ST ANDREW'S
WAR MEMORIAL HOSPITAL

BEST PRACTICE

THE LATEST IN BEST PRACTICE AT ST ANDREW'S WAR MEMORIAL HOSPITAL

Summer 2019

1000th CASE FOR WORLD LEADING DEEP BRAIN STIMULATION TEAM

Latest Australian-first in vascular surgery

Bariatric surgery just the beginning to successful weight loss

Sacral Neuro Modulation for pelvic pain

Welcome to 2019

Welcome to this Summer edition of *Best Practice*. The year is now well underway and St Andrew's continues to excel in innovating, educating and caring.

In this edition we have plenty of interesting news to share with you, including reaching a significant milestone - the 1000th case for the St Andrew's Deep Brain Stimulation (DBS) team led by Professor Peter Silburn AM and Associate Professor Terry Coyne OAM.

The DBS team's steadfast commitment to giving patients the much longed for relief from symptoms caused by a range of debilitating conditions and diseases, particularly Parkinson's disease, has been tremendous.

We've also been continuing to invest in the latest equipment and technologies, with our Endoscopy Unit receiving a $1million investment into the latest scopes and software to now offer the most advanced diagnostic and therapeutic procedures for gastroenterology and respiratory conditions. As a result, St Andrew's is now one of the first private hospitals in Queensland to offer Cryobiopsy for lung biopsy - a less invasive alternative to surgical lung biopsy.

One of the heart-warming stories in this edition is about the wonderful 'village' that the St Andrew's Breast Cancer Service has created since its inception back in 2014. This 'village' was out in force at the Breast Cancer Awareness month event we hosted, and it was wonderful to see, hear and feel the support our staff have for the patients and vice versa.

You can also read about the talented Dr Ben Green, breast and endocrine surgeon who is working hard to minimise the psychological impact of breast cancer surgery by offering direct-to-implant surgery at St Andrew's; and upper GI and laparoscopic surgeon Dr Philip Lockie's practice, that is demonstrating bariatric surgery weight loss outcomes better than the national average, due to a comprehensive pre and post-operative program.

We hope you enjoy reading this first edition of *Best Practice* for 2019, and we wish you the very best for a healthy, prosperous and happy 2019. It promises to be another excellent year of innovation and advancements here at St Andrew's. I hope to see you at some of our events and activities throughout the year (see our education program on the back cover).

Dr Michael Gillman
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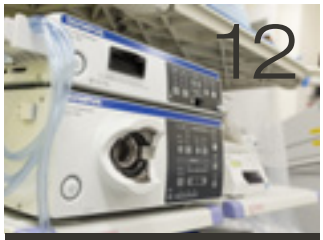
Spotlight



Service Update

Snaps

what's inside

VMP PROFILE UPDATES

Dr Kevin Chan

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Upper Gastrointestinal, Bariatric, General Surgeon and Endoscopist
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Dr Kevin Chan is a General Surgeon operating at St Andrew's War Memorial Hospital. He specialises in Upper Gastrointestinal Surgery and Bariatric Surgery. Dr Chan completed his general surgery fellowship in Queensland in 2015. He then undertook further training in upper gastrointestinal surgery through the Australian and New Zealand Gastric and Oesophageal Surgery Association (ANZGOSA) post-fellowship training program.

His fellowship posts included St Vincent's Hospital Melbourne, St Vincent's Hospital Sydney and Concord Repatriation General Hospital Sydney where he gained extensive experience in advanced upper gastrointestinal surgery and bariatric surgery.

Dr Chan's special interests are reflux disease, upper gastrointestinal oncology and bariatric surgery. He is a member of ANZGOSA, ANZMOSS and GSA and continues to keep abreast with developments in upper gastrointestinal and bariatric surgery by attending local and international conferences. He currently holds a VMO post at the Royal Brisbane & Women's Hospital, operating privately at St Andrew's War Memorial Hospital and consults from private practice rooms at Chermside. ■

Dr David Mitchell

BSc MBBS FRACS
Upper Gastro-Intestinal, Bariatric & General Surgeon
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Dr David Mitchell is an Upper Gastro-intestinal, Bariatric and General Surgeon based in Brisbane. Dr Mitchell now operates at St Andrew's War Memorial Hospital.

Dr Mitchell is a Queensland trained General, Upper Gastro-intestinal & Bariatric Surgeon. After completing a Bachelor of Science in Medical Science at Queensland University of Technology (QUT), David undertook his Medical Degree at the University of Queensland, which he completed in 2007. David commenced General Surgery training at The Royal Brisbane & Women's Hospital in 2011. Following completion of his Fellowship (FRACS) in 2015, David underwent sub-speciality training in Upper Gastrointestinal & Bariatric Surgery. David completed his first year at one of Australia's leading Upper Gastro-intestinal and Bariatrics Centres, Concord Hospital in Sydney.

David was then accepted onto the official Australian & New Zealand Gastro-Oesophageal Surgery Association (ANZGOSA) fellowship training program. He completed two further years of fellowship training at the Royal North Shore Hospital (Sydney) and The Royal Brisbane & Women's Hospital (Brisbane). During this time, David furthered his interest in advanced oesophago-gastric cancer, reflux and bariatric surgery. During David's final year of training, he held the position of University of Queensland Surgical Fellow, continuing his interest in teaching junior doctors and medical students.

David is currently appointed as an Upper Gastro-intestinal & Bariatric Surgeon at the Royal Brisbane & Women's Hospital, where he is part of both the Bariatric and Upper Gastro-intestinal Cancer Multi-disciplinary Teams. David is a passionate general surgeon who actively participates in on-call general and trauma surgery. He is a member of ANZGOSA and ANZMOSS and has published and presented on eosophageal cancer, reflux and bariatric outcomes both nationally and internationally. David is currently enrolled in a PhD at Notre Dame University furthering his interest in the field of reflux surgery and its outcomes. ■

Dr Kowsi Murugappan

MBBS FRACS
Breast and Endocrine Surgeon
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Dr Kowsi Murugappan is a Breast and Endocrine Surgeon and developed a passion for health care while growing up in northern country Victoria and seeing the impact of a dedicated medical professional. This passion took her to completing a medical degree at Monash University in 2004, followed by General Surgical training at the Austin Hospital and Monash Health between 2006-2012.

During training, she developed a strong interest toward breast cancer management. She pursued and completed three years of Breast and Endocrine fellowships at Nepean Hospital – Sydney, Christchurch Hospital and RBWH. At the end of her Fellowship at RBWH she accepted her current role as staff specialist in Breast and Endocrine surgery.

