

GP e-News

FEBRUARY 2017

Welcome from the CEO

Dear Doctor

Welcome to the start of a new year. 2017 will see some exciting new services at Macquarie University Hospital, with several already up and running.

New clinics are an important part of our service innovation strategy, aiming to directly address health needs in the community. These clinics are established using an integrated care model that is central to the Hospital's approach to improving patient care. The approach sees faster and more effective pathways – particularly at the diagnostic stage – with clinics coordinating all services under one roof. This newsletter highlights some of the new clinics that have opened at MQ Health, our parent organisation.

We are also delighted to be the first private hospital to participate in the Access program through a new partnership with the Integrated Specialist Health Care Education and Research Foundation (ISHCERF), a not-for-profit organisation committed to developing innovation in health care.

As a university-based hospital, Macquarie University Hospital is not linked to driving a profit in a traditional sense. We can, therefore, be more generous in opening our doors to patients who have private insurance but are finding the out of pocket costs prohibitive.

In other exciting news, the Hospital has invested in a second surgical robot, the latest da Vinci Xi Surgical System, which will allow us to further expand our robotic-assisted surgery program to other disciplines, ultimately allowing more patients to access robotic surgery at the Hospital.

And we are pleased to offer pioneering Computer Assisted Shoulder Replacement surgery, with Dr Mark Haber.

We invite you to join us in our purpose to heal, learn and discover at Macquarie University Hospital, and our larger MQ Health initiative. The year will be filled with opportunities for GP engagement and education through our many programs.

Carol Bryant, CEO
Macquarie University Hospital



If you would like to receive further information about our GP education activities for 2017, please email events@muh.org.au



MACQUARIE UNIVERSITY
Hospital

ENHANCING PATIENT ACCESS

MACQUARIE UNIVERSITY HOSPITAL PARTICIPATES IN A NEW PROGRAM TO DEVELOP INNOVATION IN HEALTH CARE DELIVERY.

THE ACCESS PROGRAM

[CLICK HERE TO FIND OUT MORE >](#)



For more information or to refer a patient

CALL (02) 9812 3899

EMAIL mprs@muhs.org.au

In February this year, Jenny Sheehan became the first patient to undergo major surgery at Macquarie University Hospital through a new 'Access' program – a model akin to a pro bono scheme.

The program aims to provide reduced-cost procedures to patients who otherwise could not afford them, with the cost reduction funded by the participating surgeon or hospital.

The brainchild of Head of Plastic and Reconstructive Surgery at MQ Health, Associate Professor Anand Deva, the Access program is offered by MQ Health in collaboration with Integrated Specialist Health Care Education and Research Foundation (ISHCERF) – a not-for profit organisation committed to developing innovation in health care.

ISHCERF has launched a number of initiatives in integrated care over the past year and now

partners with MQ Health in delivering the Access program. The program will be unique to the private hospital sector, where financial models allow flexibility to accommodate patients at a reduced cost.

“An overburdened public system, under significant funding pressure, along with increasing out-of-pocket costs passed onto patients even with private health insurance have meant that a large number of Australians are struggling financially to be able to access the treatment they require,” said Associate Professor Deva.

“This is particularly true for people who need either certain innovative or unusual surgeries that public hospitals cannot offer, or for those who might need a specialised procedure only available at an advanced private facility – such as Macquarie University Hospital.”

Jenny was selected for the Access program because she presents

such a case. After weighing 216 kilograms ten years ago, through a combination of bariatric surgery, exercise and diet, she now weighs just 81 kilograms.

The loss of 134 kilograms has resulted in an excessive amount of loose skin, which is causing ongoing health problems.

Associate Professor Deva says that the three-part procedure of body contouring was the only solution that Jenny had to remove the excess skin. However, the procedure is not available to her through the public system and she cannot afford the costs of private health care.

“Jenny’s case is indicative of thousands of Australians who will, ultimately, cost the government more through unaddressed health conditions,” said Associate Professor Deva. “For others, increasing demand and fiscal pressure on public hospitals has resulted in longer waiting times, thereby worsening their burden of disease and in

some cases worsening their prognosis.”

“Australia clearly needs new paradigms for delivering health care. What the Access program aims to do is to alleviate current stresses on the system by the private health sector offering a limited number of affordable procedures every year for patients who have gone through a selection process based on appropriate criteria.”

“The role of the ISHCERF is to provide bridging funds for specific cases and to negotiate with private hospital providers to allow patients to be treated at reduced or no cost. We are very pleased to be working in corroboration with MQ Health on this initiative and having Macquarie University Hospital as our first participating private hospital”, Associate Prof Deva explained.



Associate Professor Anand Deva with first patient Jenny Sheehan

FIRST BLOOD BIOMARKER DISCOVERED FOR THE PROGNOSIS OF MULTIPLE SCLEROSIS: QUICK, ACCURATE AND SOON TO BE AVAILABLE



AN INTERNATIONAL STUDY, LED BY MACQUARIE UNIVERSITY RESEARCHERS DR EDWIN LIM AND PROFESSOR GILLES GUILLEMIN, HAS DISCOVERED THE FIRST BLOOD BIOMARKER – A CHEMICAL IDENTIFIER IN THE BLOOD – FOR MULTIPLE SCLEROSIS (MS), A DEBILITATING DISORDER OF THE CENTRAL NERVOUS SYSTEM THAT AFFECTS MORE THAN 23,000 AUSTRALIANS AND 2.3 MILLION PEOPLE WORLDWIDE.

The findings, which took 12 years to discover, will allow scientists to determine which type of MS a patient has with 85-90 per cent accuracy. While following the course of the disease has traditionally proved problematic and lengthy, requiring patients to undergo an array of expensive tests, the new results show that a blood test could greatly simplify and speed up this process.

“This is a significant discovery because it will facilitate the ability to quickly and simply make a prognosis of the three types of MS and will allow clinicians to adapt their treatment for MS patients more accurately and rapidly,” explained Professor Gilles Guillemin, who oversaw the study.

“With the support of Dianti MS Pty. Ltd., an Australian company, we are currently developing a new prognostic kit with Dr Alban Bessede at ImmuSmol, France, which will help the medical profession and laboratories around the world quickly and easily identify the type of MS the patients has,” he added.

