NEWSLETTER OF THE HONG KONG COLLEGE OF PATHOLOGISTS

PATHOLOGUE

The Hong Kong College of Pathologists, Incorporated in Hong Kong with Limited Liability

THE HONG KONG COLLEGE OF PATHOLOGISTS
SCIENTIA ILLUMINAT MEDICINAM
香港病理學專科學院

VOLUME 21, ISSUE 1 MAY 2012

Message from the President

This year marks the 20th anniversary of the College. We are facing a few major changes in the road ahead. Our TEC (Training and Examinations Committee) will start to implement a structured training programme in Molecular Pathology for different disciplines, including conducting the first round of inspection on training centres. The essence of the programme is to introduce some practical experience for our trainees. My personal feeling is that, analogous to performing deliveries during our undergraduate days, our trainees will understand the technology as well as its implications and limitations for their future practice. After all, it is the pathologist who is responsible for the interpretative reporting in pathology practice. The programme is simply an introduction to the field. Pursuit on further understanding in the subject does not stop there. We have witnessed Molecular Pathology developing into a separate discipline in other countries. It will be one of our future directions.

Our partnership with scientists is currently under close review. Following a favourable response from a survey initiated by the Council last year, an open forum is scheduled on 13 April for all members. The forum is an opportunity when all members will discuss on admitting scientists to the College under a new category, "Scientists of the Hong Kong College of Pathologists" (ScHKCPath). A Task Force, chaired by our Vice-President, Dr. Edmond MA, held meetings with representatives from different disciplines and worked out some preliminary admission criteria over the past 2 months. The new category is separate from our existing categories of Associates, Members and Fellows, and bears no voting right. In accordance with our Articles, our trainees need to be medically qualified, and fulfill our training requirement before they are allowed to take the Fellowship Assessment. Through recognition of the contribution by our "Scientists", we wish to strengthen a closer collaboration between pathologists and scientists. The input of our new members will be channeled to the betterment of our profession. Hopefully, the local development of pathology practice will be taken to a new level.

In my last article, I mentioned about hosting an EGM last year. It was postponed because of some technical issues. By the end of this year, we shall host an EGM just before our AGM. I look forward for your continual support.

Dr. Michael SUEN
The President
March 2012

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The 20th Annual General Meeting 2011 and the 20th T.B. Teoh Foundation Lecture

The 20th Annual General Meeting (AGM) was held after the 7th trainee presentation on 19th November, 2011. Two new Council Members, Dr. QUE Tak Lun and Dr. MAK Siu Ming, were elected. We would like to take this opportunity to thank the immediate past Council Members Professor HO Pak Leung and Dr. LUK Sheung Ching Ivy for their contribution to the College.

In the conferment ceremony, 11 Fellows and 14 Members were admitted to the College. The honourable guests included Professor LIANG Hin Suen Raymond (President of the Hong Kong Academy of Medicine) and Dr. Hon. LEUNG Ka Lau (Member of the Legislative Council of Hong Kong, Medical Functional Constituency). The College President Dr. SUEN Wang Ming Michael encouraged our new fellows and members with emphasis on evidence-based practice, teamwork and finished his speech by quoting the popular saying from the <Spider Man> movie "With great power comes great responsibility".

The 20th T.B. Teoh Foundation Lecture was delivered by Professor LEE Sum Ping (Dean, Li Ka Shing Faculty of Medicine, The University of Hong Kong). In the lecture titled "Whither Humanities", Professor LEE enlightened the audience on issues of being human / humane / humanitarian, as well as shared his vision of incorporating Humanities in medical education. The guests, senior fellows, new fellows and members enjoyed the subsequent Chinese banquet dinner.

We would like to thank Professor CHIU Wai Kwun Rossa for being the Mistress of Ceremonies in the AGM. We thank Dr. POON Wai Ming for his great effort in the publishing of the commemorative book for the 20th anniversary of the College. We thank Dr. TO Ming Chun Elaine and Dr. LEUNG Ying Kit Frank for taking photos during the Trainee Presentation Session, AGM, conferment ceremony, T.B. Teoh Foundation Lecture and the dinner. We would also like to express our gratitude towards our College Secretary, Ms. Adrienne YUNG, as well as Ms. Maizie CHAN and Ms. Heidi CHU, for their continuous support in organizing the AGM.

Looking forward to seeing you all in the coming AGM.

▲ *The annual general meeting started the celebration of the 20th anniversary of the College. From left to right: Prof. Annie CHEUNG (Vice-President), Dr. Michael CHAN (Registrar), Dr. Michael SUEN (President), Dr. Cindy TSE (Treasurer) and Dr. Edmond MA (Vice-President).*

▶ *President Dr. Michael SUEN reporting on college businesses.*

▲ *Guests of honour at the conferment ceremony.*

▶ *A group photo of the stage party.*

▲ *This year we had a nice backdrop for capturing the special moments.*

▶ *Professor Sum ping LEE, Dean of the Li Ka Shing Faculty of Medicine, The University of Hong Kong, delivered the 20th TB Teoh Lecture.*