Over the years, she has broadened her experience in her field including a special interest in oncoplastic and reconstructive breast surgery. She also has a strong academic focus with active involvement in breast cancer research through University of Queensland Centre for Clinical Research.

She is available for consults through Specialist Services Medical Group at St Andrew's. ■

Dr Karl Poon

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Structural and Coronary Interventional Cardiologist, TAVI Specialist
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Dr Poon is an experienced interventional cardiologist with a special interest in structural heart disease intervention, particularly as a teacher/proctor and high volume operator in TAVI (transcatheter aortic valve implantation).

Dr Poon graduated from the University of Melbourne in 2001 and went on to training at prestigious institutions such as Royal Melbourne Hospital and St Vincent's Hospital. He undertook an interventional cardiology fellowship at The Prince Charles Hospital and became a senior interventional fellow in 2012 at William Beaumont Hospital in Michigan USA with exposure to MitraClip, TAVI, Watchman devices amongst other complex structural interventions.

In 2015, along with Dr Alex Incani, Dr Poon set up the first private sector TAVI program in QLD and has since established the St Andrew's Heart Valve Program to be one of the leading programs in the Australasia with best in class efficiency and outcomes, with no procedural mortality after over 300 cases.

Dr Poon is a proctor/teacher for TAVI for Edwards transcatheter heart valve and regularly travels locally and internationally to help teach new TAVI operators and set up new programs. He is an invited panelist at national and international meetings and presents regularly at EuroPCR, LondonValves & ANZET amongst other meetings. He has published over 40 peer reviewed articles, authored 5 book chapters, and practices at The Prince Charles Hospital as a senior cardiologist involved in teaching the next generation of interventional cardiologists.

Dr Poon consults privately at St Andrew's Specialist Suites and the Northlakes Specialist Medical Centre, he performs invasive procedures including TAVI at St Andrews War Memorial Hospital. Dr Poon has a passion for the awareness of structural cardiac disease and is a founding director of the recently established Queensland Heart Institute. ■

ANOTHER AUSTRALIAN FIRST FOR ST ANDREW'S

St Andrew's War Memorial Hospital continues to pioneer advancements in vascular surgery following the completion of the first Valiant Navion stent graft in Australia.

St Andrew's Acting Director of Medical Services Dr Michael Gillman said it was a major milestone for the hospital which is focused on providing innovative options for their patients.

"Announcing this latest Australian-first in vascular surgery demonstrates the commitment by our surgical teams to find the best possible outcomes for our patients.

"For more than 60 years, St Andrew's has been pioneering lifesaving treatments and this recent procedure in vascular surgery complements previous advancements at our hospital.

"These ongoing developments are a success due to the innovation, collaboration and dedication by a team of highly skilled specialists at St Andrew's," said Dr Gillman.

Used to treat patients suffering from a thoracic aneurysm (a dilated and weakened wall of the major artery of the chest), the Valiant Navion stent graft is specialised due to its smaller size and precise ability to treat the aorta.

Dr Toby Cohen, Endovascular Surgeon at St Andrew's and the first surgeon to complete this procedure in Australia, said that without access to this lifesaving treatment, the patient's survival rates were low.

"Previously, patients with smaller iliac arteries would not be eligible to receive treatment, but with the smaller profile of the Valiant Navion we were able to carefully guide the graft into the arteries of the leg.

"With limited access to the appropriate size of stent graft in Australia, we were determined to find the most appropriate treatment and searched overseas.

"Not only has this further improved the life of the patient, but it has also expanded the opportunity for patients into the future who are eligible for this lifesaving treatment," said Dr Cohen. ■

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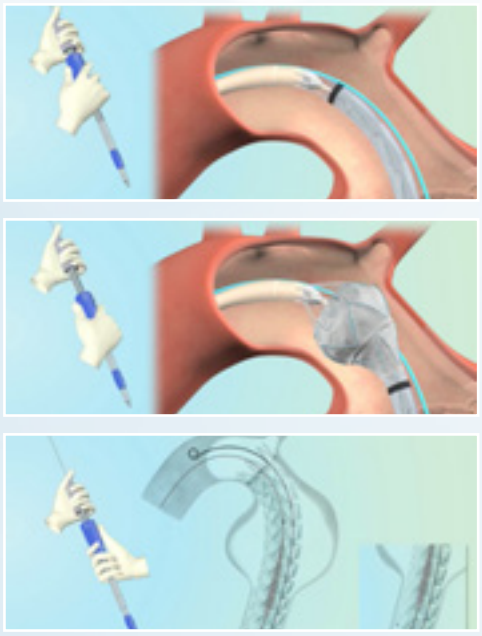

Images courtesy Medtronic

St Andrew's welcomes new General Manager: Mairi McNeill

St Andrew's welcomed Mairi McNeill as General Manager in December 2018. Mairi is an experienced healthcare executive who has worked in the private industry for over 23 years.

"I'm excited to be on board at St Andrew's and leading such a highly regarded hospital and team. Over the years, through my professional experience, I have become acutely aware of St Andrew's excellent reputation and extensive history of best practice clinical outcomes.

"I look forward to working with the entire St Andrew's team – our specialist medical practitioners, our GP partners, our nurses, our non-clinical teams and our amazing volunteers - all of whom help keep St Andrew's as a leader in the medical field," Mairi said.

With continuing pressure on the private health sector including dwindling numbers of privately insured patients and greater competition, Mairi is keen for St Andrew's to continue to stand out from the rest for our GP referrers and partners. All feedback is encouraged and Mairi looks forward to collaborating on ideas and initiatives to continue to strengthen St Andrew's as a robust service and continuing leader.

Most recently, Mairi was the General Manager of Brisbane Private Hospital where she oversaw complete hospital refurbishment and redevelopment. ■

1000TH CASE FOR WORLD LEADING DEEP BRAIN STIMULATION TEAM

Since their Deep Brain Stimulation (DBS) partnership commenced back in 2002, neurologist Professor Peter Silburn AM and neurosurgeon Associate Professor Terry Coyne OAM never imagined they would reach their 1000th DBS case milestone.

But reach it they have in December 2018, with the help of a tremendous DBS team of health professionals and a steadfast commitment to giving patients the much longed for relief from symptoms caused by a range of debilitating conditions and diseases.

Not only has the St Andrew's DBS team achieved this significant clinical milestone, they continue to forge ahead on the neuroscience research front with partnerships with the University of Queensland's (UQ), Queensland Brain Institute (QBI) and Asia Pacific Centre for Neuromodulation (APCN), to record, analyse and interpret DBS data.

The team also commit extensively to educating and training others in the field, having taught at least 85% of other DBS practitioners in the Australia - making St Andrew's one of the largest DBS training centres in the world.

