Annual Scientific Meeting in Anaesthesiology 2026

Date
31 October - 1 November 2026

Venue
Hopewell Hotel, Hong Kong

Official Satellite Session of World Congress of Intravenous Anaesthesia (WCIVA) 2026

A collaborative scientific programme fostering academic exchange, innovation, and inspiration between Hong Kong and WCIVA Experts.

One Congress, Two Cities



e-Programme

Jointly Organized by:

The Hong Kong College of Anaesthesiologists

The Society of Anaesthetists of Hong Kong

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Welcome Message

Dear Colleagues and Friends,

Welcome to the **Annual Scientific Meeting in Anaesthesiology 2026 – Safety**.

In anaesthesia, safety is the unshakable foundation. This year's meeting returns to our cornerstone to redefine safety for a new era. We will explore its full spectrum: advancing **patient safety** through precision and innovation; designing resilient systems for **quality & safety**; and championing **our own safety**—ensuring the psychological and physical well-being of every professional.

This year, we are proud to collaborate with the **World Society of Intravenous Anaesthesia (WSIVA)** to design a joint scientific programme. Through this partnership, we have curated a series of integrated sessions aiming to foster academic exchange, innovation, and inspiration between Hong Kong and leading experts from around the world.

Join us to engage with cutting-edge topics from human factors to technology-enhanced vigilance and team well-being. Through dynamic symposiums and hands-on workshops, we will strengthen the timeless skills and forward-thinking leadership that keep our practice safe and secure.

Your presence is vital. Together, we will fortify the foundation that protects our patients, our teams, and our future. We look forward to welcoming you.



Dr. Yee-Eot CHEE
President
The Hong Kong College of Anaesthesiologists



Dr. Timmy CHAN
President
The Society of Anaesthetists of Hong Kong



Dr. Kevin CHAN
Chairperson
Organizing Committee
ASM 2026



Organizing Committee

Chairperson

Dr Kevin CHAN

Scientific Sub-Committee

Dr Morgan CHAN
Dr Jane KO
Dr Max LAU
Dr Swan LAU
Dr Yiu-Chung LAU
Dr Aaron LEE
Dr Bryan LEE
Dr Calvin LIU
Dr Katherine LIU
Dr Emily MA
Dr Irving TENG
Dr Michael WAN
Dr Matthew WONG
Dr Justine YAU
Dr Daniel YIP
Dr Jessica YU

Nursing Symposium Sub-Committee

Ms Sze-Man KWOK
Ms Cindy YIP

Treasurer

Dr Eric Hang-Kwong SO

Honorary Advisors

Dr Simon CHAN
Dr Tom CHAN
Dr Donovan WONG



Faculty List

International Faculty

Prof. Eric ALBRECHT (Switzerland)
Prof. Bernd Walter BÖTTIGER (Germany)
Dr. Tim Chi-Ho CHAN (Singapore)
Prof. Sophia CHEW (Singapore)
Prof. Won-Joo CHOE (South Korea)
Dr. Michelle CHONG (Australia)
Dr. Daniel J. COLE (USA)
Dr. Anna Margarita CORSIGA (Philippines)
Prof. Thomas M. HEMMERLING (Canada)
Prof. Izumi KAWAGOE (Japan)
Dr. Deborah KHOO (Singapore)
Prof. Hyung-Chul LEE (South Korea)
Dr. Chih-Min LIU (Taiwan)
Prof. Suraphong LORSOMRADEE (Thailand)
Prof. Hasmizy B. MUHAMMAD (Malaysia)
Prof. Jaideep PANDIT (United Kingdom)
Prof. Quirino PIACEVOLI (Italy)
Dr. Owais Ahmed Mohamed RAFIQ (Kingdom of Bahrain)
Prof. Timothy G. SHORT (New Zealand)
Prof. Edgard M. SIMON (Philippines)
Prof. David STORY (Australia)
Prof. Michael VELTMAN (Australia)
Prof. Li-Ze XIONG (China)
Dato' Dr. Chow-Yen YONG (Malaysia)
Prof. Jamie YOUNG (Australia)

Local Faculty

Dr. Albert CHAN
Dr. Timmy CHAN
Prof. Yau-Wai CHAN
Dr. Yee-Eot CHEE
Prof. Chi-Wai CHEUNG
Ms. Hiu-Yee CHUNG
Dr. Kevin FUNG
Prof. Chi-Tim HUNG
Dr. Vansie KWOK
Ms. Jaime LAM
Prof. Simon LAM
Dr. Vivian LAU
Dr. Ralph LEE
Dr. Rowena LEE
Prof. Gilberto LEUNG
Dr. Wesley LEUNG
Dr. Wing-Cheong LEUNG
Dr. Rock Yuk-Yan LEUNG
Prof. Lowell LING
Dr. Frances LUI
Ms. Shirley WY NG
Dr. Wincy NG
Dr. Hing-Yu SO
Dr. Tsz-Ha TANG
Ms. Oonagh TONER
Dr. Kin-Chung TSE
Dr. Benney YC WONG
Prof. Henry WONG
Prof. Stanley WONG
Mr. Jason WU
Dr. Keith YEUNG
Dr. Rebecca YIM
Dr. Louisa YUEN

International Workshop Facilitators

Prof. Eric ALBRECHT (Switzerland)
Dr. Naveen Naik BANAVATHU (India)
Dr. Tim Chi-Ho CHAN (Singapore)
Dr. Michelle CHONG (Australia)
Dr. Jijo FRANCIS (India)
Dr. Venkata GANESH (India)
Dr. Sahil GARG (India)
Prof. Manoj KAMAL (India)
Prof. Izumi KAWAGOE (Japan)
Dr. Sekar L. (India)
Prof. Suraphong LORSOMRADEE (Thailand)
Prof. Hasmizy B. MUHAMMAD (Malaysia)
Prof. Goverdhan Dutt PURI (India)
Dr. Tanvir SAMRA (India)
Dr. Soumya SARKAR (India)
Dato' Dr. Chow-Yen YONG (Malaysia)



Faculty List

Local Workshop Facilitators

Dr. Chin-Chin CHAN
Dr. Kevin CHAN
Dr. Morgan CHAN
Prof. Yau-Wai CHAN
Dr. Dickson CHEUNG
Dr. Clara CHONG
Dr. Lawrence CHU
Dr. Wesley CHU
Dr. Vito HO
Dr. Shing KO
Ms. Sze-Man KWOK
Dr. Jason LAI
Dr. Kitty LAM
Dr. Katherine LAM
Ms. Rosanna LAM
Dr. Bryan LEE
Dr. Rowena LEE
Dr. Wincy NG
Dr. Adrian TAN
Dr. Michael WAN
Dr. Andy WONG
Dr. Matthew WONG
Dr. Oi-Fung WONG
Dr. Patrick Chung-Pak WONG
Ms. Yuen-Shan WONG
Ms. Yun-Yu WONG
Dr. Timothy YANG
Dr. Justine YAU
Dr. Louisa YUEN

International and Local Judges

Dr. Albert CHAN (Hong Kong)
Dr. Benny CHENG (Hong Kong)
Prof. Sophia CHEW (Singapore)
Dr. Daniel J. COLE (USA)
Prof. Stanley WONG (Hong Kong)
Dr. Steven WONG (Hong Kong)
Dato' Dr. Chow-Yen YONG (Malaysia)

(Listed in alphabetical order)

Scientific Programme

30 October 2026 (Friday)

Venue: Hong Kong Academy of Medicine (HKAM), HKAM Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong

	W9: Advanced Haemodynamic Monitoring PBLD
09:00 - 10:00	**W9 - PBLD 3: Intraoperative Management of Patients Undergoing Laparoscopic Liver Tumour Resection**
10:00 - 11:00	**W9 - PBLD 2: Intraoperative Management of Patients Undergoing Elective Open Repair of Abdominal Aortic Aneurysm**
11:00 - 12:00	**W9 - PBLD 1: Intraoperative Management of Patients Undergoing Elective VAT Esophagectomy**
09:00 - 13:00	**W10: TIVA Workshop**
14:00 - 17:00	**W7: ADAM Airway Instructor Workshop**
Evening	**Faculty Dinner (By invitation only)**

31 October 2026 (Saturday)

Venue: Crystal Court, 19/F and Salons, 20/F, Hopewell Hotel, Hong Kong

08:00 – 08:45	**Pre-Function Area of Crystal Court, 19/F** Registration			
08:45 – 09:00	**Crystal Court II** Opening Ceremony			
09:00 – 10:30	**Crystal Court II** **Plenary Session 1** Moderators: *Dr. Kevin CHAN* *Dr. Katherine LIU* *(Hong Kong)* **Perioperative Medicine: A Move towards Greater Safety** *Prof. David STORY* *(Australia)* **A Global Perspective on Perioperative Safety** *Dr. Daniel J. COLE* *(USA)* **East Meets West in Leadership** *Prof. Chi-Tim HUNG* *(Hong Kong)*	**Salon 2-3, 20/F** **Nursing Symposium** Moderators: *Ms. Sze-Man KWOK* *Ms. Cindy YIP* *(Hong Kong)* **AI-Powered VR Simulation to Strengthen Nursing Students' Communication** *Dr. Benney YC WONG* *(Hong Kong)* **Bridging the Gap: Comprehensive Pre-and Post-Procedure Nursing Protocols for Image-Guided Pain Interventions** *Ms. Shirley WY NG* *(Hong Kong)* **High Frequency Jet Ventilation (HFJV): An Update** *Prof. Yau-Wai CHAN* *(Hong Kong)*		
10:30 – 11:00	**Pre-Function Area of Crystal Court, 19/F** Coffee Break and Healthcare Industry Exhibition			
11:00 – 12:30	**Crystal Court II** **Airway Symposium** Moderators: *Dr. Justine YAU* *Dr. Michael WAN* *(Hong Kong)* **Safety in Difficult Airway Management of Head and Neck Tumors** *Dr. Anna Margarita CORSIGA* *(Philippines)* **Safety in Paediatric Airway Management** *Dr. Deborah KHOO* *(Singapore)* **What Can We Do to Collapse the Lung Better: Techniques and Evidence** *Prof. Yau-Wai CHAN* *(Hong Kong)*	**Crystal Court I** **Education, Leadership and Professionalism Symposium** Moderators: *Dr. Bryan LEE* *Dr. Max LAU* *(Hong Kong)* **Staying Competent in a Changing World: What Lifelong Learning Really Takes** *Dr. Hing-Yu SO* *(Hong Kong)* **Introduction of Institute for Medical Advancement and Clinical Excellence (IMACE)** *Prof. Gilberto LEUNG* *(Hong Kong)*	**Salon 2-3, 20/F** **Continued Medical Education Panel Discussion** Moderators: *Dr. Yee-Eot CHEE* *Dr. Albert CHAN* *(Hong Kong)* *Prof. David STORY* *(Australia)* *Dr. Daniel J. COLE* *(USA)* *Prof. Sophia CHEW* *(Singapore)* *Prof. Hasmizy B. MUHAMMAD* *(Malaysia)* *Prof. Izumi KAWAGOE* *(Japan)* *Prof. Simon LAM* *(Hong Kong)* *Dr. Simon CHAN* *(Hong Kong)*	**Salon 4, 20/F** **W1: Nursing Workshop** *Facilitators:* *Ms. Sze-Man KWOK* *Ms. Rosanna LAM* *Ms. Yuen-Shan WONG* *Ms. Yun-Yu WONG* *(Hong Kong)*



Scientific Programme

31 October 2026 (Saturday)

12:30 – 14:00	**Crystal Court I** **Lunch Symposium** *(Sponsored by Merck Sharp & Dohme (Asia) Ltd.)* Moderator: *Dr. Emily MA* *(Hong Kong)* **From Reversal to Recovery: Optimizing Patient Safety Through Modern Neuromuscular Blockade Management – Taiwan Experience, Including DMD and SMA Scoliosis Surgeries** *Dr. Chih-Min LIU* *(Taiwan)*			
14:00 – 15:30	**Crystal Court II** **Perioperative Symposium** Moderators: *Dr. Donovan WONG* *Dr. Keith YEUNG* *(Hong Kong)* **Advanced Haemodynamic Monitoring: From Parameters to Clinical Decisions** *(Sponsored by Becton Dickinson Asia Limited)* *Dr. Yee-Eot CHEE* *(Hong Kong)* **Optimising Bleeding Management with Fibrinogen Replacement** *(Sponsored by CSL Behring Asia Pacific Ltd.)* *Dr. Ralph LEE* *Dr. Kin-Chung TSE* *(Hong Kong)* **Perioperative Sleep Apnea Management** *Prof. Eric ALBRECHT* *(Switzerland)*	**Crystal Court I** **Cardiothoracic Symposium** Moderators: *Dr. Morgan CHAN* *Dr. Irving TENG* *(Hong Kong)* **Updates on TIVA in Thoracic Procedures** *Prof. Izumi KAWAGOE* *(Japan)* **Revisit Volatile versus TIVA in Cardiac Surgery** *Prof. Hasmizy B. MUHAMMAD* *(Malaysia)* **Methadone Revival: Angels & Demons** *Prof. Henry WONG* *(Hong Kong)* **From Surgery to Recover: Impact of Postoperative Complications After Cardiac Surgery** *Prof. Sophia CHEW* *(Singapore)*	**Salon 2-3, 20/F** **Formal Project Prize Session** Moderator: *Dr. Louisa YUEN* *(Hong Kong)* *Judges:* *Dr. Steven WONG* *(Hong Kong)* *Prof. Stanley WONG* *(Hong Kong)* *Dato' Dr. Chow-Yen YONG* *(Malaysia)*	**Salon 4, 20/F** **W2: Airway Workshop** Moderator: *Dr. Michael WAN* *(Hong Kong)* *Facilitators:* *Dr. Clara CHONG* *Dr. Lawrence CHU* *Dr. Vito HO* *Dr. Kitty LAM* *Dr. Adrian TAN* *Dr. Matthew WONG* *Dr. Justine YAU* *(Hong Kong)*
15:30 – 16:00	**Pre-Function Area of Crystal Court, 19/F** Coffee Break and Healthcare Industry Exhibition			
16:00 – 17:30		**Crystal Court I** **Critical Care Symposium** Moderators: *Dr. Irving TENG* *Dr. Bryan LEE* *(Hong Kong)* **Prioritizing Safety in Early Sepsis Management** *Prof. Lowell LING* *(Hong Kong)* **Cardiogenic Shock in 2026: From Guideline-Based Staging to Echocardiography-Guided Phenotyping** *Dr. Wincy NG* *(Hong Kong)* **Postoperative Care of Cardiac Surgical Patients** *Dato' Dr. Chow-Yen YONG* *(Malaysia)*	**Salon 2-3, 20/F** **Round Table Discussion: Management of Trauma-Induced Coagulopathy** Moderators: *Dr. Jane KO* *Dr. Swan LAU* *(Hong Kong)* *Panelists:* *Dr. Tsz-Ha TANG* *Dr. Rock Yuk-Yan LEUNG* *Dr. Ralph LEE* *(Hong Kong)*	



Scientific Programme

31 October 2026 (Saturday)

17:30 – 18:00	**Pre-Function Area of Crystal Court, 19/F** Cocktail Reception for HKCA Congregation
18:00 – 19:30	**Crystal Court II** HKCA Congregation
19:30 – 22:00	**Crystal Court I** Conference / Congregation Dinner

Formal Project Prize Session	
Innovative Approach for Implementation of Structured Positive Psychology Interventions to Improve Wellbeing and Resilience Amongst Anesthesiologists in Hong Kong	*Dr. Stacie Yeung-Yan HOI (Hong Kong)*
A Non-Inferiority Clinical Audit: Evaluating A New Opioid and Catheter Sparing Multimodal Perioperative Analgesic Protocol Versus the Previous Intravenous Patient Controlled Analgesia (IV PCA) And Regional Anesthesia Based Protocol for Total Knee Arthroplasty	*Dr. Fung HUNG (Hong Kong)*
Comparing Analgesic Efficacy and Quality of Recovery of Bi-Level and Single-Level Erector Spinae Plane Block for Open Inguinal Hernia Repair Surgery - A Randomised, Observer-Blinded Active-Controlled Trial	*Dr. Patricia Kit-Ying IP (Hong Kong)*
Effect Of Intertransverse Process Block on The Quality of Recovery Post-Open Hepatectomy: A Pilot Non-Randomized Study of Intervention	*Dr. Vicki Wing-Sum LI (Hong Kong)*
Diagnosis Using 4AT (Chinese), Incidence and Risk Factors of Post-Operative Delirium in Geriatric General Surgical Patients: A Prospective Study at A Tertiary Centre in Hong Kong	*Dr. Jessica Jie-Xi YU (Hong Kong)*

