

# GP e-News

DECEMBER 2017

## Welcome from the CEO

Dear Doctor

I'd like to extend my heartfelt thanks to all of you who have kept in touch with us via this newsletter, and other means. 2017 has been a wonderful year for the Hospital as we have enhanced existing services and implemented new ones.

We value greatly our relationship with GPs, a vital link in keeping patients and the community abreast of innovations in the healthcare sector and in facilitating access to specialist services and facilities best suited to an individual patient's needs.

We look forward to the ongoing engagement of you and your practice in 2018 – not only through this newsletter but also through our GP specialist evenings and other GP resources.

**I invite you all to participate in our 2017 GP survey that has been sent in conjunction with this newsletter. It is your opportunity to provide us with feedback about our services as well as the types of educational activities you may be interested in, in 2018.**

Happy and safe holidays to you and your loved ones.

**Carol Bryant, CEO**

Macquarie University Hospital



If you would like to receive further information about our GP education activities for 2018, please email [events@muh.org.au](mailto:events@muh.org.au)

## NEWLY ANNOUNCED MEDICARE REBATE FOR TAVI HERALDS BROADER ACCESS FOR AUSTRALIANS WITH AORTIC STENOSIS



IN NOVEMBER THIS YEAR, THE MINIMALLY INVASIVE TRANSCATHETER AORTIC VALVE IMPLANTATION (TAVI) PROCEDURE WAS GIVEN A MEDICARE BENEFITS SCHEME (MBS) ITEM NUMBER, MAKING THE TREATMENT MORE ACCESSIBLE FOR SUITABLE PATIENTS.

For more information or to refer a patient please call

CALL 0491 215 002

TAVI has revolutionised the treatment of heart disease by enabling the keyhole replacement of the aortic valve without the need for open heart surgery.

The procedure is fast becoming the treatment of choice for aortic stenosis, particularly in older patients or those with complex medical conditions who might be at higher risk from surgical valve replacement.

Aortic stenosis is the most common form of valvular heart disease, especially in older patients where it affects about 1 in 10 Australians over the age of 75.

Dr Jason Kaplan, Head of the Cardiovascular and Respiratory Program at Macquarie University Hospital, said that the formal MBS item number for TAVI and re-imburement for the prosthesis significantly reduces the cost previously associated with the procedure, providing equitable access to this technology.

“This is a proven alternative to surgery that is especially beneficial for older patients and those with multiple other medical problems,” said Dr Kaplan. “More than seven years of robust data now demonstrates TAVI is as effective

as traditional open surgical valve replacement for appropriate patients.

“Our TAVI program has been in place for several years. Patients choosing Macquarie University Hospital for this procedure enter a well-established program, with balanced multidisciplinary team assessment, and cardiologists and cardiothoracic surgeons who are the most experienced in this procedure in Australia.”

The Hospital’s TAVI team is unique in NSW with every procedure being attended by an interventional cardiologist and cardiothoracic surgeon. This provides a high level of care and expertise to perform the procedure safely.

Interventional cardiologist Professor Martin Ng and cardiothoracic surgeon Professor Michael Wilson perform about 60 TAVI procedures annually as a team at Macquarie University Hospital – well over 100 per year overall, when factoring in their cases at Royal Prince Alfred Hospital. This makes the Macquarie University Hospital TAVI team one of the highest volume TAVI proceduralists in the Southern Hemisphere.

“With TAVI, there is a clear volume-outcome relationship that is well-demonstrated in the literature,” said Professor Ng, who is actively engaged in TAVI clinical trials and has published extensively on the procedure and patient outcomes.

“Macquarie University Hospital currently has the largest TAVI program across the private hospital sector in Australia, with our data showing that we achieve better patient outcomes than in other international registries.”

The TAVI team at Macquarie University Hospital is also innovative. It was the first to use TAVI in congenital heart disease and in conjunction with by-pass surgery, and has developed approaches using alternative access routes where the femoral artery is not viable.

“TAVI is the lead program in Macquarie University Hospital’s Structural Heart Program with a multidisciplinary clinic offering a comprehensive range of procedures from minimally invasive surgery, TAVI and Mitraclip to Robotic Mitral Valve Repairs,” said Professor Wilson, a leading Sydney surgeon and pioneer in off-pump coronary artery by-pass graft surgery.



Professor Martin Ng

TO FIND OUT MORE CLICK HERE

# A CONCISE APPROACH TO THE HOARSE VOICE



PERSISTENT DYSPHONIA HAS A SIGNIFICANT IMPACT ON A PATIENT'S QUALITY OF LIFE AND REMAINS A COMMON PROBLEM WITHIN THE GENERAL PRACTICE SETTING. WHILE A SIGNIFICANT PROPORTION OF PATIENT PRESENTATIONS ARE OF THE ACUTE INFLAMMATORY NATURE IN ASSOCIATION WITH UPPER RESPIRATORY TRACT INFECTIONS, THE PERSISTENT OF DYSPHONIA BEYOND A PERIOD OF 2 WEEKS REQUIRES FURTHER ASSESSMENT.

