Chronic rhinosinusitis (CRS) associated with nasal polyposis is a common condition. In the general population, the prevalence of nasal polyps (NP) is four percent.

The reason why polyps develop in some patients and not in others remains unknown. Although far from being completely understood, pathomechanisms in NP are better understood today and begin to allow us to differentiate this disease via its cytokine profile, pattern of inflammation as well as remodeling processes, see figure 1.

The significant advance in the management of nasal polyposis, is the realisation that rather than aiming for symptomatic relief we can now achieve disease curation and symptomatic relief in the majority of patients presenting with nasal polyposis.

Historically symptomatic relief was achieved with debulking of polyps (often referred to as nasal polypectomy) and pulsed courses of oral steroids. Advances in the surgical techniques and post-operative medical management has allowed us to re-think the aims of intervention, which is now disease eradication.

Continued on page 2
Nasal Polyposis: New Ways of Managing a Common Problem

Continued from page 1

Medical Therapy

The role of medical therapy in the management of nasal polyposis is two-fold. Firstly, reduction of symptoms through the use of pulsed oral steroids and ancillary treatments such as topical saline irrigations and steroids. There is no role for the use of oral antibiotics, aside from their role in treating associated bacterial super-infection. So primary medical therapy should be thought of as symptomatic relief, rather than disease eradication.

The real change in medical therapy has been in the post-operative treatment of patients. Probably the most important advance has been in the understanding of bacterial biofilms and their role in nasal polyposis. A biofilm is a multicellular community of bacteria that are embedded in a self-produced exo-polysaccharide matrix and irreversibly attached to a surface. Eighty percent of patients with NP are biofilm positive. Topical application of mupirocin via nasal irrigation successfully eliminates Staph aureus biofilms present on the sinus mucosa of patients with CRS with nasal polyposis.

It should be noted that mupirocin douches are only able to be used after patients have undergone sinus surgery; otherwise it is not possible for topical treatments to enter the sinus cavities.

Surgical Intervention

The aim of surgical intervention in nasal polyposis is the meticulous removal of all areas of polyposis, eosinophilic fungal mucin, and biofilm laden mucin plus the wide ventilation of all paraanalar sinuses. Two more complex endoscopic sinus surgery procedures have been developed over recent years that have significantly improved the results achieved with standard Endoscopic Sinus Surgery (ESS). These are the Endoscopic Modified Lothrop and Modified Maxillactomy.

1. Endoscopic Modified Lothrop (EML)

Endoscopic Modified Lothrop (EML) is the term used to describe an operation, the aim of which is to co-joint the natural drainage pathways of the frontal sinuses into one large neo-ostium. Originally this was described using an external cut on the face. This was modified recently to be performed instead through the nostrils using an endoscope for visualisation, thereby avoiding incisions on the face. In patients with severe nasal polyps there is a requirement to widely provide aeration into the frontal sinuses, either as a primary or secondary operation for the application of topical antibiotics and steroids, see figure 2.

2. Modified Maxillactomy (MMM)

Managing the maxillary sinus requires a graduated array of techniques. For most patients with nasal polyposis it is imperative that all disease from this large sinus is removed. The most common intervention is through naturally enlarging the maxillary sinus ostium, and utilising angled 120° micro-debrider blades. However, recurrence of disease, primarily dominated by bio-film activity, leads to the requirement of more significant ventilation of the maxillary sinus. The next step is an endoscopic MMM. This procedure results in the removal of the medial wall of the maxillary sinus, but preserving the lacrimal duct and anterior end of the inferior turbinate that would usually be removed in a full medial maxillactomy.

Results

Our unit recently analysed the long term results of patients with severe nasal polyposis. Over 86% of patients with nasal polyposis were disease and symptom free at 41 months follow-up. For those patients with severe disease, there was a 27% chance of needing an EML, and 14% chance of needing a MMM within two years of their initial ESS to achieve this goal.

Summary

Our understanding of the aetiology, immunology and microbiology of nasal polyposis, along with advances in surgical techniques has allowed us to develop an integrated approach to managing nasal polyposis. These surgical techniques, backed by complimentary medical therapy, allows us to achieve disease eradication in a significant number of patients with nasal polyposis.

Mr Robinson is an Otolaryngologist who consults from the Wakefield Specialist Medical Centre, Wakefield Hospital, Newtown, Wellington. Mr Robinson specialises in endoscopic sinus surgery including revision sinus surgery, management of complex frontal sinus disease, endoscopic DCR (dacrystocystorhinostomy) and endoscopic management of sinus and skull base tumours. For further information contact Mr Robinson, P: (04) 381 8120.
Ankle Arthritis – Fusion or Joint Replacement?

Joint replacement is an option in the management of ankle arthritis, as in the hip or knee. However, unlike in the hip and knee, ankle fusion (arthrodesis) is a comparable alternative to total ankle replacement (TAR).