Scientific Programme

1 November 2026 (Sunday)

Venue: Crystal Court, 19/F and Salons, 20/F, Hopewell Hotel, Hong Kong

08:00 – 09:00	**Pre-Function Area of Crystal Court, 19/F** Registration			(08:00-08:45) **Pre-Function Area of Salons, 20/F** **W8: HKCA Welfare Workgroup Workshop "Reset & Recharge - Morning Energizing Yoga"** *Instructor:* *Dr. Katherine LAM* *(Hong Kong)*
09:00 – 10:30	**Crystal Court II** **Plenary Session 2** *Moderators:* *Prof. Won-Joo CHOE* *(South Korea)* *Dr. Timmy CHAN* *(Hong Kong)* **Patient Safety is Eternal Theme of Anaesthesia and Perioperative Management** *Prof. Li-Ze XIONG* *(China)* **Artificial Intelligence and Patient Safety** *Prof. Hyung-Chul LEE* *(South Korea)* **Healing the Healers: Wellbeing and Psychology Safety as Foundations for Patient Care** *Dr. Albert CHAN* *(Hong Kong)*	**Crystal Court I** **Medicolegal Symposium** *Moderators:* *Dr. Vivian LAU* *Dr. Louisa YUEN* *(Hong Kong)* **Medical Council Reform: Key Changes and Potential Impact** *Ms. Jaime LAM* *(Hong Kong)* **The Dos and Dont's of Giving Evidence, And Preparing Medical and Expert Reports** *Ms. Hiu-Yee CHUNG* *Ms. Oonagh TONER* *Mr. Jason WU* *(Hong Kong)*	**Salon 4, 20/F** **W3: Regional Workshop** *(Sponsored by Aspen Pharmacare Asia Limited)* Moderators: *Dr. Morgan CHAN* *Dr. Tom CHAN* *(Hong Kong)* *Facilitators:* *Prof. Eric ALBRECHT* *(Switzerland)* *Dr. Tim CHAN* *(Singapore)* *Dr. Michelle CHONG* *(Australia)*	
10:30 – 11:00	**Pre-Function Area of Crystal Court, 19/F** Coffee Break and Healthcare Industry Exhibition			
11:00 – 12:30	**Crystal Court II** **Regional Symposium** Moderators: *Dr. Morgan CHAN* *Dr. Matthew WONG* *(Hong Kong)* **Selective Nerve Blocks for Shoulder Pain and Revisiting Recovery Outcomes** *Dr. Michelle CHONG* *(Australia)* **Regional Anaesthesia for Arteriovenous Fistula Surgery** *Dr. Tim Chi-Ho CHAN* *(Singapore)* **Enhancing Analgesia in Regional Blocks: An Evidence-Based Guide to Additives** *Prof. Stanley WONG* *(Hong Kong)*	**Crystal Court I** **Pain Symposium** Moderators: *Dr. Yiu-Chung LAU* *Dr. Aaron LEE* *(Hong Kong)* **Pain Integration for ERAS Success: Insights from a Dedicated Cancer Centre in Australia** *Prof. Jamie YOUNG* *(Australia)* **Update on the Management of Trigeminal Neuralgia** *Dr. Timmy CHAN* *(Hong Kong)* **Advancing Safety, Governance, and Clinical Quality in Pain Medicine: Systems-Level Initiatives from the Faculty of Pain Medicine (FPM)** *Prof. Michael VELTMAN* *(Australia)*	**Salon 4, 20/F** **W4: Advanced Transthoracic Echo and Basic Transesophageal Echo Workshop** Moderators: *Dr. Daniel YIP* *Dr. Bryan LEE* *(Hong Kong)* *Facilitators:* *Prof. Yau-Wai CHAN* *Dr. Dickson CHEUNG* *Dr. Jason LAI* *Dr. Wincy NG* *Dr. Timothy YANG* *(Hong Kong)*	**Salon 5, 20/F** **W5: Anaesthesia Game** Moderators: *Dr. Emily MA* *Dr. Louisa YUEN* *(Hong Kong)*
12:30 – 13:30	**Crystal Court II** **Lunch Symposium** *(Sponsored by Viatris Healthcare Hong Kong Limited)* Moderator: *Dr. Justine YAU* *(Hong Kong)* **Foundations of ERAS: Why Legacy Non-Opioid Adjuncts Remain Essential in the Perioperative Period** *Prof. Chi-Wai CHEUNG* *(Hong Kong)*			

Scientific Programme

1 November 2026 (Sunday)

13:30 – 15:00	**Crystal Court II** **TIVA Symposium (WCIVA)** Moderators: *Dr. Yiu-Chung LAU* *Dr. Katherine LIU* *(Hong Kong)* **Advances in PKPD models -Propofol, Remifentanil and Dexmedetomidine** *Prof. Timothy G. SHORT* *(New Zealand)* **From Target-Controlled Infusion to Intelligent Closed-Loop Systems** *Prof. Thomas M. HEMMERLING* *(Canada)* **Clinical Risk Management: Proactive Systems for Patient and Staff Safety** *Prof. Quirino PIACEVOLI* *(Italy)*	**Crystal Court I** **Obstetrics Symposium (WCIVA)** Moderators: *Dr. Max LAU* *Dr. Keith YEUNG* *(Hong Kong)* **Beyond Neuraxial: TIVA for the High-Risk Parturient at Cesarean Delivery** *Prof. Edgard M. SIMON* *(Philippines)* **What's New in Obstetric Anesthesia?** *Dr. Frances LUI* *(Hong Kong)* **Ever-Increasing Incidence of Postpartum Haemorrhage - What Went Wrong?** *Dr. Wing-Cheong LEUNG* *(Hong Kong)*	**Salon 3-4, 20/F** **Non-Operating Room Anaesthesia (NORA) Symposium (WCIVA)** Moderators: *Dr. Aaron LEE* *Dr. Matthew WONG* *(Hong Kong)* **TIVA in Interventional Cardiology: Precision, Flexibility, and Safety Beyond the Operating Room** *Prof. Suraphong LORSOMRADEE* *(Thailand)* **Paediatric NORA: Not Just Adult NORA in a Smaller Patient** *Dr. Vansie KWOK* *(Hong Kong)* **Into the Deep: Navigating the Waters of Remote Location Anaesthesia in Private Practice** *Dr. Wesley LEUNG* *(Hong Kong)*	
15:00 – 15:30	**Pre-Function Area of Crystal Court, 19/F** Coffee Break and Healthcare Industry Exhibition			
15:30 – 17:00	**Crystal Court II** **Neuroanaesthesia Symposium (WCIVA)** Moderators: *Dr. Emily MA* *Dr. Daniel YIP* *(Hong Kong)* **Translational Research of Perioperative Stroke: Current Status and Prospects** *Prof. Li-Ze XIONG* *(China)* **Interpreting Movements During General Anesthesia: The Efference Copy Network and Links to Accidental Awareness** *Prof. Jaideep PANDIT* *(United Kingdom)* **Resuscitation Science, Brain Injury, and Anaesthesia: What Anaesthesiologists Need to Know** *Prof. Bernd Walter BÖTTIGER* *(Germany)*	**Crystal Court I** **Paediatrics Symposium (WCIVA)** Moderators: *Dr. Calvin LIU* *Dr. Rebecca YIM* *(Hong Kong)* **Optimizing EEG and Density Spectral Array (DSA) Monitoring During Total Intravenous Anaesthesia in Paediatric Patients: Practical Interpretation and Clinical Applications** *Dr. Owais Ahmed Mohamed RAFIQ* *(Kingdom of Bahrain)* **Beyond Individual Heroics: Building Institutional Preparedness for the Paediatrics (and Adults) "Cannot Intubate, Cannot Oxygenate" Crisis** *Dr. Rowena LEE* *(Hong Kong)* **Seeing is Believing: Enhancing Safety through Paediatric Anesthesia-Radiology Collaboration** *Dr. Kevin FUNG* *(Hong Kong)*	(15:15-17:00) **Salon 3-4, 20/F** **Free Paper Presentation** Moderator: *Dr. Jessica YU* *(Hong Kong)* *Judges:* *Prof. Sophia CHEW* *(Singapore)* *Dr. Daniel J. COLE* *(USA)* *Dr. Benny CHENG* *(Hong Kong)* *Dr. Albert CHAN* *(Hong Kong)*	**Salon 5, 20/F** **W6: Advanced Haemodynamic Monitoring Workshop** Moderator: *Dr. Swan LAU* *(Hong Kong)* *Facilitator:* *Prof. Suraphong LORSOMRADEE* *(Thailand)*
17:00 – 17:30	**Crystal Court II** Closing Ceremony			
Evening	**Personalised and Precision Medicine: Advanced Hemodynamic Workshop & Dinner** *(Sponsored by Becton Dickinson Asia Limited)* *(By invitation only)*			



Scientific Programme

1 November 2026 (Sunday)

Free Paper Presentation Session	
Ab. 2 Improvement In Glottic View When Using the Upper Trunk Back-Up Position in Difficult Video Laryngoscopy: A Prospective Observational Study	*Prof. Jiwon HAN (South Korea)*
Ab. 3 A Prospective Comparison Between Mallampati Classification and Friedman's Tongue Positions for Airway Assessment and Their Correlation with Cormac-Lehane Grading	*Dr. Sohan Lal SOLANKI (India)*
Ab. 4 Perioperative Intravenous Methadone for Elective Intra-Abdominal General Surgery: A Retrospective Case-Matched Service Evaluation	*Dr. Ho-Hin LAM (Hong Kong)*
Ab. 5 High-Flow Nasal Oxygenation Reduces Emergence Cough and Accelerates Recovery during Laryngeal Microsurgery	*Dr. Jiyoung PARK (South Korea)*
Ab. 6 Effects of IPACK Combined with ACB on Sleep Quality and Cognitive Function in Elderly Patients Undergoing Total Knee Arthroplasty	*Dr. Zhao XU (China)*
Ab. 8 A Randomised Controlled Double-Blind Study to Compare Ketamine-Dexmedetomidine Versus Ketamine-Propofol Combinations for Opioid Free Anesthesia in Patients Undergoing Brachial Plexus Injury Repair	*Dr. CHAREN R (India)*
Ab. 10 Focused Echocardiography to Detect Preoperative Hypovolemia as A Predictor of Post Induction Hypotension; A Prospective Observational Feasibility Study	*Dr. AJAAI GOGULAN P (India)*
Ab. 11 Surveillance of Troponin T and NT-proBNP for Predicting the Risk of Major Adverse Cardiovascular Events (MACEs) in Patients Undergoing Non-Cardiac Surgery	*Dr. ABINAYAA KALIDOSS (India)*
Ab. 12 Assessing Mechanical Versus Cardiopulmonary Functional Capacity Before Major Surgery: A Retrospective Study of CPET, 15 seconds Sit-to-Stand test, and Hand-Grip Strength	*Dr. Peter Wang-Ngai YAU (Hong Kong)*
Ab. 13 Association Between Persistent Opioid Use and Health Outcomes After Gastrointestinal Cancer Surgery: A Population-Based Retrospective Cohort Study	*Mr. Martin Ming-chi SUEN (Hong Kong)*

The programme is subject to change without prior notice.



Optional Workshops

W1: Nursing Workshop

Date: 31 October 2026
Time: 11:00 – 12:30
Fee: Included in Nursing Symposium

This hands-on intubation workshop elevates nurses' airway management skills through immersive simulation. Master direct and video laryngoscopy, patient positioning, device selection and safe endotracheal intubation-while building a systematic approach that includes thorough pre-intubation preparation and proper equipment usage. Practice in a safe and supportive environment. Walk out with enhanced procedural confidence, sharper clinical judgment and the ability to lead decisively during airway emergencies. This is your opportunity to transform theoretical knowledge into simulation practice. Spots are strictly limited-claim yours today.

W2: Airway Workshop

Date: 31 October 2026
Time: 14:00 – 15:30
Fee: HK$ 1,500

This advanced airway workshop is built for Specialist Anaesthetists, with multiple hands-on stations delivering a blend of expert insight and practical training to sharpen skills in modern airway management. With a strong focus on videolaryngoscopy, front-of-neck access, and the SALAD technique, the session is designed to strengthen first-pass success, enhance performance in contaminated airways, and support decisive action when every second counts.

W3: Regional Workshop – Upper & Lower Limb Blocks

Date: 1 November 2026
Time: 09:00 – 10:30
Fee: HK$ 1,500

This dedicated workshop offers a comprehensive, hands-on approach to mastering ultrasound-guided regional anaesthesia techniques for both upper and lower limb blocks. Rotating through practical stations led by our international expert faculty, participants will refine their skills in anatomical identification using live model scanning and leave with enhanced procedural competence and practical salvage strategies.



Optional Workshops

W4: Advanced Transthoracic Echo and Basic Transesophageal Echo Workshop

Date: 1 November 2026
Time: 11:00 – 12:30
Fee: HK$ 1,500

Join us for an interactive echocardiography workshop designed for anaesthesiologists who want to build confidence in practical perioperative ultrasound. Through three focused stations — valvular assessment, LV/RV quantitative assessment, and TEE simulation — you'll practise core scanning techniques, refine image interpretation, and explore clinically relevant applications for everyday anaesthetic practice.

You'll gain:
- Hands-on practice on a real patient model for transthoracic assessments
- Dedicated time on a high-fidelity TEE simulator to develop safe, structured TEE skills
- Expert faculty offering real-time feedback and practical clinical pearls
- A small-group setting that encourages questions and skill-building at your own pace

W5: Anaesthesia Game – Escape Room

Date: 1 November 2026
Time: 11:00 – 12:30
Fee: FREE (Subject to limited quota)

Escape Room: Obstetrics

This interactive, game-based learning session is designed to reinforce and enhance participants' competence in obstetric crisis management, aligned with current best practices. Participants will be divided into teams and immersed in a series of realistic obstetric scenarios that require timely recognition of key clinical issues and formulation of appropriate anaesthetic management plans.

Through a dynamic "escape room" format, teams will work collaboratively under time pressure to solve clinical challenges, simulating real-world decision-making in obstetric emergencies. The session fosters active engagement, encourages peer-to-peer learning, and strengthens participants' ability to apply clinical knowledge under pressure while refining teamwork and communication in crisis situations.

W6: Advanced Haemodynamic Monitoring Workshop

Date: 1 November 2026
Time: 15:30 – 17:00
Fee: HK$ 1,500

This interactive workshop offers an unparalleled learning experience through intimate small-group teaching led by a distinguished overseas expert. Engage with complex case-based scenarios that challenge your clinical reasoning in high-risk cases. Our international faculty will guide you in interpreting the latest technological advancements and translating cutting-edge data into actionable perioperative strategies. Leave this session with refined skills and updated clinical perspectives, equipping you to become a potential trainer in advanced haemodynamic monitoring.

Optional Workshops

W7: Pre-Meeting Workshop: ADAM Airway Instructor Workshop

Venue: Hong Kong Academy of Medicine
Date: 30 October 2026
Time: 14:00 – 17:00
Fee: HK$ 1,500
Workshop Director: Prof Yau-Wai CHAN
Facilitators:
Dr. Chin-Chin CHAN
Dr. Kevin CHAN
Dr. Morgan CHAN
Dr. Wesley CHU
Dr. Shing KO
Dr. Bryan LEE
Dr. Rowena LEE
Dr. Michael WAN
Dr. Oi-Fung WONG
Dr. Justine YAU

Designed for airway instructors and fellows with an interest in updating advanced & difficult airway management skills delivered in HKCA ADAM-A workshops. This workshop advances clinical proficiency and instructional capability in advanced airway training. Participants will rotate through the core airway skills stations, including video-laryngoscopes, new supraglottic devices, front-of neck access, flexible and rigid intubation scopes, lung isolation devices and paediatric airway devices. This workshop equips current and prospective instructors with the standardized skills & expected techniques to lead institutional training and elevate departmental standards. It represents a strategic investment in professional development, fostering excellence in patient safety and the cultivation of airway leaders.

W8: HKCA Welfare Workgroup Workshop "Reset & Recharge - Morning Energizing Yoga"

Date: 1 November 2026
Time: 08:00 – 08:45
Fee: FREE (Subject to limited quota)
Instructor: Dr Katherine LAM MBChB FHKCA FANZCA FHKAM (Anaesthesiology)

Enjoy a short session of yoga to energise yourself before the start of the academic lectures!

The workshop is completely beginner-friendly and consists of 45 mins of simple stretches and movements, performed in the sitting position (on a chair or on a floor sitting mat) and in the standing position. The practices will be targeted to the anaesthetist's daily work practice, to help with back and neck stiffness and the general lack of exercise. Learn breathing exercises as well to help calm yourself in our stressful work practice.

Registrants who signed up and attended the workshop can take home a 40 x 60cm sitting mat which can also be used on top of a regular mat for non-slip practices for the hands or for extra padding for the knees (while stock lasts - we have 15!). Wear comfortable clothes that can allow good range of movements, such as T-shirts and long pants. Walk-in participants can be entertained if we still have space.



Optional Workshops

W9: Pre-Meeting Workshop: Advanced Haemodynamic Monitoring PBLD

Venue: Hong Kong Academy of Medicine
Date: 30 October 2026
Time: 09:00 – 12:00
Fee: HK$500 per 1-hour Session

This intensive Problem-Based Learning Discussion (PBLD) combines cutting-edge device demonstrations with three sequential, high-fidelity case scenarios. Led by distinguished international and local experts, each 60-minute session tackles a distinct high-risk surgical case. Participants will engage in deep-dive discussions to interpret simulation-based advanced haemodynamic parameters to guide individualized interventions in a collaborative, small-group setting.

Overall aim: To establish a structured, physiology-based approach to the intraoperative management of high-risk surgeries, utilizing advanced hemodynamic monitoring to guide fluid optimization, vasoactive therapy, and goal-directed blood-product administration.

