中国医师协会
心血管外科医师分会
第三届年会香港分会场

2007年3月18日　香港威尔斯亲王医院

3rd Annual Meeting
Chinese Association of Cardiovascular Surgeons
Chinese Medical Doctor Association

18 March 2007　Prince of Wales Hospital, Hong Kong

建立全国心血管外科数据库：从技术到临床
Establishing a National Database in Cardiovascular Surgery: Technological and Clinical Aspects

Programme Book

主办单位 Organizers：
中国医师协会心血管外科医师分会
香港中文大学医学院外科学系
Chinese Association of Cardiovascular Surgeons,
Chinese Medical Doctor Association;
Department of Surgery, The Chinese University of Hong Kong

We would like to thank you for joining us at our

3rd Annual Meeting

Chinese Association of Cardiovascular Surgeons
Chinese Medical Doctor Association (CACS 2007)

Forthcoming Event

Cardiothoracic Surgery Update Course

23rd - 24th November 2007 (Friday & Saturday)
Hong Kong

Highlights:

Extensive International Faculty from the United Kingdom, Singapore, Australia and Belgium

The course will utilize formal lectures, video presentations and interactive small group teaching

An additional section for nurses and allied health care professionals

Organized by
Department of Surgery
The Chinese University of Hong Kong
&
Royal College of Surgeons of Edinburgh
United Kingdom

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心血管外科医师分会第三届年会香港分会场
3rd Annual Meeting
Chinese Association of Cardiovascular Surgeons, Chinese Medical Doctor Association

WELCOME MESSAGE

Welcome Message From the Chairman of Department of Surgery

It gives me great pleasure to welcome you to the Third Annual Meeting of Chinese Association of Cardiovascular Surgeons, Chinese Medical Doctors Association, hosted by Department of Surgery, Chinese University of Hong Kong, to be held on 18 March 2007 at the Prince of Wales Hospital, Hong Kong.

For many years, this annual event has served as a regional platform for novel ideas exchanged among stakeholders in cardiovascular surgery. This year we have chosen the theme "Establishing a National Database in Cardiovascular Surgery: Technological and Clinical Aspects". Distinguished experts will share their knowledge and experience of "Clinical Audit" which, although established internationally, remains in its infancy in the Asian region. National databases and quality assurance programmes in surgery will also be brought into sharp focus.

We are energized that our vision is being supported by the Government of the Hong Kong Special Administrative Region. With backing from The Professional Services Development Assistance Scheme, the Department of Surgery, Chinese University of Hong Kong has initiated the first phase of a Clinical Audit system with Cardiothoracic Surgery pioneering the project. It is pivotal for us to have more stakeholders in the field to support this initiative. We undertake that you will be enlightened and draw value from the event and invite you to work together with us towards raising professional standards in Surgery.

I would like to express my deep appreciation to Faculty speakers, sponsors and participants of this event. I wish you a memorable stay in Hong Kong!

Andrew van Hasselt
Chairman, Department of Surgery
The Chinese University of Hong Kong

Overview by Professor Malcolm J. Underwood

Quality Assurance in Surgery

A quality assurance programme in cardiac surgical practice is quite simply a mechanism to ensure that the patient is subjected to the least threatening journey through the hospital during a period of treatment, with an outcome that is deemed acceptable by International standards. This process inherently incorporates data collection and outcome analysis, but is in fact conceptually broader and includes assessment not only of patient outcomes, but institutional processes, appropriateness of care and patient and health-care provider satisfaction. All of these variables inherently, but not exclusively affect the patient journey.

The essential element for a successful quality assurance programme is without question, the determination and commitment of health care professionals (providers of direct clinical care as well as financiers) to embrace the concept. The most important practical aspect is the provision of an appropriate institutional infrastructure (system) which allows collection of relevant, validated data. Without this, any attempt to provide information regarding patient outcome is doomed to failure.

Computerized systems and information technology are globally available which provide the facility for clinical data storage and complex outcome analysis. It is essential that along with these systems, institutions have method and mechanisms, to demonstrate data validation procedures are undertaken. This will allow confidence in the accuracy of outcome reporting. The provision of these facilities should be given priority and resourced by health-care providers. The natural progression of having these resources in place would be the development of National databases, enabling institutional comparisons, collaboration and 'benchmarking' exercises appropriate to the local population.

Within this overall system there also has to be the adoption of the 'culture' of quality assurance and data collection, and a belief of its place in improving patient outcomes. The recognition of increased mortality or morbidity must be seen as an opportunity to find the reason, change practice, and reassess results with subsequent documentation of improvement. This can only be achieved if there is validated National data available for benchmarking and comparison and which is relevant to the local population.