Professor Silburn said DBS allows neurologists and neurosurgeons to electrically stimulate a specific part of the part of the brain to calm and often stop the movement disorders associated with Parkinson's, Tourette's, dystonia, essential tremor and phantom limb pain, and it is now a highly evolved surgical procedure (Class 1 evidence).

"With advances in DBS technologies in areas like current-steering leads and imaging we are now better able to selectively stimulate certain areas in the brain, and through improvements in wireless technologies we are better able to program the DBS device implanted deep within the brain to deliver the mild electrical pulses to more precisely targeted areas of the brain," said Prof Silburn.

Due to its partnership with UQ's APCN, the team has also been able to carry out an unprecedented amount of DBS research and clinical trials allowing for an immense amount of knowledge to be gained and harnessed about DBS and the human brain.

Associate Professor Coyne said through the advances in technology and research he is now able to access deeper into the brainstem to the pedunculopontine nucleus (PPN), the so-called "brainstem locomotive centre" that processes sensory and behavioural information.

"Such advances are giving us the ability to also treat psychiatric conditions like obsessive-compulsive disorder (OCD) and anorexia nervosa by targeting the nucleus accumbens in the brain," Professor Coyne said.

As a result, the DBS team have already undertaken an obsessive-compulsive disorder (OCD) clinical trial. Currently, six patients have received DBS for OCD with good outcomes. They are then monitored closely for 18-24 months post-surgery.

The next DBS clinical trial is planned for 2019 in collaboration with the Royal Brisbane and Women's Hospital (RBWH) for anorexia nervosa patients.

"Sadly, anorexia nervosa has the highest mortality rate of any mental disorder. We will be trialling DBS on patients that have been deemed to have treatment resistant anorexia," said Professor Silburn.

"Similarly to our OCD cases we will be trying to understand what is going on by stimulating different parts of the brain for anorexia nervosa patients," he said.

DBS has already been trialled on anorexia patients in Holland and other countries with good reported outcomes.

However, Professor Sillburn said that Parkinson's disease patients remain the highest proportion of patients to be treated by DBS and make up 85% of St Andrew's cases.

"Our DBS Parkinson's patients have ranged from 37 to 80 years old, and our youngest patient to-date was an 8-year old with dystonia who has had a gratifying outcome – DBS has given him a new lease on life," Professor Silburn said.

The success of DBS at St Andrew's is entirely due to the multi-disciplinary team that collectively hold an expertise in the area that is second to none, according to Professor Silburn.

"Surgery alone is not enough for our patients, our dedicated team of psychiatrists, psychologists, DBS nurses, theatre staff and rehabilitation specialists all work together to ensure the patient's wellbeing pre, during and post-surgery is the number one priority," he said.

Having been on the frontier of DBS for 17 years, the list of accolades for the team is long. One published study ranked them in the top five DBS teams in the world for surgical efficiency; both Professor Silburn and Associate Professor Coyne have received Order of Australia medals for their work in the field of medicine and neurology and neurosurgery respectively; and they have authored and co-authored 27 peer reviewed clinical and basic science research publications about DBS, including in prestigious journals such as Nature Neuroscience, Brain, and Neurosurgery.

In addition, they have been involved in over 72 presentations at peer scientific conferences and meetings. One of the team's psychiatrists, Dr Phil Mosely, was lead author for the best scientific poster award at the American Society of Stereotactic & Functional Neurosurgery Biennial Meeting in June 2018 in Denver. ■

For more information or to make a referral please contact:
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SPOTLIGHT

Breast Cancer Awareness event brings St Andrew's 'village' together

The third St Andrew's War Memorial Hospital Breast Cancer Awareness morning tea was held in October, bringing together nearly 100 guests including past and present patients, friends and family.

The atmosphere in the room was full of support and optimism for the wonderful St Andrew's Breast Care Service and reconfirmed the sentiment on the day of St Andrew's Breast Care Nurse Natasha Keir, "it takes a 'village' to support our patients".

This 'village' was there in force, including our dedicated breast care nurses, allied health staff, doctors, imaging staff, volunteers, St Andrew's executive and even students from St Columban's College Caboolture who hand-make some very special gifts for the patients.

The St Columban's school have had an after-hours activity group since 2014, who sew mastectomy cushions and drain bags for St Andrew's patients.

"These practical gifts make such a difference to the patients' recovery, and it was wonderful the students could be part of the day," said Ms Keir.

At the event, Jana Suthers, breast and lymphoedema physiotherapist at St Andrew's spoke about the importance of exercise being part of routine cancer care.

Ms Suthers said currently 60% of cancer patients in Australia don't meet the aerobic exercise guidelines and 80-90% don't meet resistance guidelines.

"At St Andrew's we understand the exercise capabilities of cancer patients and we can therefore support them to achieve their goals. This support goes a long way to reducing the fear and anxiety about exercise that is often experienced by cancer patients," said Ms Suthers.

Next, patient Jane Dowsett, 45, bravely shared her breast cancer journey since October 2014. She said while there were many hard moments she mostly remembers the good parts.

"At St Andrew's, I felt I was being cradled and in the best possible care. Every single time we left Professor Ung's office we felt inspired as we had an action plan," Ms Dowsett said.

The final guest speaker was Dr Ben Green, breast and endocrine surgeon who spoke about the five most common questions he receives from patients after breast cancer surgery, and here they are:

Q: Is the cancer going to come back?
A: It doesn't usually reoccur, but if it does it is treatable. If you follow your treatment plan, you are setting yourself up for every chance that it won't return. But remember, no two breast cancers are the same and not two people are the same. The worst thing you can do is compare yourself. Take a deep breath and keep going.

Q: Do I still need to have a mammogram?
A: Yes, I still recommend yearly mammograms.

Q: Can I have a breast reconstruction?
A: Yes, everyone can have symmetry back. Once things have settled down, speak with your surgeon as to the best method for you.

Q: Are my children at risk?
A: No, not always. Several factors come into play here including the age you were at diagnosis, the type of cancer, and other family genetic issues.

Q: What happens after five years?
A: Firstly, have a celebratory drink! At this milestone many can stop endocrinology therapies if advised, but active self-surveillance should continue. ■

For more information about our breast care service, visit standrewshospital.com.au


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SERVICE UPDATE

ENDOSCOPY UNIT UPGRADE PUSHES SERVICE TO FOREFRONT IN QUEENSLAND

St Andrew's Endoscopy Unit has invested over $1 million into the latest equipment and technologies to now offer the most advanced diagnostic and therapeutic procedures for gastroenterology and respiratory conditions. As a result, it is now one of the first private hospitals in Queensland to offer Cryobiopsy for lung biopsy.