For more information or to refer a patient

CALL (02) 9633 2133

## PATIENT HISTORY

So beginning with the history, some key questions in my mind are:

1. **Any recent upper respiratory infections?** Even a minor viral URTI can cause sufficient abnormality of the delicate mucosal folds of the larynx or exacerbate pre-existing pathology
2. **Are there any associated sinister upper aerodigestive tract symptoms?** In the region of the larynx and hypopharynx, malignancies cause symptoms such as dysphagia, odynophagia, haemoptysis or referred otalgia
3. **Smoking and alcohol history?** The risk of malignancy is proportional to the pack year smoking history. Alcohol has a synergistic effect. Smoking can also cause a range of benign laryngeal pathology that can be treated such as hyperkeratosis, Reinke's oedema (Fig 1) as well as lung cancers that can lead to recurrent laryngeal nerve palsy leading to breathiness
4. **Pattern of symptoms?** Excessive voice use with occupational demands can create vocal strain. Anxiety/Depression and public speaking fears are often associated with muscle tension. Reflux generally creates an episodic pattern, and is usually worse in the morning. Sudden onset after excessive strain (eg. football spectator) can indicate an acute haemorrhage into the vocal cord
5. **Voice demand of patient?** Are there occupational factors that are associated with risk of developing benign nodules (teacher, lawyers, doctors, singers, salespeople) and what are the occupational voice needs of the patient

6. **Presence of laryngopharyngeal reflux?** Silent extra-oesophageal acid reflux can cause a range of symptoms ranging from globus, irritation, throat clearing, "phlegminess" and dysphonia
7. **Any associated chest disease?** The use of steroid inhalers for COPD can cause laryngeal candidiasis. Persistent cough from reflux, COPD or post-nasal drip from rhinosinusitis can cause vocal cord microtrauma. Lung cancer, TB or thoracic surgery can cause recurrent laryngeal nerve palsy which can manifest as breathy dysphonia
8. **Thyroid disease and surgery?** Myxedema can cause deposits of proteoglycans that thicken the vocal cords manifesting as a deep hoarse dysphonia and thyroid surgery is a risk factor for vocal cord palsy
9. **Any associated neurological symptom?** Conditions such as a CVA, multiple sclerosis, motor neurone disease can cause bulbar dysfunction which results in centrally mediated vagal dysfunction
10. **Recent intubation?** This can be associated with vocal cord granuloma and scarring/indentation disrupting the mucosal wave and cricoarytenoid unit dysfunction
11. **Impact on the patient's quality of life?** Assessment of the impact of the condition on the patient's psychological, social and occupational demands. Motivation to seek treatment and pursue speech therapy if required

These questions can rapidly give clues to the causes of the patient's diagnosis and also the overall impact of the disability. Very often like the old medical adage, the answer remains hidden in the history.

## THE EXAMINATION

Moving on to the examination, I begin with a general vocal assessment. This involves the patient uttering a sentence in their normal voice projection. It is crucial at this stage to identify if possible if the dysphonia is **breathy** or **hoarse**. **Breathiness indicates air escape within the larynx. It signifies a range of conditions where the mobility of vocal cords is affected (eg recurrent laryngeal nerve palsy).** **Hoarseness indicates pathology of the mucosal fold and where the vocal wave is affected (eg malignancy, Reinke's oedema, nodules) Fig 2.**

After this I move on to a systematic physical examination of the patient in the following order:

1. **Examination of nose and nasopharynx including nasendoscopy.** Are there polyps or any evidence of post-nasal drip? Is there significant crusting or septal perforation heralding Wegener's (Fig 3)?
2. **Examination of oropharynx.** Is there candidiasis? Is there another sinister ulcer/lesion?
3. **Examination of the larynx.** Direct per-nasal or per-oral laryngoscopy to assess mucosal fold, mobility and pyriform fossa. Complete assessment for malignancy and reflux. Analysis of vocal cord mobility and glottis closure (eg presbylarynx in old age leading to atrophy and air escape) or vocal cord palsy
4. **A thorough examination of all nodal regions of the neck and the thyroid gland**

Once the history and examination are completed, an accurate diagnosis can be made in a vast majority of patients. Unless a malignancy is suspected a biopsy under general anaesthetic or further imaging is not required. In some cases stroboscopy may be required in a setting of a voice clinic.