The advantages and importance of establishing a National Cardiac database has been ably demonstrated in the United Kingdom as well as in the North America (STS database), and more recently by the European database. In China, it is estimated that about 8 million patients need cardiac surgical intervention every year. According to a national survey in 2005, open heart surgical programs are now available at 653 hospitals in mainland China and they are carried out by 1,225 cardiac and 3,405 cardiothoracic surgeons. Logically, the annual cardiovascular surgical workload is steadily increasing (76,319 in 2003 and 90,812 in 2004). The above figures emphasize the unique dilemmas and problems in replicating Western advances in data collection and national database establishment in Asia. However, they also represent a unique opportunity, which if grasped, can only be of benefit to health-care financiers, health care providers and most importantly the patients we are privileged to treat. To quote Lao-tzu 'A journey of a thousand miles begins with a single step'. To establish a National Database for cardiac surgery in our Region, the first step needs to be bold.

Professor Song Wan

Professor Wan graduated from Beijing Medical University (current Peking University Health Science Center), where he also received his basic surgical training. Between April 1994 and March 1998, he was a Clinical Fellow at Department of Cardiac Surgery, University Hospital Erasme, *Université Libre de Bruxelles* in Brussels, Belgium. From this university he obtained his Doctor of Medical Science (PhD) degree with *Plus Grande Distinction* in 1997. He also received a Young Investigators Award of American College of Chest Physicians in 1996. He joined the Chinese University of Hong Kong in 1998 and is currently Associate Professor and senior cardiac surgeon at Division of Cardiothoracic Surgery, CUHK.

Professor Wan is a Fellow of the Royal College of Surgeons of England and the College of Surgeons of Hong Kong. He is a member of ten learned professional bodies including the Society of Thoracic Surgeons. He has contributed to more than 100 peer-reviewed scientific publications and 14 book chapters. He serves as a reviewer for over 20 international refereed journals. He is an editorial board member of the *Heart Surgery Forum* and an advisory board member of the *Asian Cardiovascular and Thoracic Annals*.

Professor Malcolm J. Underwood

Professor Malcolm J. Underwood obtained his MBBS from the University of Leicester in 1987 and subsequently, his FRCS from the Royal College of Surgeons, Edinburgh in 1991. This was soon followed by a Doctorate of Medicine in 1994 and FRCS (CTh) four years later.

Professor Underwood's scientific contribution led to him being awarded The Ronald Edwards Medal by the Society of Cardiothoracic Surgeons of Great Britain and Ireland in 1993; and The Cardiac Research Club Prize for 1992 and 1993.

And in 1997 alone, he was further awarded several other prizes, namely from the European Association of Cardiothoracic Surgeons, University of Louvain (Brussels), and the Royal College of Surgeons, Edinburgh.

Over the years, he has held several positions of responsibility including the Programme Director in Cardiothoracic Surgery and Chairman of the Specialist Training Committee for the UK South West Region; and was a Research and Development Leader for the UBHT Trust, UK. He is presently a Lead Auditor for Cardiac Surgery, UBHT, UK.

In addition, Professor Underwood is presently the Chairman of Specialty Group in Cardiothoracic Surgery, Hong Kong and is Professor, Division of Cardiothoracic Surgery at the Chinese University of Hong Kong.

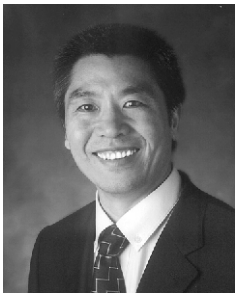
His clinical interests are centred around valvular surgery, mitral valve repair, heart failure surgery, in addition to clinical audit and training.

Professor Sir Bruce E. Keogh

Professor Sir Bruce E. Keogh is the Professor of Cardiothoracic Surgery at University College Hospital, London, UK. He is President of the Society of Cardiothoracic Surgeons of Great Britain and Ireland and Secretary General to the European Association of Cardiothoracic Surgeons. Professor Keogh is also Co-ordinator of the UK Cardiac Surgical Register and National UK Adult Cardiac Surgical Database which reflects his interest and expertise in clinical governance, surgical audit and information management. He has been instrumental in the development of both the UK and European Databases for Cardiac Surgery and has been primarily responsible for compiling the annual reports for each professional body. His work for the Commission for Healthcare Audit and Inspection within the UK has provided unique insight into these processes applicable to cardiac surgery and un-paralleled experience in the mechanism of establishing National and International data collection.

Dr Peter K. H. Walton

Dr Peter K. H. Walton graduated in Medicine from Cambridge University and St Thomas's Hospital London UK. He also subsequently graduated through the Masters of Business Administration program at London Business School. After working in healthcare management consultancy, Dr Walton co-founded Dendrite in 1993. His particular interest and expertise lies in the field of establishing specialist National Databases, with particular experience in the field of cardiac surgery and at present he is a standing member on over ten national/international cardiovascular database committees. Dr Walton was awarded an honorary life membership of the Society of Cardiothoracic Surgeons of Great Britain and Ireland in 2005, for his services relating to developing the UK adult cardiac surgical database and reporting system.