PBLD 3: Intraoperative Management of Patients Undergoing Laparoscopic Liver Tumour Resection
Time: 09:00 – 10:00
Fee: HK$500

PBLD 2: Intraoperative Management of Patients Undergoing Elective Open Repair of Abdominal Aortic Aneurysm
Time: 10:00 – 11:00
Fee: HK$500

PBLD 1: Intraoperative Management of Patients Undergoing Elective VAT Esophagectomy
Time: 11:00 – 12:00
Fee: HK$500



Optional Workshops

W10: Pre-Meeting Workshop: TIVA unlocked - From Marsh to Eleveld TCI to Closed-Loop Anaesthesia Delivery (CLADS)

Venue: Hong Kong Academy of Medicine
Date: 30 October 2026
Time: 09:00 – 13:00
Fee: HK$1,500
Facilitators:

Prof Goverdhan Dutt PURI (India)
Prof Manoj KAMAL (India)
Dr Tanvir SAMRA (India)
Dr Sekar L (India)
Dr Sahil GARG (India)
Dr Jijo FRANCIS (India)
Dr Naveen Naik BANAVATHU (India)
Dr Venkata GANESH (India)
Dr Soumya SARKAR (India)

Target Participants:
Anaesthesiologists, intensivists, and anaesthesia/ICU trainees

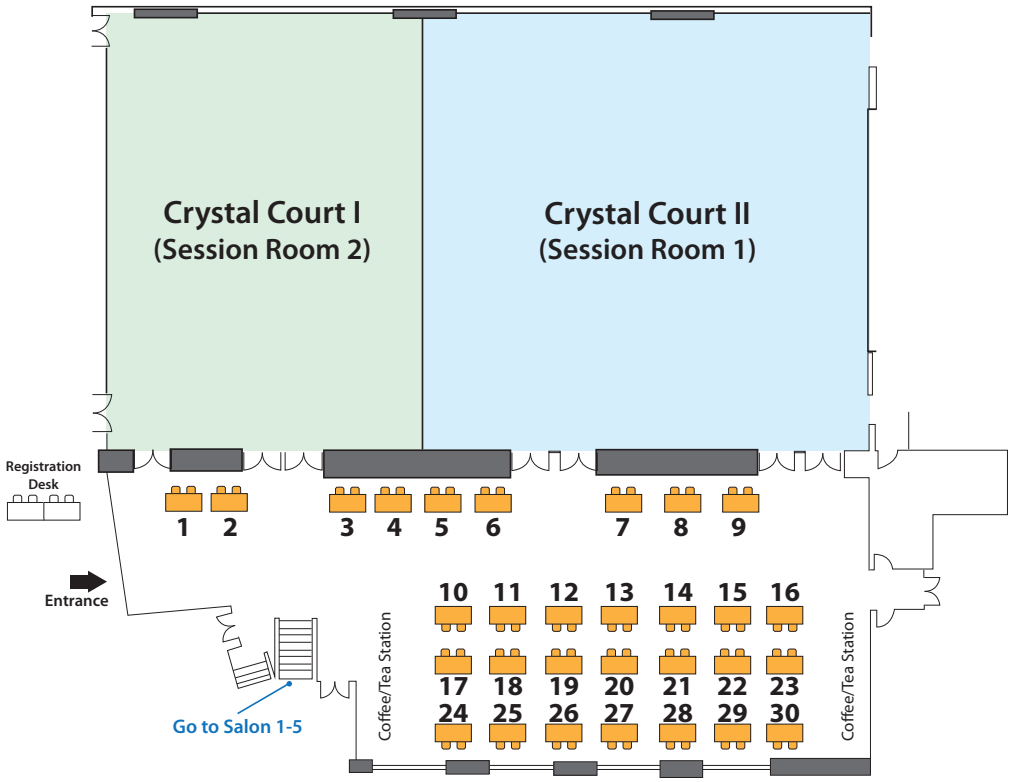
Overall Aim
Designed to advance personalized care in Total Intravenous Anesthesia (TIVA), this workshop bridges pharmacokinetic (PK) and pharmacodynamic (PD) principles with practical bedside application. Through focused didactics, small group hands-on stations, and clinical case discussions, participants will master three core delivery techniques: manual infusion, computer-driven Target-Controlled Infusion (TCI), and Closed-Loop Anesthesia Delivery Systems (CLADS). Equal emphasis is placed on EEG interpretation and depth-of-anaesthesia monitoring, empowering clinicians to titrate intravenous agents safely and intelligently.

Learning Objectives
By the end of the session, participants should be able to:
- **Execute** manual propofol infusion regimens safely across pediatric, adult, and geriatric populations.
- **Operate** Target-Controlled Infusion (TCI) systems using both plasma and effect-site targeting modes.
- **Apply** Eleveld universal PK-PD model to titrate propofol, remifentanil, and dexmedetomidine accurately.
- **Demonstrate** the clinical workflow and application of Closed-Loop Anesthesia Delivery Systems (CLADS).
- **Interpret** depth-of-anesthesia monitoring and processed EEG to guide intelligent agent titration.
- **Perform** passive TIVA administration techniques effectively in clinical practice.

The programme of workshops is subject to change without prior notice.

Venue & Exhibition Floor Plan

Crystal Court, 19/F, Hopewell Hotel



Exhibitors	Table No.
A. Menarini Hong Kong Ltd.	25
Abbvie Limited	5
Aspen Pharmacare Asia Limited	10
B. Braun Medical (H.K.) Ltd.	21
Baxter Healthcare Ltd.	20
Becton Dickinson Asia Limited	3
CSL Behring Asia Pacific Ltd.	12
Draeger Hong Kong Limited	17
Fisher & Paykel Healthcare Ltd	19
Fresenius Kabi Hong Kong Ltd.	14
Getinge Group Hong Kong Ltd.	15
ICU Medical	30
KARL STORZ Endoscopy China Ltd.	2
Legend Master Technology Ltd.	4
Linde HKO Ltd.	28

Exhibitors	Table No.
Masimo Hong Kong Limited	11
Médecins Sans Frontières Hong Kong	27
Medtronic Hong Kong Medical Ltd.	1
Merck Sharp & Dohme (Asia) Ltd.	6
Mölnlycke Health Care Hong Kong Ltd.	26
Pacific Medical Systems Limited	22
Philips Electronics Hong Kong Ltd.	16
Prism Technologies Limited	29
Shenzhen Mindray Bio-Medical Electronics Co., Ltd.	9
Shun On Healthcare Limited	23
Solar-Med Limited	13
Solventum	18
Sunshine Medical Supplies Ltd.	8
United Italian Corp. (HK) Ltd.	24
Viatris Healthcare Hong Kong Ltd.	7

Plenary Session 1



31 October 2026 (Saturday) | 09:00 – 10:30

Prof. David STORY

Immediate Past-President, Australian and New Zealand College of Anaesthetists (ANZCA), Australia

Perioperative Medicine: A Move towards Greater Safety

The broad aims of health care are to continually improve four aspects: 1) individual patient journeys; 2) public health; 3; value; and 4) health care workforce wellbeing. Perioperative medicine programs should aim to improve all four aspects.

Perioperative medicine is the science and practice of working with patients from the moment surgery is contemplated, to optimise their health and wellbeing, minimise the risk of perioperative complications, and facilitate optimal recovery, underpinned by shared decision making. Through all phases of the patient's journey, perioperative medicine complements the decision making and care delivered by others.

The London Declaration signed by many leading anaesthesiology organisations states: *"Good perioperative care improves patient recovery, reduces the personal and societal burden of avoidable postoperative harm and delivers healthcare efficiency and productivity. Meeting this global challenge demands international collaboration - supporting and empowering patients, investing in a skilled multiprofessional healthcare workforce, and strengthening partnerships to drive better outcomes for all".*

Depending on the hospital and the nature of procedures and patient characteristics other perioperative medical specialists include community medicine practitioners, pain medicine physicians, geriatricians, intensivists, and rehabilitation physicians. The broader Perioperative Care Team includes all individuals who may be involved in a patient's perioperative journey. This may include doctors, nurses and other health professionals in hospitals or clinics, as well as family members or other carers. Importantly, allied health practitioners include physical physiotherapists, pharmacists, and exercise physiologists.

The phases of the patient journey include the preoperative period which should consider the best option for a patient including not-operating and may also include prehabilitation. Enhanced recovery (ERAS) programs have an important role to play with emphasis on the endpoints of drinking, eating, and mobilising (DrEaMing). Pain medicine is a vital part of perioperative medicine.

Plenary Session 1

31 October 2026 (Saturday) | 09:00 – 10:30



Dr. Daniel J. COLE

President, Anesthesia Patient Safety Foundation, USA

A Global Perspective on Perioperative Safety

Perioperative care is entering a new era—one in which success is defined not simply by survival of an operation, but by preserving health, function, cognition, and independence across the entire surgical journey. This lecture presents a global perspective on perioperative patient safety, with particular attention to the population of older adults and the shared challenges facing Hong Kong and the United States.

Using the journey of "Alex," a 75-year-old surgical patient, the presentation illustrates how a single preventable complication can alter the trajectory of an older person's life. It examines the burden of chronic disease, frailty, diminished physiologic reserve, and age-related changes in the brain that increase vulnerability to perioperative stress. Postoperative delirium is highlighted as a common, costly, and frequently preventable complication, with important consequences including functional decline, prolonged hospitalization, loss of independence, and possible acceleration of cognitive deterioration.

The lecture emphasizes that frailty and cognitive screening provide meaningful information before surgery. It reviews practical strategies across the perioperative continuum of care. Surgery is also considered a potential "brain stress test" that may reveal underlying vulnerability and create an opportunity for longer-term assessment and intervention.

Finally, the presentation explores how medical imaging, healthcare analytics, conversational artificial intelligence, personalized treatment, continuous monitoring, and wearable technologies may reshape perioperative care. Their value lies not in the technology itself, but in connecting data, anticipating risk, supporting decisions, and enabling timely action. The central message is that knowledge becomes meaningful only when it changes practice. By expanding our focus from the operative episode to the patient journey, perioperative teams can prevent harm and help older adults return home with their cognition, function, and independence preserved.

Plenary Session 1

31 October 2026 (Saturday) | 09:00 – 10:30



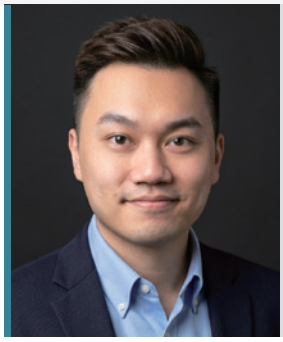
Prof. Chi-Tim HUNG

Professor of Practice in Health Services Management, The Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong, Hong Kong

East Meets West in Leadership

The understanding of leader and leadership has changed quite substantially in the last century especially after the Second World War with the advent of the humanistic theory and the rise of followership. The western literature sees an abundance of leadership theories and new leadership theories, some of which relates more to a way of life, or the characters/behaviours one should possess, especially in leadership positions. As it gets more and more into the philosophical arena, it would be interesting to compare the leadership behaviours as proposed by Chinese scholars such as the Taoist and the Confucian. Applying the philosophical context will help us to understand the leader/follower duality, which is a key concept one should grasp when aspiring to get into leadership positions. This talk will cover the various key leadership theories with some of my personal insights.

Nursing Symposium



31 October 2026 (Saturday) | 09:00 – 10:30

Dr. Benney YC WONG

Lecturer, School of Nursing, The University of Hong Kong, Hong Kong

AI-Powered VR Simulation to Strengthen Nursing Students' Communication

Effective communication is essential in nursing practice, directly impacting patient safety, interprofessional teamwork, and care quality. Poor communication remains a leading cause of adverse events, yet nursing students frequently report inadequate preparation for complex clinical interactions, particularly patient assessments and handovers. Traditional teaching methods like role-play and standardized patients provide limited structured practice and immediate feedback opportunities.

This educational innovation introduces an AI-powered virtual reality (VR) simulation system designed to bridge this training gap. Developed collaboratively by nursing educators, students, and technical experts, the system features different realistic clinical scenarios addressing communication challenges including difficult patients, interprofessional handovers, and emergencies.

Nursing Symposium

31 October 2026 (Saturday) | 09:00 – 10:30



Ms. Shirley WY NG

Associate Nurse Consultant, Department of Anaesthesia, Pain, and Perioperative Medicine, Queen Mary Hospital, Hong Kong

Bridging the Gap: Comprehensive Pre-and Post-Procedure Nursing Protocols for Image-Guided Pain Interventions

Image-guided pain interventions—ranging from fluoroscopic-guided nerve blocks to ultrasound-assisted radiofrequency ablations—have transformed interventional pain management, delivering precise diagnostic and therapeutic relief to patients with complex chronic pain conditions. However, the ultimate success and safety of these advanced techniques rely heavily on the continuum of nursing care provided before, during, and long after the procedure. In real-world practice, maintaining consistency across pre-procedure preparation, immediate post-procedure monitoring, and ongoing follow-up often requires careful coordination.

This presentation explores the vital role of standardized, comprehensive nursing protocols in bridging these critical care gaps. Pre-procedurally, specialized nursing care extends beyond routine screening to include rigorous risk stratification, optimal anticoagulation management, targeted patient education, and anxiety mitigation. Post-procedurally, structured recovery protocols ensure the immediate detection of potential complications—such as local anesthetic systemic toxicity (LAST), hematomas, or nerve injury.

Beyond the procedure room, the Pain Management Nurse Clinic serves as a crucial bridge for sustained patient care. Through structured follow-up pathways, pain nurses systematically evaluate treatment efficacy, track functional outcomes, and conduct surveillance for late-onset complications. This continuous monitoring framework ensures timely interdisciplinary interventions when treatments wane and provides essential self-management support to patients.

By establishing evidence-based, nurse-led care pathways, pain nurses create a seamless transition across the entire interventional journey. Standardized nursing protocols not only optimize patient safety and clinical outcomes, but also enhance operational efficiency and continuity of care within interventional pain services. Drawing from clinical experience and collaborative Hospital Authority initiatives, this talk highlights practical strategies for developing, implementing, and evaluating nurse-led care pathways for image-guided pain interventions.

Nursing Symposium



31 October 2026 (Saturday) | 09:00 – 10:30

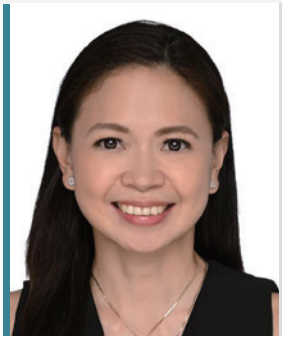
Prof. Yau-Wai CHAN

Honorary Consultant, Queen Mary Hospital, Hong Kong

High Frequency Jet Ventilation (HFJV): An Update

A discussion of the theories, application and limitations of HFJV in modern anaesthesia practice.

Airway Symposium



31 October 2026 (Saturday) | 11:00 – 12:30

Dr. Anna Margarita CORSIGA

Associate Professor, University of the Philippines College of Medicine, Philippines

Safety in Difficult Airway Management of Head and Neck Tumors

The difficult airway scenario is one of the most unsafe settings an anesthesiologist can be in. Yet we are the specialty most relied upon in these situations.

The key to safety and success in difficult airway management, most especially in head and neck tumors, is mastery of basic concepts and knowledge of options. The very basic principles of peri-intubation oxygenation and patient positioning can be life-saving. The more options in airway management you are aware of and are skilled in, on the other hand, translates to greater chances of success. From the very basic tools to the most advanced, from the most basic skill to the most complex – you will find that in airway management, the number of options you have is inversely proportional to your anxiety level. This lecture will navigate through the basics of airway management and will present increasing options in progressively more difficult situations in head and neck tumors while ensuring our patients' safety.

Airway Symposium



31 October 2026 (Saturday) | 11:00 – 12:30

Dr. Deborah KHOO

Senior Consultant Anaesthetist, Department of Anaesthesia, National University Hospital, Singapore

Safety in Paediatric Airway Management

Children can deteriorate rapidly when airway management goes wrong. Limited physiological reserve, unfamiliar anatomy and the rarity of paediatric airway emergencies make **anticipation, preparation and first-pass success** critical.

This session explores how to make paediatric airway management safer—from assessment and preoxygenation to videolaryngoscopy, optimisation of the first attempt and rescue when Plan A fails. We will examine approaches to difficult airways, common causes of airway complications, and discuss how teamwork, cognitive aids and clear airway strategies can reduce harm.

Airway Symposium

31 October 2026 (Saturday) | 11:00 – 12:30



Prof. Yau-Wai CHAN

Honorary Consultant, Queen Mary Hospital, Hong Kong

What Can We Do to Collapse the Lung Better: Techniques and Evidence

To share the various strategies, techniques & evidence to facilitate better lung collapse using double lumen tubes (DLT) & bronchial blockers (BB).

Education, Leadership and Professionalism Symposium

31 October 2026 (Saturday) | 11:00 – 12:30



Dr. Hing-Yu SO

Immediate Past President, The Hong Kong College of Anaesthesiologists, Hong Kong

Staying Competent in a Changing World: What Lifelong Learning Really Takes

Maintaining competence throughout a professional lifetime requires more than accumulating continuing medical education (CME) points. Clinical work continually changes as medicine advances, technologies evolve, and our roles, workplaces and patient populations shift—often demanding capabilities that could not have been anticipated during specialist training. Drawing on my own experiences of lifelong learning, both in clinical medicine and as my professional roles have evolved, alongside contemporary educational principles, this talk explores what it actually takes to remain capable throughout a career.

Staying capable requires clinicians to recognise emerging needs, take ownership of their development, choose learning approaches suited to those needs, seek feedback and support, and continually adapt their practice. This agency and motivation should be nurtured during postgraduate training and sustained throughout professional life—but they cannot depend on individual effort alone. The College and Academy have important roles in creating an environment that enables development rather than simply mandating it. Flexible opportunities, supportive professional communities and sound educational design can make continuing growth both meaningful and achievable.

Technology, e-learning and artificial intelligence offer real opportunities, particularly by improving access, personalising learning and supporting development over time. But these tools amplify good educational design; they do not substitute for it. The challenge, then, is not simply to provide more CME, but to help specialists become effective lifelong learners—equipped and supported to keep evolving with the changing demands of their practice.

Education, Leadership and Professionalism Symposium

31 October 2026 (Saturday) | 11:00 – 12:30



Prof. Gilberto LEUNG

Director, School of Clinical Medicine, The University of Hong Kong, Hong Kong

Introduction of Institute for Medical Advancement and Clinical Excellence (IMACE)

The Institute for Medical Advancement and Clinical Excellence (IMACE) is an independent, professional platform established by the Government of the Hong Kong Special Administrative Region in May 2025 with the mandate to provide guidance on medical practice and health policy. One of its core missions is to develop and disseminate clinical practice guidelines (CPGs) with a view to reducing unwarranted variations in clinical practice, optimising resource utilisation, and improving patient outcome.

This presentation will begin with a discussion about the medicolegal implications of CPGs—whether adherence to CPGs would always provide an effective defence and whether deviation would always amount to negligence—and the future role of the IMACE as a connector between regulation, health economics and health technology assessment within what is, arguably, a system of fragmented governance pertaining to health technology adoption in Hong Kong.

