GP ROUNDS
CENTRAL COAST NEWS
DECEMBER 2019

Gosford Private Hospital
Brisbane Waters Private Hospital
Tuggerah Lakes Private Hospital
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A NOTE FROM MATT KELLY

REGIONAL MANAGER AND GOSFORD PRIVATE HOSPITAL CEO

Since our last newsletter in July there have been a lot of great achievements made at Gosford Private Hospital. The first sod was turned on our $32million expansion which will see three more theatre spaces, a new recovery and day surgery, a new purpose-built maternity ward, expanded surgical beds and capacity for more beds into the future. It will mean that our site will be a construction zone all of next year, but services will not be interrupted at all. We are spending a lot of time focusing on way finding so that patients' and relatives' experiences here are not hampered.

Our staff continue to focus on the patient's experience and we are being recognised for the fantastic work that they do. We have been referenced in a publication read across 80 countries with regards to our engagement with staff and patients, as well as winning several awards this year with the NSW Business Chamber at a local, regional and State level. The staff also are dedicating their own time to their love of sustainable practices, and we have had contact now from around the country and the globe about how we are working to achieve our sustainability goals.

We also continue to invest in the latest technology and provide our medical staff with everything they need to care for your patients. This year alone we have spent over $2 million on our facility and equipment. We are also working at a national level on improving the

information that we send out with patients, and to you as their GP. We will hopefully be enhancing that discharge information very soon.

I look forward to keeping you updated with the building and exciting new services, such as robotic surgery that we will be able to offer with our new facility.

A NOTE FROM KATHY BEVERLEY

BRISBANE WATERS PRIVATE CEO

It's been a busy time at Brisbane Waters Private Hospital since the last GP rounds was delivered to your practices – with many of you attending our 3rd Mental Health Conference in October at the Crown Plaza Terrigal. With such great support from the GP community, our Central Coast Clinic continues to be extremely busy and now with the recruitment of a new Nurse Unit Manager with specialist qualifications as a Nurse Practitioner and ten Psychiatrists in private practice, the unit is ready to continue its phenomenal growth in 2020.

Our surgical services have continued to grow over 2019, which I know has been pleasing for many GPs being able to refer locally. With more surgeons attending the Hospital in plastics, dental, gastroenterology, general and bariatric surgery we have seen an increase of 25% in surgical services which has impacted positively on other aspects of the Hospital. If you are a GP or Referrer from the southern end of the coast and wish to schedule a visit to your practice from one of our Specialists, or join one of our upcoming Educational events, please contact our Regional GP and Community Relationship Manager, Petrina Waddell, at **petrina.waddell@healthecare.com.au**

I would like to thank you all for your support of Brisbane Waters Private during 2019 and look forward to working with you in 2020.

Finally I would like to wish everyone a very Merry Xmas and prosperous New Year and to thank our exceptional staff who continue to work extremely hard to provide a great patient experience at Brisbane Waters Private.

IN THIS EDITION

A NOTE FROM GLEN AULD

TUGGERAH LAKES PRIVATE CEO

Tuggerah Lakes Private Hospital has got off to a flying start and over the last 6 months has gone from strength to strength. The hard work in the planning and establishment phase is now paying dividends as we are seeing more surgical cases with increasing acuity and more overnight cases. The three theatres are now fully allocated and the team is working on plans to increase both the theatre and ward capacity along with new services that are needed in the local area. Dr Jim Hasn and Dr Indu Gunawardena provided the first Tuggerah Lakes GP education evening and we are looking forward to many more educational events in 2020.

If you are a GP or Referrer from the northern end of the Central Coast or Lake Macquarie area and would like to tour the hospital, schedule a visit to your practice from one of our Specialists, or join one of our upcoming Educational events, please contact our Regional GP and Community Relationship Manager, Petrina Waddell, at **petrina.waddell@healthecare.com.au**

I would like to take this opportunity to thank the amazing staff at Tuggerah Lakes Private Hospital for their dedication and patient centred care, the exceptional specialists who are bringing desperately needed services to the local area, and our local GP's for their fantastic support. We are looking forward to continuing to grow and adding more services in 2020.

I wish you all a safe and festive Christmas and New Year.

Petrina Waddell

Petrina Waddell is Health Care's Regional GP & Community Relationships Manager for the Central Coast. Petrina helps to raise the profile of the Specialists and admitting VMO's across our three private hospitals and is available to support local GPs, Referrers and the business community in learning more about the services we offer, any new procedures, and to facilitate meet and greet opportunities with our new and experienced Specialists. Petrina also coordinates our RACGP accredited education events. For more information, contact Petrina on 0459 988 236 or at **petrina.waddell@healthecare.com.au**

HIATAL HERNIAS – WHO BENEFITS FROM REPAIR

– with General Surgeon, Dr Peter Hamer

Hiatal hernias are common and often reported on CT scans, gastroscopy and contrast swallows. The majority are relatively asymptomatic or associated with mild reflux symptoms and should be managed expectantly, however there are particular groups of patients with moderate to large hiatal hernias who are better off with a surgical repair, often obtain substantial improvements in their quality of life, and are very grateful post operatively. The indications are broader than merely reflux disease.

1) Volume reflux

When taking a history of reflux disease, it is important to delineate what the patient means by reflux. Patients can mean anything from mild retrosternal discomfort, burping (unlikely to be reflux), through to what can be termed volume or mechanical reflux. It is this latter group that need a mechanical (surgical) solution to a mechanical problem (their hiatus hernia). Volume reflux is a term used to describe the feeling of large volumes of gastric fluid refluxing into the oesophagus. Patients will describe a feeling of fluid rushing up when they bend over to do up shoelaces or when doing the gardening. On questioning they won't be able to sleep flat, often using pillows or raising the head of the bed to use gravity to prevent the fluid rush. A PPI will make gastric fluid neutral but it won't take it away, meaning that these patients are often PPI resistant – when on anti-reflux medications they still feel gross amounts of fluid refluxing into their oesophagus, it just happens to be pH neutral fluid rather than acidic.

2) Regurgitation and early satiety

Similar to volume reflux, a hernia that is large enough can cause mechanical problems such as regurgitation of food and early satiety. If this is happening on a regular basis, repair is the only way of fixing this.