The researchers say that a clinical blood test kit could potentially be available in as little as two years, and the research will also likely provide an entirely new avenue of multiple

sclerosis therapeutics with the possibility for the development of a more personalised treatment regime for those affected.

“The unique information that we will receive from the biomarker within an individual, means that it could also be possible to develop biomarker-guided personalised treatment for each patient,” said Dr Lim, the lead researcher of the study, who is currently based at Macquarie University and who was previously an MS Research Australia Postdoctoral Research Fellow at UNSW Sydney, where the research for this study was first initiated.

Dr Matthew Miles CEO of MS Research Australia, one of the early and ongoing supporters of this work, commented: “MS Research Australia has been an enthusiastic supporter of this research right from its inception. We have been excited to be part of the translation of this initially fundamental research into a potential clinical test. This has the clear capacity to be the first ever blood biomarker for the prognosis of MS, and in doing so will meet one of the real unmet needs in the clinical management of MS.”

The results are also likely to be integral in understanding the

progression of other diseases caused by inflammation and neurodegeneration, including Alzheimer’s, Parkinson’s and Amyotrophic Lateral Sclerosis, also known as Lou Gehrig’s or Motor Neurone Disease.

“The test itself relies on detecting compounds within a specific biochemical pathway that uses a chemical called tryptophan,” Professor Guillemin concluded. “Tryptophan is known to be involved in brain inflammation, and so by increasing our understanding of how our cells process tryptophan, we will be better able to identify its involvement in many types of neurodegenerative diseases.”

RESEARCH FUNDING

The research in this study was kindly funded by Multiple Sclerosis Research Australia, Australian Research Council, National Health and Medical Research Council, Ramaciotti Foundation, Deb Bailey Foundation and Macquarie University.



Gilles Guillemin

ABOUT MULTIPLE SCLEROSIS (MS)

MS is the most common neurological disease affecting young adults, often diagnosed between the ages of 20 to 40 and affects three times more women than men. As yet, there is no cure.

MS is the result of damage to myelin – a protective sheath surrounding nerve fibres of the central nervous system. When myelin is damaged, this interferes with messages between the brain and other parts of the body. The symptoms of MS are different for each person; sometimes they even vary within the same person. For some, MS is characterised by periods of relapse and remission, while for others it has a progressive pattern. For everyone, it makes life unpredictable.

ABOUT DOCTOR LIM

Edwin Lim is a Senior Research Fellow at the Department of Biomedical Sciences, Faculty of Medicine and Health Sciences, at Macquarie University.

ABOUT PROFESSOR GUILLEMIN

*Gilles Guillemin is Professor of Neurosciences at Macquarie University, a world leader in tryptophan research, President of the International Society for Tryptophan Research (ISTRY), past President of the international Neurotoxicity Society (NTS) and Editor-in-chief of the International Journal for Tryptophan Research and co-founder of the Deb Bailey Motor Neurone Disease Research Laboratory.

MACQUARIE UNIVERSITY'S PROFESSOR JOHN BOYAGES RECEIVES ORDER OF AUSTRALIA



MQ HEALTH'S PROFESSOR JOHN BOYAGES, PROFESSOR OF BREAST ONCOLOGY AND DIRECTOR OF ALERT (AUSTRALIAN LYMPHOEDEMA EDUCATION RESEARCH AND TREATMENT) HAS BEEN HONOURED WITH AN ORDER OF AUSTRALIA IN THE AUSTRALIA DAY QUEEN'S HONOURS LIST.



Professor John Boyages

The prestigious honour was awarded to Professor Boyages in recognition of his dedication and contribution to his discipline.

"I'm very humbled by this award. Most of my work has involved developing new models of patient centred care underpinned by research and education as well as patient advocacy particularly in the West of Sydney. This award would not have been achieved without the support of my family and the good people I've always had around me to help realise a vision of better health care," said Professor Boyages.

With more than 30 years' experience in the diagnosis and treatment of breast cancer Professor Boyages has played a key role in shaping the care and treatment of patients suffering from cancer and lymphoedema.

Macquarie University's Deputy Vice-Chancellor (Research), Professor Sakkie Pretorius congratulated Professor Boyages on his outstanding contribution to his discipline on this well-deserved award.

"On behalf of Macquarie University I would like to congratulate Professor Boyages on this incredible achievement. Excellence in research that helps to shape the world we live in is a key pillar of the University and his work in the areas of oncology and lymphoedema highlights the direct impact that this research can have on individuals and the broader community. We are proud to have him as part of our world-class team."

Professor Boyages joined Macquarie University in 2011 as the Director of the cancer program and has since helped to establish many clinical, research and patient support programs related to cancer.

Highlighting Professor Boyages excellent work, the clinical care ALERT program at MQ Health has already achieved an international reputation with a world-first trial of early detection and treatment of lymphoedema after breast cancer with Vanderbilt University. Professor Boyages is also involved in a soon to be launched trial involving a new tablet for advanced lymphoedema with Stanford University. Thanks to this world-class treatment patients come to MQ Health from all over Australia and New Zealand for advice regarding early detection and intervention methods and surgical options for lymphoedema.

The Order of Australia was instituted by Her Majesty The Queen to recognise Australian citizens and other persons for achievement or for meritorious service.

PIONEERING COMPUTER-ASSISTED SHOULDER REPLACEMENT SURGERY COMES TO MUH



MACQUARIE UNIVERSITY HOSPITAL NOW OFFERS COMPUTER NAVIGATED SHOULDER REPLACEMENTS (CNSR) – THE INNOVATIVE SHOULDER SURGERY THAT WILL BRING PATIENTS ENHANCED OUTCOMES.

For more information or to refer a patient

CALL 1300 747 077
VISIT markhaber.com.au/

In February this year, Associate Professor Mark Haber began performing computer navigated shoulder replacements (CNSR) at Macquarie University Hospital. Prior to that, he performed the first CNSR in Australia using the Blue Ortho System.

Computer-assisted orthopaedic surgery (CAOS) applies computer technology pre- and intra-operatively to improve the outcome of orthopaedic surgical procedures. This allows us to couple pre-operative planning using a high-resolution CT scan (see image below) with surgical implementation, using tools with radiofrequency trackers to provide accurate intra-operative data like the position of the bone, and tools to precisely position the implants.

CNSR increases accuracy to within one millimetre and one degree, a

significant improvement on using a non-CAOS approach.