Continued Medical Education Panel Discussion

31 October 2026 (Saturday) | 11:00 – 12:30



Prof. David STORY

Immediate Past-President, Australian and New Zealand College of Anaesthetists (ANZCA), Australia



Dr. Daniel J. COLE

President, Anesthesia Patient Safety Foundation, America



Prof. Sophia CHEW

Senior Consultant, Department of Anaesthesiology, Singapore General Hospital, Singapore



Prof. Hasmizy B. MUHAMMAD

President, Malaysian Society of Anaesthesiologists, Malaysia



Prof. Izumi KAWAGOE

Professor and Chair, Anesthesiology and Pain Medicine, Juntendo University, Japan



Prof. Simon LAM

Professor, Department of Paediatrics, The Chinese University of Hong Kong, Hong Kong



Dr. Simon CHAN

Honorary Consultant, Department of Anaesthesia, Hong Kong Sanatorium & Hospital, Hong Kong

Lunch Symposium

31 October 2026 (Saturday) | 12:30 – 14:00



Dr. Chih-Min LIU

Department of Anesthesia, National Taiwan University Hospital, Taiwan

From Reversal to Recovery: Optimizing Patient Safety Through Modern Neuromuscular Blockade Management – Taiwan Experience, Including DMD and SMA Scoliosis Surgeries

Effective neuromuscular blockade management extends beyond achieving reversal to ensuring safe and complete recovery throughout the perioperative journey. This lecture will explore how modern approaches to neuromuscular blockade management can support patient safety, reliable recovery, and improved perioperative outcomes, with consideration of quantitative neuromuscular monitoring and appropriate reversal strategies. Drawing on clinical experience from Taiwan, Dr Liu will share practical perspectives on incorporating modern neuromuscular blockade management into clinical practice and the broader recovery pathway. The lecture will also highlight experience in managing complex surgical patients, including Duchenne muscular dystrophy (DMD) and spinal muscular atrophy (SMA) patients undergoing scoliosis surgery, providing practical insights and considerations from these challenging cases.

Perioperative Symposium

31 October 2026 (Saturday) | 14:00 – 15:30



Dr. Yee-Eot CHEE

President, The Hong Kong College of Anaesthesiologists, Hong Kong

Advanced Haemodynamic Monitoring: From Parameters to Clinical Decisions

Pending

Perioperative Symposium

31 October 2026 (Saturday) | 14:00 – 15:30



Dr. Ralph LEE

Associate Consultant, Princess Margaret Hospital / Yan Chai Hospital, Hong Kong



Dr. Kin-Chung TSE

Consultant Anaesthetist, Tseung Kwan O Hospital, Hong Kong

Optimising Bleeding Management with Fibrinogen Replacement

Severe perioperative bleeding remains a major cause of morbidity, driven by rapid dilutional coagulopathy and consumption in which plasma fibrinogen is the first coagulation factor to fall to critically low levels. Traditional standard laboratory assays are limited by delayed turnaround times and inaccuracy during active resuscitation. Viscoelastic haemostatic assays (VHAs), offer real-time point-of-care evaluation of fibrin-based clot firmness, allowing clinicians to distinguish true fibrinogen deficits from thrombocytopenia at the bedside.

Implementing VHA-guided goal-directed transfusion protocols significantly reduces overall blood component requirements, and potential exposure to allogeneic fresh frozen plasma (FFP) and its associated complications.

Fibrinogen concentrate allows rapid and VHA-guided dosing in minimal infusion volume without the delays of thawing or cross-matching, thereby mitigating transfusion-associated circulatory overload and immune-mediated risks.

This talk explores the clinical rationale, diagnostic algorithms, and case sharing of integrating VHA monitoring with targeted fibrinogen replacement to establish precision patient blood management protocols and its potential in improving patient safety in the patient blood management.

Patient blood management (PBM) is a patient-centred, systematic and evidence-based approach that aims to improve outcomes by managing and preserving patients' own blood while promoting safety and patient empowerment. The Hong Kong Society of Clinical Blood Management updated its previous consensus to incorporate recent evidence and clinical experience and provide a practical framework for clinicians in Hong Kong and the Asia-Pacific region.



Perioperative Symposium

31 October 2026 (Saturday) | 14:00 – 15:30

A multidisciplinary expert panel used a modified Delphi process incorporating a literature review, subgroup discussions, anonymous electronic voting and final consensus review. Of 118 proposed statements, 117 achieved acceptance, defined as ≥80% agreement. Recommendations were structured around three core PBM pillars: optimisation of red blood cell mass and anaemia management, minimisation of perioperative blood loss, and rational use of blood and blood components. Key implementation priorities include early detection and treatment of iron-deficiency anaemia, patient education and shared decision-making, point-of-care coagulation testing, appropriate haemostatic therapy, anticoagulant reversal strategies, and restrictive single-unit transfusion where clinically appropriate.

The updated consensus provides a multidisciplinary framework spanning the perioperative pathway and diverse patient populations. Future development should broaden specialty and patient participation and strengthen collaboration with professional bodies and health authorities to advance PBM implementation.

Perioperative Symposium



31 October 2026 (Saturday) | 14:00 – 15:30

Prof. Eric ALBRECHT

Director, Regional Anesthesia Program and the Clinical Research Program, University Hospital of Lausanne, Switzerland

Perioperative Sleep Apnea Management

Consequences of OSA span metabolic syndrome, cardiovascular disease, stroke, road traffic accidents, depression and mortality. Diagnosis rests on polysomnography, with apnoea defined as cessation of airflow beyond 10 seconds and severity graded by the apnoea–hypopnoea index (mild 5–15, moderate 16–30, severe >30 events/h). Treatment options include weight loss, CPAP, mandibular advancement devices and surgery.

Perioperatively, OSA predicts difficult airway management and 30-day complications. Registry data on 349,008 hip arthroplasties showed adjusted odds ratios of 1.98 for pulmonary and 1.53 for any complication. Screening tools are compared: the Berlin questionnaire, STOP-BANG (derived in 211 patients) and NoSAS (derived in 2121 patients), with NoSAS showing superior positive predictive value. HypnoLaus data from Switzerland confirm high community prevalence (moderate-to-severe sleep-disordered breathing in 50% of men and 23% of women aged over 40).

Literature shows that short-acting anaesthetic agents did not reduce postoperative AHI. Intrathecal morphine did not worsen AHI on any postoperative night. Oxycodone and tramadol produced comparable AHI. Pooled data from 120 patients showed AHI falling on night 1 and rising on night 3, irrespective of general or spinal anaesthesia.

The take-home message challenges routine intermediate care admission on night 1, since risk appears to shift to night 3. Ongoing work (PoMAD, negative for mandibular advancement devices) and the planned SADEX trial address that unresolved gap.

Cardiothoracic Symposium

31 October 2026 (Saturday) | 14:00 – 15:30



Prof. Izumi KAWAGOE

Professor and Chair, Anesthesiology and Pain Medicine, Juntendo University, Japan

Updates on TIVA in Thoracic Procedures

Total Intravenous Anesthesia (TIVA) is often preferred in thoracic anesthesia and typically involves propofol, remifentanil, and rocuronium, largely because one-lung ventilation is required. Over the past two decades, there's been ongoing debate over whether to use intravenous or inhalational anesthetics in thoracic procedures, but strong evidence is still lacking.

We have more than 700 thoracic cases annually. I tend to favor TIVA for thoracic cases not only due to HPV considerations, but also because it pairs exceptionally well with various forms of regional anesthesia, including epidural and peripheral nerve blocks. I'd like to explain why this combination is so effective. I also find TIVA advantageous for patients with certain organ dysfunctions, such as respiratory, renal, or hepatic issues. Furthermore, since Remimazolam became available in 2020, I'd like to share our experience using it in thoracic surgery and present our clinical research in thoracic anesthesia.

31 October 2026 (Saturday) | 14:00 – 15:30



Prof. Hasmizy B. MUHAMMAD
President, Malaysian Society of Anaesthesiologists, Malaysia

Revisit Volatile versus TIVA in Cardiac Surgery

The debate between **Volatile Anesthetics** (e.g., sevoflurane, desflurane) and **Total Intravenous Anesthesia (TIVA)** (typically propofol-based) in cardiac surgery centers on myocardial protection, organ preservation, and long-term clinical outcomes.

Volatile Anesthetics

Volatile agents provide a theoretical advantage through anesthetic preconditioning and postconditioning. By opening mitochondrial K_ATPchannels, volatile anesthetics mimic ischemic preconditioning, which helps protect cardiac tissue against ischemia-reperfusion injury during cardiopulmonary bypass (CPB).

- Cardioprotection: Associated with reduced biomarkers of myocardial damage (e.g., lower cardiac troponin levels postoperatively).
- **Hemodynamic Effects:** Promotes vasodilatation and reduces systemic vascular resistance, which can decrease cardiac workload but may require vasopressor support.
- **Clinical Evidence:** While smaller trials demonstrated reductions in postoperative intensive care unit (ICU) length of stay and cardiac morbidity, large-scale randomized controlled trials showed no significant difference in 1-year mortality compared to TIVA.

Total Intravenous Anesthesia (TIVA)

TIVA, primarily using propofol combined with short-acting opioids like remifentanil, offers distinct pharmacokinetic and systemic advantages:

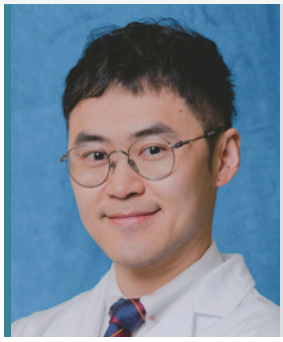
- Anti-inflammatory & Antioxidant: Propofol exerts anti-inflammatory effects and scavenging properties that reduce oxidative stress during reperfusion.
- Organ Protection: TIVA provides smooth anesthetic depth without the respiratory irritant effects of inhalational agents, making it well-suited for patients with severe pulmonary hypertension or non-cardiac comorbidities.
- Hemodynamic Stability: Offers predictable hemodynamics, smooth emergence, and reduced incidence of postoperative nausea and vomiting (PONV).

Current Consensus

While volatile anesthetics offer biochemical evidence of myocardial conditioning, large-scale clinical outcomes—including short- and long-term mortality, stroke, or major adverse cardiac events (MACE)—show minimal hard difference between the two techniques. The choice of anesthetic technique in modern cardiac surgery is largely tailored to individual patient risk profiles, institutional protocols, and surgeon/anesthesiologist expertise rather than a definitive superiority of one over the other.

Cardiothoracic Symposium

31 October 2026 (Saturday) | 14:00 – 15:30



Prof. Henry WONG

Clinical Assistant Professor and Honorary Consultant, Department of Anaesthesia and Intensive Care, Prince of Wales Hospital, Hong Kong

Methadone Revival: Angels & Demons

Conventional perioperative opioid regimens frequently cause fluctuating drug levels, increasing the risk of under/over-dosing, tolerance, and chronic post-surgical opioid dependence. Methadone is undergoing a clinical resurgence as a key component of multimodal analgesia designed to overcome these limitations. Clinical evidence across a wide range of surgical procedures has been favourable in reducing postoperative pain, opioid consumption, and enhances patient satisfaction. Our recent clinical trial on methadone use in cardiac surgery will be presented. It is the first RCT to compare methadone against morphine in cardiac surgery, and one of the few to correlate plasma concentration analysis with acute pain outcomes. Safety concerns surrounding this long-acting opioid will be reviewed based on the currently available literature.

Cardiothoracic Symposium

31 October 2026 (Saturday) | 14:00 – 15:30



Prof. Sophia CHEW

Senior Consultant, Department of Anaesthesiology, Singapore General Hospital, Singapore

From Surgery to Recover: Impact of Postoperative Complications After Cardiac Surgery

Globally, about 1.5 million cardiac surgeries are performed annually. With a rapidly aging population, cardiac anesthesiologists face increasing challenges in managing complex, high risk patients. Recent advances in cardiac anesthesia and advances in technology and surgical expertise have significantly improved outcomes after cardiac surgery.

Nevertheless, despite a technically perfect surgery, patients may suffer complications in the postoperative period which is associated with mortality and morbidity, greatly driving up healthcare costs. Not only do complications impact survival but perhaps, far more important to patients is the long-term disability.

The Society of Thoracic Surgery identifies five major postoperative complications: stroke, renal failure (defined as a threefold or greater rise in creatinine or new dialysis requirement), prolonged intubation (>24 h), unplanned reoperation, and deep sternal wound infection/mediastinitis. While some of these complications may resolve in the short term, renal failure and strokes persist long after the acute surgical event with significant impacts on patients' quality of life.

Acute kidney injury is the most common complication after cardiac surgery and once thought to be a minor aberration in the renal function is now recognized as part of a continuum of renal disease that increases both the risks of chronic kidney disease and end stage renal failure requiring renal replacement therapy. Atrial fibrillation is common following cardiac surgery and increases the risks of both short term and long-term strokes.

Strategies to prevent postoperative complications will focus on what is currently known including perioperative risk profiling, monitoring, emerging technologies for early detection and intervention. Key areas of future strategies will examine the roles of biomarkers, drugs, emerging concepts in the field of perioperative medicine and geroscience. The holistic approach enables the refinement of cardiac anaesthesia practice and ensures patients recover back to their baseline or better after cardiac surgery.

Critical Care Symposium

31 October 2026 (Saturday) | 16:00 – 17:30



Prof. Lowell LING

Clinical Associate Professor, Department of Anesthesia and Intensive Care, The Chinese University of Hong Kong, Hong Kong

Prioritizing Safety in Early Sepsis Management

Antibiotic therapy is an essential treatment for sepsis. Delays in antibiotic treatment is associated with higher mortality, particularly for patients with septic shock. Therefore, clinical guidelines prioritize early broad-spectrum coverage. However, indiscriminate use of broad-spectrum antibiotics may lead to rise in antimicrobial resistance. Furthermore, some studies suggest administration of overly-broad antibiotics may be associated with harm. Antibiotic stewardship and rapid diagnostics are essential strategies to optimize antibiotic therapy and enhance patient safety.

Critical Care Symposium

31 October 2026 (Saturday) | 16:00 – 17:30



Dr. Wincy NG

Associate Consultant, Adult Intensive Care Unit, Queen Mary Hospital, Hong Kong

Cardiogenic Shock in 2026: From Guideline-Based Staging to Echocardiography-Guided Phenotyping

Cardiogenic shock (CS) remains a leading cause of mortality in the intensive care unit, with short-term mortality of 30–40% and one-year mortality approaching 50% despite advances in classification and mechanical circulatory support (MCS). The 2019 SCAI staging system provides a common language for severity and escalation of care but offers limited guidance on mechanism-specific therapy. This presentation argues for a shift from a "one-size-fits-all" staging approach towards an early, phenotype-driven strategy built on echocardiographic and haemodynamic characterisation.

Echocardiography is uniquely positioned as the first-line bedside tool for CS assessment, enabling rapid differentiation of LV-dominant, RV-dominant, and biventricular failure, detection of mechanical complications of myocardial infarction, and identification of under-recognised phenotypes such as dynamic LVOT obstruction and Takotsubo-related shock. A low left ventricular outflow tract velocity–time integral (LVOT VTI) offers an objective, reproducible marker of severely reduced forward flow that informs both diagnosis and the timing of MCS escalation. Integrating echocardiographic phenotyping with invasive haemodynamics (PAC-derived cardiac index, cardiac power output, pulmonary artery pulsatility index) sharpens selection between micro-axial pumps, right-sided support devices, and V-A ECMO, while clarifying an explicit exit strategy for each device.

This talk will present a practical, echocardiography-centred framework for CS diagnosis, monitoring across the different phases of shock (salvage, optimisation, stabilisation, de-escalation), and MCS decision-making, while acknowledging the persistent limitations of echocardiography — operator dependence, limited precision, and unproven independent mortality benefit.



31 October 2026 (Saturday) | 16:00 – 17:30

Dato' Dr. Chow-Yen YONG
President, College of Anaesthesiologists, Academy of Medicine of Malaysia, Malaysia

Postoperative Care of Cardiac Surgical Patients

Learning Outcomes

By the end of this session, participants should be able to:

1. Understand the importance a systematic approach to the immediate postoperative management of the cardiac surgical patient, including safe transfer of care and hemodynamic stabilization.
2. Recognize and respond to common postoperative complications—such as bleeding, acute kidney injury, and neurological changes—at an early stage.
3. Select appropriate evidence-based strategies for vasoactive support, arrhythmia control, and assessment of ventricular function using echocardiography and other advanced monitoring tools.
4. Integrate Enhanced Recovery After Surgery (ERAS) principles in cardiac care, including multimodal analgesia, early extubation, and delirium prevention.
5. Discuss how new technologies are beginning to influence postoperative cardiac care and what this may mean for future practice.

Round Table Discussion: Management of Trauma-Induced Coagulopathy

31 October 2026 (Saturday) | 16:00 – 17:30



Dr. Tsz-Ha TANG

Specialist, Accident and Emergency Department, Queen Elizabeth Hospital, Hong Kong



Dr. Rock Yuk-Yan LEUNG

Consultant and Division Head of Haematology Division, Department of Pathology, Queen Mary Hospital, Hong Kong



Dr. Ralph LEE

Associate Consultant, Princess Margaret Hospital / Yan Chai Hospital, Hong Kong

Plenary Session 2

1 November 2026 (Sunday) | 09:00 – 10:30



Prof. Li-Ze XIONG

President, Shanghai Fourth People's Hospital Affiliated to Tongji University School of Medicine, China

Patient Safety is Eternal Theme of Anaesthesia and Perioperative Management

Is Anaesthesia Safe? It was estimated that anesthesia-related mortality in Chinese mainland remains higher than developed countries. In a retrospective study including 28 million perioperative cases in Germany during 2014-2017, 54% of postoperative in-hospital deaths suffered perioperative organ injury, with high incidence of neurological complications. It was reported that 30-day mortality was 5.8% in elderly hip surgery, 1-year mortality was 13.4% after elderly major surgery in the United States. Therefore, in 2016, I proposed that the development direction of anesthesiology is from anesthesiology to perioperative medicine. Surgery is not the goal, nor is anesthesia. Patient postoperative recovery is the ultimate, emphasizing the role of anaesthesia in perioperative safety and quality.