Professor Sheng-Shou Hu (胡盛寿)

Professor Sheng-Shou Hu graduated from Tongji Medical University in Wuhan, China in 1982. He completed his specialty training in cardiovascular surgery at the Cardiovascular Institute of Chinese Academy of Medical Sciences and Fuwai Hospital in Beijing, from which he obtained his Master degree in 1989. Subsequently he also had advanced trainings in cardiac surgery at several internationally prominent centers in the USA, Canada, and Australia. He has been one of the leading surgeons involved in the coronary surgery program at Fuwai Hospital since 1995, and has personally performed thousands CABG operations with an overall surgical mortality of less than 1%. His contributions in the development of minimally invasive CABG operations, the use of left ventricular assist devices in patients with acute critical myocardial injury, cellular therapy and heart transplantation for patients with end-stage ischemic heart disease have won him several national professional awards.

Professor Hu has been President of the Cardiovascular Institute of Chinese Academy of Medical Sciences and Fuwai Hospital since 2003. This institution is currently the biggest cardiovascular center in Asia. He and his colleagues have conducted some new research projects such as perioperative risk stratification in Chinese population, hybrid approaches for treating complex congenital heart diseases, and new classifications for primary pulmonary hypertension.

Professor Hu is also Director of the National Center for Cardiovascular Disease Prevention and Director of the National Key Laboratory for Cardiovascular Regenerative Therapy (both organizations are directly affiliated to the Ministry of Health). Professor Hu has contributed to more than 180 scientific articles and has edited several books in cardiovascular surgery. He serves as the Editor-in-Chief of the Chinese Circulation Journal and has editorial duties in several other professional journals. Being a renowned expert in both adult and pediatric cardiac surgery, Professor Hu was elected President of the Chinese Society for Thoracic and Cardiovascular Surgery in 2006.

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Malcolm J. Underwood

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Sir Bruce E. Keogh

Clinical Data Collection and Outcome Monitoring: the European Experience

Experience with the European Adult Cardiac Surgical Database which includes data on over a third of a million patients in 160 hospitals and 18 countries has shown that :

1. It is possible to successfully standardise, merge and analyse data from a large number of contributors using the protocols described.
2. There are notable differences between European countries in terms of the relative proportions of each kind of operation performed.
3. There are demonstrable differences in the demographic characteristics of patients undergoing cardiac surgery in different European countries.
4. The average age for a cardiac surgery patient is increasing year on year. This is most evident in the group of patients undergoing isolated coronary surgery.
5. Early trends suggest that the proportion of higher risk patients is increasing. This is reflected by increasing age coupled with similarly increasing incidences of other co-morbidities such as diabetes and hypertension.
6. There are notable differences in post-operative stay between countries. The data are not yet robust enough to detect whether this reflects difference in patient populations, surgical management strategies of social support, or a combination of all these influences.

This database is still in its infancy but the experience demonstrates the feasibility of large multi-centre and multi-national cardiac surgical database establishment

Sir Bruce E. Keogh

Measuring and Publishing surgical performance: How, why and what next?

In 2001 the UK Government responded to a 3 year public inquiry into the excessive mortality of children undergoing cardiac surgery in Bristol. The inquiry concluded, among other things, that there was a greater need for information on clinical outcomes in the National Health Service. The Society of Cardiothoracic Surgeons had already begun developing a national clinical database. The aim was to collect data to help us understand our practice, understand surgical risk and provide risk adjusted benchmark data to inform local clinical governance. The data were published in a series of public reports of increasing complexity. As this initiative evolved the media and Government encouraged the Society to develop and use this data to publish risk adjusted results on individual surgeons along the lines used in New York State. In September 2004 the Society of Cardiothoracic Surgeons published its national adult cardiac surgical database report which included an analysis of mortality data for every surgeon in the United Kingdom over a three year period. The analysis was based on crude mortality data because risk adjusted data were simply not available for all surgeons. The analysis presented the data as a funnel plot indicating that all surgeons fell within pre-determined limits of acceptability. But we were criticised in the press for not presenting a specific mortality rate for each surgeon.

Surgeons had argued that whilst publishing unit specific outcomes was appropriate, publishing results down to individual surgeon level was not. Ministers and the media argued that, in the aftermath of "Bristol", such data were in the public interest, and that the precedent existed in Pennsylvania, New York and New Jersey and would soon be introduced in Massachusetts and California. Recognising the unstoppable momentum an increasing number of units began publishing their surgeons' results on trust websites, generally in differing formats. This not only put pressure on other units to do the same, but also fuelled the belief in the media that such data had merit and that perhaps units shying away from publication had something to hide.