Dr Farzad Bashirzadeh, respiratory specialist at St Andrew's, said advances in scopes and biopsy equipment are allowing his specialty of respiratory medicine and the gastroenterology doctors at St Andrew's, to see better and further, and in turn treat and diagnose more accurately, yet less invasively.

"Many of the patients who would have previously required hospital admission and surgical procedures can now visit as day-patients and receive less invasive diagnosis and treatments," said Dr Bashirzadeh.

The unit's recent additions include the latest generation Olympus gastroscopes, colonoscopes, single balloon enteroscope, and bronchoscopes with Endobase software.

The new single balloon enteroscope allows viewing of the upper reaches of the small intestine/bowel that cannot normally be viewed using traditional methods and scopes. In turn, patients with ulcers or lesions that may be bleeding in the small bowel, can now be quickly visualised, diagnosed and treated non-invasively in the day-surgery unit.

Meanwhile, patients with possible lung disease now benefit from the new Cryobiopsy equipment - a less invasive alternative to surgical lung biopsy. The technique uses a special cryoprobe with compressed gas to freeze small portions of lung tissue and allow for a larger lung tissue biopsy to be taken. Previously, this would have required surgery to get a large enough sample size for some diagnostic tests. This new technique is also an outpatient day-surgery procedure.

"This method can pick up interstitial lung disease, early lung tumours and other conditions so appropriate treatment can be given promptly to patients," said Dr Bashirzadeh.

The new Cryobiopsy unit was generously donated to the hospital by the St Andrew's Ladies Auxiliary.

Every week, the St Andrew's Endoscopy Unit performs a wide range of high-end diagnostic and therapeutic procedures and if required, has the ability to transfer patients within the facility to other specialists and care, without the need transfer to another health care provider. Services provided at the St Andrew's Endoscopy Unit include:

- **Gastroscopy**: both paediatric and adults, inclusive of the balloon enteroscope, ERCP (endoscopic retrograde cholangiopancreatography) for gallstone removal, endoscopic ultrasound, and overstich procedures for gastric leaks
- **Colonsocopy**: paediatric and adults
- **Bronschoscopy**; endo bronchial ultrasound (EBUS) with needle aspirate and lung biopsy; cryobiopsy; endobronchial lung volume reduction; endobronchial stents; and thermoplasty
- **Trans Oesophageal Echo** (TOE)
- **Cardioversion and bone marrow biopsy** ■

DOCTORS CONSULTING AT ST ANDREW'S ENDOSCOPY UNIT

Respiratory Specialists

Dr Farzad Bashirzadeh
Dr Alex Ritchie
Dr Samuel Kim
Dr Ian Brown

Gastroenterologists

Dr Sunny Lee
Dr Jason Huang
Dr Natalie Kiel
Dr Gautam Ramnath
Dr Tom Zhou
Dr James Daveson
Dr Richard Muir (paediatrics)
Dr Kavin Nanda
Dr Ruth Hodgson
A/Prof David Hewett

General Surgeons (colorectal)

Dr Damien Petersen
Dr Hajir Nabi
Dr Keith Towsey
Dr Craig Harris

BARIATRIC SURGERY JUST THE BEGINNING TO SUCCESSFUL WEIGHT LOSS

Currently bariatric surgery is the most effective treatment for obesity and associated co-morbidities such as diabetes. However, to sustain long-term weight loss success and for resolution of co-morbidities, St Andrew's War Memorial Hospital's upper GI and laparoscopic surgeon, Dr Phil Lockie warns that surgery needs to be combined with behavioural and dietary change.

Latest results from Dr Lockie's practice, demonstrate weight loss outcomes better than the national average, and he credits these results to his team approach before and particularly following a patient's surgery.

"We know, through experience, that bariatric surgery is not an easy option, and it is important that patients participate in the pre and post-operative psychological and dietetic support that we offer to sustain their weight loss," said Dr Lockie.

Dr Lockie's patients at 12 months post-surgery had an average BMI of 30 (compared to a national average of 32.5); an excess weight loss of 80.2% (compared to a national average of 64.8%); and a total weight loss of 31.3% (compared to a national average of 25.5%).

Dr Lockie's pre and post-operative care program for patients includes the following key elements:

Bariatric co-ordinator: a complimentary consultation for patients to discuss their surgical options and learn how the practice works. This helps guide the patient through the process and acts as a point of contact for questions.

Dietician: regular sessions in person and over the phone with a dietician to discuss diet changes immediately post-surgery, and then at specific intervention points like hair loss at three months and managing appetite beyond twelve months. Vitamins and micro-nutrients are checked on a regular basis by Dr Lockie and the dietician.

Psychologist: patients are provided with pre- and post-op sessions to help put in place the fundamental lifestyle changes required to help consolidate behavioural change. Behavioural change is essential for long-term weight management. The team's psychologist specialises in bariatric patients and has completed a PhD in weight loss patients.

Weight loss support group: a monthly support group provides the opportunity for patients to discuss their concerns in a group setting under the supervision of a psychologist. Guest speakers present on a regular basis on a range of topics including post-weight loss plastic surgery.

Specialist consultations: as part of weight loss surgery is managing and improving weight related co-morbidities such as diabetes, we collaborate with a number of specialists at St Andrew's, both pre-operative, in-hospital and post-operatively, to ensure patients are as well as possible prior to surgery, have the best possible management of their co-morbidities in hospital and as they lose weight post-operatively.

Exercise: patients are encouraged to attend the support group with an exercise physiologist and have the opportunity to book individual one-on-one sessions with the exercise physiologist. Formal and incidental exercise is important for long-term weight management.

Dr Lockie said bariatric surgery should be regarded as a tool to aid weight loss and the importance of behavioural factors (eating behaviour, diet and exercise) cannot be overemphasised.

"Modification of poor behaviour or food choices, through dietary and psychological assistance is important for long-term success. Our team members, have been working together for ten years, and are here to provide as much support as needed," he said.

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IN FOCUS

What losing 40kg taught me about change [Greg, 50]

Before my surgery, with the help of the team I worked through my problems with food, my emotional food triggers, and then worked out my big 'why' for surgery now. We explored food plans and options as well as discussing the experience of what to expect physically post-surgery.

Now looking back, the change process kept my 'why' at the forefront, and helped me think through potential problems and coping strategies. The team repeatedly followed up to check that my thinking was still on track and embedded over a number of weeks, and made sure that I clearly knew the process and potential areas of failure.

They worked on getting things right over many weeks before the actual event, and not just a quick one week hit (like the fat camp).

Mental rehearsal and pre-emptive trouble-shooting is an intensely powerful tool in change.