How to Ensure Safety? In this lecture, I will present with three aspects: 1. Outstanding department chair, 2. High-quality talent team, 3. A comprehensive safety assurance system. My point is that "Not seeing hazards does not mean there are none. It only means your safety standards are insufficient."

The major hidden dangers include inadequate safety awareness, non-compliance with regulations and guidelines, lack of necessary knowledge and skills, and absence of a well-established safety system. The studies showed that 90% of incidents stem from weak safety awareness, and 10% are related to technical proficiency. 90% of training focuses on clinical skills and nursing competence, while only 10% covers safety training. People often overemphasize on safety infrastructure such as IT, automation and digitization. The clinical thinking is very important. We should be trained to know what, and know why! To have a safety assurance system, we should establish protocols for big data acquisition and analysis, design safety policies, tools and workflows, build a safety management system for hospital departments, and improve clinical safety and quality through scientific research. "One mistake may be just one incident in a physician's career, yet it means 100% to the patient."

Plenary Session 2

1 November 2026 (Sunday) | 09:00 – 10:30



Prof. Hyung-Chul LEE

Director, Healthcare AI Research Institute, Seoul National University Hospital, South Korea

Artificial Intelligence and Patient Safety

Recent advancements in Artificial intelligence (AI) offer a way to turn continuous physiological data and clinical records into timely, actionable support for patient safety. This talk reviews how AI is moving from retrospective prediction to real-time clinical assistance, and what is required to make that transition safe.

First, I will introduce VitalDB and K-MIMIC, an open, high-resolution biosignal dataset from surgical patients that researchers worldwide now use, and explain why open, well-curated data is the foundation of trustworthy perioperative AI. Building on such data, deep learning models can forecast adverse events such as intraoperative hypotension and hypoxaemia minutes before they occur, and reinforcement learning models can recommend ventilator and drug settings. I will share our experience developing and validating these models, including VentPilot, an AI-based recommendation system for mechanical ventilation, and discuss the gap between good performance on retrospective data and real benefit at the bedside.

Second, I will discuss large language models and clinical AI agents. At Seoul National University Hospital, we are deploying a medical large language model and an agent platform that operate inside the hospital network, allowing clinicians to query records, summarise patient histories and automate documentation without patient data leaving the institution. These tools can reduce cognitive load and documentation errors, but they also introduce new risks: hallucination, automation bias, prompt injection and silent failure when data or practice patterns shift.

AI will not make anaesthesia safe on its own; used carefully, it can help us detect deterioration earlier, act more consistently and focus our attention where patients need it most.

Plenary Session 2

1 November 2026 (Sunday) | 09:00 – 10:30



Dr. Albert CHAN

Chief of Service, Department of Anaesthesia, Pain and Perioperative Medicine, Prince of Wales Hospital, Hong Kong

Healing the Healers: Wellbeing and Psychology Safety as Foundations for Patient Care

Safety is fundamental to anaesthesiology. It is supported by careful preparation, robust systems, effective teamwork, and the ability to identify and respond to risk. However, patient safety also depends on the wellbeing and psychological safety of the clinicians delivering care.

Anaesthesiologists and intensivists work in high-pressure environments that demand vigilance, precision, and consistent performance. While these qualities are essential to safe practice, they may also contribute to stress, emotional exhaustion, isolation, and burnout. Clinicians may continue to function effectively while experiencing significant personal distress, often without feeling able to speak openly or seek support.

This presentation examines physician wellbeing through the frameworks of positive psychology and psychological safety. It will consider the roles of meaning, connection, compassion, strengths-based practice, and supportive teams in promoting individual and collective wellbeing. It will also explore how psychologically safe workplaces enable clinicians to communicate openly, acknowledge uncertainty, raise concerns, learn from error, and seek help without fear of judgement or stigma.

Drawing on evidence, practical perspectives, and the speaker's personal experience of burnout, the presentation will highlight the relationship between clinician wellbeing, psychological safety, and patient safety.

A culture of safety must include not only the safety of patients, but also the safety of the people responsible for their care. Healing the healers is therefore not separate from patient safety; it is an essential part of it.

Medicolegal Symposium

1 November 2026 (Sunday) | 09:00 – 10:30



Ms. Jaime LAM

Partner, Johnson Stokes & Master, Hong Kong

Medical Council Reform: Key Changes and Potential Impact

The recent Medical Registration (Amendment) Bill 2026 seeks to reform the medical regulatory framework to address longstanding concerns over delays and case backlogs in disciplinary proceedings, while responding to the evolving needs of the medical profession and public expectations of ethical standards of doctors.

During this presentation, the speaker will focus on the overhaul of the complaint handling and disciplinary procedures of the Medical Council under the reform, highlighting the potential and practical impact on the medical profession. In particular, the speaker will cover the key changes, including the replacement of the current Preliminary Investigation Committee and Inquiry Panel with the Medical Investigation Committee (**MIC**) and Medical Tribunal Panel (**MTP**) respectively, the enhanced investigation powers of the MIC, the new sentencing options and the publication of target timeframes by the Medical Council for different stages of the disciplinary proceedings.

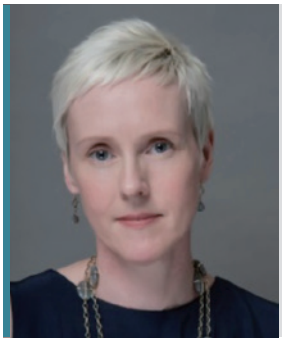
Medicolegal Symposium

1 November 2026 (Sunday) | 09:00 – 10:30



Ms. Hiu-Yee CHUNG

Partner, Howse Williams, Hong Kong



Ms. Oonagh TONER

Partner, Howse Williams, Hong Kong

The Dos and Dont's of Giving Evidence, And Preparing Medical and Expert Reports

Doctors are occasionally invited to act as a factual or expert witness in various legal proceedings, yet their role and responsibility may be misunderstood at times.

This workshop and presentation will explore and discuss the role of doctors when acting as factual and expert witnesses in legal proceedings. Through providing attendees with practical guidance, it will discuss the key principles and best practices and highlight the pitfalls in relation to the preparation of medical and expert reports, and in giving evidence in various Court hearings and in Medical Council inquiry hearings.

1 November 2026 (Sunday) | 11:00 – 12:30



Dr. Michelle CHONG
Consultant Anaesthetist, St Vincent's Hospital Melbourne, Australia

Selective Nerve Blocks for Shoulder Pain and Revisiting Recovery Outcomes

Regional anaesthesia for shoulder surgery has traditionally relied on proximal brachial plexus blockade, particularly the interscalene block, to provide dense and reliable analgesia. However, increasing emphasis on phrenic nerve preservation, motor function and patient-centred recovery has driven interest in more selective approaches targeting the peripheral nerves responsible for shoulder nociception.

Advances in anatomical understanding, ultrasound imaging and cadaveric simulation have enabled increasingly precise targeting of the suprascapular, axillary, lateral pectoral and other articular nerves of the shoulder. This talk will examine the anatomical basis and evolving evidence for selective peripheral nerve blocks, including the development of novel ultrasound-guided techniques and their translation from anatomical validation into clinical practice.

Importantly, the value of selective regional anaesthesia should extend beyond demonstrating technical success or preservation of diaphragmatic function. Evaluation should incorporate outcomes that matter to patients, including pain, opioid requirements, motor function, quality of recovery and the ability to participate in early rehabilitation.

The SAXIPec approach, combining selective blockade of the suprascapular, axillary and lateral pectoral nerves, will be introduced as an example of this anatomy-driven strategy. Its development illustrates a broader evolution in shoulder regional anaesthesia: moving from routinely blocking the brachial plexus towards identifying the relevant pain generators, selectively targeting their neural supply, and evaluating success through patient-reported recovery.

Regional Symposium

1 November 2026 (Sunday) | 11:00 – 12:30



Dr. Tim Chi-Ho CHAN

Consultant, Department of Anaesthesia, Singapore General Hospital & Sengkang General Hospital, Singapore

Regional Anaesthesia for Arteriovenous Fistula Surgery

The choice of anaesthetic technique for arteriovenous fistula (AVF) creation and arteriovenous graft (AVG) surgery depends on several factors, including surgical requirements, patient comorbidities and potential effects on vascular access outcomes. Patients undergoing these procedures often have end-stage kidney disease with significant cardiovascular comorbidities, which may increase the risks associated with general anaesthesia (GA) and make regional anaesthesia (RA) an attractive alternative.

This talk will discuss the advantages, limitations and considerations of GA, RA and local anaesthesia (LA), with particular emphasis on the potential benefits of RA, including sympathetic blockade, increased vascular calibre and blood flow, and their implications for AVF maturation and patency. Current evidence comparing the different anaesthetic techniques and their impact on vascular access outcomes will also be reviewed.

Relevant regional anaesthesia techniques for AVF and AVG surgery will also be discussed, including ultrasound-guided supraclavicular, infraclavicular and axillary brachial plexus blocks, with considerations for selecting the appropriate approach based on the surgical site. This will also cover techniques for blocking the intercostobrachial nerve, which is not reliably covered by conventional brachial plexus blocks, to achieve adequate anaesthetic coverage for more proximal upper-arm procedures. Common pitfalls, limitations and safety considerations of these techniques will also be highlighted.

The aim of this talk is to provide a practical approach to selecting and performing appropriate anaesthesia for AVF and AVG surgery.

Regional Symposium

1 November 2026 (Sunday) | 11:00 – 12:30



Prof. Stanley WONG

Clinical Associate Professo, Department of Anaesthesiology, The University of Hong Kong, Hong Kong

Enhancing Analgesia in Regional Blocks: An Evidence-Based Guide to Additives

Regional analgesic blocks provide excellent short-term analgesia, but block duration usually does not extend beyond 24 hours, creating the possibility of rebound pain, which is a major limitation. A range of perineural pharmacological adjuncts, continuous catheter techniques, and non-pharmacological techniques have been investigated to prolong analgesia, improve postoperative pain and reduce opioid consumption, yet questions remain about their comparative efficacy, optimal dosing, and side effect profiles. This talk will critically appraise the evolving evidence base for regional analgesia strategies—including pharmacological adjuncts (eg dexamethasone, dexmedetomidine, liposomal bupivacaine), continuous perineural catheter techniques, and also explore newer strategies such as cryoneurolysis. Perineural and intravenous dexamethasone have both been studied extensively for their analgesic effects, with debate continuing over whether the perineural route offers meaningful advantages over systemic administration. Dexmedetomidine's impact on block enhancement is weighed against its haemodynamic and sedative side effects. Liposomal bupivacaine is another option to enhance regional analgesia, but its high cost remains an issue for widespread clinical implementation. Continuous perineural catheters can extend analgesia but are associated with high technical demand and other problems such as catheter kinking/dislodgement. The rationale and evidence for these analgesic strategies will be discussed to help guide clinical practice.

Pain Symposium



1 November 2026 (Sunday) | 11:00 – 12:30

Prof. Jamie YOUNG

Clinical Head, Department for Pain Management, Peter MacCallum Cancer Centre, Australia

Pain Integration for ERAS Success: Insights from a Dedicated Cancer Centre in Australia

This presentation explores the evolution of perioperative pain management within Enhanced Recovery After Surgery (ERAS) pathways. It highlights modern, structured pain strategies integrated across all surgical phases to optimize rehabilitation, patient flow, and safety. Attendees will gain practical insights into aligning acute pain techniques and multidisciplinary care with ERAS principles to improve recovery outcomes.

Pain Symposium

1 November 2026 (Sunday) | 11:00 – 12:30



Dr. Timmy CHAN

President, The Society of Anaesthetists of Hong Kong, Hong Kong

Update on the Management of Trigeminal Neuralgia

Trigeminal neuralgia (TN) is a chronic facial pain disorder marked by sudden, severe, shock-like attacks in the distribution of the trigeminal nerve. Effective management requires an accurate diagnosis, individualized treatment selection, and coordinated long-term follow-up.

First-line pharmacologic therapy typically involves anticonvulsant medications, most commonly carbamazepine or oxcarbazepine. For patients with an inadequate response, intolerable adverse effects, or medication-refractory disease, procedural options should be considered. These may include microvascular decompression, stereotactic radiosurgery, radiofrequency lesioning, or balloon compression of the trigeminal ganglion, as well as other peripheral nerve procedures. The choice of intervention depends on factors such as patient age, overall surgical risk, imaging findings, and local expertise.

This talk reviews current strategies for TN management, with a particular emphasis on international approaches to pain management. Ultimately, our goal is to improve pain control, functional recovery, and treatment confidence for people living with TN.

1 November 2026 (Sunday) | 11:00 – 12:30



Prof. Michael VELTMAN
Dean, Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (ANZCA), Australia

Advancing Safety, Governance, and Clinical Quality in Pain Medicine: Systems-Level Initiatives from the Faculty of Pain Medicine (FPM)

As pain medicine gets more complex with increasing government regulation, we need better ways to both keep patients safe and demonstrate that we do so. This presentation looks at three main system-wide areas that we are working on.

First was the Electronic Persistent Pain Outcomes Collaboration (ePPOC). By standardising how we collected patient-reported outcomes across the board, ePPOC let us actually see what was working and what wasn't. It helped clinics spot variations in care and adjust their approach based on real data. Due to funding conditions unrelated to FPM, the University of Wollongong made a decision to close ePPOC. The faculty is actively exploring alternative options to continue this vital work. I will update you on what has been looked at and where this is likely to go.

Second, the Spinal Cord Stimulation (SCS) Registry tracks long-term implant safety, including device issues and explant rates. With neuromodulation tech changing so fast, this registry acts as a crucial safety net to catch complications early and guide our clinical decisions. We are currently trialling a pilot phase of this in a select few sites, to assess suitability.

Finally, technical safety comes down to proper credentialing. The FPM Procedures Endorsement Program sets clear, objective standards for training and competency. This ensures that complex interventional therapies are only delivered by qualified specialists that our faculty will stand behind as trained as part of a multidisciplinary approach in their management.

Having all three of these will provide a solid framework for assessing outcomes, quality assurance and general clinical governance of pain management.

Lunch Symposium



1 November 2026 (Sunday) | 12:30 – 13:30

Prof. Chi-Wai CHEUNG

Director, Pain Management Center, Gleneagles Hong Kong Hospital, Hong Kong

Foundations of ERAS: Why Legacy Non-Opioid Adjuncts Remain Essential in the Perioperative Period

In an era captivated by novel therapeutics and the rapid proliferation of ultrasound-guided interfacial plane blocks, it is easy to overlook the quiet workhorses of perioperative medicine. Yet, the true bedrock of Enhanced Recovery After Surgery (ERAS) remains firmly rooted in legacy non-opioid systemic adjuncts.

This session challenges anesthesiologists to look beyond the needle and re-examine the indispensable role of foundational systemic pharmacology. While advanced regional anesthesia is invaluable, a robust, synergistic multimodal foundation is what guarantees opioid-sparing success—even when regional techniques are contraindicated, wear off, or prove incomplete.

Designed to bridge classic pharmacology with modern ERAS evidence, this presentation will explore how accessible, highly efficacious systemic agents provide multi-target nociceptive blockade and pleiotropic benefits that extend far beyond simple pain reduction.

Session Highlights:

- **The Synergistic Scaffold:** Re-evaluating the secondary physiological benefits of legacy mainstays—from the anti-hyperalgesic properties of sub-anesthetic NMDA antagonists to the anti-inflammatory cascade modification of traditional NSAIDs.
- **Targeting Inflammation with Precision:** A nuanced look at COX-2 inhibitors, balancing their potent peripheral analgesic efficacy against their specific perioperative safety profiles, particularly regarding platelet function and anastomotic healing.
- **The Gabapentinoid Evolution:** Navigating the shifting consensus on gabapentinoids. We will clarify their targeted utility for neuropathic pain modulation and anxiolysis versus the tangible risks of compounding perioperative sedation.
- **Strategic Implementation:** Practical, evidence-based frameworks for combining these foundational agents while safely navigating patient-specific comorbidities and surgical constraints.

1 November 2026 (Sunday) | 13:30 – 15:00



Prof. Timothy G. SHORT

Specialist Anaesthetist, Department of Adult and Trauma Anaesthesia and Perioperative Medicine, Auckland City Hospital, New Zealand

Advances in PKPD models -Propofol, Remifentanil and Dexmedetomidine

Pharmacokinetic model controlled infusions came into anaesthesic use in 1996 with the commercial Diprifusor. This was followed by the Open TCI initiative in 2003 enabling model controlled infusions of propofol and remifentanil using the well-known Schnider and Minto models. Numerous studies confirmed these models had reasonable accuracy for the typical adult but were less accurate at extremes of age and weight. In 2018 The Groningen group published a general model based on a pooled analysis of 30 PK studies, and suitable for use in a much broader group pf patients.[1.2] The model has been found to be very useful in Paediatrics, as has a similarly derived model for remifentanil based on 3 studies.[3]

A model suitable for TCI of Dexmedetomidine became available in 2017. Based on a detailed PKPD study of just 18 adults it has some advantages over the standard manual infusion regimes.[4-6] Dexmedetomidine has a complex PKPD profile. The dose response relationship is markedly faster for cardiac effects than CNS effects, the elimination of CNS effects is very slow . The drug also markedly reduces opioid requirements. The much smaller dose at induction compared to use of loading doses with model based TCI reduces the bradycardia and hypotension which is commonest in the early stages of an infusion.

The question of drug delivery using closed-loop has been around as long as I have! It is totally feasible and has been made easier with modern computing and better targets of effect.[7] Almost all studies have used bispectral index for sedation, but the more useful devices are probably the two input two output ones that target BP as well. The systems work well, the question is not feasibility, but utility in our setting.