CLICK HERE TO FIND OUT MORE ABOUT DR FARUQUE RIFFAT



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## TREATMENT

My general treatment approach is outlined below:

### Vocal Hygiene

1. I take every opportunity to educate my patients about vocal hygiene, including projection, breath control and avoidance of shouting
2. Maintain adequate hydration, this is crucial to the lubrication of the cords
3. Complete smoking cessation including discussion of quitting techniques and medications
4. Reduction of caffeine (drying effect)

### Treatment of Laryngopharygeal Reflux

1. General dietary and lifestyle modifications for reflux including avoiding alcohol and spicy meals
2. Initial double dose proton-pump inhibitor for 3 months followed by maintenance once daily
3. Judicious use of prokinetics (domperidone) and alginates
4. Consider fundoplication for treatment refractory reflux in consultation with gastroenterology and upper GI surgery colleagues

### Speech Therapy

1. Speech therapy has a crucial role in treating the aetiology of vocal pathology (eg nodules), treating the effect of vocal pathology on the function of the patient (eg. muscle tension dysphonia) and training in compensatory techniques (eg supraglottic swallow for cord palsy)

### Surgery

1. **Laser treatment.** The carbon dioxide and KTP lasers have revolutionised the endoscopic management of benign and malignant laryngeal conditions. I routinely offer this for pre-malignant and malignant pathology as the oncological outcomes are identical to radiotherapy (RT) and it keeps the options of radiotherapy open for future use. RT can generally only be used once in a lifetime within a field and furthermore these patients are at up to 20% lifetime risk of another cancer in the head and neck region which may require RT. All malignant cases are discussed at the Westmead Comprehensive Cancer Care Centre, where I am a surgeon at the cancer MDT. This allows for discussion with my RT colleagues of the planned treatment.

The laser is also very useful for a range of benign conditions such as Reinke's oedema, granulomas and webs.

2. **Coblation treatment.** This is a radiofrequency based technique which I utilise for benign conditions such as polyps and papillomas.
3. **Injection and thyroplasty techniques.** These techniques offer a very effective treatment for breathy dysphonia due to volume loss in the cords (eg age atrophy) or for vocal cord palsy. Depending on the aetiology and the expected prognosis the appropriate implant materials can be injected or inserted into the vocal cord. For example, in a palliative setting of advanced lung cancer and vocal cord palsy causing aspiration, a temporary injectable such as Perlane/Restylane can be used or alternatively bioplastique when longer duration is desired. A Gore-tex implant inserted externally for a more permanent solution.

The decision for surgery is taken with the patient being aware of the technical aspects of the procedure, risk and benefits, expected outcome and post-operative care including any speech therapy that may be required.



Figure 1: Reinke's Oedema



Figure 2: Early vocal cord cancer



Figure 3: Nasal septal Perforation

### CONCLUSION

A precise diagnosis can be obtained for the vast majority of phonatory conditions. It is important not to underestimate the impact of dysphonia on a patient's psychosocial functioning. The bright side of it is that good outcomes can be obtained for benign and malignant conditions with a combination of surgery and speech therapy, including for vocal cord cancers where up to 90–95% 5-year survival is achievable with laser treatment, one of the highest in head and neck cancers.

## PRIMUM NON NOCERE AND THE COMPLEXITY OF NEUROSURGERY AND SKULL BASE SURGERY



**DURING HIS THREE-YEAR FELLOWSHIP IN SKULL BASE SURGERY AT THE ST. MICHAEL'S HOSPITAL, UNIVERSITY OF TORONTO, CANADA, NEUROSURGEON ASSOCIATE PROFESSOR ANTONIO DI IEVA REALISED NOT ONLY HOW COMPLEX DEALING WITH SUCH A KIND OF SURGERY WAS, BUT ALSO HOW MULTIDISCIPLINARY AND TRANSLATIONAL HIS COMPETENCE HAD TO BE.**



### ABOUT ASSOCIATE PROFESSOR ANTONIO DI IEVA

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For every single patient, he was managing several different issues, and had to continuously liaise with other specialists such as ENT and plastic surgeons, craniomaxillofacial surgeons and radiation oncologists, diagnostic and interventional radiologists, endocrinologists and oncologists, ophthalmologists and pathologists, anaesthetists and GPs, among others. This is not to forget the expertise required at each level of the professionals involved in the management of patients affected by pathologies of the skull base, such as nurses, physiotherapists, speech therapists.

He soon realised that a compact summary of the plethora of technical and medical information regarding the management of patients affected by pathologies of the skull base was missing. In response, he organised a multidisciplinary international group of specialists and, along with the well-known Canadian neurosurgeon Michael Cusimano and an ENT surgeon colleague, led the writing of the Handbook of Skull Base Surgery (Thieme, New York, 2017), the first and only compact textbook in the genre.

“Skull base surgeons deal with pathologies located at the base of the skull, therefore involving the surrounding structures, such as the brain and brain stem, cranial nerves and blood vessels, orbits and ears, paranasal sinuses and head/neck structures,” said Associate Professor Di Ieva. “Pathologies of the skull base include, among others: pituitary adenomas, meningiomas, acoustic neuromas (an historical misnomer that should be replaced with ‘vestibular schwannoma’), chordomas and others.

“It is true that a great many of the skull base pathologies are tumours, but skull base techniques are often required to also deal with intracerebral pathologies, cerebrovascular diseases, spinal conditions involving the craniocervical junction, and neurotraumatology as well.”