Macquarie University Hospital is currently the only hospital on the North Shore to offer this innovative procedure. At the hospital, the dedicated Navigated Shoulder System connects to the integrated theatre suite to provide all theatre staff the opportunity to observe the procedure. Training will be an important part of the Macquarie University Hospital program.

With shoulder replacements in Australia increasing, this leap forward in technology will improve the quality of life for many Australians requiring shoulder replacement surgery.

In all, CNSR reduces time in the operating theatre, speeds up recovery and extends the life of the replacement.

A study looking at the effects of glenoid component positioning on humeral head displacement and joint forces suggest that both instability and glenoid component loosening may be related to the version of the glenoid component (Nyffeler 2006)

A further study published in July 2015 concludes that "CT-based preoperative planning and intraoperative navigation allows improved accuracy...compared with conventional techniques in reverse shoulder arthroplasty".



Associate Professor Mark Haber

ASSOCIATE PROFESSOR MARK HABER

Specialty: Orthopaedic Surgery
Subspecialty: Shoulder

Macquarie University Orthopaedics
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Suite 303, Level 3 2 Technology Place,
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HEALTHY WEIGHT LOSS CLINIC OPENS AT MQ HEALTH



SYDNEY'S FIRST COMPREHENSIVE WEIGHT MANAGEMENT CLINIC IN A PRIVATE SETTING IS NOW OPEN - CATERING TO A BROAD RANGE OF METABOLIC-RELATED WEIGHT CONCERNS.

For more information
or to refer a patient

CALL (02) 9812 2941

FAX (02) 9887 8800

EMAIL hwc@mqhealth.org.au

VISIT mqhealth.org.au/hospital-clinics/healthy-weight-clinic



GPs can now refer patients requiring specialist care in weight management to MQ Health's new comprehensive Healthy Weight Clinic.

This clinic is the first in a private setting and offers additional options and alternative pathways to existing public sector care.

"The medical literature has shown that BMI alone is not the best way to assess weight as a risk factor," explained Associate Professor Ken Ho, one of two endocrinologists with the new clinic who was instrumental in setting up the coordinated service.

"Looking at a patient's metabolic profile and effects are much more important. If a patient has diabetes or hypertension, for example, and are just modestly overweight, then it is worth considering a weight management care plan for that person that aims for modest weight loss through improving lifestyle."

The clinic will have a suite of specialists and medical professionals available to patients – all based at MQ Health adjacent to Macquarie University

Hospital. MQ Health has outstanding capacity in streamlining services, and patients attending the Healthy Weight Clinic will have all their care available under one roof and coordinated for them.

The multidisciplinary nature of the Clinic will ensure that co-morbidities such as diabetes, cardiology problems and joint injuries – common in severely overweight or obese people – are also addressed. The clinic also provides expert allied health care through the involvement of dietician and nutrition specialists, exercise physiologists and physiotherapists, and clinical psychologists.

For patients requiring bariatric surgery, Macquarie University Hospital performs all the major weight loss operations – predominantly laparoscopic sleeve gastrectomy and also laparoscopic adjustable gastric banding and gastric bypass operations. With the acquisition of a second robotic system, robot-assisted bariatric surgery will also be introduced at Macquarie University Hospital this year. The team is led by

Professor Reginald Lord, who as one of the first surgeons worldwide to perform the sleeve gastrectomy operation has more than 15 years' experience with this operation. Sleeve gastrectomy is now the most frequently performed bariatric/metabolic operation.

The surgical program is also linked to a research program that looks not only at surgical outcomes, but also at the genetic causes. "Obesity is a resource-intensive condition to manage," said Associate Professor Ho. "It is often hard to coordinate the various treatments and specialists needed."

"Macquarie University Hospital is an excellent place to set up this clinic. There is a lot of local expertise and coordination available, that forms a core part of our systems and how we approach patient care."

This is a multidisciplinary clinic lead by endocrinologists Dr Veronica Preda and Associate Professor Ho. Referrals can be directed from GPs or other specialists who need assistance with managing weight loss for their patients. Please fax or email referrals.

NEW TRANSITION IBD SERVICE TACKLES HIGH RATES OF IBD IN SYDNEY



WITH A MULTIDISCIPLINARY TEAM NOW IN PLACE, THE IBD TRANSITION CLINIC SUPPORTS CHILDREN AND YOUNG ADULTS TO TRANSITION TO ADULT IBD CARE.

For more information
or to refer a patient

CALL 0401 094 218

Recent research led by Macquarie University Hospital gastroenterologists Professor Rupert Leong and Dr Cheng Hiang Lee^[1] identified Sydney as having one of the highest rates of Inflammatory Bowel Disease (IBD) in the world. The prevalence of IBD is 372 per 100,000 and split evenly for Crohn's disease and ulcerative colitis, the two main forms of IBD.

The onset of these conditions is often in the young (as early as 5 and most commonly between the ages of 15 and 30), indicating potential lifelong suffering for some patients. IBD is a chronic and largely hidden disease where diagnosis is often delayed. There is a massive burden on patients' personal, social and work life, as well as to the healthcare system. Typically patients have chronic recurrent abdominal pain, diarrhoea, bleeding, malabsorption and fatigue.

With this in mind, Professor Leong and his

team have established a dedicated IBD Clinic at Macquarie University Hospital.

"Our multidisciplinary team, which includes myself, paediatric gastroenterologist Dr Cheng Hiang Lee, an IBD clinical nurse specialist Esther Lee RN, as well as colorectal surgeons, radiologists, a stoma therapist, nutritionist, social worker and psychologist who all work closely together to provide effective and efficient IBD services," he explained.

"Our IBD Infusion Clinic provides infusions of Infliximab and Vedolizumab at patients' convenience in a pleasant environment. We also provide counselling, phone consultations and follow-up reminders. We welcome children, adolescents and young adults to our IBD Transitional Clinic to facilitate smooth handover and transition of paediatric IBD care to adult IBD care."

The MUH IBD clinic is also dedicated to increasing

public awareness of the disease for better quality of life for people living with IBD, as well as lobbying the government for better service provision and funding. We welcome referrals to these services and can offer a personalised consultation respecting all opinions and preferences.

Our research on IBD is making progress towards better understanding the causes and therapies of IBD. Non-privately insured patients on Remicade (Infliximab) will have full access to a personal IBD nurse at our privatised MUH IBD Infusion Clinic. This is ideal for those patients who prefer the convenient location of MUH. For more information or referral, please contact us on details provided.