3) Shortness of breath

It was long debated whether or not a hiatus hernia can get large enough to pressure the lungs and cause shortness of breath. We now know this is both incorrect and correct. A large hiatal hernia can cause quite significant shortness of breath on exercise, but it is due to left atrial compression and a decrease in venous return to the heart (the left atrium sits right up against a hiatal hernia), rather than lung compression. After repair it is not uncommon for patients in their 60s and 70s to describe an increase in the distance they can walk from 2-300m to 2-3km. Exclusion of cardiac and respiratory causes is obviously the first step if you suspect this, it occurs only in hernias large enough to cause atrial compression and sometimes the patient will notice that their shortness of breath is worse after a meal (when food distends the stomach which then pushes on the atrium).

4) Iron deficiency anaemia

Having a hiatus hernia means your stomach is straddling the hiatus and the diaphragmatic crura. This puts tension on the stomach mucosa and can cause ischaemic ulceration of the stomach mucosa known as Camerons ulcers. These ulcers are intermittent in nature, coming and going and are therefore only sometimes seen on gastroscopy. Patients with problematic iron deficiency, known large hiatal hernias and no other cause for their deficiency will often benefit from repair regardless of whether ulcers are seen at gastroscopy or not.

5) Volvulus and pain

These patients are relatively easy to manage. When a hernia is large enough to start volving and causing ischaemic pain symptoms they need early referral for repair.

6) 40-50 year old males

This group warrants a mention on their own. Although most large hiatal hernias start causing problems in 60-70yo females, there is a younger group of male patient who develop large hiatal hernias in their 40s and 50s. They are poor at describing their symptoms, and incorrectly attribute a lot of their symptoms to middle age rather than their hernia. However they almost invariably have moderate to severe symptoms, which they only recognise fully in hindsight. They are invariably very grateful post surgery and describe marked improvements in their exercise tolerance, energy levels, eating patterns and reflux.

Surgery

Surgery for hiatal hernia repair is laparoscopic and involves a 1-2 night stay in hospital followed by a 4-6 week pureed diet. It is often tolerated well even by those in their 80s and 90s. Side effects involve gas-bloat syndrome in 20-30% so if patients have reflux controlled by medications, and none of the above symptoms they are often best managed without surgical referral.

UPDATE ON BREAST CANCER TREATMENT

– with Breast and General Surgeon, Dr Mary Ling

Neoadjuvant chemotherapy

The treatment sequence for breast cancer is traditionally surgery followed by chemotherapy and then radiotherapy. Neoadjuvant chemotherapy (NACT; chemotherapy before surgery) was reserved for cases of locally advanced, inoperable or inflammatory breast cancer. Nowadays, NACT is increasingly being used for early breast cancer, specifically triple negative (oestrogen, progesterone and HER2-receptor negative) and HER2-positive tumours. Studies have shown overall survival rates are similar for adjuvant versus NACT, however, a major advantage of NACT is that it has prognostic significance. If NACT is given and no residual cancer is found in the surgical specimen, the patient is said to have a 'pathological complete response (pCR)' and survival is significantly improved when compared with a patient who does not achieve a pCR. If pCR is not achieved, there is an opportunity to give further chemotherapy after surgery. Other benefits of NACT are tumour shrinkage reducing the need for mastectomy and axillary lymph node dissection, and improving aesthetic outcomes for patients already suitable for breast conserving surgery, as well as time for genetic testing and surgical planning.

Around **1 in 20** women with breast cancer and **1 in 7** women with ovarian cancer have an inherited genetic mutation.

Gene testing

Around 1 in 20 women with breast cancer (and 1 in 7 women with ovarian cancer) have an inherited genetic mutation. Patients with a personal history of breast cancer that warrant a referral to a family cancer clinic for assessment include:

- Breast cancer < 40 years or < 50 years with limited family structure or knowledge (e.g. adopted)
- Triple negative breast cancer < 50 years
- Male breast cancer at any age
- Jewish ancestry
- Two breast cancers, where the first occurred < 60 years
- Two or more different but associated cancers at any age (e.g. breast and ovarian cancer)
- Lobular breast cancer and family history of lobular breast or diffuse-type gastric cancer
- Personal history suggestive of
  - Peutz-Jegher syndrome (oral pigmentation and/or gastrointestinal polyposis)
  - PTEN hamartoma syndrome (macrocephaly, specific mucocutaneous lesions, endometrial or thyroid cancer)
  - Li Fraumeni syndrome (breast cancer < 50 years, adrenocorticocarcinoma, sarcoma, brain tumours).

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Breast cancer-related lymphoedema

Breast cancer-related lymphoedema (BCRL) affects 1 in 5 patients treated for breast cancer, and has a significant negative impact on patient's quality of life after treatment. Established risk factors include axillary surgery (with incidence 4 times higher in patients who have had axillary lymph node dissection (20%) compared with sentinel lymph node biopsy (5%)), regional lymph node radiation and elevated BMI.

Previously, BCRL is diagnosed at the symptomatic stage when there is visible limb swelling. Nowadays, there is evidence that if BCRL is diagnosed at an early stage, it can be reversible, thus reducing the need for more complex and costly interventions. Prospective surveillance using bioimpedance spectroscopy (BIS), which measures extracellular fluid build up in the at risk limb, is capable of detecting subclinical lymphoedema (prior to onset of symptoms and signs). Early intervention, with physical therapy and compression garments, at the subclinical stage is effective in reducing progression to clinical BCRL.

Australasian Lymphology Association (ALA) position statement recommends all breast cancer patients have pre-treatment measurements (prior to surgery or chemotherapy) and repeat measurements at 3 to 6 monthly intervals for the first 2 years post treatment.

Exercise

The Clinical Oncology Society of Australia (COSA) position statement on Exercise in Cancer Care recommends all cancer patients aim for 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity aerobic exercise (e.g. walking, jogging, cycling, swimming) each week and 2 to 3 resistance exercise sessions (e.g. weight lifting) each week involving moderate- to vigorous-intensity exercises targeting the major muscle groups. Research has shown the benefit of exercise on cancer-related health outcomes, specifically quality of life, anxiety, depression, fatigue, sleep and bone health. There is also evidence to suggest exercise is associated with improved cancer-specific survival in breast, colon and prostate cancer.