There are two aspects of paramount importance in skull base surgery. The first is a detailed knowledge of anatomy (mastered in the anatomical lab on cadavers) and of the very specific patient's anatomy (by means of advanced study of the radiological images). The second is related to the functional preservation. Several pathologies of the skull base are ‘benign’ tumours but, despite their biological behaviour, can still cause mortality or severe morbidity of patients, as they may affect the brain stem, blood vessels and multiple cranial nerves.

“I will never forget an opera singer who had a relatively rare tumour – a paraganglioma at the level of the jugular foramen, from which the nerve controlling the vocal folds comes out,” said Associate Professor Di Ieva. “After four hours of surgery spent only to reach the tumour, and seven further hours to resect it, we were faced with the dilemma of whether to remove the last piece of the huge tumour, risking the function of that nerve and therefore the patient's career, or to preserve the function by leaving some remnants.

“For a surgeon, it is hard to accept that leaving tumour remnants might be the better decision but for a patient, having certain specific functions affected, can be worse than death.

“The Latin sentence that popped into my mind was *primum non nocere*, repeated in the Hippocratic Oath and re-echoed in the famous book *Do No Harm* by the retired British neurosurgeon Henry Marsh. The tumour remnant was treated with Gamma Knife Radiosurgery, and the patient continued to sing my favourite Verdi operas.

“Removing all of the pathology is always the final aim, but only in respect to the preservation of the function, according to the patient's needs and wishes. Nowadays there are several other modalities to treat pathologies, like radiosurgery and targeted therapies.”

Associate Professor Di Ieva is applying such a philosophy at the Macquarie University Hospital, where there is a consolidated multidisciplinary expertise, including Gamma Knife radiosurgery, in dealing with all of the pathologies of the brain and skull base.

# SPECIALIST MODEL OF CARE FOR HEALTHY WEIGHT CLINIC

AN INTEGRATED SPECIALIST APPROACH TO WEIGHT LOSS GAVE 75-YEAR-OLD ANTHONY DEEHAN RENEWED VITALITY AND A BELIEF THAT HE COULD MANAGE HIS WEIGHT OVER THE LONG TERM.

Macquarie University Hospital's Healthy Weight Clinic takes a multi-pronged approach in assisting patients with weight management. The multidisciplinary team looks at the whole person, understanding them from dietary, exercise, endocrine and psychological points of view.

Seventy-five-year-old Anthony Deehan was referred to cardiologist Dr Jason Kaplan when excess weight was having an impact on the health of his heart.

He presented with comorbidities including dyslipidaemia, hypertension, paroxysmal atrial fibrillation and coronary artery disease.

## INITIAL REVIEW

At his initial consult in May this year, Tony weighed 126 kilograms, at a height of 181 centimetres. His BMI was 38.5kg/m<sup>2</sup> (Obese, N 24 – 30 for >65 years).

Waist circumference: 138.5 centimetres, putting him at very high risk. Recent weight increase was noted, previously around 118 – 120 kilograms for 10+ years. He had attended weight watchers 25 – 30 years ago and successfully lost ~15 kilograms.

## DIETETICS REVIEW

At his initial appointment Tony discussed that his weight had been increasing recently and he was keen to lose weight to feel well and increase his longevity. Dietary assessment indicated that large portion sizes and a higher than recommended intake of discretionary (non-core) foods was contributing to Tony's weight gain. Tony had lost weight in the past and was confident he could do it again and keep it off if he had appropriate support.

**Advice and goals:** Tony was provided with nutrition advice on portion control and how to meet recommendations for healthy eating based on the Australian Dietary Guidelines. A plan was made to reduce his intake of discretionary (non-core) foods to assist in reducing his kilojoule intake.

**Review appointment 24/4:** Tony had lost almost 4 kilograms after 3 weeks on his diet, exercise and medication regime. In addition to the weight loss Tony's waist circumference had decreased by approximately 4 centimetres. At this review Tony was encouraged to focus on consuming adequate protein to enable gradual weight loss while preserving lean muscle mass. A further nutrition goal was discussed to increase his intake of protein and calcium through 3 serves of dairy per day. His progress will be monitored at regular reviews.

## EXERCISE PHYSIOLOGY

- **Initial consult 3/5:** Anthony's whole day physical activity patterns were assessed across a typical week and revealed a moderate to high level of sedentary behaviour (6-7 hours/day) and limited participation in moderate to vigorous intensity physical activity (10 min per week). The major barriers to Anthony's activity participation were identified as shortness of breath with exertion and previous knee and ankle joint issues.

- **Advice and goals:** Anthony was provided with advice on increasing his participation in moderate intensity aerobic activity such as cycling and water-based exercise to optimise his cardiovascular health and to assist with weight management. He was also encouraged to include regular joint mobility, strength and balance exercise to maintain mobility and his capacity to participate in regular golfing games.