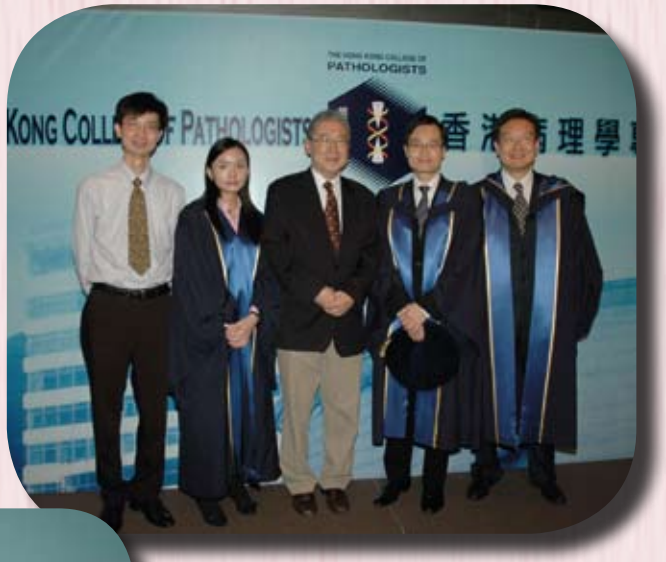
▲ *Dr. SUEN expressed our gratitude to Professor LEE through the presentation of a souvenir.*

◀ *It is touching to have seniors sharing the joy.*

◀ *It is touching to have seniors sharing the joy.*

▼ *It was a precious opportunity to meet up with friends at the annual College event.*

▲ *Public and private sectors, together we contribute to the College.*

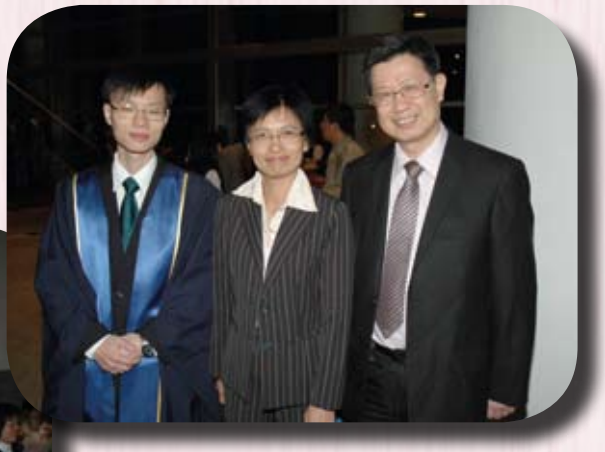


▲ *Congratulations to the Haematology colleagues.*

◀ *The AGM is also an inter-hospital gathering.*

▶ *Pillars of justice in our society.*

▼ *Thanks to guests from other Colleges.*



▲ *Let's have more interdisciplinary meetings.*

▼ *This is no artifact. We have twin brothers in our College.*

▲ *It is very nice to meet with friends.*

◀ *Thanks for your support to the College event.*

▼ *We enjoyed the presence of Prof. Sum Ping LEE at the head table.*

▲ *Let's chat and dine.*

▲ *Let's chat and dine.*

◀ *Presentation of souvenir to Dr. Ivy LUK, retiring Council member, for her dedicated effort in the College.*

The next Annual General Meeting of our College will be held on November 17, 2012 (Saturday). Mark it in your diary now!

Experience on Participation in the 7th Trainee Presentation Session

The ability to communicate with colleagues from different specialties is an essential attribute of a competent pathologist. The annual Trainee Presentation Session organized by the Hong Kong College of Pathologists is therefore an important milestone in every trainee's training experience, as it provides the perfect platform for us to familiarize ourselves with other colleagues working in the different branches of pathology, and to have a fruitful academic discussion with them on the numerous interesting projects being presented.

▲ *A big thank you to the judges for their very important contribution to the event (left to right): Dr. Tony MA, Dr. POON Wai Ming, Dr. Anthony SHEK, Dr. Michael WONG and Prof. Samson WONG.*

I was especially honoured to be awarded the Best Presentation Prize at this year's 7th Trainee Presentation Session. My presentation was based on our group's recent publication titled "Disseminated pencilliosis, recurrent bacteremic nontyphoidal salmonellosis, and burkholderiosis associated with acquired immunodeficiency due to autoantibody against gamma interferon" in the journal Clinical and Vaccine Immunology. In our clinical experience, we occasionally saw patients who were apparently immunocompetent, but suffered from concomitant or sequential atypical infections including disseminated non-tuberculous mycobacteriosis, pencilliosis, nontyphoidal salmonellosis, and burkholderiosis. We therefore tested the archived sera of these patients for autoantibody against gamma interferon, which was an emerging clinical entity previously linked with non-tuberculous mycobacteriosis only. We found a total of eight patients who exhibited the autoantibody. The study deepened our understanding in the intriguing interactions between these intracellular organisms and our immune system, and alerted us of this emerging clinical immunodeficiency syndrome among our patients. The work was made possible by the leadership of Professor Kwok Yung YUEN, the coordinating work of Dr. Bone TANG, and the collaborative efforts of many other colleagues.