A simple approach to "prescribing exercise":

- **Assess** current physical activity at regular intervals
- **Advise** on recommended activity levels & convey message that moving matters
- **Refer** to appropriate health care professional (exercise physiologist or physiotherapist with experience in cancer care) or exercise programs (specific programs for breast cancer patients include YWCA Encore, Strength After Breast Cancer & Next Steps).

Reference: eviq.org.au/cancer-genetics/adult/referral-guidelines/1620-referral-guidelines-for-breast-cancer-risk-as

Reference: Schmitz K, Campbell A, Stuiver M et al. Exercise is medicine in oncology: engaging clinicians to help patients move through cancer. CA Cancer J Cain 2019; 699: 468-484.

ROBOTIC ANTERIOR TOTAL HIP REPLACEMENT

– with Orthopaedic Surgeon, Dr John Limbers

MAKO® robot

Total hip replacement has been a highly successful procedure for over 50 years, with numerous new approaches and techniques developed over that time. Over the last 10 years the direct anterior approach has become popular with many surgeons throughout the world. In the last few years this has been combined with MAKO® assisted robotic technology, with the aim of using robotic technology to increase accuracy.

A number of studies have documented potential benefits of anterior hip replacement in the first 6 weeks following surgery. These include less pain in the post-operative period, quicker return to function and shorter hospital stays. This is due to the approach sparing all muscle envelopes, utilising an internervous plane. There has been no long term functional or implant survivorship benefit demonstrated with this. However, MRI studies have demonstrated less residual muscle damage and atrophy after the anterior approach.

When the direct anterior approach is combined with MAKO® robotic technology, a pre-operative CT scan is performed. This is segmented and loaded onto the MAKO® system software, to provide a patient specific 3-D CT model of the total hip replacement (Figure 1). This virtual total hip replacement is then reviewed by the surgeon and modified as necessary before the initial skin incision.

The surgeon then performs the anterior approach to the hip joint. Navigation pins are inserted into the pelvic bone. This is followed by mapping the anatomy of the hip joint utilising a specialised probe. This information is detected by a specialised camera and passed to the MAKO® robotic unit. This allows the patient's hip joint to be matched to the individualised plan. The surgeon then reams the acetabulum (Figures 2 & 3) and inserts the acetabular component under robotic control. The tactile, auditory and visual feedback of the robotic arm limits the bone preparation to the diseased areas and allows

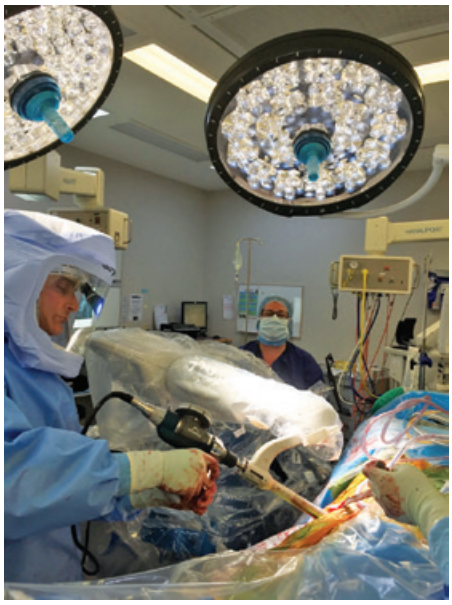

Figure 2

real time adjustments. The robotic technology ensures that the acetabular component is inserted with the same anteversion and inclination angles as the pre-operative plan. The femur is then broached and the hip reduced with a trial femoral stem and head in place. Further measurements are then taken with the specialised probe to check the leg length and offset. If these are correct then the definitive femoral stem and head are inserted. This technique provides highly accurate placement of the components of the total hip replacement, in terms of acetabular component inclination and version as well as leg length and hip offset. These are parameters

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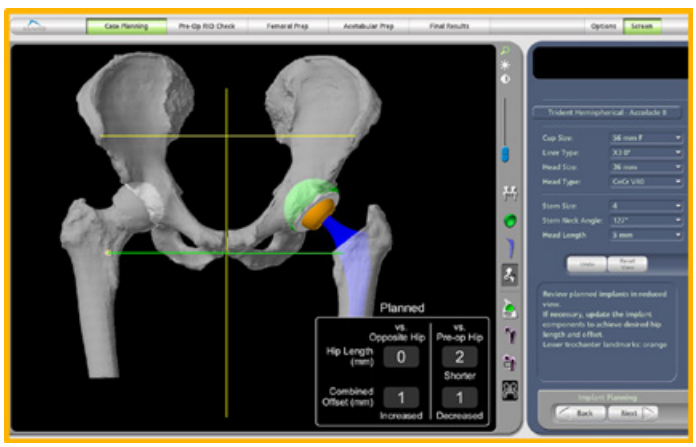

Figure 1

Figure 3

that are critical to having a high long term hip implant survivorship rate and a very low dislocation rate. This potentially results in a lower incidence of leg length inequality and a reduced chance of post-operative hip dislocation. It has the potential to improve long term results of total hip replacement surgery, by ensuring optimal implant position.

Is Robotic Anterior Total Hip Replacement of benefit to patients?

Direct anterior approach total hip replacement has been shown to have functional benefits in the first 6 weeks. One issue raised with direct anterior hip replacement is the learning curve, with the potential for complications if the surgery is not performed properly. However, increasing numbers of surgeons experienced in the technique are training registrars and surgeons learning the technique. There are also many training workshops and courses available. This has allowed adoption of the technique by many surgeons, with excellent results. With regard to the robotic assisted technique, the acetabular cup placement was examined in robotically assisted and conventional total hip replacement surgery in a comparative study. A statistically significantly higher number (30% higher) of acetabular cups were positioned within the desired range of anteversion and inclination in the robotically assisted cases. Whether this translates into lower revision rates and increased patient satisfaction remains to proven.