So the newspapers lay in wait. The Freedom of Information Act (2000) became effective on 4th January 2005 in England and "in the public interest" several major national papers approached the Society of Cardiothoracic Surgeons for their data on surgeon activity and mortality. But we're not a public body we said, we receive no public funding, we don't believe in the publication of crude mortality data, our data is getting better and we'll publish when the data is good enough. This defence didn't last long. The first off the blocks was the Guardian who approached Trusts directly for the information using the weight of the law to bypass the Society, the Department of Health and the Healthcare Commission and making

our historical protestations irrelevant. Of course there were problems with the published data: some was risk adjusted, some was crude; some units submitted calendar years, some fiscal years, some included redo operations some did not. One unit was left out completely and some surgeons were attributed to the wrong hospitals. Whilst this provided some comfort to detractors of the process the shortcomings are not important in the grand scheme of public disclosure. The point is that the genie is now out of the bottle, there is no going back. The deficiencies will be corrected in a relatively brief iterative process, if not by the Guardian then by other papers who are already circling.

In the meantime this whole issue has cast a blight over British cardiac surgery. Other important, impending issues remain unaddressed while we worry about the negative consequences of this forensic scrutiny on our behaviour. We worried about operating on high risk cases, particularly if we think we are near some mythical limit (generally over 2% mortality for isolated coronary surgery). We worried about how to train future generations of surgeons on a population of patients whose demographics are changing because of more effective percutaneous intervention, whilst keeping our mortality low. Most of all we were concerned by the potential, unnecessary humiliation of surgeons whose mortality may be high. At worst this would result in the public crucifixion of a competent surgeon; at best it would further humiliate a surgeon in difficulty, who with the current systems in place will already have been identified, and hopefully helped, by a combination of the Trust and Society clinical governance mechanisms, and such humiliation will make remedial measures even more difficult. In the end we agreed to work with an independent regulator, the Healthcare Commission, to produce compulsory risk adjusted comparisons of hospital results and voluntary individual surgeon results. This has been extremely well received by the media, patients and politicians and has stimulated interest in publication of results for a variety of other surgical and non-surgical therapies. This is likely to happen in mid 2007.

Professor Sheng-shou Hu 胡盛寿

Chinese Database for Cardiac Surgery: Questions and Thoughts

With China's rapid economical development, the disease burden has changed dramatically in the past 20 years. Currently, cardiovascular diseases have become one of the leading causes of death among Chinese adults. Considering the growing huge population, it is estimated 100,000 neonates born with congenital heart disease annually. Furthermore, around 2.5 million patients with rheumatic heart disease, 3 million with myocardial infarction, and 1.6 million with idiopathic cardiomyopathy are registered. The registry data in 2004 form Chinese Society for Thoracic and Cardiovascular Surgery showed there were 653 centers capable of performing cardiovascular surgery nationally including 1,225 cardiac surgeons and 3,405 cardiothoracic surgeons. However, the annual volume of open-heart surgery was 74,840 in 2004 which means on average each Chinese cardiac surgeon only can perform 16 cases per year. Therefore, we still call for more popularization of modern cardiac surgery in China to meet the demand of the rising patient population. With accumulated government support more heart centers will be established in the years to come. The establishment of quality control system of cardiac surgical procedures plays a critical role in the comprehensive strategies for developing cardiac surgery in China. Summarizing the clinical data and establishing a national database is the first step for this purpose. Compared with our counterparts in North America and Europe, Chinese patients appeared differently in many aspects which may impact on our surgical practice. For example, the follow-up data showed Chinese patients after valve replacement tend to follow lower INR levels for anticoagulation. So far, majority of published Chinese clinical data are often the summaries of single center experiences. Many available risk stratification models are still based on the data from the Western society. Hence it is necessary to establish Chinese Database for Cardiac Surgery (CDCS) to define risk factors and outcome for our local patients. Chinese Society for Thoracic and Cardiovascular Surgery and Chinese Medical Doctor Association of Cardiovascular Surgeons devote to promoting CDCS and call for more academic suggestions form the specialists all over the region.

CDCS needs the cooperation from the entire community of cardiac surgeons and the heart centers in China. We are facing many challenges in establishing CDCS. The following issues have been identified:

- How to arouse the enthusiasm of each potential contributing center and surgeon?
- How to modify the established STS and Europe database for CDCS?
- How to collect data efficiently when there are no common database and electric records in most centers?