Anyone who says weight loss surgery is easy, is talking out of their hat. It is the second hardest thing I have done in life, after parenthood. It is a whole of life, irreversible change and is simply a tool rather than a total solution. Yes, you can still go back to pre-weight if you are not careful and try and 'game' the system.

What I have found by losing 40kgs is that effective change is a blend of many things as follows:

- Start with hope;
- An expert support team is vital (remember, it may take many attempts to find the right team);
- Know your 'why' and keep that front and center;
- Mentally rehearse the change process by thinking through all the steps and processes;
- Pre-emptive trouble-shooting matters. By working through potential pitfalls and how to deal with them before they kick in, you minimise failure;
- Find a change buddy for the early days;
- Get the support of your immediate family and friends before you start;
- Have unpleasant consequences for mistakes while you are learning;
- Set reminders to keep your actions on track and to reflect your new way of thinking and acting;
- Ensure you have daily monitoring and take corrective action when the alert is triggered;
- Set small goals and celebrate each win. ■

Minimising the impact of breast cancer surgery

Dr Ben Green has been practising as a breast and endocrine surgeon at St Andrew's since 2013 and has been part of a change in how breast reconstruction happens in Queensland - with direct-to-implant reconstructions now a popular choice for several reasons.

Dr Green said, some years ago the focus of the initial surgery was solely on removing the cancer, however with breast cancer survival rates now at 95%, there has been a movement in thinking to try to also maximise the aesthetic outcome for the patient as quickly as possible.

"Patients are often in a fragile state when going into breast cancer surgery. To come out of surgery minus a breast can have a massive psychological impact on them," Dr Green said.

Approximately 40% of women with breast cancer will require a mastectomy, however according to a 2018 Breast Cancer Network Australia (BCNA) paper, Queensland's rate for reconstruction after surgery is only 6% of cases. This figure compares to a national average of 12% and an international average of 30%.

"There are many barriers to reconstruction surgery particularly cost, timing, and the need for multiple surgeries. But about 70% of women who are suitable prefer implant reconstruction, while others have tissue-based reconstruction which is the preferred method for particular patients," he said.

Dr Green said, traditionally, implant based reconstruction was done in two-stages, either delayed sometime after a mastectomy or immediately at the time of mastectomy, by using a two-stage approach with a temporary tissue expander then after several months having the permanent implant inserted.

"There has been a reluctance to perform immediate reconstruction with an implant due to concerns over complication. However, since 2014 direct-to-implant surgery has been my preferred method in suitable patients as it cuts out the expander stage, there is less pain and an immediate result, with low complications rates," he said.

"For my patients to wake up after surgery and still have a breast, positively impacts their whole mental state, the symmetry is often better than with delayed surgery, wounds are minimised and further surgery is not normally required.

Dr Green, said this type of surgery is suitable for patients who have a mastectomy, who have a smaller breast size, have no co-morbidities and are unlikely to need radiation – equating to approximately 50% of patients having a reconstruction according to Dr Green.

The process for direct-to-implant based breast reconstruction surgery involves a silicone filled implant being placed under the pectoral muscle and with the aid of dermal matrix (donated skin) such as FlexHD to recreate the breast shape. The procedure is quite quick (takes about 4hrs for a bilateral case) and gives a good cosmetic outcome especially while wearing a bra. Recovery is fast and patients are mobile and returning to normal activities usually within a few weeks from surgery.

Dr Green said symmetry is often an ongoing issue after breast reconstruction implant surgery whether immediate or delayed, due to the implant having a fixed shape. With direct-to-implant surgery the healthy breast can also be altered at the same time to create symmetry. This may be in the form of a breast lift or reduction to match the newly created reconstructed breast. Symmetry is an important factor to prevent back pain and difficulties in fiting into clothes. ■

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Photos - Case study 41F

Photo 1 - Self detected right breast cancer (23mm grade 3, node negative, triple negative) on background of strong family history (later found to be BRCA 1 gene carrier)

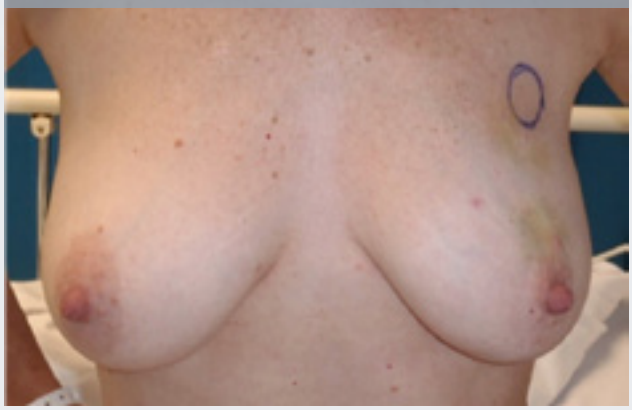
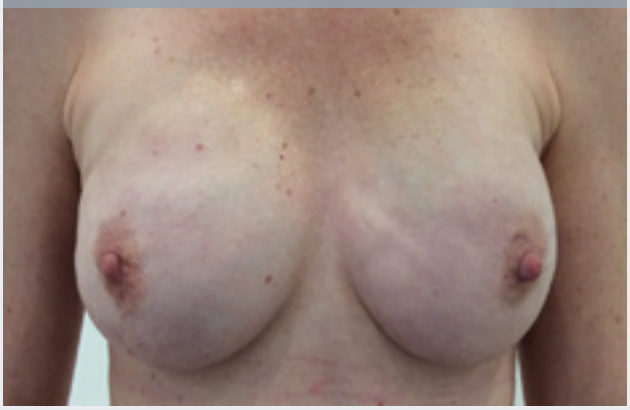


Photo 2 - Nipple sparing subcutaneous mastectomy with sentinel node biopsy and immediate implant reconstruction, followed by chemotherapy. 495cc Mentor Breast Implant placed with the use of FlexHD.