500th MAKO® ROBOT JOINT REPLACEMENT SURGERY

Gosford Private Hospital recently undertook its 500th MAKO® Robot joint replacement surgery, positioning the Hospital as the second highest user of the cutting-edge technology in NSW.

The $1.7 million MAKO® was first used at Gosford Private at the end of 2017, providing a highly accurate, customised solution that allows the surgeon to align and position replacement joints at an angle that optimises outcomes and matches the unique anatomy of each patient.

Orthopaedic Surgeons Dr John Limbers, Dr Sarah Hanslow, Dr John Morton and Dr Jim Hasn are currently credentialed to use the Robot at Gosford Private for knee and hip replacements. Learn more about the Orthopaedic Surgeons and the MAKO® at **gosfordprivate.com.au/about-us/news**

Dr John Limbers is an Orthopaedic Surgeon who specialises in hip and knee replacement surgery as well as reconstructive foot and ankle surgery. He has particular expertise in MAKO® robotic anterior total hip replacement surgery and MAKO® robotic knee replacement surgery. He was the first surgeon in NSW to perform robotic total knee replacement after its worldwide launch in September 2017. He has performed over 500 robotically assisted joint replacements.

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COMMON (AND LESS COMMON) NERVE ENTRAPMENT SYNDROMES

– with Neurosurgeon, Dr Vanessa Sammons

Ulnar Neuropathy (Cubital Tunnel Syndrome)

Ulnar neuropathy is most commonly caused by compression at the elbow (cubital tunnel) and less commonly at Guyon's canal at the wrist.

Clinically, patients describe numbness and paraesthesia to the fourth and fifth digits and the ulnar aspect of the hand. The patient will often feel that the hand is weak and less dextrous because of loss of innervation to the hand intrinsic muscles.

A basic examination is to check the pattern of sensory change (splitting of the fourth digit is a big clue), and checking abduction of the fingers (particularly the fifth digit) and flexion of the distal joints of the fourth and fifth digit. Wasting of the intrinsic muscles is a sign of severity (look for wasting in the first webspace, dorsally).

It can be confused with a cervical radiculopathy. A careful history and examination can distinguish the two and nerve conduction studies can help.

To optimise outcome, I prefer to see these patients sooner rather than later, before muscle wasting occurs.

Median Neuropathy (Carpal Tunnel Syndrome)

Median Neuropathy is most commonly caused by compression at the hand (carpal tunnel) and less commonly at other sites in the forearm and arm (with slightly different presentations).

Clinically, patients describe numbness and paraesthesia to the thumb and next two to three digits. The palm of the hand should be spared in carpal tunnel syndrome. The patient will often feel that the hand is less dextrous because of loss of adequate sensation. There may be thenar muscle (and so thumb) weakness. A feature is forearm, wrist and hand pain which is often worse at night.

A basic examination is to check the pattern of sensory change (splitting of the fourth digit is a big clue), and checking thumb abduction (the thumb moves perpendicular to (or away from) the palm).

It can be confused with a cervical radiculopathy (particularly C6). Again, a careful history and examination can distinguish the two and nerve conduction studies can help.

Meralgia Paresthetica

Meralgia Parasthetica is caused by compression of the lateral femoral cutaneous nerve usually at the inguinal ligament.

This has a classic clinical picture: the patient describes pain, numbness and /or paraesthesia to the anterolateral aspect of the thigh. The sensory change does not extend below the knee, is sharply demarcated and doesn't migrate.

Nerve conduction studies can be done and can help. Steroid injections also have a role and can be diagnostic as well as therapeutic. Surgical decompression is an option for some patients and is a very effective treatment even after years of compression.

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Dr Vanessa Sammons is a Neurosurgeon who treats all neurosurgical conditions, but with a particular interest in Peripheral Nerve Surgery. She completed fellowship training in Peripheral Nerve Surgery under the mentorship of Dr Rajiv Midha, a world renowned Peripheral Nerve Surgeon in Calgary, Canada.

Vanessa prides herself on providing personalised and thoughtful patient care and utilising her skills to achieve the best outcome possible.

Vanessa consults weekly in Erina and Woy Woy and operates regularly at both Gosford Private and Brisbane Waters Private Hospitals.

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Common Peroneal Neuropathy

Common Peroneal Neuropathy is caused by compression at the lateral knee (neck of the fibula). It is an underdiagnosed nerve compression and can be confused with an L5 radiculopathy or knee pathology.

Clinically, patients describe numbness and paraesthesia to the dorsum of the foot and the lateral aspect of the leg (upper two thirds). The patient may have weakness of dorsiflexion and of foot eversion (in an L5 radiculopathy usually inversion is weak and eversion is spared).

A basic examination is to check the pattern of sensory change and movements of the foot (look for dorsiflexion and eversion weakness). I also look for wasting and fibrillations in tibialis anterior and peroneus longus. The key to this diagnosis is keeping it in mind.

A careful history and examination can distinguish this from spinal and knee pathology and, again, nerve conduction studies can help. This is a condition I prefer to evaluate sooner rather than later since decompression loses its efficacy when done late in the process.

Tarsal Tunnel Syndrome

Tarsal tunnel syndrome is caused by compression of the tibial nerve at the tarsal tunnel (medial ankle). The nerve courses under a ligament similar to that in carpal tunnel syndrome and can be compressed.

Clinically, patients describe numbness, burning pain and paraesthesia to the plantar aspect of the foot radiating to the first four toes. Foot cramping can occur. I look for a Tinel sign between the medial malleolus and the heel which is sometimes present. Nerve conduction studies can help with establishing the diagnosis.

Tarsal tunnel syndrome can be confused with plantar fasciitis.

Surgical decompression is effective.

Nerve compression can be easily overlooked as a pain syndrome or misdiagnosed as a spine or other joint problem.

General thoughts

Nerve compression can be easily overlooked as a pain syndrome or misdiagnosed as a spine or other joint problem. As a Neurosurgeon, I treat conditions in all regions, so naturally look critically at where in the nervous system the pathology may lie. With peripheral nerve problems, the key to the diagnosis is keeping the possibility in the back of your mind, even if more common causes exist (such as radiculopathy, for example).

Nerve compressions are best evaluated early since the success of surgery can be dependent on timing, which differs according on the nature and location of the problem.