Professor Sheng-shou Hu 胡盛寿 Chinese Database for Cardiac Surgery: Questions and Thoughts

A national registry study involving 33 centers for Coronary Artery Bypass Grafting in China has been undertaking since 2006. The purpose of this registry is to retrospectively collect at least 10,000 cases and figure out the current status of CABG in China. This study is expected to be finished in March 2007 and will be the milestone for the development of CDCS. Another adult cardiac surgery registry study will be initiated in April 2007 with the financial support form the Ministry of Science and Technology. Forty Centers will participate in the study and clinical information including blood test results and image data will be prospectively collected. In conclusion, CDCS will be the first national clinical database in the field of surgery, and the CDCS-derived risk model will improve the quality control for cardiac surgical procedures. However, stronger cooperation and endeavor is necessary for colleagues in China to fulfill this purpose.

Professor Sheng-shou Hu 胡盛寿

中国心血管外科数据库 - 问题和思考

胡盛寿
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尽管中国心血管发病率要低于西方发达国家，但巨大的人口基数使得中国心血管疾病和各类高危因素的患病人数巨大，缺血性心脏病患病率为4.6%，高血压的患病率为26.2%，糖尿病的患病率为5.6%，先天性心脏病的患病率为1.3‰～13.8‰（<17岁），围产儿患病率6.87%～14.39%，估计每年10万先心病患儿出生，风湿性心脏病患者估计全国在250万人以上。我国至2004年，中华医学会胸心血管外科分会登记注册中国大陆开展心脏外科手术医院653家，登记心外科医师1225人，心胸外科医师3405人，2004年中国大陆心脏及主动脉外科手术总量90812。其中先心病占55～60%，瓣膜病占20～25%，冠心病近年显著增加。心血管外科的手术量还远远不能满足需求，未来的心血管外科数量仍会大幅度增加。

中国大陆目前大多数据来自单中心的病例总结，而现有的数据显示中国心血管外科病例具有与国外相应病例不同的病例特点和危险因素，采用一些通用的危险因素模型无法准确预计手术结果；在手术方式的选择和围术期处理上也有一定的差异，如非体外循环冠状动脉旁路移植手术的选择、瓣膜置换术后抗凝治疗的标准等；缺乏中国心血管外科的卫生经济学参考信息，如费用、资源使用等。因此，目前迫切需要建立中国的心血管外科数据库。建立心血管外科数据库或者注册登记有助于确定中国心血管病人的危险因素和可以与国外数据库相比较的结果；使临床医师更好遵循循证医学的原则和临床实践指南；可建立临床质量控制和提高体系；并可在此基础上开展临床热点问题的研究和临床试验。

建立中国心血管外科数据库面临以下一些问题：

1. 因为缺乏行政干预，数据登记是基于相互协作的基础上进行，如何提高心血管外科医师对数据库工作的重视程度和积极性；
2. 数据表的确定即要与国际通用数据库如STS和欧洲心血管外科数据库接轨，又要符合中国心血管外科的临床实践；
3. 如何提高数据的准确性和正确性，减少数据采集、录入过程中的错误；

4. 电子病历和数据登记在大多数中心还不普及，网络的应用受到限制。

因此，在建立中国心血管外科数据库时我们需要考虑：

1. 促进与协作医院的合作，提高协作医院的积极性和主动性，认识并真正从数据库工作中获得益处；
2. 了解参加协作中心和医师的需求，调动其积极性，加强参加登记工作医师的教育，提高其认同感和责任感；
3. 强化参加登记医师的培训，统一数据标准；
4. 加强数据采集、录入的全程监控，提高数据质量；
5. 各中心直接录入数据并通过网络传输的方式还需要进一步完善。

目前我们已经进行中国冠状动脉旁路移植注册登记研究，回顾性登记中国大陆33家单位2004～2005年超过10000例冠状动脉旁路移植手术的病例，从2006年10月开始，至2007年3月结束，主要尝试心血管外科多中心注册登记的形式和建立心血管外科数据库，以反映中国大陆冠状动脉旁路移植手术的概况。受国家科技部支持，从2007年4月开始成人心脏外科注册登记研究，将有40家单位参加，研究将前瞻性收集病例资料、血样和影像学资料，在建立成人心脏外科数据库同时进行几个热点问题的前瞻性观察。

总而言之，目前在中国大陆心血管外科的数据库和循证医学的研究刚刚起步，但相信在同道们的真诚协作和支持下，中国全国心血管外科数据库将会很快建立并发挥重要作用。

Dr Peter K.H. Walton

How to establish a National Database

For many years, cardiac surgeons have led the way world-wide in the process of data collection and presentation of national outcome results. Examination of the initial development and the continuing progress of national and international cardiac surgery databases in the US and Europe over the last 2 decades, should enable a newcomer wishing to start a registry to concentrate on strategies for success and avoid some of the pitfalls.