References

	No. of patients	Age range (years)	Weight range (kg)	Number of blood samples	Adjustable parameters
Propofol Eleveld 2018	1033	0.5 - 82	0.68 - 160	15,433	Wgt, hgt, age, sex, opioids
Remifentanil Eleveld 2017	131	5 d - 85	2 - 106	2634	Wgt, hgt, age, sex
Dexmedetomidine Hannivort, 2017	18	20 - 70	51-110	408	Wgt

1. Eleveld DJ. Br J Anaesth 2018, 120:942
2. Vellinga R. Br J Anaesth 2021, 126:386
3. Eleveld DJ. Anesthesiology 2017, 126:1005
4. Hannivort LN. Anesthesiology 2015; 1323:375
5. Colin PJ. Br J Anaesth 2017:119; 200-210
6. Colin PJ. Br J Anaesth 2017:119; 211-220
7. Felipe VA, Br J Anaesth 2026:136; 1811-21

1 November 2026 (Sunday) | 13:30 – 15:00



Prof. Thomas M. HEMMERLING
Professor, Anesthesia and Surgery, McGill University, Canada

From Target-Controlled Infusion to Intelligent Closed-Loop Systems

Target-controlled infusion (TCI) transformed intravenous anaesthesia by replacing manually adjusted infusion rates with model-based drug delivery designed to achieve and maintain predefined plasma or effect-site concentrations. Pharmacokinetic–pharmacodynamic models for agents such as propofol and remifentanil have enabled increasingly individualised drug administration and established the conceptual foundation for automated anaesthesia. Nevertheless, conventional TCI remains fundamentally open loop: the clinician selects the target concentration and must continuously interpret patient responses and adjust the target accordingly.

Closed-loop systems extend this concept by incorporating real-time physiological feedback into drug delivery. Measures derived from electroencephalography, neuromuscular monitoring and haemodynamic variables can provide continuous feedback to controllers that automatically modify anaesthetic, analgesic or neuromuscular-blocking drug administration. Clinical studies have demonstrated that such systems can maintain selected physiological targets with high consistency while reducing the requirement for repetitive manual adjustments.

The next transition is from conventional feedback control towards intelligent closed-loop systems capable of integrating multiple physiological signals, pharmacological models and contextual clinical information. Artificial intelligence may add a reasoning layer that interprets changing patient states, anticipates therapeutic requirements and coordinates multiple control loops while maintaining predefined safety constraints. Such systems should not simply automate drug delivery but support increasingly adaptive and personalised perioperative care.

The evolution from TCI to intelligent closed-loop anaesthesia therefore represents a progression from model-based dosing, through **physiological feedback control**, towards **context-aware autonomous decision support and therapy**. Future clinical adoption will depend on rigorous validation, transparent decision-making, robust safety architectures, cybersecurity, regulatory oversight and preservation of meaningful clinician supervision.

1 November 2026 (Sunday) | 13:30 – 15:00



Prof. Quirino PIACEVOLI
President, World Society of Intravenous Anaesthesia, Italy

Clinical Risk Management: Proactive Systems for Patient and Staff Safety

Introduction

The core objective of clinical risk management is to protect both patients and healthcare staff from harm by proactively identifying, assessing, and resolving medical errors and hazards before they manifest. In rapidly evolving healthcare environments driven by shifting organizational dynamics and technological progress, risk management must constantly anticipate future problems. By foreseeing changes in advance, institutions can effectively implement targeted safety protocols. The primary goals of this practice are to maximize patient safety by preventing adverse events like medication errors or hospital-acquired infections, continuously elevate the quality of clinical care by learning from past mistakes, and lower institutional costs by reducing expensive legal claims and financial losses.

Methodology and Key Steps

An effective clinical risk management strategy relies on three sequential operational steps. First, specialists systematically review daily workflows to spot active and latent institutional risks. Second, they assess the overall impact by evaluating how severe the potential harm might be and how frequently it is likely to occur. Finally, they actively reduce harm by restructuring the system with updated safety regulations and continuous staff training.

Discussion and Conclusions

Improving the quality of medical practice requires a systematic culture of safety. Identifying high-risk departments—such as orthopedics, traumatology, emergency care, general surgery, neurosurgery, and radiology—allows hospitals to strategically allocate resources. Employing dedicated clinical risk management specialists in these specific wards is essential to structurally prevent adverse events, manage malpractice claims, and continuously improve the overall performance quality of healthcare services.

1 November 2026 (Sunday) | 13:30 – 15:00



Prof. Edgard M. SIMON
Director, World Society of Intravenous Anesthesia, Philippines

Beyond Neuraxial: TIVA for the High-Risk Parturient at Cesarean Delivery

Neuraxial anaesthesia remains the clear default for caesarean delivery. Over four decades, direct anaesthetic maternal mortality has fallen roughly 240-fold—driven overwhelmingly by the retreat from general anaesthesia and its two enduring hazards: the difficult obstetric airway and pulmonary aspiration. But default is not dogma. This lecture defines the boundaries of that practice and argues that, when general anaesthesia is unavoidable, total intravenous anaesthesia (TIVA) offers superior controllability.

The indication for general anaesthesia is physiological, not diagnostic. Four scenarios convert neuraxial blockade from safe option to liability: fixed cardiac output unable to tolerate sympathectomy; coagulopathy, where the needle itself is the risk; haemodynamic instability with no reserve; and an unavailable or failed block. Pulmonary hypertension and pre-eclampsia are addressed honestly—neither is an absolute bar.

Where general anaesthesia is mandated, TIVA earns its place through maternal haemodynamic control, with uterine-tone preservation as secondary. The neonatal case is acknowledged but not overstated. A critical caveat: target-controlled infusion models are not validated in term pregnancy. The pump predicts; the clinician titrates. Processed EEG is non-negotiable given the elevated awareness risk in obstetrics.

The lecture translates these principles into a phase-based framework: titrated manual induction, controlled infusion for maintenance, vigilance across delivery, and protected awake emergence. Attendees will leave able to recognize when neuraxial gives way, and to deliver TIVA safely.

Obstetrics Symposium (WCIVA)

1 November 2026 (Sunday) | 13:30 – 15:00



Dr. Frances LUI

Consultant Anaesthesiologist and the Chief of Service, Department of Anaesthesia, Pain and Perioperative Medicine, Queen Mary Hospital, Hong Kong

What's New in Obstetric Anesthesia?

Recent literature Obstetric Anesthesia would be discussed.

1 November 2026 (Sunday) | 13:30 – 15:00



Dr. Wing-Cheong LEUNG
Consultant Obstetrician & Gynaecologist, Department of Obstetrics and Gynaecology, Kwong Wah Hospital, Hong Kong

Ever-Increasing Incidence of Postpartum Haemorrhage - What Went Wrong?

Postpartum haemorrhage (PPH) is a leading cause of maternal morbidity and mortality. In 2022, the incidence of PPH in Hong Kong increased to a historic high of 14.7%, despite advances in prevention and treatment modalities such as the use of uterotonics, balloon tamponade, and compression sutures. In 2023, a PPH Concern Group comprising representatives from Obstetrics Units of all eight HA Hospitals under the QA subcommittee of COC O&G was formed to investigate the ever-increasing incidence of PPH and to recommend solutions. One of the recommendations is to use Carbetocin as universal prophylaxis of PPH for all Caesarean sections starting from 1st Jan 2025. Surprisingly, the incidence of PPH after one year has further increased to 18.0%. So actually what went wrong? On the other hand, a recently published retrospective study in a HA Obstetrics Unit using the HA electronic audit form (under CMS, clinical management system) showed that despite the increasing incidence of massive PPH (>1500ml), reductions in blood loss and peripartum hysterectomy rates were observed along with increased utilisation of second-line therapies (balloon tamponade and compression sutures). Regular clinical audit is essential.



1 November 2026 (Sunday) | 13:30 – 15:00



Prof. Suraphong LORSOMRADEE
Associate Professor and Head of Cardiac Anesthesia, Faculty of Medicine, Chiang Mai University Hospital, Thailand

TIVA in Interventional Cardiology: Precision, Flexibility, and Safety Beyond the Operating Room

Background:
The rapid expansion of interventional cardiology has transformed the cardiac catheterization laboratory into an increasingly complex non-operating room anesthesia (NORA) environment. Procedures such as transcatheter valve interventions, electrophysiology procedures, structural heart interventions, and complex coronary interventions increasingly involve patients with significant cardiovascular comorbidity and limited physiological reserve. In this setting, anesthetic management must provide adequate comfort and immobility while preserving respiratory and cardiovascular stability and allowing rapid adjustment to changing procedural demands.

Role of TIVA:
Total intravenous anesthesia (TIVA), particularly when delivered using target-controlled infusion (TCI), provides a highly titratable approach to sedation and anesthesia. The combination of short-acting intravenous hypnotics and analgesics allows the anesthesiologist to continuously adjust anesthetic depth according to procedural stimulation, patient physiology, and the requirements of the interventional cardiology team. TIVA can also facilitate rapid recovery and may be particularly useful when spontaneous ventilation and early neurological assessment are desirable.

Clinical Challenges:
Successful TIVA in the catheterization laboratory requires more than drug selection. Appropriate patient selection, airway planning, hemodynamic monitoring, depth-of-anesthesia assessment, communication with the interventional team, and preparation for rapid conversion to general anesthesia are essential. Particular attention is required in patients with severe aortic stenosis, impaired ventricular function, pulmonary hypertension, arrhythmias, or hemodynamic instability. The anesthesiologist must also anticipate critical procedural events, including rapid changes in preload and afterload, arrhythmia induction, coronary ischemia, vascular complications, tamponade, and the potential need for emergency airway or circulatory support.

Conclusion:
TIVA in interventional cardiology should be viewed as a dynamic anesthetic strategy rather than simply an alternative drug technique. When combined with appropriate monitoring, TCI technology, physiological understanding, and robust NORA systems, TIVA can provide precise control of anesthetic depth while maintaining the flexibility required for complex cardiovascular procedures. The key principle is to match the depth and technique of anesthesia to the patient, the procedure, and the physiological risk—while always being prepared for the unexpected.

Non-Operating Room Anaesthesia (NORA) Symposium (WCIVA)

1 November 2026 (Sunday) | 13:30 – 15:00



Dr. Vansie KWOK

Consultant Anaesthesiologist and Deputy Chief of Service, Hong Kong Children's Hospital, Hong Kong

Paediatric NORA: Not Just Adult NORA in a Smaller Patient

Non-operating room anaesthesia (NORA) has become an increasingly important component of modern paediatric anaesthesia, extending well beyond sedation for diagnostic imaging. Children undergo anaesthesia outside the operating theatre for MRI and other diagnostic studies, interventional radiology, endoscopy, lumbar puncture and other repeated painful procedures, radiotherapy, and increasingly complex minimally invasive interventions. However, paediatric NORA presents challenges that extend beyond the physiological differences between children and adults. Developmental maturity, ability to cooperate, anxiety, pain, previous healthcare experiences and the need for repeated procedures may determine whether anaesthesia is required in the first place. At the same time, remote environments can restrict airway access, monitoring and rescue. This presentation explores how the child, procedure and place interact to shape the anaesthetic plan, and considers how each anaesthetic experience may influence future procedures and the child's longer-term healthcare experience.

Non-Operating Room Anaesthesia (NORA) Symposium (WCIVA)

1 November 2026 (Sunday) | 13:30 – 15:00



Dr. Wesley LEUNG

Specialist in Anaesthesiology, Private Practice, Hong Kong

Into the Deep: Navigating the Waters of Remote Location Anaesthesia in Private Practice

Background: As of late 2024, Hong Kong's healthcare landscape features over 250 licensed day procedure centres (with around 80 licensed for anaesthetic services) and 13 private hospitals. Out-of-operating-room interventions have been increasing with time. Consequently, private anaesthetists are increasingly required to deliver Monitored Anaesthetic Care (MAC) or general anaesthesia across a diverse constellation of remote settings, like Gastroenterology & Endoscopy suites, Interventional Radiology & Imaging suites, IVF clinics, Cardiac Catheterization Laboratories and dental surgery clinics.

The Challenge: Navigating these diverse settings poses distinct challenges, particularly for practitioners transitioning into private practice. Unlike standardized operating theatres, each remote location presents a unique configuration of specialized equipment, physical layouts, structural constraints, and varying levels of immediate nursing and resuscitation support. To ensure uncompromised patient safety and clinical proficiency, anaesthetists must rapidly adapt and thoroughly familiarize themselves with each specific environment.

The Safety Framework: This operational environment shares similarities with exploring an unfamiliar diving site, where safety relies entirely on meticulous pre-procedural verification. Just as divers use strict pre-dive checklists to mitigate hidden underwater risks, anaesthetists operating in NORA settings should do the same. This systematic approach ensures equipment integrity, clarifies emergency pathways, and aligns expectations with the procedural team before any sedative or anaesthetic agent is administered.

Conclusion: Drawing from my private Non-Operating Room Anaesthesia experience spanning minimally invasive heart interventions and different day surgery settings, this presentation offers practical insights into managing these remote complexities and above all, prioritizing patient safety. This ensures that each out-of-theatre procedure is completed proficiently, safely, and satisfyingly for the patient.

1 November 2026 (Sunday) | 15:30 – 17:00



Prof. Li-Ze XIONG
President, Shanghai Fourth People's Hospital Affiliated to Tongji University School of Medicine, China

Translational Research of Perioperative Stroke: Current Status and Prospects

Perioperative stroke can be defined as any embolic, thrombotic, or hemorrhagic cerebrovascular event with motor, sensory, or cognitive dysfunction lasting at least 24hours, occurring intraoperatively or within 30 days after surgery. The incidence of perioperative stroke is as follows: 0.1-1% of most non-cardiac, non-neurologic surgeries, 5-10% in high-risk surgeries such as cardiac or major vascular procedures, and 10% covert stroke of undergoing noncardiac, non-neurologic surgeries. The patients with perioperative stroke have 2 times more of mortality compare to patients with stroke that occurs in the community. More than 85% perioperative stroke occur within the first postoperative week. At least 95% perioperative strokes are ischaemic, with 5% haemorrhagic, while for community strokes, 62.4% is ischaemic, and 37.6% is haemorrhagic. 30d mortality of perioperative ischaemic stroke following non-cardiac or non-neurological surgery is 16%-26%, tenfold higher than that without stroke (1.6%), and double for community stroke (13%).30d mortality of perioperative haemorrhagic strokes is 32%, which is roughly equivalent to that of community haemorrhagic stroke.

The translational research is based on the understanding of the mechanisms underlying stroke. For ischemic stroke, the neuronal injuries result from excitotoxicity, free radical release, and inflammation. Edaravone, an oxygen free radical scavenger, was approved for marketing in Japan in 2001. The edaravone and dexborneol sublingual tablets are available in Chinese mainland. Tat-NR2B9c (NA-1) interferes with the interaction between NR2B and PSD95, thereby disrupting the NR2B-nNOS coupling and preventing NO-mediated neuronal death. The clinical studies demonstrated that NA-1 improves functional outcomes after stroke.

A myeloid differentiation protein 2-perturbing peptide was proved to have therapeutic effects in rodent and rhesus monkey models of stroke in our laboratory. We also found that a dual-targeting nanomaterial for oxygen free radicals and lactate showed better neuroprotective efficacy than edaravone in animal stroke models. The future translational research should fucus on identification and prevention in high-risk patients, perioperative monitoring, early warning and early diagnosis, mechanisms, novel targets, and neuroprotective agents, long-term functional recovery and rehabilitation therapies.

1 November 2026 (Sunday) | 15:30 – 17:00



Prof. Jaideep PANDIT
Professor of Anaesthesia, University of Oxford, United Kingdom

Interpreting Movements During General Anesthesia: The Efference Copy Network and Links to Accidental Awareness

This lecture seeks to explain why and how patients move during general anesthesia, with or without partial neuromuscular blockade (NMB). In doing so, it explains why NMB is associated with traumatic accidental awareness (AAGA), which does not arise in the absence of NMB. Stimulation of peripheral receptors evokes subcortical motor responses and activates the 'efference copy network'. If the resulting motor response is thwarted, as in neuromuscular blockade, the neocortex is aroused. With inadequate general anesthesia this results in an awake patient with distressing AAGA. The ability to move, as facilitated by partial or no neuromuscular blockade is like a "release of tension" and cortical arousal is mitigated. This network also explains the unique responses observed in the 'isolated forearm technique'.

1 November 2026 (Sunday) | 15:30 – 17:00



Prof. Bernd Walter BÖTTIGER
Professor, Institute of Emergency Care, Pedagogy of Health and Nursing Science, University of Pecs, Germany

Resuscitation Science, Brain Injury, and Anaesthesia: What Anaesthesiologists Need to Know

How can the health of an injured brain be improved? Early identification of stroke is key; normothermia, normoxia, normoglycaemia are important. In ischaemic stroke, perform early thrombolysis or mechanical thrombectomy. Sepsis associated encephalopathy is frequent and supportive treatment is important. Choice of sedation may involve midazolam or propofol. Muscle relaxant should be avoided [1]. **How to keep the brain healthy in neonates and infants?** Animal studies suggest that anaesthesia may have negative effects. Large-scale clinical studies show that single exposure is safe. If possible, postpone surgery until later development stage. Necessary surgery should not be denied; avoid ketamine, limit preoperative anxiety and avoid and manage pain [1]. **How to keep a healthy adult brain unimpaired?** Brain healthy patients are not necessarily at no risk of perioperative neurological disorders. This can be reduced by up to 40% through the implementation of structure screening and evidence-based treatment including avoidance of anti-colonic medications, pain control, avoidance of unnecessary prolonged fasting time and involvement of relatives whenever possible [1]. **How to keep the anaesthesia and ICU caregivers`brain healthy?** Burn out among anaesthesiologist is very frequent. It is on a personal level important to combat with micro aggression, acknowledge feelings, build connections and find a mentor early [1]. **How important is post-resuscitation care?** For the brain, early recognition and early CPR after a collapse is of utmost importance. No drugs help to increase post-resuscitation neurologic recovery. The only thing that we have in our hands is temperature management. A recent Cochrane library systematic review confirms that neurologically outcome is increased by the use of therapeutic hypothermia in areas with bystander resuscitation rates of <70% [2].