Revolutionary technique reducing back pain

Gosford Private Hospital Neurosurgeon, Dr Marc Coughlan, has led the way for Neurosurgery in Australia, introducing minimally invasive endoscopic radio frequency denervation for the treatment of back pain in patients on the Central Coast.

Under the revolutionary technique, radio waves are channeled through a needle inside a long, thin, flexible tube less than the width of a pencil. The needle is guided directly into the affected facet joints of the spine and the radio waves produce small, targeted areas of heat which desensitise the affected joints, thus alleviating the patient's pain.

Unlike traditional radio frequency techniques, the revolutionary endoscopic approach includes a video camera, allowing the surgeon greater vision and control, ensuring effective treatment, whilst also allowing the patient to be sedated throughout the procedure.

Learn more at **gosfordprivate.com.au/about-us/news**

BREAST IMPLANT RUPTURE, ALCL AND CAPSULAR CONTRACTURE

– with Plastics and Reconstructive Surgeon, Dr Chaithan Reddy

Breast augmentation remains one of the most popular aesthetic procedures in our country.

While generally considered a safe procedure, both short term risks and longer-term complications may arise

There has been increasing media attention pertaining to the safety of breast implants over the last 12 months, particularly as more demographic data and knowledge is gained about the association between Breast implants and Anaplastic Large Cell Lymphoma.

Breast Implant rupture

Most breast implant ruptures remain silent without signs or symptoms. Many of these cases are detected incidentally at the time of breast imaging or breast screening. Symptomatic ruptures may present with pain, hardening, or change in breast shape.

The risk and rates of breast implant rupture varies depending upon the age of the implants and the quality of the implants used. Rupture rates have been reported in multiple studies and vary between 1.1-17% over a 6-10 year period. The rates have generally decreased with the advent of newer generation implants which exhibit a thicker outer silicone core and a more cohesive gel.

Implant rupture may be detected by US, Mammogram, CT or MRI. MRI is generally considered the preferred method of evaluation with a high sensitivity and specificity. US is a good cost-effective alternative but operator dependent.

Following breast augmentation, the body's response is to form a fibrous capsule around it.

- In the case of **intracapsular** rupture, free silicone remains within the capsule layer, and the decision to proceed with surgery would be based on symptoms, complicating features (e.g. capsular contracture), and anaesthetic risk.

- In the case of symptomatic **extracapsular** rupture, silicone has leaked out of the capsule and into the breast parenchyma, and surgery is generally indicated entailing implant removal and capsulectomy.

Capsular Contracture

Capsular contracture remains one of the most common implant related complications and refers to contracture and hardening of the breast Implant capsule.

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Dr Chaithan Reddy is a Specialist Plastic, Reconstructive & Cosmetic Surgeon. He has been consulting and operating on the central coast since 2012. After receiving his Fellowship, he undertook further training in Microsurgery and advanced Head & Neck cancer reconstruction and remains an active member of the Crown Princess Mary MDT Cancer Clinic.

His reconstructive surgery interests include:

- Skin Cancer surgery
- Advanced Head & Neck Cancer reconstruction
- Hand surgery (carpal tunnel syndrome, Dupuytrens Disease)

His cosmetic surgery interests include:

- Breast reduction and breast implant removal surgery
- Post weight loss body contouring
- Rhinoseptoplasty

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It is essentially an excessive fibrotic reaction to a foreign body (implant). The Baker Scale (1-4) is a common method of classifying the severity of capsular contracture. **In mild forms (grade 2), the breast may feel slightly firmer but normal appearance. In later stages (grade 4), the breast(s) may feel hard, tender and appear distorted.** Rates of capsular contracture vary from 2% to 20% in various studies, depending on the type of implant used and the site of implant placement. The incidence of capsular contracture is generally lower when implants have a textured surface and or are placed in a subpectoral position.

Treatment of capsular contracture is often dictated by symptoms and severity.

Typically, definitive management of grade 3 and 4 capsular contracture involves surgery, entailing implant removal and total capsulectomies.

Breast Implant associated ALCL

BIA-ALCL is a rare form of non-Hodgkin's lymphoma and has been found in a small cohort of women with breast implants. The aetiology remains uncertain, but It is thought to develop as a result of bacterial contamination ('**Biofilm**') leading to a protracted inflammatory response. The incidence is rare with approximately 500 cases worldwide on a background of at least 60 million textured implant insertions. Australia, however accounts for 1 in 7 of all global cases. Risk does increase with the degree of implant surface texturing and ranges from 1 in 4000 (macrotextured implants) to 1 in 60,000 (microtextured implants). Certain macrotextured implants were removed from the Australian market this year but given the extremely low risk, the current consensus is that asymptomatic disease-free women who already textured implants in situ do not require implant removal.

BIA-ALCL may present as a mass lesion, capsular contracture, lymphadenopathy, or effusion associated with the capsule.

More commonly it manifests as a delayed onset seroma, typically 7-10 years following implant insertion.

Any suspicion should prompt imaging and US guided FNA of a seroma (or mass) with specific pathological testing.

Once detected, treatment typically entails removal of the implants, capsulectomies and adjuvant therapy when indicated.

Medicare, Health Fund and Manufacturer Coverage for revision surgery

With improvements in implant technology and safety, leading breast implant manufacturers provide warranty policies for their breast prostheses. For complications such as breast implant rupture, or capsular contracture, manufacturers may offer complete replacement cost of the prostheses and a contributing amount towards corrective surgery.

Medicare item numbers and rebates exist for breast implant removal and capsulectomies, enabling health funds to potentially provide rebates (surgery and anaesthesia) and cover associated hospital costs. Medicare item numbers (and health fund coverage) can also apply for implant replacement to correct breast implant related ruptures and capsular contracture.

World First for ENT Patients

Ear, Nose and Throat specialist, Dr Indu Gunawardena, has become the first surgeon in the world to use the revolutionary Smith & Nephew Werewolf Coblator to treat patients at Gosford Private Hospital.

The new technology is set to deliver quicker procedure times, higher accuracy and minimal bleeding for patients, leading to reduced complications post-operatively and a quicker recovery. The product's ergonomic design also ensures a positive experience for the surgeon.