It can be tempting to think that establishing a national surgical registry is solely about choosing a particular database system. This is not true. In the same way that good cardiac surgery is not just about who does the operation, but is also about good leadership, excellent communication, teamwork, planning and the challenging task of managing risks and the on-going process of care - establishing a successful national database involves of a complex mix of skills and the execution of an integrated plan of action.

The starting point is the creation of a proper project plan, which involves writing down clear objectives with an understanding of operational constraints. The roles and responsibilities of all the parties involved must be explicit, well documented and agreed from the start. This applies to the specialist Society itself, to the steering committee, the individual surgeons and the software supplier. The plan must include realistic timelines and involve a pilot project followed by systematic roll-out with defined deliverables.

Experience with other existing national registries shows that the speed of take up by participating centres/individuals can be very variable. The speed is often dependent upon a multitude of local and external factors such as the availability of resources for collecting data at a hospital level and the level of demand for data from commissioners of care and other stakeholders – such as referrers and even patients themselves.

The presentation will focus on the lessons learnt from a number of existing registries in Europe and will identify key practical steps for developing a successful national database.

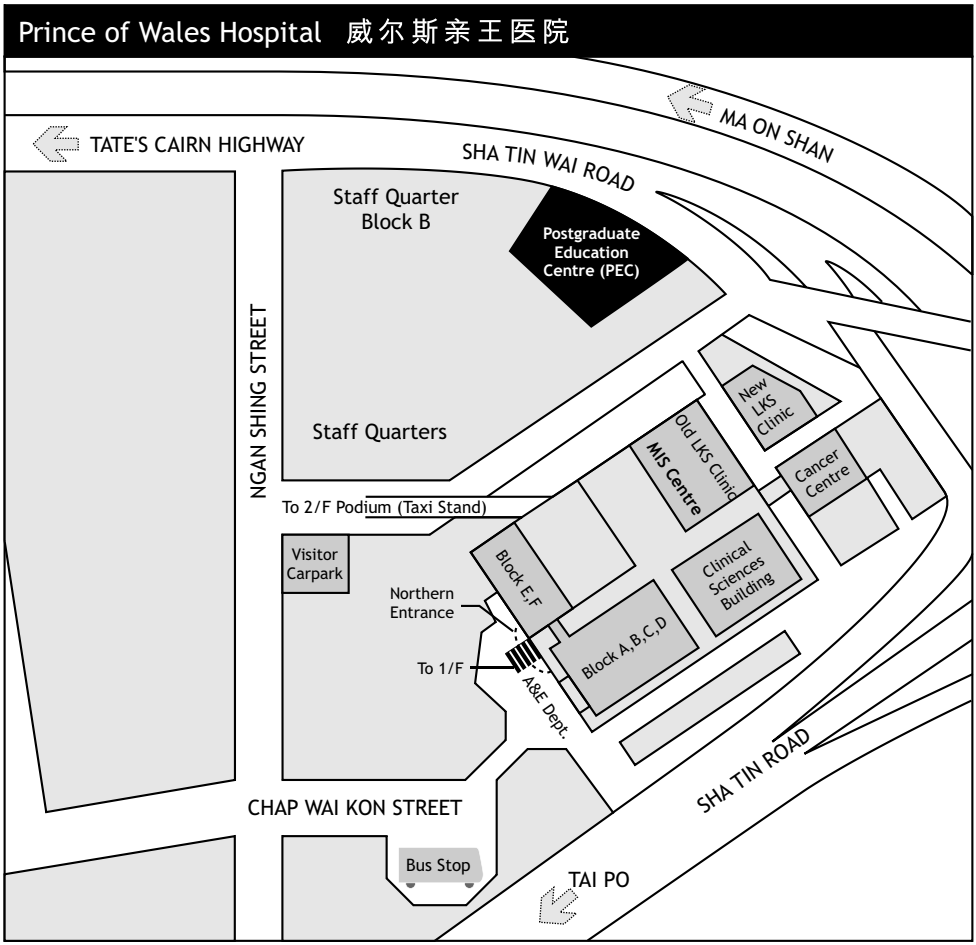
PROGRAMME OVERVIEW

18 March 2007 (Sunday)

Moderators: Professor Song Wan & Professor Malcolm J. Underwood
Interpreter: Professor Song Wan

0800 – 0900	Registration and Refreshment
0900 – 0910	Welcome Speech by Professor Andrew van Hasselt
0910 – 0940	**Clinical Data Collection and Outcome Monitoring** Professor Sir Bruce E. Keogh
0940 – 1010	**Establishing a National CABG Registration in Mainland China** Professor Sheng-shou Hu (胡盛寿)
1010 – 1030	Q & A (Simultaneous Interpretation available)
1030 – 1100	~ Tea Break ~
1100 – 1130	**Technical Advances in Data Collection and Analysis** Dr. Peter K.H. Walton
1130 – 1200	**Prospective Analysis of Clinical Outcome** Professor Malcolm J. Underwood
1200 – 1220	**Establishing a Pediatric Database for Congenital Heart Disease** Dr. Zhao-hui Lu (陆兆辉)
1220 – 1250	Q & A (Simultaneous Interpretation available)
1250 – 1305	Concluding Remarks by Professor Feng Wan & Professor Song Wan
1305 – 1400	~ Lunch and CME/CNE Registration ~