The challenge for me as the presenting trainee was the need to summarize the key scientific findings of the work, and to present them in a succinct yet informative manner to an audience consisting of medical professionals with different backgrounds in a very limited timeframe. The experience was highly challenging but rewarding, and the feedbacks from the honourable judges were truly invaluable. Therefore, I would encourage all trainees of the College to take advantage of this precious learning opportunity in the years ahead. Last but not least, I would like to thank Dr. Wei Kwang LUK, the judges, and all the others who helped to organize and make this year's Trainee Presentation Session a success.

Dr. Jasper Fuk Woo CHAN
Department of Microbiology
Queen Mary Hospital

▶ *With everyone's contribution, this year's Trainee Presentation Session was another success.*

▲ *Dr. Jasper CHAN (right) receiving the prize from Dr. Janice LO, chairman of the Education Committee (left).*

Abstract from Winning Trainee

▲ *The plaque for the trainee awarded the Best Presentation Prize.*

Disseminated Penicilliosis, Recurrent Bacteraemic Nontyphoidal Salmonellosis, and Burkholderiosis Associated with Acquired Immunodeficiency due to Autoantibody against Gamma Interferon

CHAN Fuk Woo Jasper,
Department of Microbiology, Queen Mary Hospital

Acquired immunodeficiency due to autoantibody against gamma interferon has recently been associated with opportunistic nontuberculous mycobacteriosis, especially among Southeast Asians. We report another 8 cases, all except one apparently immunocompetent hosts who suffered from concomitant or sequential infections by other intracellular pathogens causing penicilliosis, extraintestinal nontyphoidal salmonellosis, and burkholderiosis. The only case with an underlying immunodeficiency syndrome had systemic lupus erythematosus that was quiescent throughout the multiple infective episodes. Eight out of 10 (80.0%) patients with serological evidence of penicilliosis, 5 out of 7 (71.4%) with culture-positive extraintestinal nontyphoidal salmonellosis, 5 out of 28 (17.9%) with serological evidence of melioidosis, and 7 out of 13 (53.8%) with culture-positive nontuberculous mycobacteriosis possessed autoantibody against gamma interferon, whereas only 1 out of 100 patients with systemic lupus erythematosus did. The study represents the first and largest case series linking this emerging immunodeficiency syndrome with these atypical infections in apparently immunocompetent hosts. Thus, we advocate that any patient with unexplained recurrent or polymicrobial infections due to these intracellular pathogens should be screened for acquired immunodeficiency due to autoantibody against gamma interferon.

THE HONG KONG COLLEGE OF PATHOLOGISTS:

TOPICAL UPDATE

Volume 7, Issue 1 January 2012

Editorial note: *Chronic lymphocytic leukaemia (CLL) is the commonest chronic lymphoproliferative disorder of mature B-cells. Most cases have typical morphological and immunophenotypic profiles; on the contrary, they have extremely heterogeneous clinical courses. Cytogenetics and molecular cytogenetics classify the disease into different prognostic subgroups according to the genetic abnormalities in addition to enable us to understand the pathogenesis of the disease. In this topical update, we would like to introduce the common genetic abnormalities encountered in CLL and their role in pathogenesis, prognosis and treatment. In addition, our local experience in the application of cytogenetics and FISH in CLL will be shared. We welcome any feedback or suggestions. Please direct them to Dr. Wong Wai Shan (e-mail: sws_wong@yahoo.com.hk) of Education Committee, the Hong Kong College of Pathologists. Opinions expressed are those of the authors or named individuals, and are not necessarily those of the Hong Kong College of Pathologists.*

The Hong Kong College of Pathologists, Incorporated in Hong Kong with Limited Liability

Chronic Lymphocytic Leukaemia – the Role of Conventional and Molecular Cytogenetics

Dr. W. S. Wong
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Introduction

Chronic lymphocytic leukaemia (CLL) is the commonest chronic lymphoproliferative disorder of mature B-cells and affects mainly the elderly. It is characterized by the presence of ≥5x10^9/L monoclonal and often CD5+ CD23+ B-lymphocytes in peripheral blood. Haematologists usually have no problem in reaching the diagnosis as the majority of the cases have classical morphological and immunophenotypic features; however, it is an extremely heterogeneous disease clinically with highly variable clinical course. Some patients are asymptomatic and do not require treatment while others progress early and require aggressive treatment. A number of clinical and biological parameters as well as molecular biomarkers have been demonstrated to predict the clinical outcome of the disease [1]. Molecular diagnostics have greatly improved the understanding of pathogenesis of CLL by pointing to candidate genes; for example 17p13 deletion, a common genetic aberration seen in CLL, corresponds to a tumour suppressor gene TP53. Moreover, different genetic subgroups have been shown to be associated with different prognosis: poor survival in 17p or 11q deletions and better survival in trisomy 12, normal karyotype or 13q deletion, with the best survival found in isolated 13q deletion [2]. Cytogenetic studies may also help in the diagnosis of problem cases with atypical morphology or immunophenotypic profiles.