[1] Liu J *et al.* The prevalence of Inflammatory Bowel Disease in the City of Canada Bay Area, Sydney: A metropolitan population-based study. Australian Gastroenterological Week Conference 2017.



Macquarie University Hospital
3 Technology Place, Macquarie
University, NSW, 2109

PSI A VALID OPTION FOR SHOULDER REPLACEMENT



ARTHROPLASTY OF THE SHOULDER HAS OFFERED THE POTENTIAL FOR IMPROVED FUNCTION AND PAIN RELIEF WHERE THE NATIVE GLENOHUMERAL ARTICULATION HAS BEEN DAMAGED BY INFECTION, ARTHRITIS, OR TRAUMA. IN RECENT YEARS, PATIENT-SPECIFIC INSTRUMENTATION (PSI) WAS DEVELOPED AS AN ALTERNATIVE TO NAVIGATION SYSTEMS, ORIGINALLY FOR TOTAL KNEE ARTHROPLASTY, AND IS A VALID OPTION FOR SHOULDER REPLACEMENTS TODAY.

For more information or to refer a patient

CALL 02) 9181 2933
 FAX (02) 8882 9680
 EMAIL shc@mq.edu.au
 VISIT verakinzel.com.au/

One of the significant challenges of total shoulder replacement is providing for optimal glenoid placement. PSI technology provides increased accuracy in the placement of the glenoid component, which improves the likelihood of an optimal outcome. Improperly placed components may increase the risk of dislocation, increased component wear and loosening, and the need for revision surgery.

As a consequence of the disease process there is destruction of the joint, particularly the glenoid and as such the landmarks may be unreliable. Traditional instrumentation may contribute to suboptimal positioning of components and this may result in early failure. (2) PSI shoulder reconstruction enables the anatomical reconstruction of the joint and provides for optimisation of kinematics and kinetics; this reduces risk of implant failure. (4)

Pre-operative planning is undertaken once the patient has undergone CT imaging and preliminary surgical assessment has been performed. The company providing the PSI guide, in consultation with the surgeon, then performs final preparation of the guides using computerized 3-D imaging and once satisfied, the definitive cutting guides are manufactured. These cutting guides are specific to each individual patient in accordance with the patient's precise needs.

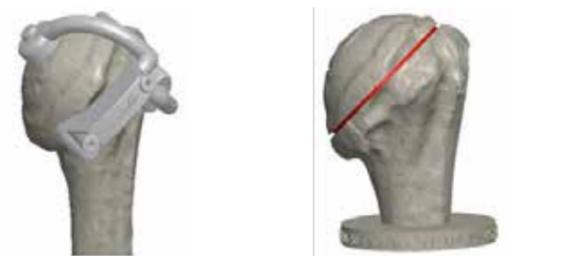


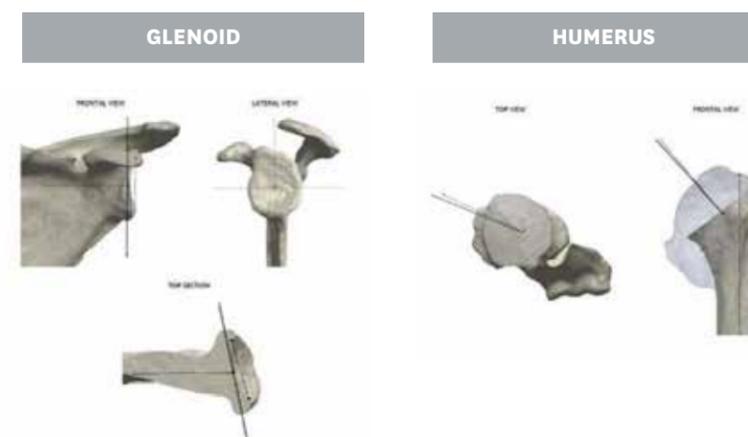
Fig 1 - Humeral head resection guide



Fig 2 - Glenoid placement of reaming guide

The PSI technology enables accurate identification of landmarks and, as such, provides for optimal glenoid placement. Various systems have been developed in the past for optimal glenoid placement, including computer navigation. However, there is strong evidence to suggest that PSI in both total shoulder replacement and reverse total shoulder replacement is favourable. Issues such as increased surgical time and loosening of pin placement for navigation markers have hampered computer navigated technology in the past. (5)

Whilst PSI has been found to be highly accurate in assisting in accurate positioning of the glenoid component to date there has been little published on the long-term outcome of this new technology. Early results, however, are quite favourable.



ABOUT DOCTOR KINZEL



Dr Vera Kinzel is an orthopaedic surgeon with a special interest in Knee, Shoulder and Trauma surgery for the adult and paediatric population.

1. Nuno Sampaio Gomes, Patient-specific instrumentation for total shoulder arthroplasty, EFORT Open Reviews DOI: 10.1302/2058-5241.1.000033 Published 31 May 2016
2. Moeckel BH, Dines DM, Warren RF, Altchek DW. Modular hemiarthroplasty for fractures of the proximal part of the humerus. *J Bone Joint Surg [Am]* 1992;74-A: 884-9.
3. Pearl ML, Kurutz S. Geometric analysis of commonly used prosthetic systems for proximal humeral replacement. *J Bone Joint Surg [Am]* 1999;81:660-71.
4. Throckmorton TW, Gulotta LV, Bonnarens FO, Wright SA, Hartzell JL, Rozzi WB, et al. Patient-specific targeting guides compared with traditional instrumentation for glenoid component placement in shoulder arthroplasty: A multi-surgeon study in 70 arthritic cadaver specimens. *J Shoulder Elbow Surg.* 2015;24:965-71.