Anthony indicated he was interested in joining a local community gymnasium with adjoining pool facilities, such as Ryde Eastwood Leagues Club. Guidance on an initial program was provided, with aerobic parameters (target heart rates) based on his recent Stress Echo test (performed with cardiologist Dr Kaplan).

- **Review consult 24/5:** Anthony reported to have attended a local gymnasium, 2 days per week, over the past month to perform intervals of cycling and arm pedalling exercise, in addition to maintaining his golf and incidental walking.

Anthony reports reduced shortness with exercise and reduced wheezing overall, in addition to an initial weight loss of 4 kilograms. To promote ongoing weight loss and gains in aerobic fitness, goals were set to gradually increase duration of his current exercise (40 minutes per gym session) and specific lower body strength and balance exercises were added to optimise lean body mass and functional mobility. His progress will be reviewed in 2 months time.

## ENDOCRINOLOGY PERSPECTIVE

Tony was assessed to exclude and be treated for metabolic disorders associated with obesity. Thyroid function was normal and he does not have diabetes or Cushing's disorder. His renal function was normal. Liver function enzymes were elevated consistent with fatty liver commonly associated with obesity. Tony was generally well apart from excessive weight gain, which exacerbated his osteoarthritis, and further limited his exercise abilities and quality of life. He has stable coronary artery disease but his cardiologist had cleared him for regular moderate intensity exercises.

We identified that Tony's diet was excessive at times. Given his relative inability to exercise adequately, our weight loss strategy for Tony was to restrict his caloric intake by reducing food portions, and encouraging good food choices, thereby resulting in gradual weight loss. To control his appetite, Tony was started on low dose liraglutide 0.6mg daily subcutaneous injections with concurrent Metformin 500mg orally twice a day. He was also prescribed a moderate intensity exercise regimen to improve cardiovascular fitness and wellbeing.

This strategy was successful as he had lost 4 kilograms of weight over 4 weeks and reported feeling well. He had less shortness of breath and was more mobile. He became highly receptive and positive. We therefore encouraged him to continue this current management for a defined period of time. He will be reviewed at the Healthy Weight Clinic at regular intervals to monitor his progress.



To find out more  
click here

## ABOUT MACQUARIE UNIVERSITY HOSPITAL'S HEALTHY WEIGHT CLINIC

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## TONY'S PERSPECTIVE

"Before I went to the Weight Clinic at Macquarie, I had seen one or two doctors elsewhere, but that was just one visit," said Tony. "They would give me a lot of instructions but I'd get confused, and I never had ongoing support.

"At Macquarie, they keep supporting you, checking on how you are doing. You are being monitored, which was a great help for me.

"I'd never been in a gymnasium before. Now I do the bike and machines, and I lost 11 kilograms over 8 weeks. I've also cut out a lot of things in my diet.

"It was my heart specialist Dr Jason Kaplan who was concerned about my weight. I said I needed help and he put me in touch with the Weight Clinic."

# MAPPING GENETIC MUTATION IN THE BRAIN: ADVANCED MAGNETIC RESONANCE SPECTROSCOPY AND THE FUTURE OF BRAIN TUMOUR BIOPSY



MACQUARIE MEDICAL IMAGING AND MACQUARIE UNIVERSITY HOSPITAL HAVE EXPANDED THE USE OF MAGNETIC RESONANCE SPECTROSCOPY IN AUSTRALIA – AND SET THE FUTURE OF NEUROIMAGING.

Macquarie Neurosurgery:  
To request an appointment,  
click here

Led by Professor John Magnussen, the MRI program at Macquarie Medical Imaging (MMI) has embarked on a ground-breaking new study in neuroimaging of crucial importance for patients with brain tumours and other neurological diseases.

MMI, located within Macquarie University Hospital, is the first site in the Southern Hemisphere to conduct a novel study using Magnetic Resonance Spectroscopy (MRS), technology that measures brain chemistry rather than anatomy.

In the new era of genomic analysis, MRS reads the chemical composition of a region of tissue, which could be used as biomarkers – now considered superior diagnostic, prognostic and therapeutic indicators in the analysis of brain tumours.

“MRS provides information on the metabolic profile of different pathologies, rather than the shape of the brain,” explains Associate Professor Antonio Di Ieva, of Neuroanatomy and Neurosurgery at Macquarie University Hospital, who worked closely with Professor Magnussen and Professor Changho Choi (from the University of Texas Southwestern Medical Centre, Dallas) to bring advanced MRS to Australia.

“Specific MRS biomarkers, their quantity and patterns of distribution of the metabolites can help in the differential diagnosis of types and sub-types of brain tumours versus tumour mimics – often seen in infective or inflammatory diseases.”

The current MMI study is investigating the ability of MRS to quantify the oncometabolite 2-hydroxyglutarate (2HG) – a product of a genetic mutation (IDH) – to improve diagnostic and prognostic outcomes for brain tumour patients.