Cytogenetics and Fluorescence In-situ Hybridization (FISH) – Basic Concepts

Cytogenetic study is the analysis of the morphology of chromosomes in metaphase nuclei. Chromosomes are identified by their differences in length and position of the centromeres. A few drops of peripheral blood or bone marrow are added to tissue culture medium and stimulated to divide. After 48 to 72 hours, the dividing cells are arrested in metaphase of cell cycles with chemicals which inhibit mitotic spindle, collected, and treated with hypotonic solution to swell the cells and separate the chromosomes. Chromosomes are then fixed, spread on glass slides and stained. The most common staining method used by clinical laboratories is Giemsa staining which produces a non-uniform staining of the chromosome in a repeatable pattern called banding (G-banding in this particular case). The chromosomes occur in 23 pairs: 22 pairs of autosomes and 1 pair of sex chromosomes. The sex chromosomes are termed X and Y; X for the female determining chromosome and Y for the male determining chromosome. Chromosomal aberrations occurring in haematolymphoid malignancies can be numerical (for example, monosomy 7

in myelodysplasia or hyperdiploidy in acute lymphoblastic leukaemia) or structural (for example, translocation between chromosome 9 and 22 in chronic myelogenous leukaemia).

Cytogenetic study and fluorescence in-situ hybridization are important diagnostic tools in identifying chromosomal abnormalities

Fluorescence in-situ hybridization (FISH) combines the DNA hybridization technique with fluorescence microscopy. During FISH, a unique DNA fragment or a mixture of DNA fragments are tagged with a fluorochrome. This combination is termed a probe. A slide with metaphase or interphase cells is subjected to conditions which allow the chromosome DNA strands to separate. It is then incubated with labeled DNA fragment (probe) and allowed to hybridize with complementary DNA sequence. The slide is then examined under ultraviolet light of appropriate wavelength and any region where the probe has bound will fluoresce. It allows the evaluation of the presence or absence of a particular DNA sequence or the number of chromosome.

Application of Cytogenetics and FISH in CLL

Conventional cytogenetic study has been performed in chronic lymphocytic leukaemia for years but the detection rate of genetic aberrations is unsatisfactory due to the low mitotic rate of leukaemic lymphocytes. Even with the addition of B-cell mitogens such as 12-O-tetradecanoly-phorbol-13-acetate (TPA), the yield improves to 40 to 50% only. Moreover, it is labour intensive and time consuming. FISH allows the detection of chromosomal aberrations not only in dividing cells but also in interphase nuclei of non-dividing cells. In addition, FISH is able to detect cryptic (submicroscopic) changes like deleted 13q (Figure 1a and 1b). Overall interphase FISH is able to detect genetic abnormalities in up to 80% of CLL cases. The major drawback is that it is limited to the specific FISH probes used and also unable to detect complex karyotypes, an adverse prognostic factor in CLL. Recently, CpG-oligodeoxynucleotides (ODNs) have been applied to stimulate the CLL cells' response to cytokines and improve the detection rate of conventional cytogenetic to 80%, comparable to FISH [3].

Common Genetic Abnormalities Seen in CLL and Their Clinical Implications

Chromosomal abnormalities in CLL are mostly deletions or amplifications of the involved chromosome regions while translocations are rare. The most frequent genetic aberrations are deletions in 13q, 11q, 17p or 6q and trisomy 12, with deleted 13q being the commonest (55%) [4]. The latter is often an interstitial deletion at 13q14 and is cryptic in nature, i.e. it cannot be detected by conventional cytogenetic study. No genes in this region have been identified to show a pathogenetic role in CLL although deletion and thus down-regulation of the micro-RNA genes at 13q14 have been described [5].

Structural aberrations of chromosome 11 have been reported in 12% to 25% of CLL, frequently involving q22 and q23 where the ataxia telangiectasia mutated (*ATM*) gene, a tumour suppressor gene, is located. CLL with 11q deletion has a poor prognosis and is associated with advanced disease, extensive lymphadenopathy and rapid lymphocyte doubling times [6]. A recent study has shown that 3 new candidate genes, *NPAT*, *CUL5* and *PPP2R1B*, with roles in cell cycle regulation and apoptosis, were significantly down-regulated in CLL with 11q deletion [7].

17p deletion (Figure 2) is another poor prognostic marker that occurs in 10 to 15% of CLL. It results in the loss of p53 located at 17p13. The *p53* gene is a tumour suppressor gene and plays an integral role in inducing cell cycle arrest and apoptosis after DNA damage. Patients with 17p deletion usually present at an advanced stage and have a high incidence of transformation. Loss of p53 is also associated with resistance to fludarabine and alkylating agent-based therapies [8].

A number of chromosomal deletions adversely affect prognosis in CLL

Trisomy 12 (Figure 3) is found in 20% to 40% of CLL by FISH. It is more common in those cases with atypical morphological and immunophenotypic features, including lymphoplasmacytoid appearance, cleaved nuclei, bright CD20 expression and FMC7 positivity. A number of genes including CDK2, CDK4, STAT6, APAF-1 and MDM-2 which play important roles in cell cycle regulation, apoptosis and oncogenesis are located in chromosome 12 but none of them are well characterized in the pathogenesis of CLL. Trisomy 12 is associated with an intermediate prognosis [9].

Deletion 6q is detected in up to 9% of CLL by FISH. It is characterized by a high incidence of atypical morphology, classical immunophenotype and intermediate incidence of IGVH somatic hypermutation [10].