CASE STUDY

FOOT AND ANKLE SURGERY



21 FEMALE WITH 2 YEAR HISTORY OF INTERMITTENT LEFT MEDIAL FOREFOOT PAIN OVER THE FIRST METATARSOPHALANGEAL (MTP) JOINT.

For more information or to refer a patient

CALL 0437 668 388



DR ANDREW STEPHENS

Specialty: Orthopaedic Surgery
Subspecialty: Foot and Ankle Surgery

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2 Technology Place
Macquarie University
NSW 2109

Her most recent exacerbation was after wearing narrow court shoes. Subsequent inflammation and redness over the area was treated with oral antibiotics with some reduction in redness. Her pain was activity related and monoarticular. Initial diagnoses included gout and inflammatory arthritis in view of a lack of trauma to the joint. There was no previous history of symmetrical joint disease or systemic illness to suggest an inflammatory condition. On examination, there was a firm swelling over the dorsomedial joint line that was firm but compressible, immobile and did not transilluminate.(image 1)



The joint was stable in varus and valgus with normal alignment. She had a full normal range of dorsiflexion and plantarflexion. Tinels was negative over the mass.

Radiographs identified an extraarticular radioopaque area with sharp defined margins in the dorsomedial tissue overlying the first metatarsal head. The mass was distinct from the periosteum and did not communicate with metatarsal bone. (image 2)



MRI performed indicated good chondral thickness on both joint surfaces no periosteal reaction and no soft tissue or bony oedema. There was no joint effusion associated with the mass. The mass was dark on T1 and T2.

Her history, examination and initial imaging narrowed the possible diagnosis to either an accessory bone, crystal arthritis or tumoral calcinosis. In view of the benign presentation, the decision was made to excise the tumour and obtain a tissue diagnosis.

Under general anaesthetic, tourniquet and routine preparation and draping a dorsomedial incision was made while ensuring haemostasis and cautery. The mass was superficial to the capsule but subdermal(image 3). An attempt to enucleate the mass was not successful with a toothpaste like consistency curretagged from the mass. The intraoperative appearance suggested either crystal arthritis or tumoral calcinosis. The wound was meticulously debrided and lavaged. No communication into the joint was found. Pathological and histological samples were sent for analysis to rule out gout and confirm the likelihood of tumoral calcinosis. The wound was closed meticulously in layers but no drain was placed.



A confirmed diagnosis of tumoral calcinosis was made on histological slides and radiographs. (image 3)

Tumoral calcinosis is a rare benign deposition of calcium hydroxyapatite with underlying hyperphosphataemia. This presents in the first to second decades of life with a familial pattern of inheritance seen more commonly in people of African descent. Patients present with swelling adjacent to joints where there is rubbing and daily trauma. It is more commonly found in the upper limb. This patient was 21 and had a 3 year history of the lump adjacent to her first metatarsophalangeal joint. Repeated friction from tight fitting shoes was the trauma causing discomfort and pain. The symptomatic nature of the condition necessitated excision and debridement of the lump while obtaining a pathological diagnosis. In view of the initial management by her local doctor, it is clear that this rare condition was misdiagnosed. Lumps or tumours need to be adequately followed to allow local and systemic staging to rule out more sinister pathology.

EARLY PROSTATE CANCER: TO TREAT OR NOT TO TREAT?



THAT IS THE QUESTION INVESTIGATED BY THE RECENTLY PUBLISHED PROTECT TRIAL, A 10-YEAR STUDY INVOLVING 1643 MEN WITH EARLY PROSTATE CANCER, RANDOMISED TO ONE OF THREE MANAGEMENT STRATEGIES – ACTIVE SURVEILLANCE, RADICAL PROSTATECTOMY OR EXTERNAL BEAM RADIATION THERAPY.

For more information
or to refer a patient

TO CONTACT MQ UROLOGY

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FAX (02) 9812 3836

EMAIL urology@mqhealth.org.au

⟨L>R> Matilda Brand, Lesley Baker, Dr Annie Ho,
Prof. David Gillatt, Samantha Redfearn



Macquarie University Hospital, to ensure patients are fully informed about the treatment options available to them.

“In addition to prompting a re-think about the reliability of active surveillance, the ProtecT Trial results indicate that the cure rates achieved by targeted radiation therapy are at least equivalent to those achieved by radical prostatectomy,” explained Dr Ho.

“Hopefully, newly diagnosed patients with localised prostate cancer will feel encouraged to know that multiple management options are available to them and they don’t need to rush into making a decision about how they will tackle their disease. We recommend they seek an initial consultation with an oncological urologist and a urological radiation oncologist, or request that they be referred to and reviewed at a urological multidisciplinary team meeting.”

Ken Burston, Prostate Cancer Specialist Nurse, is also a key part of the team, and meets up with all newly referred prostate cancer patients. Ken’s aim is to support the patient throughout their prostate cancer journey at Macquarie University Hospital.

MEET OUR PROSTATE CANCER NURSE, KENNETH BURSTON



As Prostate Cancer Nurse, Ken Burston’s role is to support men and their families in all areas of prostate cancer care, whether they are newly diagnosed or have already had treatment.

As their key point of contact, Ken assists patients with accessing services in the hospital and the community. He also provides reliable information about diagnosis and treatment, helping patients to access support groups, where appropriate.

“I think my role allows patients to be heard by having someone as their care coordinator,” said Ken, who has more than 26 years of experience working in a variety of positions – including as a nurse practitioner, nurse educator and coordinator of urology outreach programs. “It also allows them and their families to be more involved in their own treatment decisions.”

Ken is trained as a both a Hospital Psychiatric and General Nurse and has worked in New Zealand, Australia and the UK. He holds a Bachelor of Nursing and a Master Of Nursing (Advanced Practice/Health Professional Education), and completed the Prostate Cancer Course at La Trobe University.

The good news for all is that the 10-year, prostate-specific mortality was low irrespective of the treatment assigned. However, surgery and radiation therapy were associated with significantly lower rates of disease progression and metastases than the ‘watch and wait’ approach.

“The findings of the ProtecT Trial confirm the importance of multi-disciplinary care in the diagnosis and treatment of prostate cancer,” said Professor David Gillatt, Head of the Urology and Gynaecology Clinical Discipline and Director of Medical

Services at Macquarie University Hospital.

“While active surveillance may be a good option for a certain cohort of patients, we now have conclusive evidence that radical prostatectomy or curative radiation therapy achieve better clinical outcomes compared to active surveillance alone.

“Multidisciplinary care is about sitting down with patients and presenting them with options. At Macquarie University Hospital we are able to bring together cutting-edge diagnostic

techniques such as MRI-guided biopsies with an experienced, multi-disciplinary clinical team to achieve the best outcome for patients. The service is underpinned by a strong scientific and research program and comprehensive specialist, nursing and allied health services for men with prostate cancer.”