Pros and Cons of direct-to-implant breast reconstructions

PROS

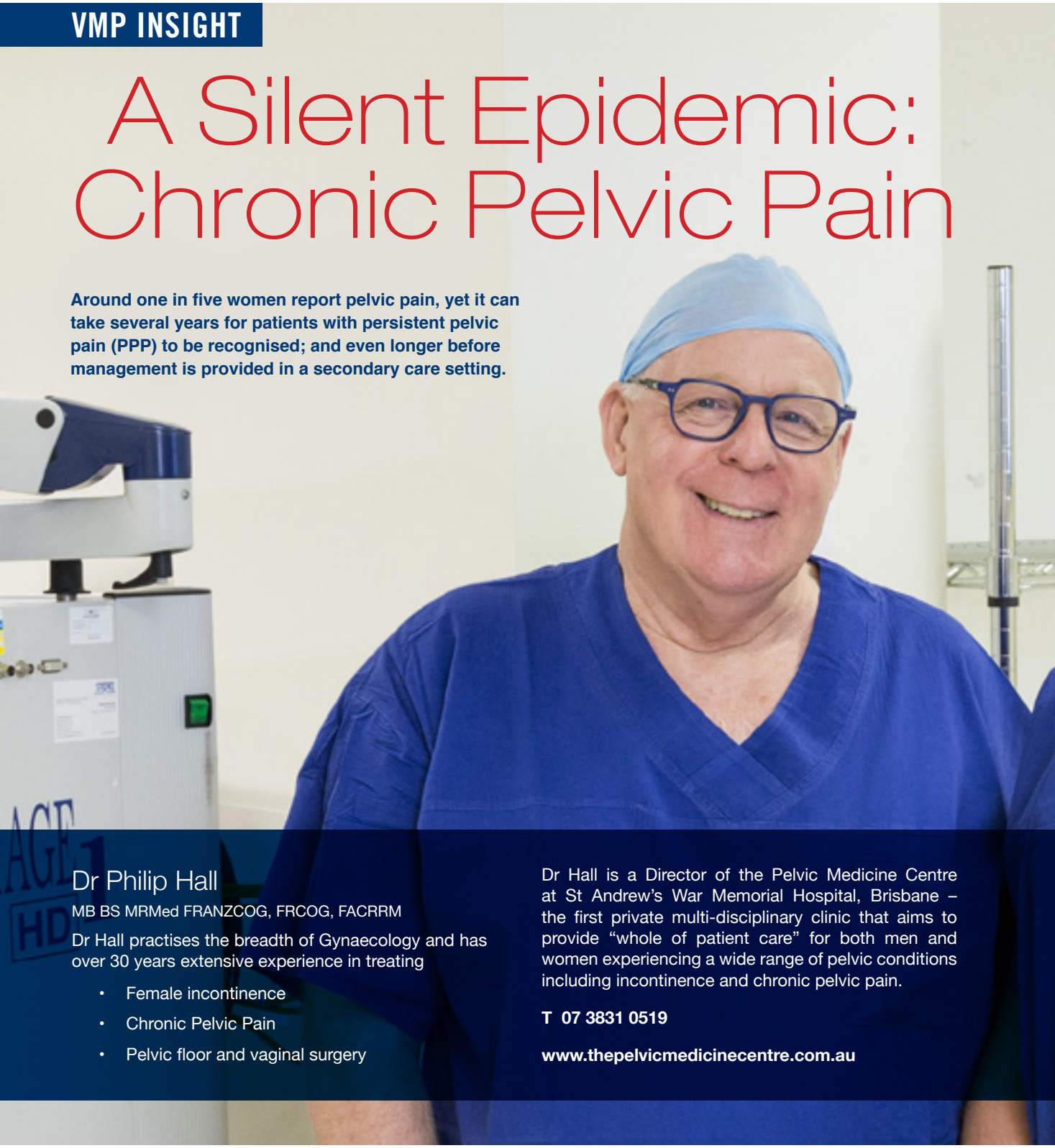
- \+ Best outcomes in smaller breasts - up to a small C-cup
- \+ Can still be performed in a larger breast if willing to sacrifice the nipple and reduce the final breast size
- \+ Good natural out-of-bra shapes are possible
- \+ Single operation at the time of initial mastectomy
- \+ No period of being ‘flat chested’ waiting for an implant
- \+ Will give shape when in a bra or wearing tight fitting clothing
- \+ Quick recovery

CONS

- \+ More complicated as need to get right first go
- \+ Need to ensure recovery does not interfere with chemotherapy or radiation therapy
- \+ Implants will need to be replaced on average every 10 years - quick operation
- \+ Implants do feel less natural

A Silent Epidemic: Chronic Pelvic Pain

Around one in five women report pelvic pain, yet it can take several years for patients with persistent pelvic pain (PPP) to be recognised; and even longer before management is provided in a secondary care setting.



Dr Philip Hall

MB BS MRMed FRANZCOG, FRCOG, FACRRM

Dr Hall practises the breadth of Gynaecology and has over 30 years extensive experience in treating

- Female incontinence
- Chronic Pelvic Pain
- Pelvic floor and vaginal surgery

Dr Hall is a Director of the Pelvic Medicine Centre at St Andrew's War Memorial Hospital, Brisbane – the first private multi-disciplinary clinic that aims to provide "whole of patient care" for both men and women experiencing a wide range of pelvic conditions including incontinence and chronic pelvic pain.

T 07 3831 0519

www.thepelvicmedicinecentre.com.au

The prevalence of PPP in women from USA, UK and New Zealand is estimated be between 14% to 25%. Then PPP is more common than asthma (10%) or back pain (14%) in Australia. PPP can be a debilitating condition impacting on daily activities, work performance and sexual function, PPP can also often contribute to depression, anxiety and poor sleep.

PPP has many potential causes and is often a complex disorder of multiple contributing aetiologies. Common causes include endometriosis, irritable bowel syndrome, painful bladder syndrome/interstitial cystitis, pelvic floor muscle spasm, vulvodynia, vaginal mesh pain, pudendal neuralgia arising from trauma or exercise, child birth complications. Pelvic surgery (gynaecological, urological or colorectal) can also lead to PPP.

Sacral Neuro Modulation (SNM) for PPP

Once PPP is established, a combination of advanced and conservative therapies may be required. Pain education and physiotherapy for pelvic muscle training are essential. Botulinum toxin and nerve blocks may also be needed. Pain medication can be helpful, but opioids are to be avoided.

Another advanced treatment option is Sacral Neuro Modulation (SNM). SNM has been a therapy choice for patients with lower urinary tract and bowel dysfunction of multiple aetiologies refractory to more conservative management for many years . In the past decade, it has been studied in the management of PPP and shown to provide unprecedented pain reduction and therapy durability.

SNM offers a testing phase and long-term treatment option, which are both reversible. In the procedure, a thin wire is placed near the sacral nerve to send mild electrical impulses to the brain. This is done by placement of a percutaneous nerve evaluation lead. The test wire is placed in the S3 or S4 sacral foramen and its location confirmed by x-ray. The wire is then connected to a small battery pack which provides stimulation power to the wire. The testing period is typically 7 to 14 days. In the permanent implant, a tyned wire is inserted in the S3 or S4 sacral foramen and then tunnelled subcutaneously to attach to an implantable neurostimulator (similar to a pacemaker).