Abnormalities involving chromosome 14q32, at which Ig heavy chain (IgH) is located, are seen in 6% to 14% of CLL. The *IgH* locus is fused with other partner genes. One such translocation involves the *BCL3* gene at 19q13. Cases with translocation (14;19)(q32;q13) usually have atypical morphology, increased prolymphocytes and cleaved/indented nuclei. Such patients present at a younger age and have an aggressive clinical course [11].

Local Experience

All Chinese patients diagnosed with CLL in Queen Elizabeth Hospital (QEH) from May 2007 to August 2010 and those from all public hospitals in Hong Kong during the 10-month period of September 2010 to June 2011 were referred to the haematology laboratory of QEH for both conventional cytogenetic and FISH analysis. 77 patients were recruited with a median age of 65 years (range: 37-94 years, mean 64.2 years) and a male to female ratio of 2.5:1. Cytogenetic study was performed on bone marrow or peripheral blood lymphocytes by 3-day 12-O-tetradecanolyphorbol-13-acetate-stimulated (TPA) and overnight fluorodeoxyuridine synchronized culture. Metaphase chromosomes were banded by trypsin/Giemsa and karyotyped according to the International System for Human Cytogenetic Nomenclature (ISCN) 2009. The cell pellets kept in Carnoy's fixative were used for the FISH study. A panel of locus-specific and centromeric probes were used, namely *ATM* (11q22.3), D12Z3 (CEP12), D13S319 (13q34) and p53 (17p13.1) in 2 cocktails of probe mixes.

A recent large-scale study has characterized common cytogenetic abnormalities in local CLL patients

Clonal cytogenetic abnormalities were detected in 33.8% of patients (26 out of 77) by conventional cytogenetic study, with trisomy 12 being the most frequent change. The majority had a single chromosomal abnormality (61.5%) and the rest had more complex karyotypes, with evidence of clonal evolution in nine patients.

FISH raised the detection rate of cytogenetic abnormality to 81.8% and over half of the cases had a single abnormality (59.7%, 46/77). Loss of 13q14.3 was the commonest abnormality detected (46/77) with the majority being heterozygous deletion (37/46). Translocation involving 13q was detected in 4 of them (12). Trisomy 12 was the second most frequent abnormality (20.8%, 16/77) and loss of *ATM* gene and p53 were found in 9.1% (7/77) and 6.5% (5/77) respectively.

Our preliminary data show that the abnormality rate and frequency of deleted 13q and deleted 17p in Chinese patients with CLL in Hong Kong are similar to those of the West. It is also found that deleted 11q is associated with a younger age of onset and deleted 17p with complex karyotypes demonstrated by conventional cytogenetics.

Conclusion

Conventional cytogenetics and FISH have been proven pivotal in separating CLL into distinct clinical subgroups for both prognostication and treatment purposes. They identify genetic aberrations that play a role in the pathogenesis of CLL. Conventional cytogenetics and FISH are complementary in the identification of chromosomal aberrations in CLL, with the former providing a global view while the latter identifying cryptic changes. FISH is also useful in providing supplementary information in those cases with a failed culture.

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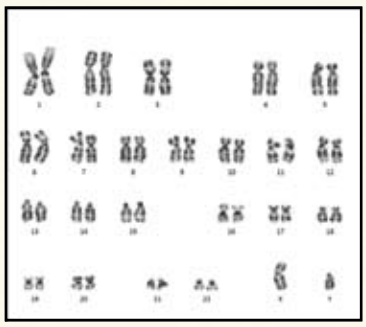
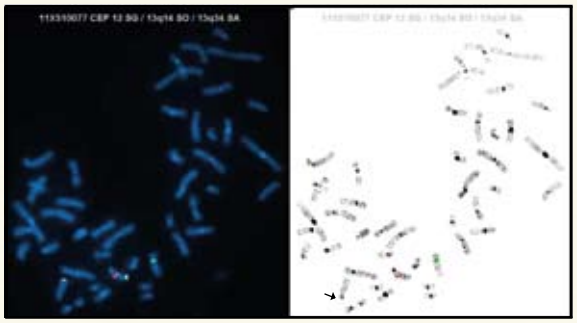
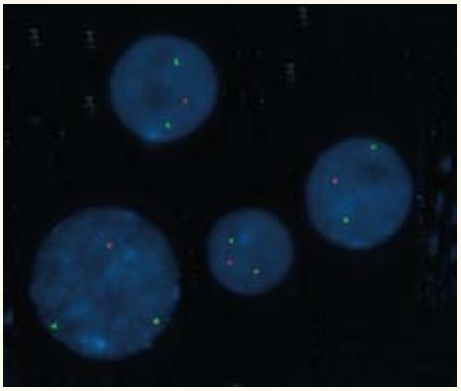


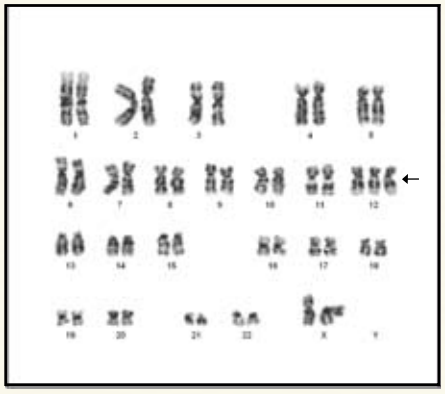
▲ ***Figure 1a.*** *A patient newly diagnosed with CLL and normal karyotype 46,XY by conventional cytogenetics, both chromosomes 13 appear normal.*