LOCATION MAP



Postgraduate Education Centre (PEC)
医学院深造中心

CUHK Jockey Club Minimally Invasive Surgical Skills Centre (MIS Centre)
香港中文大学赛马会微创医疗技术培训中心

Li Ka Shing Specialist Clinics (North Wing) (Old LKS Clinic)
李嘉诚专科疹所 (北翼)

Li Ka Shing Specialist Clinics (South Wing) (New LKS Clinic)
李嘉诚专科疹所 (南翼)

The Sir Yue-kong Pao Centre for Cancer (Cancer Centre)
包玉刚爵士癌症中心

Clinical Sciences Building
临床医学大楼

Accident & Emergency Department (A&E Dept.)
意外及急救单位

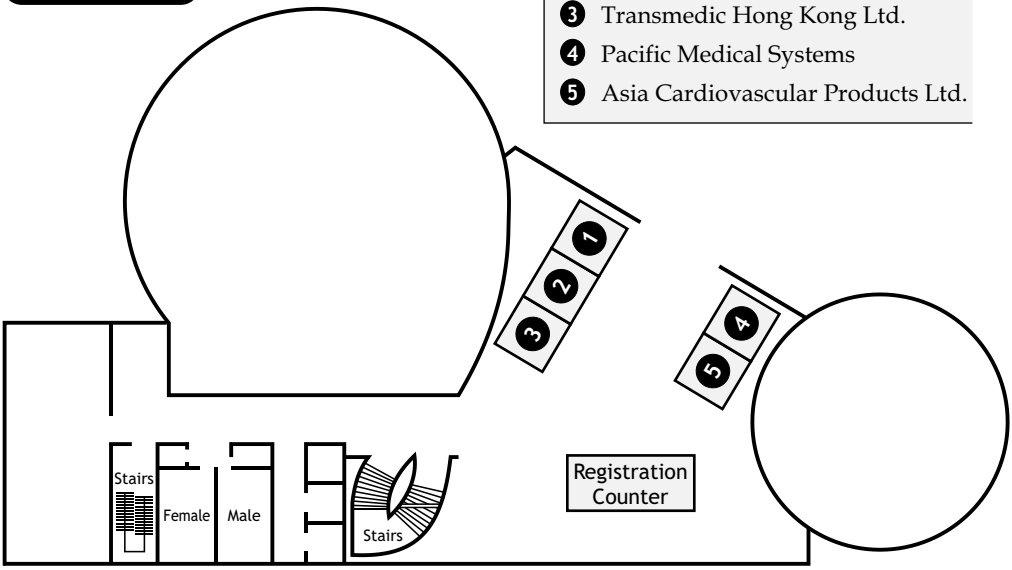
VENUE FLOOR PLAN

Postgraduate Education Centre (PEC), PWH

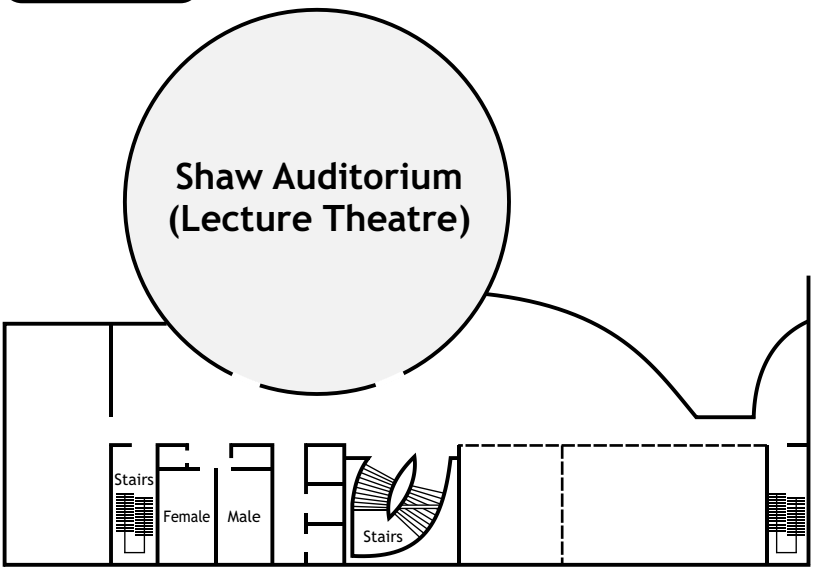
Booth Exhibitor

1. St. Jude Medical (Hong Kong) Ltd.
2. Integmed Ltd.
3. Transmedic Hong Kong Ltd.
4. Pacific Medical Systems
5. Asia Cardiovascular Products Ltd.