1. Bonhomme V et al. 2024; 2. Arrich J et al. 2023

1 November 2026 (Sunday) | 15:30 – 17:00



Dr. Owais Ahmed Mohamed RAFIQ
RCSI Medical University of Bahrain, Kingdom of Bahrain

Optimizing EEG and Density Spectral Array (DSA) Monitoring During Total Intravenous Anaesthesia in Paediatric Patients: Practical Interpretation and Clinical Applications

Electroencephalography (EEG) provides a continuous, real-time window into the functional state of the brain during anesthesia. In pediatric patients, however, interpretation is particularly challenging because EEG patterns change substantially with age, neurodevelopment, and the effects of different anesthetic agents. Processed EEG indices, often derived from adult datasets, may therefore be misleading when used in isolation in infants and younger children. This presentation provides a practical, clinically focused approach to interpreting EEG during pediatric anesthesia. It will review the essential features of the raw EEG, including frequency, amplitude, continuity, symmetry, and the evolution of age-dependent anesthetic patterns. Particular attention will be given to the characteristic signatures produced by commonly used agents such as propofol, sevoflurane, dexmedetomidine, and ketamine. The role of density spectral array (DSA) and spectrogram interpretation will be introduced as an intuitive method for following changes in brain state over time. Clinical examples will demonstrate how to recognize adequate anesthesia, excessive anesthetic depth, burst suppression, asymmetry, and common artifacts, and how these findings should be interpreted in the context of the child's age, anesthetic technique, and physiology. A stepwise approach to monitor interpretation will be presented. The presentation will also highlight the limitations of relying on a single numerical depth-of-anesthesia value and emphasize the importance of integrating raw EEG, DSA, processed indices, and clinical information. By the end of the session, participants should be able to recognize common pediatric anesthetic EEG patterns and use them to support more informed intraoperative decision-making. The overall aim is to provide anesthesiologists with a simple and reproducible framework for bedside EEG interpretation, enabling them to move beyond "reading the number" and toward understanding the underlying cerebral response to anesthesia in children.

Paediatrics Symposium (WCIVA)



1 November 2026 (Sunday) | 15:30 – 17:00



Dr. Rowena LEE

Paediatric Anaesthetist, Hong Kong Children's Hospital, Hong Kong

Beyond Individual Heroics: Building Institutional Preparedness for the Paediatrics (and Adults) "Cannot Intubate, Cannot Oxygenate" Crisis

The "cannot intubate, cannot oxygenate" (CICO) scenario represents the ultimate crisis in airway management. While rare—particularly in paediatric practice—its catastrophic potential demands absolute system readiness. This presentation explores the high-stakes landscape of CICO emergencies, contrasting the distinct anatomical, physiological, and etiological realities between adults and children. Unlike adults, where upper airway distortion and obesity frequently drive failure, the paediatric population presents razor-thin safety margins characterized by rapid oxygen desaturation, compliant tissues, and unique airway geometries that render standard rescue assumptions obsolete.

We will critically evaluate current international evidence and guidelines for emergency front-of-neck access (eFONA), highlighting the evolution from percutaneous cannula techniques toward surgical approaches, and examining why "children are not just small adults" when managing front-of-neck access.

Moving from theory to practice, the session shares our institutional experience in bridging the gap between guideline recommendations and clinical reality. We outline how our hospital tackled systemic blind spots through standardized equipment architecture, clear cognitive aids, frequent hands-on practice and multidisciplinary simulation drills. Emphasizing the vital role of human factors—because chocolate and teamwork alone have limits when an airway refuses to cooperate—this talk provides actionable insights to help clinical teams transform panic into coordinated institutional resilience.

Paediatrics Symposium (WCIVA)

1 November 2026 (Sunday) | 15:30 – 17:00



Dr. Kevin FUNG

Consultant Radiologist, Hong Kong Children's Hospital, Hong Kong

Seeing is Believing: Enhancing Safety through Paediatric Anesthesia-Radiology Collaboration

Advances in medical imaging and image-guided interventions have transformed paediatric care, creating new opportunities to enhance procedural safety through multidisciplinary collaboration. Close coordination between radiologists, anaesthetists and surgeons is essential, particularly when managing children with complex anatomy or undergoing high-risk procedures.

This presentation will explore three clinical scenarios highlighting the importance of radiology–anaesthesia collaboration. First, the management of mediastinal masses will demonstrate how imaging assessment of airway and cardiovascular compression informs anaesthetic risk stratification and procedural planning. Second, three-dimensional (3D) printing for congenital pulmonary airway malformations (CPAM) will illustrate how patient-specific anatomical models facilitate surgical planning and multidisciplinary communication. Finally, MR-guided interventions will highlight the unique challenges of delivering anaesthesia in the MR environment, including patient monitoring, positioning, restricted access and emergency preparedness.

Through these examples, the presentation will demonstrate how integrating imaging expertise with anaesthetic planning and effective teamwork can improve procedural safety and optimise outcomes for paediatric patients.

Abstracts of Formal Project Prize Presentation

31 October 2026 (Saturday) | 14:00 – 15:30

(1) Innovative Approach for Implementation of Structured Positive Psychology Interventions to Improve Wellbeing and Resilience Amongst Anaesthesiologists in Hong Kong

Dr. Stacie Yeung-Yan HOI
Prince of Wales Hospital, Hong Kong

Background: Anaesthesiologists face high occupational stress and burnout rates, yet time constraints hinder their engagement with traditional psychological intervention. Culturally adapted, web-based positive psychology interventions (PPIs) offer an accessible alternative, but their feasibility remains underexplored.

Objective: To evaluate the feasibility, acceptability, and exploratory efficacy of web-based PPIs among anaesthesiologists in Hong Kong.

Methods: An explanatory sequential mixed-methods feasibility randomized controlled trial was conducted. Fellows and members of the Hong Kong College of Anaesthesiologists were randomized (1:1:1) to individual-oriented PPI, workplace-oriented PPI, or control. Quantitative primary outcomes (PERMA-Profiler, GAD-7, PHQ-9, PSS-10, Copenhagen Burnout Inventory) and secondary outcomes (SCS-SF, WAMI, WGS) were measured at baseline, post-intervention, and one-year follow-up. Semi-structured interviews were subsequently conducted and analysed thematically to explore trial feasibility and participant perceptions.

Results: A total of 101 participants were recruited. No significant differences in primary outcomes across time points between groups were observed. Individual-oriented PPI significantly reduced depression and enhanced meaningful work post-intervention, though effects were not sustained at one-year follow-up. Qualitative findings affirmed overall intervention feasibility, highlighting intrinsic motivation and perceived applicability as key enablers, alongside barriers such as time constraints and concerns about psychological safety in WhatsApp peer groups.

Conclusion: Bite-sized, web-based PPIs are feasible and acceptable for time-constrained anaesthesiologists, with preliminary short-term well-being benefits consistent with self-determination theory. These findings provide guidance for refining the intervention and designing future large-scale efficacy trials.



(2) A Non-Inferiority Clinical Audit: Evaluating a New Opioid and Catheter Sparing Multimodal Perioperative Analgesic Protocol Versus the Previous Intravenous Patient Controlled Analgesia (IV PCA) and Regional Anesthesia Based Protocol for Total Knee Arthroplasty

Dr. Fung HUNG
Tuen Mun Hospital, Hong Kong

Background: Multimodal analgesia could reduce opioid exposure and resource requirements after total knee arthroplasty (TKA). Protocol changes must preserve analgesic efficacy. This clinical audit evaluated a new opioid- and catheter-sparing protocol against the previous patient-controlled analgesia (PCA) and adductor canal block (ACB)-based TKA perioperative management protocol.

Methods: This retrospective comparative cohort audit included 135 adults undergoing primary TKA: 55 in the Historical Control Group and 80 in the Intervention Group. The primary outcome was postoperative pain measured by the 0 to 10 Numeric Rating Scale (NRS) at rest and with activity on postoperative Days 1 to 3. Non-inferiority was assessed using a prespecified margin of 1.0 NRS point. Secondary outcomes included 72-hour oral morphine equivalents (OME), rescue opioid use, and the incidence and severity of nausea, vomiting, dizziness, and pruritus on Days 1 and 3.

Results: The pain control in the Intervention Group was non-inferior to the Historical Control Group across postoperative days 1 to 3, with none of the NRS had more than 1.0 discrepancy. Mean total OME was significantly lower with the new protocol (88.52 ± 26.53 mg vs 224.90 ± 142.56 mg; 60.64% reduction; Welch's t-test, $p < 0.0001$). Rescue opioid use was also less frequent in the Intervention Group (22.5% vs 49.1%; $p = 0.0016$). Side-effect incidence and severity were generally comparable, although nausea and dizziness showed non-significant trends toward greater persistence on Day 3 in the Intervention Group.

Conclusion: The new multimodal protocol provided non-inferior pain control with substantially lower and less variable opioid consumption, while maintaining a broadly comparable side-effect profile after TKA.



(3) Comparing Analgesic Efficacy and Quality of Recovery of Bi-Level and Single-Level Erector Spinae Plane Block for Open Inguinal Hernia Repair Surgery - A Randomised, Observer-Blinded Active-Controlled Trial

Dr. Patricia Kit-Ying IP
Hong Kong Children's Hospital, Hong Kong

Background: Erector spinae plane block is a versatile block which offers visceral and somatic analgesia. Multi-level block has been used for analgesia over an extensive area. At present, there is no study directly comparing two-level and single-level injections for open inguinal hernia repair. This study aims to investigate the effect on post-operative analgesia and recovery with bi-level (2ESP) and single-level ESP (1ESP) block in patients undergoing ambulatory open hernia repair.

Methods: An observer-blinded randomised clinical trial was performed at a day surgery centre in Hong Kong, comparing bi-level injection at T12 and L1 and single-level injection at L1. Participants were randomised on the morning of surgery by anaesthetists drawing from sealed opaque envelopes. Pain scores at PACU, at 4 hours post-op and on post-operative day 1 were collected. Quality of Recovery-15 score was assessed on post-operative day 1.

Results: 90 patients were randomised. Patients from 2ESP reported lower post-operative day 1 rest pain score [2ESP: 0 (0-0); 1ESP: 0 (0-2); $p < 0.05$] [median (IQR)] and higher quality of recovery scores [2ESP: 134 (117-145); 1ESP: 121 (113-135); $p < 0.05$] [median (IQR)]. There was a trend towards lower pain scores at rest and on movement at all time points, although results were not statistically significant.

Conclusions: In day open hernia repair patients, ESPB is effective as part of a multimodal analgesic regimen to facilitate discharge on the same day. L1 ESPB alone provides meaningful analgesia but together with T12 ESPB, day open hernia repair patients have statistically significant added analgesic benefits and better post-operative recovery.



(4) Effect of Intertransverse Process Block on the Quality of Recovery Post-Open Hepatectomy: A Pilot Non-Randomized Study of Intervention

Dr. Vicki Wing-Sum LI
Prince of Wales Hospital, Hong Kong

Background: Open hepatectomy causes severe postoperative pain, which prolongs recovery. While ERAS pathways favor opioid-sparing regional anesthesia, data on novel techniques remain limited. The intertransverse process block (ITPB) at the retro-superior costotransverse ligament (retro-SCTL) space is a novel paraspinal technique offering a safer alternative to traditional paravertebral blocks by reducing pleural puncture risks. This study evaluated the feasibility, analgesic efficacy, and quality of recovery (QoR) of the retro-SCTL ITPB in elective open hepatectomy.

Methods: Following ethics approval and consent, 20 patients undergoing open hepatectomy received a pre-induction, ultrasound-guided, three-level retro-SCTL ITPB at T5, T7, and T9 alongside general anesthesia and multimodal analgesia. Sensory/motor profiles were assessed, and recovery was evaluated using the Chinese QoR-15 score on postoperative days 1 and 2.

Results: The retro-SCTL ITPB provided predictable bilateral sensory blockade across T4–T10 while preserving lower lumbar motor function, with zero block-related complications. Postoperatively, mean 24-hour morphine consumption was 21.7±17.1 mg, with well-controlled pain scores (1.6±1.5 at rest; 4.3±1.8 during deep breathing at 24 hours). Mean QoR-15 scores improved from 98.2±16.7 on day 1 to 107.0±14.2 on day 2, alongside high patient satisfaction.

Conclusion: Retro-SCTL ITPB is a feasible, safe, and effective regional analgesic technique for open hepatic resection, offering reliable segmental coverage and supporting early recovery.



(5) Diagnosis using 4AT (Chinese), Incidence and Risk Factors of Post-operative Delirium in Geriatric General Surgical Patients: A Prospective Study at a Tertiary Centre in Hong Kong

Dr. Jessica Jie-Xi YU
Prince of Wales Hospital, Hong Kong

Post-operative delirium is a significant concern in geriatric patients undergoing surgical procedures, characterized by acute cognitive changes occurring within the first week post-surgery. This prospective observational study aims to determine the incidence and risk factors associated with post-operative delirium among geriatric general surgical patients at [redacted], Hong Kong, while validating the Chinese version of the 4AT diagnostic tool against the 3D-CAM. Of 190 patients included, 53 (27.9%) exhibited post-operative delirium. The 4AT yielded an overall sensitivity of 94.12%, specificity of 98.57%, overall accuracy of 97.87%, and AUROC of 0.971, successfully validating its ability to diagnose post-operative delirium in this patient population. From a comprehensive list of patient, anaesthetic, and surgical variables, four were identified as having statistically significant associations with post-operative delirium: older age, emergency surgery, intra-operative hypotension, and post-operative placement in HDU/ICU. These findings enable targeted preventive strategies to mitigate delirium and its associated impact on patients and the healthcare system, while future multi-centre trials should refine risk-prediction models and promote widespread 4AT adoption in Hong Kong's geriatric perioperative care.

Abstract No. 2

Improvement In Glottic View When Using the Upper Trunk Back-Up Position in Difficult Video Laryngoscopy: A Prospective Observational Study

Prof. Jiwon Han[1], Dr. Bo Young Kim, Prof Bon Wook Koo[2]
[1]Chung-Ang University, Seoul, South Korea, [2]Seoul National University, Seoul, South Korea

Background/Objectives: Video laryngoscopy generally provides superior laryngeal visualization compared with direct laryngoscopy; however, difficult laryngoscopy may still occur and require adjunctive maneuvers. The upper trunk back-up position improves glottic exposure during direct laryngoscopy, but its effectiveness during video laryngoscopy remains unclear. We evaluated the impact of the back-up position on laryngeal view in patients with difficult video laryngoscopy and identified the optimal back-up angle.

Methodology/Implementation: In this prospective observational study, 35 adult patients with Cormack–Lehane grade 3 or 4 views during video laryngoscopy were enrolled. After assessment in the supine position, the operating table was raised to flex the torso at the hip joint (back-up position). Changes in Cormack–Lehane grade and percentage of glottic opening (POGO) score were recorded. Intubation success rates, use of assistive maneuvers, and the angle providing the best glottic view were also evaluated.

Results: The back-up position significantly improved laryngeal visualization. Improved Cormack–Lehane grades were observed in 94% of patients. The median POGO score increased from 0 to 40 ($p<0.001$). Successful intubation using the back-up position alone was achieved in 57% of patients. Additional maneuvers were required in 43% of cases: backward-upward-rightward pressure (8.6%), stylet use (14.3%), or both (20%). The median back-up angle associated with optimal glottic visualization was 15°.

Conclusion: The upper trunk back-up position improved glottic exposure during difficult video laryngoscopy. A median elevation angle of 15° provided the best laryngeal view, although patient-specific optimization may be required. This simple positioning maneuver may be a useful adjunct in difficult video laryngoscopy.



Abstract No. 3

1 November 2026 (Sunday) | 15:15 – 17:00

A Prospective Comparison Between Mallampati Classification and Friedman's Tongue Positions for Airway Assessment and Their Correlation with Cormac-Lehane Grading

Dr. Sohan Lal Solanki[1], Dr Vaibhavi Desikan[1], Dr Jeson Doctor[1]
[1]*Tata Memorial Hospital, Mumbai, India*

Background: The Modified Mallampati Classification (MPC) is the most widely used bedside screening tools for predicting difficult intubation. The Friedman Tongue Position (FTP) score is based on the relative position of the tongue within the oropharyngeal cavity. Unlike Mallampati, which requires phonation, FTP is assessed in a more natural resting state of the tongue, potentially minimizing variability. Direct laryngoscopy with Cormack-Lehane (CL) grading continues to be the gold standard reference for evaluating laryngeal view during intubation.

Methodology: This prospective observational study compared two airway assessment indices MPC and FTP, in predicting difficult intubation with CL grading during direct laryngoscopy serving as the standard reference. Secondary objectives include evaluating interobserver variability and correlation with advanced intubation techniques like video laryngoscopy.

Results: Total 214 patients (>18 years) were enrolled. MPC 3 and more and FTP 2b or more significantly correlated with CL grades of 2b or more. Interobserver agreement was moderate for MPC (Kappa=0.514) and strong for FTP (Kappa=0.814). The use of assistance is significantly related to the Friedman tongue positions, with a moderate degree of association (Spearman correlation 0.150, p-value = 0.028). Video laryngoscopy was used in 34 cases when difficult airway was predicted based on high MPC and FTP grades.

Conclusion: Both grading systems are effective in predicting difficult airway as overall accuracy was comparable, with Friedman's method providing better inter-observer agreement and simulation of intubation conditions (tongue in neutral position).