“With this technique, we are now able to identify a relevant genetic mutation in brain cancer even before the operation,” said Associate Professor Di Ieva, who introduced the term ‘spectroscopy’ – along with other ground-breaking innovations in neurosurgery and neuroimaging.

The study is also applying advanced computational analysis to radiological images to address the growing challenge of interpreting the exponential sums of data produced by MRS and other parametric diagnostic tools that are now the norm in neuroradiology and neuropathology.

“This large and complex data is difficult to interpret – even for experienced sub-specialists – let alone be easily translated into general use,” explains Associate Professor Di Ieva.

“Computation modelling, artificial intelligence-based and machine learning tools for big data analysis will become the diagnostic routine of brain tumours and other pathologies over the next few decades. At Macquarie University we are at the frontline of such advancements, for the benefit of patients.”



Professor John Magnussen



Associate Professor  
Antonio Di Ieva

## GP REFERRALS

GPs can refer patients suspected of having neurological disease or patients with brain tumours to MMI for advanced imaging and to the MUH neurosurgeons for advanced multidisciplinary management.

All MMI neuro-radiologists have sub-specialist fellowship training and significant experience delivering high-calibre expertise in their area

Patients can be assessed for suitability for the 2HG study, or treated through other pathways.

READ THE FULL ARTICLE  
VIA THE FOLLOWING LINKS:

LINK 1

LINK 2

## KEEPING AN EYE ON BREAST IMPLANTS OPENING FEBRUARY 2018



INTEGRATED BREAST HEALTH CLINIC IS OPENING FEBRUARY 2018 AT MACQUARIE UNIVERSITY CLINIC. THE LATEST EVIDENCE SUGGESTS THAT WOMEN WITH BREAST IMPLANTS SHOULD RECEIVE REGULAR LIFELONG CHECK-UPS. AT THE INTEGRATED BREAST HEALTH CLINIC, WITH A MULTI-DISCIPLINARY TEAM LOCATED WITHIN A SINGLE STATE-OF-THE-ART PRECINCT, WE PROVIDE IMMEDIATE ACCESS TO A WORLD-CLASS SERVICE THAT HELPS TO IDENTIFY PROBLEMS EARLY. NO REFERRAL IS NEEDED.

Patients can book in for their annual breast implant check here

T: (02) 9812 3765  
E: [integrated.clinics@muh.org.au](mailto:integrated.clinics@muh.org.au)

The latest evidence suggests that women with breast implants should receive regular lifelong check-ups. At the Integrated Breast Health Clinic soon to open at MQ Health, we'll provide immediate access to a world-class service that helps to identify problems early. No referral is needed.

Breast implants have been associated with a range of problems – including rupture, leak, capsular contracture and a rare breast implant related lymphoma.

A regular check is now available and is backed by research work published by Macquarie University. The ground breaking research has shown that low grade infection around breast implants is one of the major causes of complications. Professors Anand Deva and Karen Vickery developed a 14-point plan, which outlines operative strategies for surgeons to reduce the risk of implant contamination. The best treatment is prevention but if the problem is detected early, it can be treated.

Dr Henny Tamboto – best known for her earlier experimental research that demonstrated the causal link between sub-clinical infection and capsular contracture – heads the clinic. “Most women who have had breast implant surgery were probably followed up by their surgeon for a few years afterwards, and then not at all,” says Dr Tamboto. “However, it's important to have lifelong follow-ups as problems can occur many years after surgery – including a rare implant-associated lymphoma.”

### ABOUT THE CLINIC

Committed to helping women with breast implants identify problems early, Dr Tamboto is working alongside Professor Deva to set up the weekly clinic here at MQ Health. No referral is needed.

The weekly service offers assessment by Dr Tamboto herself for leaks, ruptures or ‘double-bubble’. Women are also assessed for the rare lymphoma associated with breast implants, breast implant-associated (BIA) ALCL. A no cost ultrasound scan can also be accessed at Macquarie Medical Imaging if required on the same day.

“The incidence of BIA ALCL is between 1 in 1000 and 1 in 10,000,” says Dr Tamboto. “Although it's not high, it is more closely associated with textured implants.”

“The good news is that BIA ACLC takes about eight years to develop, so women have a long time to determine their best course of action. It's important to get checked

regularly and to know that an infection is treatable by removal and replacement of the infected implant.”

If surgical correction is required, Dr Tamboto refers to either a participating surgeon in the MQ Health and Integrated Healthcare network, or elsewhere as available.

Dr Louis Wessels is one of the participating surgeons at Integrated. He is a plastic and reconstructive surgeon and a Senior Clinical Lecturer in Cosmetic and Plastic Surgery at Macquarie University Hospital. His fields of interest include cosmetic breast surgery and reconstructive microsurgery for breast cancers, in addition to body contouring surgery. “Breast implants are a medical device,” said Dr Wessels. “Like other devices – pacemakers, for example – they should be checked regularly. This service plays an important role in helping women achieve this.”