Professor Gillatt – who was involved in establishing the trial at the University of Bristol in the United Kingdom in the late 1990s – works closely with Dr Annie Ho, radiation oncologist and Clinical Director at GenesisCare,



WATCH

Watch a short video on the results of the ProtecT trial on the New England Journal of Medicine website



ACCESS

Access the full article via this link



USEFUL LINKS

Other useful links for newly diagnosed cancer patients



FURTHER INFORMATION

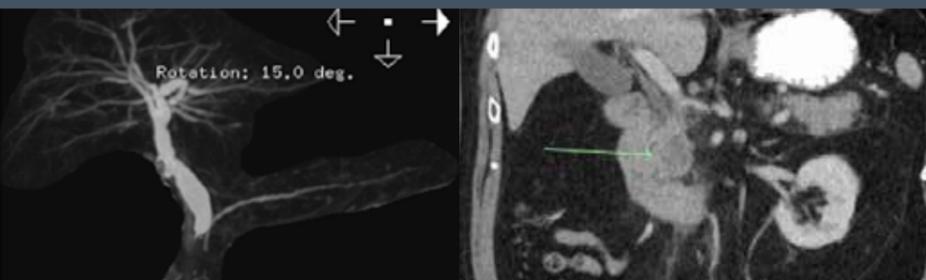
Click here for further information

ACUTE PANCREATITIS: CURRENT APPROACH AND MANAGEMENT



MRCP: Distal biliary stricture due to pancreatic cancer

1. Pancreatic adenocarcinoma causing focal pancreatitis



THE APPROACH TO ACUTE PANCREATITIS HAS BEEN ENHANCED FOLLOWING RECENT DEVELOPMENTS IN IMAGING AND ENDOSCOPY. AETIOLOGY REMAINS PREDOMINANTLY THAT OF GALLSTONES AND ALCOHOL (APPROXIMATELY IN A 2:1 RATIO IN AUSTRALIA¹) AND THE GREAT MAJORITY OF PATIENTS WILL EXPERIENCE A MILD CLINICAL COURSE WITH COMPLETE RECOVERY.

To make an appointment or to find out more

CALL (02) 9793 1995
FAX (02) 8008 1596
VISIT gastrosurgery.com.au/

Severe pancreatitis remains a clinical challenge and management of these patients is appropriately carried out in the intensive care setting with a multidisciplinary approach.

There have been recent consensus statements with the aim of optimising management towards best care outcomes^{2,3}.

DIAGNOSIS AND CAUSE

This is confirmed in the appropriate clinical setting, with an acute onset of epigastric pain, often radiating to the back. A history of alcohol or gallstones may be present. Elevation of amylase/lipase to more than 3 times normal serves as biochemical confirmation, with lipase proving more sensitive and with a longer period of increase following the attack.

Abdominal CT scan is required if the diagnosis is uncertain, or if the clinical course does not follow as expected after 3-5 days. Routine use of CT has been shown not to improve clinical outcomes and is not recommended⁴.

Determination of the cause is based on: 1) a detailed history, including medications 2) abdominal ultrasound is used to evaluate for cholelithiasis 3) laboratory tests for liver enzymes, triglyceride levels and serum calcium. Alanine aminotransferase (ALT) levels

greater than 150IU/L have a strong positive predictive value in diagnosing gallstone pancreatitis.

Additional causes that need to be considered include post procedural pancreatitis, when the clinical picture will be evident and autoimmune pancreatitis (AIP). AIP is a recognised entity with typical radiological picture of diffuse inflammation of the pancreas; elevate serum immunoglobulin in most (IgG) and clinical response to steroids.

Up to approximately 15% of patients will be considered to suffer from idiopathic pancreatitis. It is in this group, especially in the older patient, that further investigations are needed to exclude underlying neoplastic lesions.

The two predominant modalities are magnetic resonance imaging cholangiopancreatogram (MRCP) and endoscopic ultrasound (EUS).

MRCP allows evaluation of the biliary and pancreatic ducts with regards to narrowing/strictures caused by tumours. EUS is excellent in evaluation of the pancreatic tissue and definition of stones. Combination of these tests increases the diagnostic accuracy of pancreatitis. If uncertainty remains, it is important to follow up with interval imaging after recovery in 4-6 weeks.

ASSESSMENT OF SEVERITY AND MANAGEMENT⁴

Mild acute pancreatitis

- No organ failure or systemic complications
- Mild and self limiting

Moderately severe acute pancreatitis

- Transient organ failure (<48 hrs)
- Local complications (fluid collections)
- Exacerbation of pre-existing disease

Management of above groups is based on early in hospital aggressive fluid resuscitation and reassessment, which improves clinical outcomes (REF). Gut rest should be implemented until symptoms have improved, with nutritional support unlikely required in these patients.

Laparoscopic cholecystectomy should be performed in the index admission^{2,3} in cases of mild biliary pancreatitis to avoid recurrence⁵.

Severe acute pancreatitis

- Persistent organ failure
- These patients require treatment in the intensive care setting. Principles of care include:
- Early enteral support
 - ERCP in presence of cholangitis
 - Rational antibiotic use
 - Transfer to specialist centres

SUMMARY

- Acute pancreatitis (AP) is common and potentially severe
- Recent new consensus guidelines have been published
- Cause should be determined:
 - o History
 - o Laboratory tests (LFTs, calcium, TGs)
 - o Transabdominal ultrasound
 - o EUS/MRCP idiopathic cases
- AP should be managed with aggressive fluid resuscitation and fasting, feeding in mild attacks once symptoms settle
- Laparoscopic cholecystectomy in index admission for mild AP
- Severe pancreatitis managed in ICU setting
- Early ERCP reserved for patients with cholangitis
- Follow up with imaging in elderly patients with unknown cause

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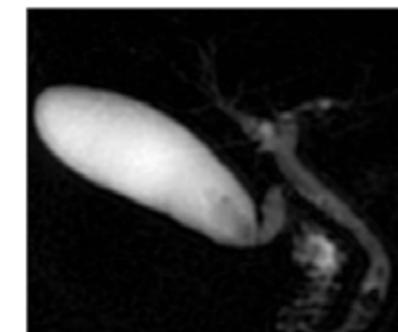
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2. EUS with features of bile duct filling (arrow)



3. ERCP: stone extraction



4. MRCP indicating choledocholithiasis

ABOUT CHRISTOS APOSTOLOU



Dr. Christos Apostolou

Dr. Christos Apostolou is an Upper Gastrointestinal and Pancreatic Surgeon and a conjoint senior lecturer at the University of NSW and a clinical lecturer with Macquarie University. He is a consultant surgeon at the Sydney Adventist, Bankstown-Lidcombe and Macquarie University Hospitals.