GROUND FLOOR



FIRST FLOOR



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Kwai Chung, NT, Hong Kong
Tel : (852) 2484 9759
Fax : (852) 2484 9616
Website : www.acp-asia.com.hk

MEETING INFORMATION

1. Date and Venue:
   Date : 18 March 2007
   Venue : Postgraduate Education Center,
   Prince of Wales Hospital, Shatin, Hong Kong
   Tel : (852) 2632 2951 / (852) 2632 2635 (during conference period)

2. Registration
   Registration Counter is located at G/F and open on 18 March at 0800-1300
   Delegates are entitled to all lectures on 18 March 2007
   Breakfast, Coffee and Tea break and Lunch on 18 March 2007
   Delegates kits and all official publications
   Access to exhibition area

3. Name Badges
   Please put on name badges at all times for all sessions and social functions. Entry may be denied for people not wearing the badges.

4. Official Language
   The official language of the Symposium is English. Putonghua with English simultaneous interpretation will be provided at Q&A Session.

5. Lunch & Tea
   Breakfast, tea break and lunch will be served to all registered delegates in Ground floor, Foyer area of Postgraduate Education Centre.

6. Exhibition
   An exhibition of pharmaceutical products, medical equipments and books is held throughout the congress period in Ground floor of Postgraduate Education Centre.

7. CME/CNE Accreditation
   Accreditation is given by the following Colleges on condition that the College fellows will sign on the Record of Attendance at the congress venue to document their attendence:

College	Points
The Nerthersole School of Nursing	4
College of Surgeons of Hong Kong	4

8. Useful Telephone Numbers

Police / Emergency	999
Congress Secretariat (during congress period)	2632 2951 / 2632 2635
Regal Riverside Hotel	2132 1213
Harbour Plaza Metropolis Hotel	3160 6888

9. Transportation (For Mainland Faculty)

Date : 18 March 2007

Free coach transfer to and from Harbour Plaza Metropolis Hotel to conference venue

	From	To
08:00am	Harbour Plaza Metropolis Hotel	Postgraduate Education Centre
14:00pm	Postgraduate Education Centre	Harbour Plaza Metropolis Hotel

GENERAL INFORMATION OF HONG KONG

1. Climate
   Hong Kong has a subtropical climate of hot and humid summer. Average temperature in March is around 16°C - 20°C.

2. Airport Departure Tax

Adult	:	HK$120
Children under 12	:	Free

3. Language
   English is the language of international business, while Cantonese is the territory's local language. Street signs, menus, tourist and government publications are bilingual.

4. Currency, office and bank hours
   Hong Kong's unit of currency is the Hong Kong dollar (HK$) which is currently tied to the US dollar (US$) at a fixed exchange rate of HK$7.8=US$1. Most foreign currencies and travellers cheques are easily changed at banks, hotels and moneychangers. Credit cards are widely accepted at major hotels, large restaurants, department stores and shops. Banks open from 9am to 4:30pm weekdays, 9am to 12:30pm on Saturdays. Offices generally open from 9am to 5pm Monday to Friday and Saturday morning.

5. Telecommunication
   Hong Kong has a well-developed telecommunications infrastructure which provides easy access to a variety of international telecommunications network services. Electronic mail and database access services are widely used. International Direct Dial (IDD) and facsimile service cover most countries.

6. Transport
   Getting around is easy in Hong Kong, thanks to an inexpensive, efficient public transport system. Networks of double-decker buses and taxis operate territory-wide. The underground Mass Transit Railway offers fast, modern and air-conditioned services on Hong Kong Island and Kowloon, while the above-ground Kowloon Canton Railway offers a scenic route through the New Territories to China. Hong Kong's taxis are cheap and efficient with a HK$15 (less than US$2) flagfall. And for those looking for a mode of travel that has been used for decades, there are the Star Ferries and Hong Kong Island's street trams.

7. Customs and Duties
   Except for the usual prohibitions against drugs, explosives, firearms, and ammunition, and modest limits on alcohol, tobacco products, and perfume, you can bring anything you want into Hong Kong, including an unlimited amount of money. Non-resident visitors may bring in, duty-free, 200 cigarettes or 50 cigars or 250 grams of tobacco, and 1 litre of alcohol.

中国医师协会

心血管外科医师分会第三届年会香港分会场

3rd Annual Meeting

Chinese Association of Cardiovascular Surgeons, Chinese Medical Doctor Association

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