▲ ***Figure 1b.*** *Metaphase ISH with a panel of probes for chromosome 12 (SpectrumGreen, Vysis), 13q14.3 (SpectrumOrange, Vysis) and 13q34 (SpectrumAqua, Vysis) performed on the same patient of Figure 1a. Arrow indicates the abnormal chromosome 13 with loss of 13q14.3 signal (red).*



▲ ***Figure 2.*** *Interphase ISH with probes for* ATM *(11q22.3) (SpectrumGreen, Vysis) and* p53 *(17p13.1) (SpectrumOrange, Vysis), showing loss of one signal for 17p13.1 (red).*



▲ ***Figure 3.*** *Trisomy 12, shown by G-banding in conventional cytogenetics.*

Position Available

A position is available at Diagnostix Pathology Laboratories Ltd based at Canossa Hospital. We are looking for a pathologist with at least 2 year post-fellowship experience to join our current team of 3 pathologists. The position is a full time position but permanent part-time arrangement may also be considered. An attractive remuneration package will be offered to the successful candidate. For further information, please contact Dr. K W Chan on 25260867 or by email kwchan@diagnostix.com.hk. All enquiries and discussion will be kept strictly confidential.

Out of the Whitecoat:

Medical Service in Northern Thailand

Dr. Rocky SHUM
Public Health Laboratory Services Branch,
Centre for Health Protection,
Department of Health

▲ *The author is at the most right.*

The Bird Flu caused immense fear not only in Asia but all over the world back in 2003.

In early November, 2005, a child contracted bird flu and died in Bangkok.

"To go or not to go …?" I asked myself.

Thanks to my parents' supportive attitude, I finally decided to go. There were 13 people in our team: doctors, dentists, nurses, and other supporting staff. We left Hong Kong on 12th November and arrived at the Chiangrai Airport the same day, and then went straight to Thoed Thai Village, which is situated in the notorious "Golden Triangle".

The next morning, we headed to the morning market for breakfast. There were many stalls selling fruits, fish, vegetables and uncooked food. We could not find any noodle stalls. It was not until we made a 30-minute walk that we finally found a very good Shan noodle stall. We were so happy we ordered all the different noodle choices available immediately. It turned out our order was "big" enough for the stall to "call it a day" immediately after our visit.

We visited some orphans at a local church's children hostel, which was set up by a Christian from Taiwan. There were more than 70 children there, all supported by donations. Their parents were the asylum seekers of the modern civil wars of China and many of them died in the wars. Having lost their loved ones, many teens were left on their own: the boys then joined street gangs to make ends meet, and the girls became prostitutes. The hostel not only provided a physical shelter for their basic needs, but also education and love for them. Their fears had gone. I took the opportunities to talk to and encourage them. We also presented songs, drama and Chinese Kung Fu to them.

Medical and Dental Services

We started first day of our medical and dental clinic at the Thoed Tai Church in Thoed Thai village. As we provided the medical and dental services free of charge, many people came. Some patients from other villages even walked 3 hours just to visit the clinic. Most patients had minor problems only, but we also encountered cases of abscesses that required surgical intervention. We saw about 30 dental cases and about 50 medical cases.

At the dental clinic, dental care education was also given to the children. As many children are as young as 5 years old, we use cartoons and songs to teach them the importance of oral hygiene. We also gave away tooth brushes and tooth paste as gifts.

The Refugee Camp

There were many Shan refugees staying on the mountains between Myanmar and Thailand. They were forced to leave their homes and hide on the Thai-Myanmar border. They did not have enough food to eat, clean water to drink, or a pair of shoes to wear. There were no schools for the children to attend and no hospitals for the sick and ill.

We visited one of the refugee camps near Thoed Thai Village. We brought rice, towels and milk powder for the refugees there. There was no road for cars, and so we had to walk up and down the hill for half an hour. To my surprise, there were 2500 refugees waiting for us. We were then divided into 2 teams: one group of medical staff offered medical/dental service, while the other played games with the kids. The clinic was held in bamboo-school-building. The setting was very simple, but we were glad that we helped a child who came with a lacerated wound to be cleaned and sutured. During my "time off", I played games with the children. Even though we could not communicate with each other, I could see them through their big smiling faces. All my tiredness was hence driven away and my life was refreshed.

Seeing what we were doing for the orphans, the person in charge of the school said in tears, "Thank you for coming and offering your help. We thought no one in the world would know about our suffering. Thanks for your love".

Did we really do something great for them? My answer has gradually changed from "yes" to "no" after joining several similar trips.

I used to think that I did treat many patients and relieve them from their pain. I felt good telling people that I helped people with my own time, money, abilities and efforts.

Yes- I probably saved some lives by draining the abscesses and prevented possible complications. But the fact is: I do not deserve their compliments for what I did.