SNM and a multidisciplinary approach for the successful management of chronic pelvic pain and bladder and bowel control has been an integral part of Dr Hall's practice for more than five years. ■

i. Steven Siegel, Elisabeth Paszkiewicz, Charlene Kirkpatrick, Beverly Hinkel and Kimberly Oleson From the Metropolitan Urologic Specialists, St. Paul and Medtronic Functional Stimulation Therapies, Minneapolis, Minnesota, *Sacral Nerve Stimulation In Patients With Chronic Intractable Pelvic, 2010*

ii. Mathias SD, Kuppermann M, Liberman RF, Lipschutz RC, Steege JF. *Chronic pelvic pain: Prevalence, health-related quality of life, and economic correlates.* Obstet Gynecol 1996;87:321-7. Back to cited text no. 1

iii. Australian Bureau of Statistics Data

iv. Oeslemans D, van Kerrebroeck P: *Sacral nerve stimulation for neuromodulation of the lower urinary tract.* Neurol Urodyn 2008, 27:28–33.

v. Siegel S, Paszkiewicz E, Kirkpatrick C, et al.: *Sacral nerve stimulation in patients with chronic intractable pelvic pain.* J Urol 2001, 166:1742–1745.

vi. Everaert K, Devulder J, De Muynk M, et al.: *The pain cycle: implication for the diagnosis and treatment of pelvic pain syndromes. Int Urogynecol J Pelvic Floor Dysfunct 2001*, 12:9–14.

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Prof David Paterson
Infectious Diseases Specialist

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Visiting doctors can choose a range of services to be incorporated into their package including: meet, greet, receipt, theatre billing, debt collection and medical typing. Reception staff currently utilise the Genie booking platform, however doctors can bring their own software and medical administration if required.

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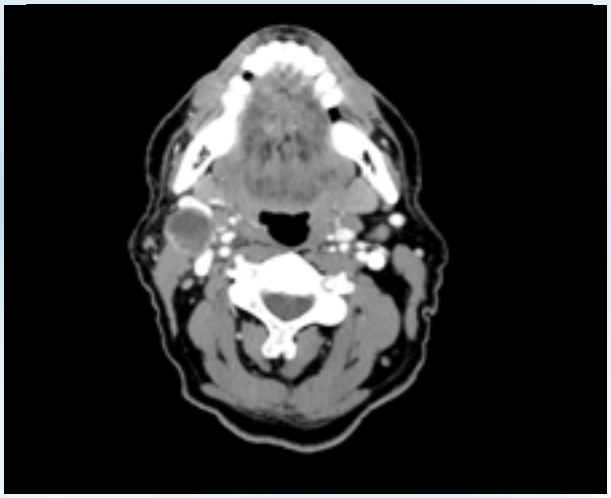
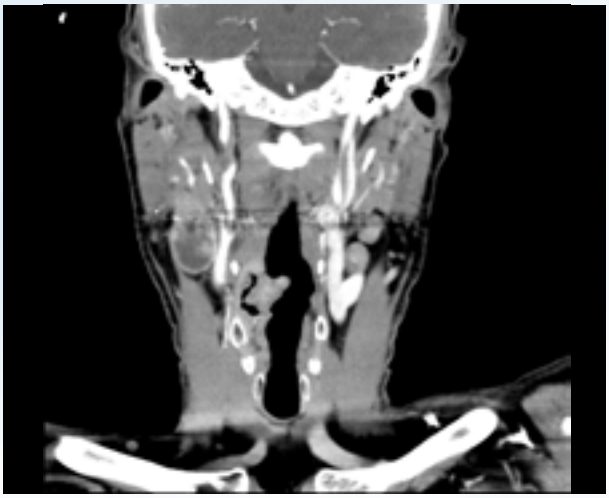
VMP ADVICE

NECK LUMPS

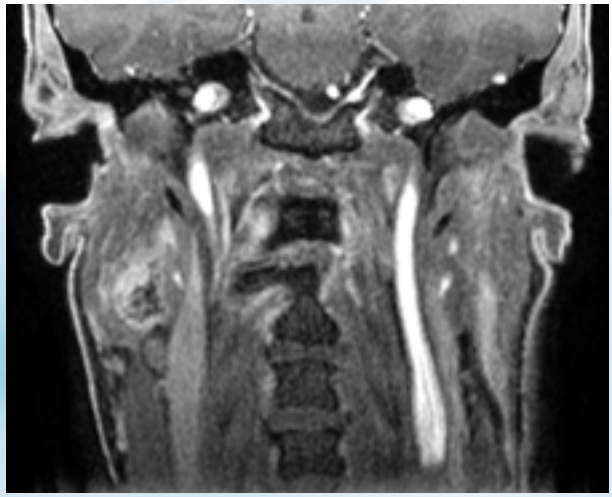
WHEN TO REFER AND HOW TO INVESTIGATE PRIOR TO REFERRAL



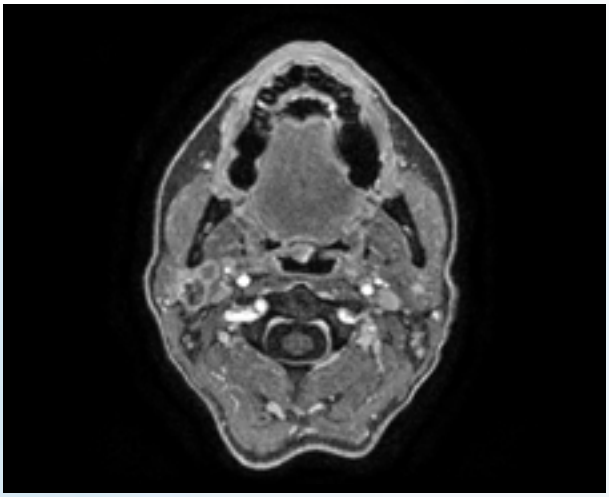
L neck lump CT axial



L neck lump CT coronal



R parotid lump MRI coronal



R parotid lump MRI

Management of a neck lump is something many GPs will regularly face. It is important to be able to triage patients and identify those who may need urgent specialist management. Broadly, neck lumps in an adult patient can be placed into the following common categories:

1. Inflammatory lesions
2. Neoplasms – benign
3. Neoplasms – malignant
4. Vascular lesions
5. Congenital lesions
6. Endocrine
7. Trauma

A good history should either enhance or reduce the level of concern. Is the lump new, changing or related to certain activities? Is the lump painful or painless?

A neck lump that is new, painless, steadily increasing in size, and unilateral should be treated with suspicion of neoplastic aetiology. The full head and neck history will then allow further characterization, particularly when combined with general features such as smoking and alcohol history, skin cancers and family history of thyroid cancer.