Abstract No. 4

1 November 2026 (Sunday) | 15:15 – 17:00

Perioperative Intravenous Methadone for Elective Intra-Abdominal General Surgery: A Retrospective Case-Matched Service Evaluation

Dr. Ho Hin Lam[1], Dr Richard Hawkins[1]
[1]*St Peter's Hospital, Chertsey, United Kingdom*
Perioperative Intravenous Methadone for Elective Intra-Abdominal General Surgery: A Retrospective Case-Matched Service Evaluation
Ashford and St Peter's Hospitals NHS Foundation Trust, UK

Background/Objectives: Intraoperative methadone reduces postoperative opioid consumption in cardiac and spine surgery, but evidence in colorectal and general intra-abdominal surgery is sparse, and the only dedicated prior study found no benefit. Ashford and St Peter's Hospitals introduced a perioperative intravenous (IV) methadone pathway for elective intra-abdominal general surgery in 2026. We report the first outcomes from this pathway.

Methodology/Implementation: Retrospective, case-matched service evaluation comparing 41 consecutive patients receiving perioperative IV methadone (January-April 2026) with 41 case-matched historical controls (January-March 2025), matched by procedure subtype across colorectal, hernia, and upper gastrointestinal/bariatric surgery. Primary outcomes were PRN and total oral morphine equivalent (OME) at 72 hours, and safety signals. Continuous outcomes were compared with the Mann-Whitney U test and binary outcomes with Fisher's exact test.

Results: Opioid use trended lower with methadone across the whole cohort (PRN OME 20mg vs 40mg, P=0.086) and reached significance in the colorectal subgroup (20mg vs 55.5mg, P=0.043; n=25 vs 24). Two safety events occurred in the methadone group and none in controls; the sample was underpowered to draw a safety conclusion. No secondary outcome differed significantly between groups.

Conclusion: Perioperative IV methadone was associated with reduced postoperative opioid consumption in elective intra-abdominal general surgery, statstically significantly in colorectal procedures, without apparent safety signal at this sample size. These findings support continuation of the pathway pending a larger, prospective comparison.

Abstract No. 5

1 November 2026 (Sunday) | 15:15 – 17:00

High-Flow Nasal Oxygenation Reduces Emergence Cough and Accelerates Recovery during Laryngeal Microsurgery

Dr. Jong Yeop Kim[1], Dr Tae Kwang Kim[1], Dr Young il Kim[1], Dr Ha Yeon Kim[1], **Dr. Jiyoung Park**[1], Dr Sung Yong Park[1]

[1]*Ajou University Hospital, Suwon, South Korea*

Background: Laryngeal microsurgery (LMS) presents a unique airway challenge because anesthesiologists and surgeons must share the airway. High-flow nasal oxygenation (HFNO) enables tubeless anesthesia while maintaining oxygenation and may improve recovery quality. We investigated whether HFNO reduces emergence cough and enhances recovery compared with conventional ETI during LMS.

Methods: In this prospective study, 50 adult patients undergoing elective LMS were completed and analyzed (HFNO n=26; ETI n=24). Total intravenous anesthesia with propofol and remifentanil was administered in all patients. The primary outcome was the incidence of moderate-to-severe emergence cough (grade ≥2 on a 4-point scale). Secondary outcomes included recovery profiles (time to eye opening, time to emergence, PACU stay), postoperative sore throat, and intraoperative gas exchange (lowest SpO_2 and highest $EtCO_2$).

Results: The incidence of moderate-to-severe emergence cough was significantly lower in the HFNO group than in the ETI group (7.7% vs 58.3%, P<0.001). Recovery occurred faster with HFNO. Time to eye opening and time to emergence was shorter in the HFNO group than in the ETI group, respectively, P=0.002, respectively). PACU stay did not differ between groups (P=0.924). Postoperative sore throat at 1 h and 24 h was similar between groups (P=0.518 and P=0.466). The lowest SpO_2 values were comparable (P=0.345), whereas the highest $EtCO_2$ was higher in the HFNO group (P<0.001).

Conclusions: HFNO significantly reduced emergence cough and accelerated early recovery compared with endotracheal intubation during laryngeal microsurgery while maintaining adequate oxygenation.



Abstract No. 6

Effects of IPACK Combined with ACB on Sleep Quality and Cognitive Function in Elderly Patients Undergoing Total Knee Arthroplasty

Dr. Zhao Xu[1], Dr. Hui Wang[1], Dr. Yulong Song[1], master Long Fan[1]
[1]*Shaanxi Provincial People's Hospital, Xi'an, China*

Objective: This study aimed to investigate the effects of combined infiltration between the popliteal artery and capsule of the knee (IPACK) block and adductor canal block (ACB) on perioperative stress response, postoperative sleep quality and cognitive function in elderly patients undergoing total knee arthroplasty (TKA).

Methods: Eighty elderly patients undergoing elective TKA were prospectively enrolled and randomly allocated to two groups (n=40 each). The control group received ACB alone, whereas the intervention group received combined IPACK and ACB. Repeated-measures ANOVA with Greenhouse-Geisser correction and Bonferroni post hoc analysis was performed to compare perioperative stress hormones, Pittsburgh Sleep Quality Index (PSQI), Montreal Cognitive Assessment (MoCA) scores and adverse events at baseline, postoperative day (POD) 1 and POD 3.

Results: Baseline stress indicators, PSQI and MoCA scores were similar between groups (all $P>0.05$). Significant group-by-time interaction was detected in perioperative stress changes ($P<0.05$). The intervention group exhibited significantly lower postoperative cortisol, epinephrine and norepinephrine levels, lower PSQI scores and higher MoCA scores than the control group at POD 1 and POD 3 (all $P<0.05$). Moreover, the intervention group had a substantially lower incidence of adverse reactions (2.5% vs 20.0%, $\chi^2=6.14$, $P<0.05$).

Conclusion: Combined IPACK and ACB multimodal analgesia effectively attenuates perioperative stress responses, optimizes postoperative sleep quality, preserves cognitive function and reduces procedure-related adverse events in elderly TKA patients, which is a safe and superior analgesic strategy for vulnerable elderly populations.

Abstract No. 8

1 November 2026 (Sunday) | 15:15 – 17:00

A Randomised Controlled Double-Blind Study to Compare Ketamine-Dexmedetomidine Versus Ketamine-Propofol Combinations for Opioid Free Anesthesia in Patients Undergoing Brachial Plexus Injury Repair

Dr. CHAREN R[1], Dr. Veparala Prudhvi Raj[1], Dr. Vikas Saini[1], Dr. Tanvir Samra[1]
[1]*PGIMER, Chandigarh, India*

Background: Opioid-free anesthesia enables enhanced recovery after surgery. Primary aim was to compare dose of ketamine when co-administered with either dexmedetomidine or propofol.

Methods: A prospective, double blinded, randomized controlled study enrolling 36 patients aged 18-65 years undergoing brachial plexus injury repair was conducted. Patients were randomised into Group P (propofol + ketamine) and Group D (Dexmedetomidine + ketamine). Dose of Propofol (induction + maintenance @100mcg/kg/min) and Dexmedetomidine (bolus of 1mcg/kg followed by maintenance @0.5 mcg/kg/hr) was fixed. Ketamine was administered as bolus of 1 mg/kg followed by infusion @1mg/kg/hr; switched off 20 minutes before end of surgery. 20% increase in HR and MAP from the baseline value was considered inadequate analgesia and 0.5 mg/kg of ketamine bolus was given.

Results: Ketamine consumption in group D was (187.4 ± 30 mg) as compared to group P (132.9 ± 45.2 mg). Total ketamine consumption is significantly more in group D compared to group P (p value<0.001). Group D had longer time of extubation and awakening (Group P = 27.8 ± 7.7; Group D = 47.7 ± 11 mins ; p <0.001). Immediate postoperative pain scores were significantly less in group D. Time to first rescue analgesia was 52±10 minutes in group P while it was 81.3±15 minutes in group D; p value of <0.001. Post-operative Rickers sedation-agitation scale was comparable in both the groups.

Conclusion: Ketamine consumption is more with Dexmedetomidine, which delays post-operative recovery but provides better post-operative analgesia.



Abstract No. 10

1 November 2026 (Sunday) | 15:15 – 17:00

Focused Echocardiography to Detect Preoperative Hypovolemia as A Predictor of Post Induction Hypotension; A Prospective Observational Feasibility Study

Dr. AJAAI GOGULAN P[1], Dr TANVIR SAMRA[1], Dr VIKAS SAINI[1], DR JS RAHUL[1]
[1]*Postgraduate Institute of Medical Education and Research, India*

Introduction: We studied the use of transthoracic echocardiography to detect preoperative hypovolemia as a predictor of post induction hypotension

Material and Methods: Study was conducted in 185 patients aged 18-60 years scheduled for general anaesthesia. Hypovolemia was diagnosed if either one of the following was present;IVC diameter < 1 cm, Phasic respiratory collapse of IVC >50%, Left ventricular end diastolic area (LVED)<10cm2, VTI variation >12.5 % across LVOT. Decrease of >25% of baseline MAP or a MAP < 60 mm Hg was regarded hypotension.

Results: VTI variation >12.5% across LVOT with spontaneous respiration was reported in 41 patients and they were thus grouped under fluid responder group of which 35 (85.7%) developed hypotension immediate post induction. VTI variation of <12.5% suggesting normovolemia was reported in 142 patients (77.59%) of which 61(42.6%) developed hypotension; positive predictive value (PPV=85.7%) and specificity (93.1%) of VTI was good but, low on negative predictive value (57.4%) and sensitivity (36.4%). LVED area of < 10cm2 was seen in 17 patients out of 183(9.3%) and all had hypotension; PPV=100% and sensitivity=18.3%. IVC diameter of <1cm was in 9 patients (4.91%) and all developed post induction hypotension. Phasic respiratory collapse>50% was in 54 patients (29.50%) of which 48 developed hypotension ; PPV=89.7% and a sensitivity of 48.0%.When all the four parameters were cumulatively analysed across groups sensitivity was 72.0% and Specificity was 88.9%, PPV=87.0% and NPV=75.5%.

Conclusions: Pre operative focussed echocardiography is feasible and a good predictor of post induction hypotension



Abstract No. 11

1 November 2026 (Sunday) | 15:15 – 17:00

Surveillance of Troponin T and NT-proBNP for Predicting the Risk of Major Adverse Cardiovascular Events (MACEs) in Patients Undergoing Non-Cardiac Surgery

Dr. ABINAYAA KALIDOSS[1], Dr Tanvir Samra[1], Dr Nitika Goel[1]
[1]*Post Graduate Institute of Medical Education and Research, CHANDIGARH, India*

Background: Usefulness of the combined surveillance of Troponin T and NT-proBNP for predicting the risk of major adverse cardiovascular events (MACEs) in patients undergoing non-cardiac surgery

Methodology: In this prospective observational study the incidence of MACE and cumulative mortality at 30 days and 1 year, Cut off values of NT- proBNP and hs TnT in predicting MACE and cumulative mortality were investigated. A Cox proportional hazards model was undertaken as dependent variable was MACE and the independent variables included preoperative and surgical variables previously associated with MACE in bivariate analysis and absolute or relative increase in hsTnT or NT pro-BNP during the first 3 days after surgery. Model with lowest -2 log likelihood value was chosen for maximum goodness of fit.

Results: In a sample of 255 patients at a tertiary research and referral healthcare centre , the incidence of MACE was 10.2% and cumulative mortality at 30 days and 1 year was 6.7% and 13.3% respectively. In the multivariate Cox proportional hazard model, both an absolute increase in NT pro-BNP>781.55pg/ml and hs-cTnT>7.99ng/L [cumulative HR 4-5] were significant predictors of MACE. The results of Cox Regression analysis depicted CAD [HR-3.042 (95% CI 0.678-13.65)] , NYHA status III [HR-15.29 (95% CI 0.39-58.8)], RCRI grade 3 [HR- 3.41(95% CI 0.31-37.9)] as independently predictors of occurrence of MACE.

Conclusion: This study confirmed that model incorporating Trop T and NT-proBNP was shown to outperform a model based on established MACE risk factors alone in stratifying risk of MACEs in a group of at risk patients.

Abstract No. 12

1 November 2026 (Sunday) | 15:15 – 17:00

Assessing Mechanical Versus Cardiopulmonary Functional Capacity Before Major Surgery: A Retrospective Study of CPET, 15 seconds Sit-to-Stand test, and Hand-Grip Strength

Dr. Wang Ngai Peter Yau[1], Dr Yan Kit Lee[1], Dr Wai Ka Ming Joey[1]
[1]United Christian Hospital, Kowloon, Hong Kong SAR

Objective: This study evaluated the relationship between HGS, 15s STS, and CPET-derived parameters in Hong Kong Chinese patients undergoing major oncological surgery.

Methods: This single-centre retrospective study included ASA III or above patients who underwent CPET, HGS, and 15s STS as part of routine preoperative assessment between 1 January 2024 and 30 April 2026. Patients with incomplete data were excluded.

Results: The 15-second sit-to-stand test and handgrip strength showed significant positive correlations with VO_2 peak and anaerobic threshold. Multivariable regression confirmed sit-to-stand performance as an independent positive predictor of both VO_2 peak (Beta=0.34, $p<0.001$) and anaerobic threshold (Beta=0.22, $p=0.025$), while BMI was a negative predictor. ROC analysis demonstrated moderate predictive ability for VO_2 peak >15 $mL \cdot kg^{-1} \cdot min^{-1}$ (AUC 0.645–0.696, $p<0.01$). Specifically, a 15-STS cut-off of ≥9.5 repetitions yielded a high specificity of 0.95, indicating that achieving ≥10 repetitions effectively rules in adequate functional cardiorespiratory capacity.

Conclusion: The 15-second sit-to-stand test and handgrip strength are simple functional measures that independently predict key CPET parameters and may serve as practical preoperative risk assessment tools.

Abstract No. 13

1 November 2026 (Sunday) | 15:15 – 17:00

Association Between Persistent Opioid Use and Health Outcomes After Gastrointestinal Cancer Surgery: A Population-Based Retrospective Cohort Study

Mr. Martin Ming-chi Suen[1], Dr Fengfeng Wang[1], Mr Perseus Wing Fu Wong[1], Prof Francisco Tsz Tsun Lai[2,3], Prof Stanley Sau Ching Wong[1]

[1]Department of Anaesthesiology, The University of Hong Kong, Hong Kong, China, [2]Department of Pharmacology and Pharmacy, Li Ka Shing Faculty of Medicine, Centre for Safe Medication Practice and Research, The University of Hong Kong, Hong Kong, China, [3]Department of Family Medicine and Primary Care, School of Clinical Medicine, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Hong Kong, China

Introduction: Opioids are commonly prescribed for patients undergoing cancer surgery, but long-term use might lead to persistent opioid use (POU). Previous studies on POU were conducted mostly in the United States and Europe, with limited data from Hong Kong or East Asia. This study aimed to determine the rate of POU in gastrointestinal (GI) cancer surgery, including upper GI, hepatopancreatic biliary and colorectal cancer surgery, and examine whether POU is associated with worse long-term health outcomes, such as mortality, unplanned hospital readmissions and emergency department visits.

Methods: This retrospective cohort study was conducted using data from the Hospital Authority Data Collaboration Laboratory (HADCL). Patients undergoing GI cancer surgery between 2015 and 2022 were included and stratified into opioid-naive and opioid-exposed cohorts. Cox proportional hazards models were used to identify POU and mortality associations. Multivariable logistic regression was used to identify risk factors for POU and other adverse outcomes.

Results: Among 20,974 patients (16,415 opioid-naive and 4,379 opioid-exposed), the incidence of POU among opioid-naive patients and opioid-exposed patients were 11.1%, and 19.3% respectively. POU was associated with poorer overall survival (opioid-naive: aHR 1.58, 95%CI 1.47-1.70; opioid-exposed: aHR 1.36, 95%CI 1.22-1.52), higher risks of unplanned hospital readmissions at both 1 and 2 years in both cohorts, with stronger effects at 1-year and 2-year follow up.

Conclusion: The incidence of POU after GI cancer surgery was high, when compared to other countries. POU is associated with increased mortality. There is need to reduce long-term opioid dependence and its adverse consequences in cancer populations.

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Local participants can be accredited by Continuing Medical Education (CME) points, Continuous Professional Development (CPD) points and Continuing Nursing Education (CNE) points from various colleges and professional institutions.

As of 20 October 2026

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	Max. for whole function	31 Oct 2026 (09:00 - 17:30)	1 Nov 2026 (09:00 - 17:00)	31 Oct 2026 Nursing Symposium	Category and Remarks
CME					
The Hong Kong College of Anaesthesiologists	14.50	7.50	7	N/A	RC-PP
Hong Kong College of Community Medicine	10	6	6	N/A	PP-PP
Hong Kong College of Emergency Medicine	12	6	6	N/A	CME-PP
The Hong Kong College of Family Physicians	10	5	5	N/A	OEA-5.02
The Hong Kong College of Obstetricians and Gynaecologists	5	5	5	N/A	PP-PN
Hong Kong College of Paediatricians	12	6	6	N/A	A-PP
Hong Kong College of Physicians	7	3.50	3.50	N/A	PP-PP
The College of Surgeons of Hong Kong	12	6	6	N/A	CME-PP
Medical Council of Hong Kong	10	5	5	N/A	CME-PASSIVECME
CPD					
Hong Kong Physiotherapy Association	12			N/A	I
Hong Kong Occupational Therapists Board	Pending			N/A	Pending
CNE					
Accredited by The Hong Kong College of Anaesthesiologists	CNE (31 Oct) Nursing Symposium: 1.50				

College / Association	Workshop												CME / CPD Category
	1	2	3	4	5	6	7	8	9-1	9-2	9-3	10	
CME: The Hong Kong College of Anaesthesiologists	N/A	1.50	1.50	1.50	1.50	1.50	3	1	1	1	1	4	AC-AP
CNE: The Hong Kong College of Anaesthesiologists	1.50	N/A											
CPD: Hong Kong Physiotherapy Association	N/A	2	2	2	2	2	3	1	1	1	1	4	I

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c/o International Conference Consultants Ltd.
Unit C-D, 17/F, Max Share Centre, 373 King's Road, North Point, Hong Kong
Tel: (852) 2559 9973 Fax: (852) 2547 9528 Email: asmhk@icc.com.hk