It is a blessing to have been born in Hong Kong. It is a blessing that I was born to be "smart" enough, even though I did study hard to become a doctor. It is a blessing that I could earn extra money, and afford to donate some basic necessities for the needy. And I know that all these blessings are no coincidence.

Finally, I would like to share with you the two photos I took during the trip. Have a BIG smile!

▲ *Snapshot at the children hostel.*

▲ *Footsteps of hope@Refugee Camp.*

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OBITUARIES:

Prof. John Russell ANDERSON

Prof. John Russell ANDERSON passed away on 30 October 2011, at the age of 93.

Prof. Anderson was a distinguished pathologist, a professor and Head of the Department of Pathology of the University of Glasgow at the city's Western Infirmary before his retirement. He was a histopathologist as well as an immunologist, with major research interest in autoimmune diseases. He helped to establish the diagnostic immunopathology laboratory at the Centre for Rheumatic Diseases in Glasgow. He was the editor of four editions of the renowned "Muir's Textbook of Pathology", a major international undergraduate and postgraduate textbook in the 1970s to 1990s. He was also the President of the Royal College of Pathologists from 1978 to 1981.

Prof. Anderson greatly valued correspondence with friends and colleagues worldwide. He was an external examiner for the Department of Pathology of the University of Hong Kong (HKU) in the 1980s. He also supported the development of cytology in the Department of Pathology in HKU. During the establishment and early development of the Hong Kong College of Pathologists, Prof. Anderson has provided a lot of valuable advice. He will be deeply missed by us all.

Dr. MA Tung Lily

▲ *A precious photo from the Department of Pathology of the University of Hong Kong in 1983, when Prof. J.R. ANDERSON (front row, fourth from the right) was the external examiner. Dr. K.F. SO (front row, first from the left) was also working in the department during that time.*

Dr. Ray Richard LYCETTE

Dr. Ray Richard LYCETTE passed away peacefully in Brisbane, Australia on 4th April 2012, aged 82 years.

Ray, born in New Zealand on 11th November 1929, was awarded MBChB(NZ) by Otago University, Dunedin, in 1954. After completing his House Officer and Registrar training he spent 1958-60 as Assistant Lecturer/Lecturer in Pathology at Otago University and continued on to obtain his MD in 1962, with research in chromosomes forming the basis of his thesis. From 1961 until 1973 he held a joint appointment as a hospital consultant and as founding partner in a private pathology practice in Hawke's Bay. During this time he obtained his MRCPath in 1965, FRCPA in 1973 and subsequently the FRCPath in 1977.

In 1973 he decided to seek new challenges and accepted a 3-year contract at Queen Elizabeth Hospital in Hong Kong, which in those days admitted about 40,000 patients per year and the anatomical pathology laboratory dealt with equal numbers of 12,000 biopsies and autopsies, which included about 700 coroners autopsies. At the time he was one of the two qualified pathologists supervising a number of trainees working towards their MRCPath. He then returned to New Zealand for a short time before, on completion of family matters, he spent 10 months engaged as locum pathologist in England.

In early 1978 he took up the post of Clinical Pathologist in the Department of Pathology in the University of Hong Kong at Queen Mary Hospital and was promoted to Senior Clinical Pathologist 17 months later. During this period Ray's duties ranged from lecturing and tutoring medical and dental students, training pathology trainees as well as day-to-day duties in histopathology, cytopathology and autopsy service. He brought his past experience and benchmarks which he applied in deficient areas such as coding. He also played a role in the formation of the Pathology Society, which eventually evolved into the Hong Kong College of Pathologists, and was keen on encouraging a closer relationship with the RCPA.

From 1983 to 1988 he was appointed Consultant Pathologist in charge of the Hong Kong Government Institute of Pathology, which was based in Sai Ying Pun on Hong Kong Island, with about one hundred and fifty staff of all grades servicing all the main branches of Pathology. The institute was also the public health laboratory for Hong Kong Island (pop. about one million). While his duties were mainly administrative, he remained involved with daily service, and, as a member of the Consultant Pathologists Committee, was closely involved with planning Government Pathology for the whole of Hong Kong.

On reaching the retirement age of 55, he was offered an extension and this was followed by a further offer of renewal, but for family reasons he decided to return to New Zealand prior to settling in Australia. Ray and Gill formally migrated to Australia on the 30th October, 1988, and on 2nd November, he began work as a relieving Consultant Pathologist with Drs. J.J. Sullivan, N.J. Nicolaides and Partners,

Brisbane, where his duties entailed relieving as consultant-in-charge in their peripheral laboratories including Bundaberg, Maroochydore, Southport, Lismore, Coff's Harbour and Toowoomba laboratories. He retired in January 2002 after 44 years in pathology and 50 in medicine.

Ray was married to Gillian in 1953, who survives him with two adult children, two deceased, six grandchildren and three great grandchildren. He is fondly remembered by all who came in contact with him particularly for his dedication to the development of pathology at all levels and his no-nonsense pragmatic attitude to all aspects of life.

Dr. Robert COLLINS

Dr. SO Kong Fan (Kwan Wing)

Dr. SO Kong Fan (Kwan Wing), a Founder Fellow and one of the original subscribers of our College, passed away on 20 November 2011 in Brisbane due to lymphoma.