"I am delighted to have the opportunity to be the first surgeon in the world to use this industry-leading technology. With the introduction of the Werewolf we expect to deliver better outcomes for our patients with less concerns in the recovery period," said Dr Gunawardena.

Learn more at **gosfordprivate.com.au/about-us/news**

DIAGNOSIS AND REFERRAL FOR TWIN PREGNANCIES

- with Obstetrician and Gynaecologist, Dr Amrou Metawa

Twin pregnancies bring a great deal of excitement for parents with General Practitioners playing an integral role with early diagnosis through the use of dating ultrasound scans. Early screening leads to timely referrals to specialist Obstetricians which promotes improved pregnancy care, fetal surveillance and intrapartum care, and is particularly important in the management of twin pregnancies because of the higher frequency of complications.

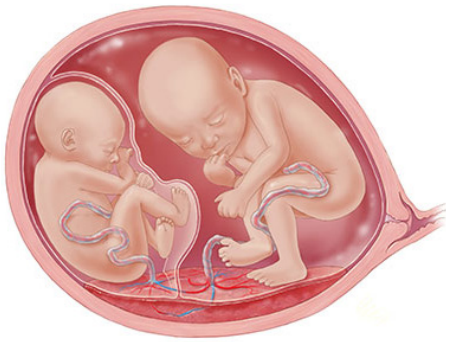
An increased likelihood of twin pregnancy may be suspected based on the use of assisted reproductive technology to conceive, large for date uterine size, family history or hyperemesis gravidarum. Other influences of dizygotic twins include maternal age, race/geographic area, parity, maternal weight/height and diet.

Twins occur in approximately 1-2% of pregnancies with both physical and emotional wellbeing of paramount importance. Multiple gestation occurs from the ovulation and subsequent fertilization of more than one oocyte resulting in genetically different dizygotic or non identical fetuses. Two thirds of all twins are dizygotic and one third are monozygotic. Genetically identical fetuses occur from splitting of one embryonic mass to form two or more genetically identical fetuses (monozygotic). Dizygotic twins have their own amniotic sac (diamniotic) and placenta (dichorionic).

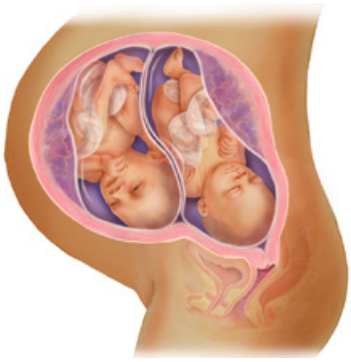
Ultrasonography

Optimal timing for performing ultrasound examination for chorioamnionicity is in the first trimester after 7 weeks. Assessment of fetal membranes is more difficult and less accurate in the third trimester and can be further complicated by oligohydramnios.

Assessment of chorioamnionicity occurs through ultrasonography and is critical to determine specific risks for serious pregnancy complications such as twin-twin transfusion syndrome



Monochorionic Diamniotic (MCDA) twins



Dichorionic diamniotic (DCDA) twins

(TTTS) and twin anaemia-polycythemia sequence. Both complications increase the risk for neurologic morbidity and perinatal mortanilty in monochorionic twins. Cord entanglement and conjoined twin risks are increased with monoamniotic twins.

Chorionicity is more easily identified at ultrasound early in a woman's pregnancy and can reliably indicate dichorionic twins. Ultrasonography in later gestations is not a reliable indicator of chorionicity as placentas often appear fused. Inter-twin membrane is absent in monochorionic/ monoamniotic (MCMA) twin pregnancies and becomes more difficult to visualise with maturing gestational age, oligohydramnios and progressive thinning of the membrane. False diagnosis may occur when separation of the amnion and chorion is mistaken for an inter-twin membrane.

Dichorionic diamniotic (DCDA) is most commonly identified at 10 – 14 weeks gestation becoming less obvious after 20 weeks gestation. It is identified with an inter-twin membrane with the 'twin peak' or 'lambda' sign. This sign refers to a triangular tissue that extends between layers of the inter-twin membrane from a fused dichorionic placenta. Fetuses of different sex are a highly reliable means of confirming a dichorionic pregnancy. Monochorionic Diamniotic (MCDA) twins inter-twin membrane with the "T" sign is comprised of two amnions attached to the placenta at a 90 degree angle.

Multiple pregnancy results in greater maternal hemodynamic changes including a 20 percent higher cardiac output and 10 to 20 percent greater increase in plasma volume. This may result in increased risk of pulmonary edema. Physiological anemia is also common. Increased risk for gestational hypertension and preeclampsia are more common in women carrying twins and require increased surveillance of mother and baby. Acute fatty liver of pregnancy is a rare complication occurring more frequently in multiple gestations.

Parents expecting twins require tailored clinical care, counselling and management

Counselling parents

Parents expecting twins require tailored clinical care, counselling and management. Education and discussion regarding optimal gestational weight gain and nutritional requirements is recommended. Management of congenital anomalies in one or both twins requires careful consideration

of available therapies and delivery times. Women experiencing multiple pregnancy require more frequent checkups to monitor babies growth and development and potential pregnancy complications.

Increased risk of miscarriage, fetal abnormalities, reduced fetal growth and preterm birth and intrauterine death is considerably higher in twin pregnancies rather than singleton pregnancies. In fact, twin pregnancies are associated with higher rates of almost every potential complication of pregnancy with the exception of post-dates and macrosomia.

Dr Metawa has experience in managing twin pregnancies at Gosford Private Maternity Services over the last 10 years. He has expertise caring for women with multiple pregnancies and enjoys providing compassionate care to these families. Expertise to identify complications at an early stage and collaboration with Gosford Private's neonatologists ensures evidenced based care and decision making is received. Dr Metawa has experience with both vaginal birth twins and caesarean births. At the time of twin deliveries, Dr Metawa ensures neonatal trained paediatricians are available for birth, care and follow-up appointments.

Dr Amrou Metawa is a devoted expert and well respected Obstetrician and Gynaecologist. Dr Metawa has extensive experience in every aspect of pregnancy care, he will give you exceptional and unique one on one care throughout your pregnancy.

