics).

These operation records were reviewed anonymously by an audit team, and the team members were asked to complete a predesigned proforma (Operation Record Scoring Sheet) by checking the completeness of each operation record. A performance score was given on both Operative Findings and Procedure in accordance with relevant operation details.

The Clinical Audit Coordinating Committee in surgery deems it necessary to convey to doctors the importance of good documentation in medical records, the operation record in particular. In fact, the issue of illegibility has also been raised by the Department of Health in its annual inspection in December last year.

Several recommendations were made based on the findings:

1. Illegibility has been found to be an issue and individual feedback should be considered in future audits.
2. The format of the operation record should be reviewed regularly to facilitate better documentation; for instance, having checkboxes to distinguish “negative” from a non-entry.
3. Surgeons are encouraged to use the electronic operation record template to facilitate data entry.
4. Regular audits should be performed on a frequent basis to ensure the quality of operation records.

Should you be interested in knowing more about the audits, don’t hesitate to contact Miss Doris CHAN, Manager (Audit & Research), at dorisllchan@hkbh.org.hk.
Surgeons
Session A: TEP Repair
Session B: Lichtenstein Repair
Director of Programme: Dr Leung Tung YUNG
Speaker: Dr Yiu Chung TANG (Session A)
Dr John WONG (Session B)
Date: March 2, 2012
Time: 8:00 – 9:30 am
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8872 (Ms Connie LOK)
Coming Meetings: April 13, 2012 / May 4, 2012 / June 1, 2012

Physicians
Session A: Contemporary Lipid Management in CKD Patients
Session B: Management of Diabetic Nephropathy
Director of Programme: Dr Peter CY WONG
Chairman: Dr Chung Ping HO
Speakers: Dr Yuk WONG (Session A)
Dr Pui Shan MA (Session B)
Date: March 5, 2012
Time: 8:00 – 10:00 pm
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8873 (Ms Polly TAM)
Coming Meetings: April 2, 2012 / May 7, 2012 / June 4, 2012

Obstetricians & Gynaecologists
Safe Sedation in the Clinic
Speaker: Dr John LOW
Date: March 13, 2012
Time: 7:30 – 8:30 pm
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8872 (Ms Connie LOK)
Coming Meetings: April 17, 2012 / April 19, 2012 / May 15, 2012

Surgical Pathology
Joint Surgical Pathology Meeting
Co-ordinator: Dr Tai Yam LEE
Date: March 16, 2012
Time: 8:30 – 9:30 am
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8872 (Ms Connie LOK)

Who’s NEW
Dr Chiu Ming LOK
Director, Nuclear Medicine Centre
Dr Brian Kin Chung AU
Resident Medical Officer
Dr Chin Wai CHAN
Resident Consultant in Obstetrics & Gynaecology

We are delighted to announce that three doctors, Dr Chiu Ming LOK, Dr Brian Kin Chung AU and Dr Chin Wai CHAN, are on board.

Dr LOK joined us as Director of the Nuclear Medicine Centre on January 3, 2012. Dr LOK has extensive clinical and administration experience in nuclear medicine. Before joining HKBH, Dr LOK served as an Associate Consultant in nuclear medicine in Princess Margaret Hospital.

Dr AU joined us as a Resident Medical Officer on January 12. Dr AU graduated from The Chinese University of Hong Kong and has obtained postgraduate qualifications in family medicine. Before joining HKBH, Dr AU served as a Resident Doctor at Tseung Kwan O Hospital.

Dr CHAN joined us as a Resident Consultant in Obstetrics & Gynaecology on January 16. Dr CHAN is an experienced O&G specialist with a particular interest in gynaecological endoscopic surgery and reproductive endocrinology. Before joining HKBH, Dr CHAN worked in private practice.

Let us welcome Dr LOK, Dr AU and Dr CHAN to the Hospital.

Editorial Enquiry We would like to hear from you! Any questions, comments or suggestions are always welcomed.
Please email us at pr@hkbh.org.hk