DR CHRISTOS APOSTOLOU

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NEW SERVICES

SYNCOPE CLINIC ADDS TO OUR CARDIOLOGY SERVICES

THE NEW SYNCOPE CLINIC AT MQ HEALTH CARDIOLOGY ASSISTS AND TREATS PEOPLE WHO ARE HAVING PROBLEMS WITH FAINTING OR TRANSIENT LOSS OF CONSCIOUSNESS.

The clinic is open every alternate Friday from 12 noon to 4pm. This clinic welcomes all patients who have had syncope experience.

To access this clinic, GPs need to provide patients with a referral letter. GPs can refer to the Syncope Clinic from Friday 10 March 2017.



Dr Imran Kassam

For more information or to refer a patient

Contact Mareen Maladda

CALL (02) 9812 2942

CALL (02) 2 9475 1155

EMAIL Mareen.Maladda@muh.org.au

For appointments

CALL (02) 9812 2942

CLINIC LOCATION

Suite 203, Level 2
2 Technology Place
Macquarie University
NSW 2109

INTRODUCING MACQUARIE UNIVERSITY'S SPEECH PATHOLOGY ADULT SERVICES TEAM



WE ARE THE SENIOR ADULT SPEECH PATHOLOGISTS, AND CLINICAL EDUCATORS, FOR THE MACQUARIE UNIVERSITY SPEECH AND HEARING CLINIC, WITHIN THE MASTER OF SPEECH AND LANGUAGE PATHOLOGY PROGRAM.

For more information or to refer a patient

CALL (02) 9850 2900

FAX (02) 9850 1470

EMAIL shc@mq.edu.au

VISIT mqhealth.org.au/hospital-clinics/speech-and-hearing-clinic



Nicola Black (left) and Erin Chalk (right), Senior Speech and Language Pathologists Macquarie University Speech and Hearing Clinic

We have been servicing Macquarie University Hospital over the past three years. With the introduction of [MQ Health](#) we are embracing the opportunity to expand the adult outpatient service, and apply a more integrated inter-disciplinary approach to client care.

We offer specialised investigation and intervention for your clients living at home or in supported living who are experiencing dysarthria, aphasia, dysphagia, cognitive-communication impairment, voice changes, stuttering, accent-related limitations, and other communication or swallowing-related challenges.

Our clients present with a range of medical conditions such as stroke, traumatic brain injury, motor neurone

disease, parkinson's disease, multiple sclerosis, myasthenia gravis, head and neck cancer, delirium, dementia, primary progressive aphasia, age-related or post-surgical deconditioning, globus, respiratory illness, cerebral palsy, and downs syndrome.

Based on campus, we are well positioned to collaborate with academic and research staff on the growing body of evidence within speech pathology, particularly in the fields of swallowing rehabilitation and group communication therapy interventions.

In 2017, following the success of previous years, we will be continuing our aphasia groups:

1. 'Visual Voices' Aphasia Art Group – 10 weekly sessions in collaboration with experienced art instructors

to facilitate social interaction, communicative independence and enhanced leisure opportunities. No previous artistic skills are required.

2. Aphasia Communication Group – 6 weekly sessions targeting an individual's communication goals in a group environment, and communication partner training. We will also be introducing two new groups focused on speech intelligibility, which will provide your clients with a safe and inclusive environment to practise their communication strategies, while sharing their experiences and tips with others:
3. Dysarthria communication group
4. Accent modification group.

THE ROLE OF AUSTRALIAN PSYCHOLOGISTS IN ASSESSING WOMEN CONSIDERING RISK-REDUCING OR CONTRA LATERAL PROPHYLACTIC MASTECTOMY

DR JEMMA GILCHRIST IS A LEADING CLINICAL PSYCHOLOGIST IN THE AREA OF PSYCHO-ONCOLOGY AND PROVIDES SPECIALIST PSYCHOLOGICAL SERVICES AT MACQUARIE UNIVERSITY HOSPITAL. SHE IS MOST RECOGNISED FOR HER EXPERIENCE WORKING WITH WOMEN AND THEIR FAMILIES FACING BREAST CANCER, AND THOSE WITH A SIGNIFICANT RISK DUE TO GENETIC VULNERABILITY.

For more information or to refer a patient

CALL (02) 8850 8100
VISIT mindmyhealth.com.au

Dr Gilchrist reports that the number of women seeking risk-reducing mastectomies (RRM) and contra-lateral prophylactic mastectomies (CPM) has increased significantly over the last 20 years, but most notably since 2013 following the “Angelina Jolie effect”. Of the women that she sees, some are carriers of the BRCA 1 or BRCA genetic mutation or have a strong family history without carrying a known mutation. Others have been diagnosed with breast cancer and opt to undergo a bilateral mastectomy in the absence of a mutation which is defined as CPM. This interest and expertise informed a recent study published in *The Breast* journal about the role of psychologists in assessing women considering risk-reducing procedures (<http://dx.doi.org/10.1016/j.breast.2017.01.011>)

“Risk-reducing procedures have been associated with decreased cancer-related intrusive thoughts, concerns, and general distress,” said Dr Gilchrist. “However, given the potentially significant psychological, psycho-sexual and physical sequelae of these irreversible procedures, there is increasing recognition that women need to be informed and understand the potential psycho-social aspects of surgery and recovery in addition to the physical risks.”

Dr Gilchrist and colleagues note there is an emerging practice of surgeons and members of the multi-disciplinary

team referring patients to psychologists for pre-operative assessments. This has raised some questions about the role expectations of the psychologist in this context and what pre-operative assessment and support entails.

“Presented with an increasing number of such referrals, my colleagues and I undertook qualitative research to obtain insights from a range of health professionals/psychologists, surgeons, breast care nurses and genetic counsellors into the perceived role of psychologists who are working with women considering RRM or CPM,” explained Dr Gilchrist.