Born 1928 in Mauritius, Dr. So belonged to the third generation of a Hakka Chinese immigrant family. At the age of 15 after completing junior high school, he supported himself and his family by working as an apprentice and a shop assistant. In 1947, he left for China to pursue higher education in his mother country. Thereafter, his life was closely linked to the events in the history of modern China.

Dr. So was admitted to the Lingnan University Medical College in Guangzhou (currently Zhongshan School of Medicine) and was awarded with scholarships for his excellent academic achievements throughout the years of study. With his savings eroded by the great inflation during the Chinese civil war at that time, he had to work after school to make ends meet. Despite the tough conditions, he graduated with outstanding results in 1953, and completed specialty training in pathology. He was offered the opportunity to work in the Chinese Academy of Medical Sciences in Beijing, but he volunteered to go to Xian instead, determined to serve the less developed part of the country.

At Xian Medical College, Dr. So helped to build up the Pathology Department. He designed the interior of the new pathology building, purchased reference books out of his own meagre salary and made teaching aids himself. During the two decades of his stay in Xian, he experienced the political and social upheavals of China, including the Anti-Rightist Movement, the Great Famine, and the Cultural Revolution; he lost one-third of his body weight in 3 months during the Great Famine. Under such circumstances, he had to work with very limited resources and access to reference materials. Years later, he recalled to us how he had performed autopsy bare-handed, only by applying paraffin wax on his hands!

In 1973, Dr. So joined the Department of Pathology at the University of Hong Kong. Life was not easy for a mainland medical graduate in the then colony. Already in his late forties, he passed the licensing examination of the Hong Kong Medical Council, and

further demonstrated his professional competence by his success in the membership examination of the Royal College of Pathologists. He was later promoted to the post of Senior Clinical Pathologist.

His superb diagnostic skills made him the definitive consultant for the difficult cases in the department. With his sharp eyes and intelligent mind, he analyzed a case starting with basic principles in anatomy and histopathology. His motto was 大膽假設，小心求證 (boldly hypothesize, carefully verify). On more than one occasion, his earlier observations on certain pathologic conditions in Xian were later validated and published by other workers.

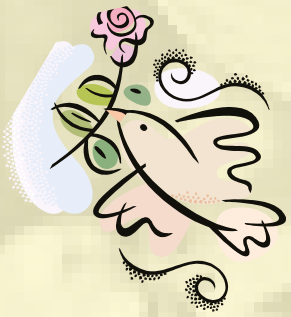
Generations of pathologists who were trained in Queen Mary Hospital between the mid 70s and early 90s were indebted to Dr. So for his guidance. He was a respectable and caring mentor, spending hours with colleagues at the double-headed microscope and going through cases with much patience. Occasionally, the topic of discussion would stray off to their personal life and frustration, and sound advice and useful tips based on his wisdom of life would be given. When allocating the autopsy cases, he would reserve a hepatitis B positive case for himself, and let the inexperienced trainees do the negative ones. With a fatherly smile, he said he was old enough not to worry about contracting the infection.

Dr. So had enjoyed his retired life in Australia with his family since 1992. His popularity had won long-lasting friendship with his colleagues. Quite a few of us visited him in Brisbane. His beautiful garden with the various flowers and plants was most impressive.

Dr. So was indeed a man of broad mind and vast knowledge, as what his name 寬宏 literally meant. As a pathologist, he had been our role model by virtue of his high standard of work and devotion to the profession. As a teacher, he inspired his students and trainees by his passion for pathology and unreserved teaching. As a human being, he possessed the kind of personal integrity that stood the test of time: generosity, kindness, humility and strength in face of adversity. Even in his final days, his great warmth was felt by those around him. He never grumbled or complained. The nurses in the ward started their days by kissing him on his forehead.

He is survived by his beloved wife of 52 years, Anne; his daughter Lily and son-in-law Terence, both dentists; and his grandson Brian. His former colleagues in HKU sent a memorial donation to the Leukemia Foundation. His charming smile would remain in our memories.

Dr. LUK Sheung Ching, Ivy



Call for Application:

Chan Woon Cheung Education and Research Fund in Pathology

In 1991, friends, colleagues and former students of the late Dr. CHAN Woon Cheung endowed a fund in his memory to promote education, training and research in Pathology. This fund shall only be applied towards the promotion of education, training and research in Pathology, such as research grants for studies in Pathology, or grants to support training in Pathology, including passage fees and subsistence, where the training is conducted in Hong Kong or the applicant is currently working in Hong Kong. Local and overseas workers in Pathology, both members and non-members of the Hong Kong College of Pathologists, may apply for the grants for the purposes set out above.

For those who are interested, please download the application form from our College website (www.hkcpath.org) and return the completed application form to the Registrar. If the fund application is aimed for conducting medical research, please also complete the last 2 pages of the application form with submission of the requested information. Please note the new requirements which have been published in our last newsletter (20(2): P.11). These requirements are also listed in the new application form. ***The deadline for application submission is 31 May 2012.***

We would like to take this opportunity to congratulate our awardee of last year, Dr. CHOI Wai Lap. We are looking forward to his report on his exciting research project.