Dr Metawa is dedicated to providing care in high risk pregnancy, VBAC (Vaginal Birth after Caesarean section) and Breech delivery.

Dr Metawa also treats all aspects of Gynaecology including, incontinence, pelvic floor prolapse, pelvic pain, endometriosis, uterine fibroid, menorrhagia, Polycystic Ovary Syndrome (PCOS), ovarian cysts, family planning and infertility, menopause, adnormal pap smear, and colposcopy.

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World renowned Neurosurgeon visits Gosford Private Hospital

We are honoured to have Professor Marc Sindou visit Gosford Private Hospital to conduct a dorsal root entry zone (DREZ) lesioning procedure, a pain relief treatment not previously undertaken in Australia. The precedure involves cutting part of the spinal cord to relieve pain in instances when nerves have been torn away from the spinal cord or through spinal cord injury.

Professor Sindou is the Professor of Neurosurgery at the University of Lyon in France, a Founding Member of International Association for the Study of Pain (IASP), and Past President of the World Society for Functional and Stereotactic Neurosurgery (WSSFN). He was also Vice-President of the European Association of Neurosurgical Societies (EANS) and Teacher in the EANS Training Course.

With 22 visiting Professorships and works in over 640 scientific publications, Professor Sindou specialises in Functional Neurosurgery, Microneurosurgery of Intracranial vascular malformations, Skull Base Tumors, Meningiomas, and Neurophysiology Applied to Neurosurgery.

MANAGEMENT OF LATE LIFE DEPRESSION

– with Psychiatrist, Dr Susil Stephen

Introduction

The Australian population is ageing, with older people a growing proportion of the total population. Depression causes significant emotional suffering in old age and is associated with poor quality of life. Key features of depression in later life are its comorbidities with various physical illnesses and risk factors for developing depression include deaths of family members and friends, increased isolation, declining health, financial constraints, decreased cognitive functioning and loss of autonomy and social roles. Depression in old age is associated with a higher risk of suicide. Older women tend to have higher rates of depression and suicidal ideation than older men, however older men are more likely to commit suicide.

Clinical features and assessment

The prevalence of depression varies from 5-15% in those attending General Practitioner's rooms and it increases to 15-25% in residents of aged care facilities. Depression in older people is often missed due to erroneous perception of some of the overlapping features as a normal part of the ageing process or conditions such as dementia. The symptoms of depression in an older adult can be subtly different to those in younger people. For example, older people are less likely to display affective symptoms, but they are more likely to show cognitive difficulties, somatic symptoms, sleep disturbances, agitation and anhedonia. The Geriatric Depression Scale (GDS-15) is a very useful and validated screening tool for depression. A score of > 5 warrants further assessment and a score of > 10 almost always indicates depression. PHQ-9 is another validated screening instrument for depression in general practice. The Cornell Scale for Depression in Dementia (CSSD) is a tool that is validated to rate depressive symptomatology in cognitively impaired patients.

Prevalence of depression varies from **5-15%** in those attending general practitioner's rooms, to **15-25%** in residents of aged care facilities

Management

The overall management of major depressive disorder in the elderly is based on RANZCP Clinical Practice Guidelines for mood disorders (2015). The guidelines recommend a stepped approach starting from addressing sleep, lifestyle, diet and adopting regular exercise regime. There is good evidence for Psychological Therapy including Cognitive Behavioural Therapy (CBT), Interpersonal Therapy, Acceptance and Commitment Therapy (ACT) as well as Mindfulness-Based Cognitive Therapy. It is recommended that some form of psychological intervention accompany pharmacotherapy whenever possible.

Pharmacotherapy for major depressive disorders in the elderly requires careful consideration, by taking into account the age related changes in metabolism such as decreased hepatic metabolism and reduced renal function. Lean body mass and total body water decreases in old age with a relative increase in body fat, and these changes could prolong the half-life of medications and may potentially lead to toxicity. The prescriber should also be aware of the potential drug interactions. The likelihood of cognitive dysfunction with associated compliance and safety issues needs to be addressed by various medication management measures. The approach is "start low and go slow". Due to the slower treatment response it is important to allow more time before switching medications. This information should be discussed with the patient and care providers at treatment initiation in order to improve medication adherence.

SSRIs are considered to be the first choice antidepressants in an older person. Citalopram, escitalopram or sertraline may be preferred as they are generally better tolerated. Paroxetine and fluoxetine can increase the risk of drug interactions due to hepatic enzyme induction and should be avoided. Other classes of

antidepressants such as mirtazapine (NaSSA), agomelatine (melatonergic agonist), along with venlafaxine, desvenlafaxine and duloxetine (SNRIs) are also part of the recommended first line treatment. The second line antidepressants include TCAs and MAOIs. Anticholinergic side effects of TCAs may be poorly tolerated and are dose related. Nortriptyline is the preferred choice as it causes less postural hypotension, sedation and anticholinergic effects than the other TCAs. Older persons are more prone to antidepressant-induced hyponatraemia, osteoporosis and prolonged bleeding and these risks are more associated with SSRIs. Regular monitoring is recommended.

If the above pharmacological treatments are ineffective, it is advisable to seek a specialist opinion. Further steps in management strategies include augmentation of antidepressant with Lithium and atypical antipsychotics or combining certain antidepressants. Predictors of likely response to Lithium augmentation include recurrent depression with more than three episodes and family history of depression in a first degree relative. Second generation antipsychotics such as aripiprazole, olanzapine, quetiapine and risperidone can be effective as augmentation agents, and are administered at much lower doses than those recommended for schizophrenia and bipolar disorder.

Electroconvulsive Therapy (ECT) is a safe and very effective treatment for severe depression with melancholic, psychotic or catatonic features or patients at high risk of suicide. Repetitive Transcranial Magnetic Stimulation (rTMS) is a treatment modality that is gathering momentum but its efficacy in older people is yet to be seen. In summary, an older person with depression should be offered the same range of pharmacological and non-pharmacological therapies and age should not be a barrier to specific therapies.