### WHAT TO DO IF YOU HAVE BREAST IMPLANTS

Make a note on your calendar to have an annual breast implant check. The clinic will open in February 2018 of this year and we are now taking appointments.

## AWARD RECOGNISES TWO DECADES OF SERVICE TO SURGERY



MACQUARIE UNIVERSITY HOSPITAL RHINOLOGIST AND SKULL BASE SURGEON PROFESSOR RAYMOND SACKS WAS HONOURED BY THE NSW BRANCH OF THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS (RACS) LAST MONTH WITH A MEDAL AND MERIT CERTIFICATE IN RECOGNITION FOR DISTINGUISHED SERVICE TO SURGERY IN NEW SOUTH WALES.



### ABOUT PROFESSOR RAYMOND SACKS

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[CLICK HERE TO  
FIND OUT MORE](#)

Professor Sacks was presented with the award by RACS NSW state committee chair Dr Raffi Quasabian, also a Visiting Medical Officer at Macquarie University Hospital.

Professor Sacks is Head of Discipline of Otolaryngology/Head and Neck Surgery at Macquarie University. He is also Clinical Professor and Head Discipline ENT Surgery at the University of Sydney.

For the past 20 years, he has held a broad range of positions. He has been Chief Examiner in Otolaryngology/Head and Neck Surgery for the RACS; President of the Australian and New Zealand Rhinologic Society; and President

of the NSW branch of the ASOHNS Society. He has convened multiple conferences, endoscopic sinus surgical courses and workshops throughout Australia, Asia and North and South America. He is also a Registrar advocate and oversees the international medical graduates in NSW.

“Being involved in the College of Surgeons has been an inspirational time for me,” said Professor Sacks. “I've become a firm believer that teaching is the best form of learning and I feel privileged to play a leadership role in training the next generation of surgeons in New South Wales.”

## PERCUTANEOUS ASD/PFO CLOSURE NOW WELL ESTABLISHED AT MUH



MACQUARIE UNIVERSITY HOSPITAL CARDIOLOGISTS NOW PERFORM ASD AND PFO CLOSURES WITH A NEW MINIMALLY INVASIVE PROCEDURE – AND LOOK TO EVIDENCE DEMONSTRATING THE BENEFITS OF SUCH CLOSURES AT A YOUNG AGE.

To find out more click here 

Macquarie University Hospital has taken another step forward in its structural heart program with proceduralists successfully closing Atrial Septal Defects (ASDs) and Patent Foramen Ovaeles (PFOs) percutaneously.

ASD – or its smaller version the PFO – can lead to the heart being overloaded and may allow oxygen-rich and oxygen-poor blood to mix. If not treated, atrial arrhythmia, pulmonary hypertension, stroke or heart failure can result.

Although PFOs can go undetected until adulthood, a recent study published in the *New England Journal of Medicine* demonstrates that closing these defects at a young age is beneficial in patients who have had strokes.

“Surgical closure for ASD/PSO had long been considered the definitive treatment, but percutaneous closure is now considered the treatment of choice,” explained interventional cardiologist Dr Mark Nallaratnam, who introduced the program to Macquarie University Hospital along with Dr Andy Yong in 2015.

“Given recent evidence of the benefits of closing atrial defects, minimally invasive treatments make more sense than ever before.

“This really is the new world standard, with advantages including a high sealing rate, an overall shorter procedure and a reduced hospital length of stay.”

The treatment involves a catheter inserted through the femoral vein and delivered to the right side of the heart where a small device – fabric mesh covering opposable double discs – is inserted.

The procedure is performed by Dr Nallaratnam and Dr Yong, with imaging assistance from Dr Arvind Iyer using advanced 3D Transoesophageal Echocardiography (TOE) to provide real time multi-planar visualisation to guide the catheter.

Macquarie is one of only a handful of centres with this advanced technology that provides a full bird’s-eye view of both physiology and device.

“3D Echo provides the cardiologist with unprecedented accuracy for optimal placing of the device, preservation of surrounding structures – particularly the aorta,” said Dr Nallaratnam. “We also use the 3D TTE in follow-up, so patients receive outstanding care with complications minimised and greater chance of long-term success.”

Since introducing the procedure, the team has completed more than 20 cases – including their cases at Concord Hospital.

“Percutaneous ASD/PFO is now part of an ever-growing suite of minimally invasive procedures offered by the Structural Heart Team,” explained Dr Nallaratnam.

“We are backed by an outstanding team of cardiothoracic surgeons who can always step in if required. Patient options and safety in this area are outstanding at Macquarie University Hospital.”



### CONTACT DETAILS

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### ABOUT MACQUARIE STRUCTURAL HEART TEAM: BOTH YOUNG AND OLD

Macquarie Heart Team focuses on structural defects. It is innovative, taking on rare cases and responding with innovative rare procedures. While many procedures suit elderly patients unable to undergo traditional surgery, younger patients with congenital heart conditions are also benefitting from the service.