In Queensland, sun exposure and skin cancer risk should not be underestimated. Secondary metastases to the parotid and upper neck from a facial or scalp squamous cell carcinoma (SCC) are a common entity faced by a head and neck surgeon. Other common neoplasms would be a parotid gland pleomorphic adenoma, an upper neck metastasis from an oropharyngeal (tonsil and tongue base) SCC, and papillary thyroid cancer metastases.

An in-depth examination will include the neck (including the parotid and thyroid glands), oral cavity, skin and the nose and ears. History taking will have revealed any voice change or breathing difficulties already.

Standard blood tests for infection, inflammatory markers will be helpful particularly if fevers are part of the presentation profile, but imaging and cytological examination are the next important step. A good CT scan of the neck can be combined with staging scans, an MRI can provide important soft tissue detail, and a PET scan can assist in staging or finding a primary when malignancy is confirmed, but USS +/- FNA is the next critical investigation. An USS guided FNA will increase the chances of an accurate result many-fold and in the uncommon vascular lesion (such as a glomus tumour or vascular malformation) the ultrasonographer will identify those features and abandon the FNA. If there is some concern about urgency and waiting for the above result, a phone call to a trusted Head and Neck Surgeon will allow discussion and planning to ensue in a timely manner. ■

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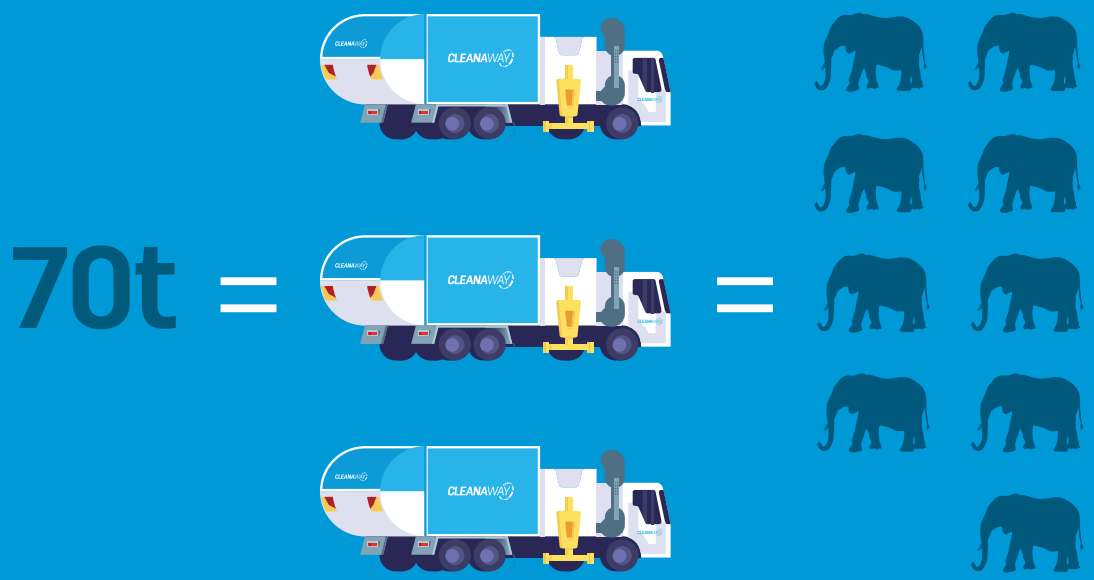
If you have an idea for a story or write-up that you would like to see included in the next edition of *Best Practice*, email your suggestion with a short description of why you think the topic will be relevant to Queensland GPs to susan.walsh@uchealth.com.au

In the past six months Cleanaway and St. Andrew's War Memorial Hospital have worked in partnership to recover

70 tonnes

of recyclable material from landfill.



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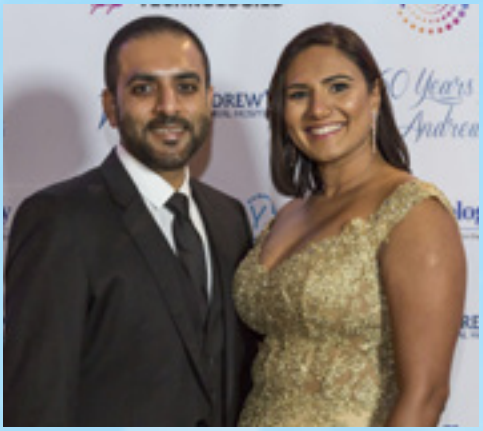
ST ANDREW'S WAR MEMORIAL HOSPITAL GALA CELEBRATING 60 YEARS

Saturday 1 December 2018, Sofitel Brisbane



ST ANDREW'S
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Inpatient Services	**07 3834 4391**
Day Patient Services	**07 3834 4285**
Rural Health Connect	**07 3834 4499**
Pelvic Medicine Centre	**07 3832 1666**
Day Infusion Centre	**07 3834 4493**
Business Development Unit	**07 3834 4371**
GP Education Enquiries	**07 3834 4371**

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St Andrew's War Memorial Hospital's quality management system has received ISO 9001 certification ensuring the hospital's safety and quality system meets the highest international and national standards.

St Andrew's earned ISO 9001:2008 and Core Standards for Safety and Quality in Health Care certification in October 2012 after a very successful audit.

St Andrew's War Memorial Hospital's certification is aligned with international best practice and complies with the 10 standards set by the Australian Commission on Safety and Quality in Health Care.

2019 GP EDUCATION EVENTS

Dates for your diary

ST ANDREW'S WAR MEMORIAL HOSPITAL

CPD Weekend

7 - 8 September	St Andrew's Signature CPD Weekend – Pioneering the way… advanced healthcare Solutions (featuring cardiology, vascular, general, neurosurgery, endocrinology & Emergency Medicine - CPR Workshop)	**Sheraton Mirage, Gold Coast**

Saturday Symposiums

30 March	Backs & Bones (featuring orthopaedic and spinal)	**Victoria Park, Brisbane**
25 May	Women's Health (featuring breast and endocrine, gynaecology, gynaecological oncology, endocrinology, IVF and gastroenterology)	**Victoria Park, Brisbane**
26 October	Men's Health (in partnership with the Wesley Hospital)	**Brisbane**

CPD Evenings

13 March	Bariatric Surgery / Gastroenterology / Endocrinology	**Brisbane**
19 June	Neurosurgery / General	**Brisbane**
18 September	Cardiology / Vascular	**Brisbane**

Country Connect Series

26 June	Cardiology / General Surgery	**Rockhampton**
9 October	Respiratory / Vascular / Breast	**Hervey Bay**

We look forward to seeing you in 2019

For more information contact:
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F 07 3834 4576
E susan.walsh@uchealth.com.au
www.standrewshospital.com.au/gpeducation

**Dates, topics and venues are subject to change*