“The findings from the interviews conducted found that psychologists are perceived by health professionals to have a key role in the multi-disciplinary care of patients considering RRM or CPM.”

Furthermore, they reported that the role of the psychologist was seen to encompass mental health, social, medical and pragmatic concerns and include a mental health assessment, checking patient understanding of information, ensuring informed decision-making, preparation for the procedure, and management of post-surgical challenges.

“Our findings suggest that explicitly defining the role of psychologists in this context would benefit patients and multidisciplinary teams,” she said. “General practitioners play a key role in facilitating referrals to psychologists and

this should be considered at diagnosis and the early stages of treatment.

“I would add that, while referring women to see a psychologist should be a key consideration for GPs, this is a specialised area of assessment and consideration should be given to referring to a psychologist experienced in working in the area of psycho-oncology.”



Dr Jemma Gilchrist is the Director of Mind My Health. She is joined by fellow clinical psychologist, Rebecca Van Lloy. They are located within the Clinical Care Suite at Macquarie University Hospital. Mind My Health focuses on the integration of emotional health, mental health and wellbeing. Whilst their specialty area of practice is psycho-oncology and health psychology, they treat patients experiencing acute and chronic mental health conditions such as anxiety and depressive disorders, weight management, adjustment and stress-related difficulties; and relationship issues.

MACQUARIE UNIVERSITY HOSPITAL INVESTS IN A SECOND ROBOT – THE LATEST DA VINCI XI SURGICAL SYSTEM.



ONE OF THE MOST RAPIDLY EXPANDING AREAS OF THE HOSPITAL, THE ROBOTIC-ASSISTED SURGERY PROGRAM IS CURRENTLY EXPANDING WITH THE ACQUISITION OF A SECOND ROBOTIC SYSTEM, THE DA VINCI XI SURGICAL SYSTEM.



Professor David Gillatt

The new surgical robot is the latest model available. It has refined features from the previous model as well as new capabilities – in particular, its capacity for increased movement across the body. This enhanced anatomical access is by way of a new overhead arm architecture and instrument shafts designed to give greater range of motion and operative reach.

Professor David Gillatt, Head of the Urology and Gynaecology Clinical Discipline and Director of Medical Services at Macquarie University Hospital, said that the new system can be used across a wide spectrum of minimally invasive procedures.

“Because of the movability of the arms and instruments, the system will make it easier for procedures where multiple sites are involved,” said Professor Gillatt. “Unlike prostate surgery, where the resection site is confined, specialist areas like colorectal, gynaecological and cardio-thoracic surgery require more movement over a larger area.

“We also anticipate the robot’s use in pancreatic, lung, and head and neck surgery. And, because we are an academic hospital with the capability to perform highly complex surgeries, we will be looking to use robotic approaches in some cases.

Robotic surgery is far less invasive than traditional surgery, with patients experiencing a much faster recovery time. The Hospital’s expanded program means that more patients can now access this advanced approach.

Training in robotic surgery will continue to be a core part of the Urology program at Macquarie University Hospital, and expand to training in other disciplines.

OPTIMISING ASSESSMENT OF PATIENTS WITH HYPERTENSION



WITH THE ADDITION OF TWO NEW DIMENSIONS TO THE STANDARD ARM CUFF MEASUREMENT FOR BLOOD PRESSURE, MUH NOW HAS THE MOST COMPREHENSIVE ARTERIAL ASSESSMENT SERVICE IN THE SYDNEY AREA.

Macquarie University Hospital has added a new clinical testing service that includes the capacity to measure both central aortic pressure and arterial stiffness. This clinical service extends the standard technique of ambulatory blood pressure (BP) measurement.

“As evidence accumulates to show the link between arterial stiffness and blood pressure – with implications for both heart and brain disease – more precise measurements will enable doctors to select the best treatments for various cardiovascular conditions,” said Professor Edward Barin, Clinical Associate Professor at Macquarie University and Co-Director of Cardiology at MQ Health.

“These laboratory measurements extend our understanding of blood pressure, heart failure and heart structure changes, and can then be used by treating doctors to adjust medication or consider other treatment options.”

The diagnosis of hypertension can be confirmed or refined. Ambulatory BP clarifies, for example, the diagnosis of ‘white-coat’ hypertension, masked hypertension, or nocturnal hypertension.

“The new service is particularly useful for ageing patients, given the link between arterial stiffness and ageing, and the non-invasive nature of the assessment,” said Professor Barin.

ABOUT THE ARTERY AND BP ASSESSMENT UNIT AT MQ HEALTH CARDIOLOGY

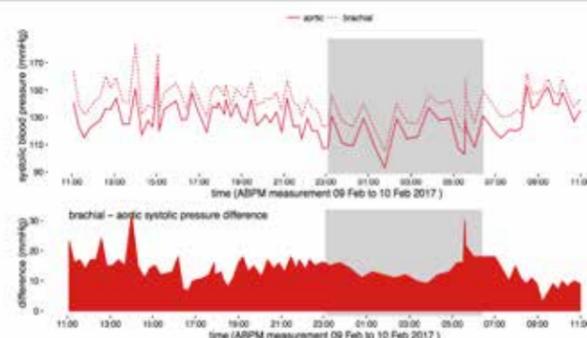
This is a weekly clinical service for patients with hypertension and vascular disorders. It is run by Professor Edward Barin, Professor Alberto Avolio, Dr Mark Butlin and Dr Isabella Tan

The Unit is able to see patients quickly, and can coordinate any additional diagnostic tests or treatments at Macquarie University Hospital that might be required.

Led by Professor Avolio, the Unit is involved with data collection and contributes to international collaborative clinical studies in the field of optimising blood pressure measurement.



Professor Edward Barin



Blood pressure recording over 24 hours showing not only elevated arm (brachial) readings but central (aortic) measurements throughout the day and night.

UPCOMING EVENTS



ORTHOPAEDIC SURGERY AT MACQUARIE UNIVERSITY HOSPITAL

DATE: Tuesday 21 March 2017

VENUE: Banjo Paterson's Cottage Restaurant.

TO FIND OUT MORE AND RSVP PLEASE CLICK HERE ▶



HEALTHY WEIGHT CLINIC AT MQ HEALTH

DATE: Wednesday 22 March 2017

VENUE: Macquarie University Hospital

TO FIND OUT MORE AND RSVP PLEASE CLICK HERE ▶