Dr Susil Stephen joined Brisbane Waters Private Hospital in 2018 and manages older patients in the outpatient and inpatient settings. He previously worked as a consultant old age psychiatrist in the UK for a few years. Since moving to Australia in 2015, he has been working as a Senior Staff Specialist Psychiatrist at Wyong Hospital. He is a faculty member of the Old Age Psychiatry division of the RANZCP and an accredited supervisor for trainee psychiatrists. Dr Stephen's special interests include mood and anxiety disorders as well as organic psychiatry.

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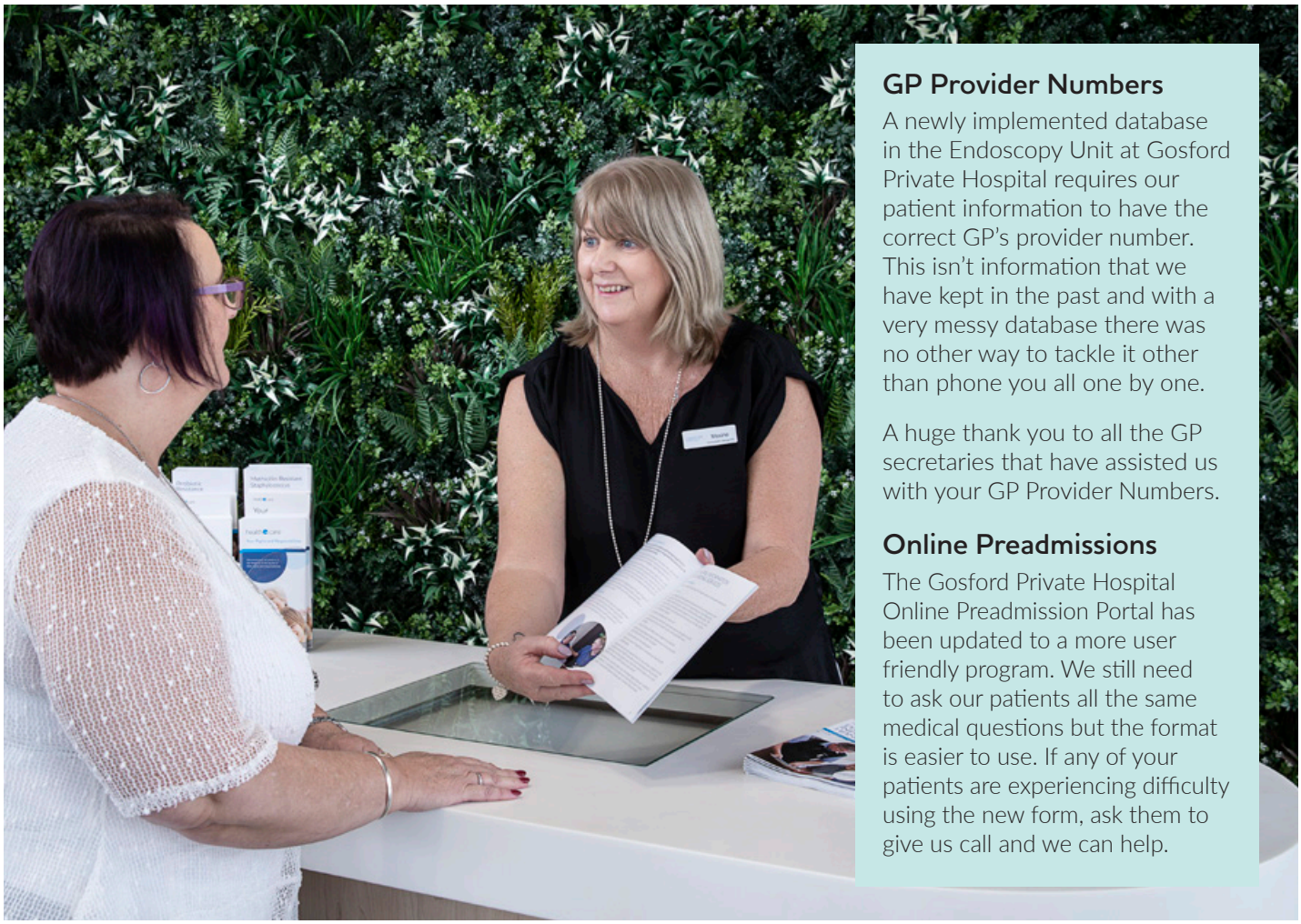
Successful 3rd Annual Central Coast Mental Health Conference

Over 100 delegates joined esteemed Psychiatrists Dr Tanveer Ahmed, Dr Mark Cross, Dr Greg Pearson (shown) and Dr Ted Cassidy at the 3rd Annual Central Coast Mental Health Conference 'From Moods to Madness – A Psychological Masterclass for Primary Health' at the Crowne Plaza Terrigal as part of Mental Health Month in October.

With topics covering everything from troubled teens to psychosis, bi-polar disorder to depression, the event has established itself as the pre-eminent Mental Health Conference for practitioners on the Central Coast and beyond.

Learn more about the services available at the Central Coast Clinic at **centralcoastclinic.com.au**

ADMIN UPDATES



GP Provider Numbers

A newly implemented database in the Endoscopy Unit at Gosford Private Hospital requires our patient information to have the correct GP's provider number. This isn't information that we have kept in the past and with a very messy database there was no other way to tackle it other than phone you all one by one.

A huge thank you to all the GP secretaries that have assisted us with your GP Provider Numbers.

Online Preadmissions

The Gosford Private Hospital Online Preadmission Portal has been updated to a more user friendly program. We still need to ask our patients all the same medical questions but the format is easier to use. If any of your patients are experiencing difficulty using the new form, ask them to give us call and we can help.

Admission Booklets

- All patients, regardless of recent admission, are required to complete an admission booklet. However, if the patient has been a patient at the hospital in the last 3 months, the admission is for the same reason as previous admission and no details have changed about medication or medical history then they don't need to complete the '*patient health history*' section of the admission booklet.
- Please remind patients to forward the admission paperwork to the relevant hospital ASAP, preferably two (2) weeks prior to admission.

Consent Forms

- Please ensure the original consent forms are left with the patient admission booklets.
- To reduce the amount of calls to your rooms, can we please request that the consent forms are completed with either the "definitive", or the "proposed" item numbers on them.