Two recent examples involved young patients with congenital heart defects. A young Solomon Islands patient is back home living a full life after doctors placed a shunt in her heart to avert blood flow in order to heal her heart condition patent ductus arteriosus. Another young male patient faces a bright future after doctors performed Australia’s first percutaneous double-valve replacement for rapidly failing health resulting from complex congenital heart disease.

## A VERY SPECIAL EXPERT



**ONE OF A HANDFUL AROUND NEW SOUTH WALES, JENNY GILCHRIST LENDS MORE THAN A HELPING HAND AS A NURSE PRACTITIONER IN BREAST ONCOLOGY.**



As a nurse practitioner, Jenny Gilchrist is one of a small group of highly specialised nursing professionals in the Australian health care system.

In New South Wales, about 10 oncology nurse practitioners are spread across the State. At Macquarie University Hospital, Jenny is the only one, and the only breast oncology nurse practitioner in Sydney.

After qualifying as a nurse and working as a clinical nurse consultant for several years, Jenny returned to university to get her Master of Nursing (Nurse Practitioner), a qualification that permits her to carry out a range of 'doctor-type' tasks.

"As a nurse practitioner, I'm a blend of nurse and doctor," explained Jenny. "I am able to physically assess patients, write scripts, order scans – everything a doctor can do.

"But I am still also a nurse, supporting patients from early diagnosis to those with metastatic disease.

"I'm also involved in clinical trials, and am often authorised to be a sub-investigator, a role usually limited to doctors."

Jenny works closely with Professor Rick Kefford, Head of Clinical Medicine at Macquarie University, who established the role.

"Breast cancer patients follow a complex journey," said Professor Kefford. "The benefits of having someone like Jenny with those additional skills are immense for both patient and hospital.

"She also brings a unique set of skills and experience to our regular Multidisciplinary Team Meetings in Breast Cancer, which she co-ordinates."

Because she is on site Monday to Friday from 9 to 5, patients have an autonomous highly experienced oncology practitioner available at all times. Without her, there would need to be a series of communications from nurses to doctors, many of whom move between different hospitals on any given day.

The benefit to doctors include reduced calls and the ability to attend to more urgent work at hand. Patients ultimately experience quicker response times to their concerns or conditions.

"I love my job," says Jenny. "I am passionate about helping women who have received a diagnosis of breast cancer, and with my additional qualifications feel that I can be of more benefit all round."

Prior to her current position, Jenny worked in oncology and palliative care for nine years, after completing a Graduate Certificate in Cancer Nursing in 2004. Last year, she completed the Master of Nursing (Nurse Practitioner) degree, then received the endorsement from AHPRA for her current position.

Jenny is highly regarded in her field of breast oncology. She has been involved in developing national guidelines for the management of side effects associated with everolimus in breast cancer patients and has worked on various other research projects.

She is a regular invited speaker at national and international conferences, including the Multinational Association of Supportive Cancer Care (MASCC) and the Clinical Oncology Society of Australia (COSA).

## RECIPES FOR LIFE: PROFESSOR RALPH MARTINS AND MAGGIE BEER



**AUSTRALIAN COOK, AUTHOR, RESTAURATEUR AND GOURMET FOOD PRODUCER MAGGIE BEER HAS TEAMED UP WITH LEADING ALZHEIMER'S RESEARCHER, MACQUARIE UNIVERSITY'S PROFESSOR RALPH MARTINS, TO WRITE A COOK BOOK WITH RECIPES THAT BOOST BRAIN HEALTH.**

Inspired by the latest scientific discoveries of Professor Martins and his neurobiology team in the Department of Biomedical Sciences, Maggie came up with Recipes For Life which contains more than 200 recipes that help provide the nutrients we need for optimum brain health.

More than one million Australians and their families are affected by Alzheimer's, but research has shown healthy eating, regular aerobic exercise and plenty of mental stimulation can help reduce the risk of developing the disease.

Professor Martins said 'lifestyle' diseases such as type 2 diabetes, high blood pressure or heart disease increases our chances of developing brain damage in the future. But he said a diet rich in fresh fruit and vegetables,

fish, dairy foods, healthy fats and whole grains can help fight cognitive decline.

"You have the power to give yourself the very best chance of a healthy future," Professor Martins said.

"The good news is that we have begun to identify the factors that can reduce a person's risk of developing Alzheimer's and some other forms of dementia, and slow its progression."

The proceeds from Recipes For Life will be shared between the Maggie Beer Foundation and the Lions Alzheimer's Research Foundation.

Maggie, whose Pheasant Farm shop in South Australia's Barossa Valley is a popular tourist destination, said meals in the new book could have immediate health benefits.

"To have a healthy old age you must act now, whether you are 30 or 50," she said.

"I have been delighted to work with Professor Ralph Martins and I have learned that if we are to avoid Alzheimer's and other lifestyle diseases, it is what we eat today that matters."

Source: [mq.edu.au](http://mq.edu.au)