Early ankle replacements in the 1970s had disappointing results, and the procedure lost favour to arthrodesis. The downside of arthrodesis is overload and potential arthritis of adjacent joints (typically the subtalar joint), which may necessitate further arthrodesis and increased hind-foot stiffness.

There has been a resurgence of newer TAR designs which more closely approximate ankle anatomy and associated biomechanics. These are typically three component designs – metal tibial and talar components sandwiching a polyethylene bearing. This bearing may be mobile, or fixed to the tibial component.

TAR is performed much less commonly than hip or knee arthroplasty. The New Zealand Joint Registry data for 2010 records 125 TARs, vs 6100 Joint Registry data for 2010 arthroplasty. The New Zealand commonly than hip or knee TAR is performed much less.

TAR at mean follow-up of 32 months2.

| Article written by: Mr Alistair Dray, Orthopaedic Surgeon, phone (06) 873 8806 |

Management

Following clinical and x-ray assessment of the patient’s ankle, an intra-articular injection of local anaesthetic and steroid is often helpful in confirming the ankle as the source of pain, especially if there is concern pain may be from adjacent joints. A CT may be indicated to assess suspected bone cysts or adjacent-joint arthritis.

The decision regarding TAR versus fusion then needs to be made with the patient. Inclusion criteria for TAR are relative, but include weight < 90kg, relatively low demand lifestyle, preferably retired1, no major deformity (mild deformity may be acceptable if it is correctable). For example, a 50 year old 105kg farmer would not be a good candidate for TAR, as the prosthesis may fail early, he would be more reliably served by an arthrodesis.

I discuss the relative merits of fusion versus TAR with my patients: arthrodesis has a similar expectation for pain relief, but a risk of subsequent subtalar arthritis, whereas TAR maintains mobility and protects against adjacent joint arthritis, but may require revision in the long-term if it fails.

Many patients are initially unkeen on arthrodesis, understandably concerned about having a stiff foot. I use a short video showing a patient’s movement three months post-fusion to demonstrate how well the other joints move and compensate.

TAR – for suitable patients – is a viable alternative to fusion, with equivalent pain relief and better function.

References

1. Saltzman, CL; Mann, RA; Ahrens, JE; et al.: Prospective controlled trial of TAR total ankle replacement versus ankle fusion: Final results. Foot Ankle Int, 30(7): 579-86, 2009
Coblation Technology and its use in Otolaryngology

Coblation – What Is It?
Coblation (Controlled Ablation) differs from conventional radiofrequency by using plasma field technology, for example radiofrequency in a wet field. This relies on low frequency, low power radiofrequency energy passing through an electrically conductive fluid (saline) rather than electrical arcing through air or direct tissue contact.

Coblation channelling wands are also available for treatment of the soft palate and uvula in snoring patients. This is often used in combination with uvulopalatoplasty using the coblation wand.

Coblation Tonsillectomy
Coblation is extensively used for tonsillectomy across the world. Single use patient coblation wands are used to dissect out the tonsils with minimal thermal damage to the underlying tonsil bed. Use of the microscope or loupes enables precise dissection between the capsule of the tonsil and the underlying muscle layer. Patients recover faster, generally with less pain than with conventional tonsillectomy techniques, and with an earlier return to normal activities. Complication rates (bleeding) are similar to traditional techniques, although there have been shown to reduce as operator experience increases. The use of disposables means that the cost of coblation is more than conventional tonsillectomy, although this is mitigated to some degree by the reduced time in theatre. Adenoidectomy can be performed with the same wand, and there are also specifically designed adenoidectomy wands.

Coblation Tonsillotomy
Tonsillotomy, or intracapsular dissection of the tonsil, is a technique which has come into its own with coblation techniques. In this situation, the tonsils are not completely removed but rather extensively de-bulked. The underlying muscle bed and capsule are not exposed with consequent reduced pain and rapid recovery. This is particularly applicable in young patients with obstructive sleep apnoea, without recurrent infection, in whom the residual tonsil tissue is unlikely to cause problems.

Other Otorhinolaryngology (ORL) Uses for Coblation
Nasal Surgery
Coblation channelling wands are available for submucous reduction of the inferior turbinates to reduce nasal obstruction without damaging the overlying mucosa.

Snoring Surgery
Coblation channelling wands are also available for treatment of the soft palate and uvula in snoring patients. This is often used in combination with uvulopalatoplasty using the coblation wand. The lingual tonsils in the base of the tongue can be de-bulked using the coblation wand. More recently surgeons are using coblation channelling wands within the larynx part of the tongue to reduce the bulk of the anterior tongue, which has shown promising results in the treatment of obstructive sleep apnoea due to tongue size.

Some authors have also used the coblation wand in open surgery to significantly reduce the size of the posterior tongue, although there are significant risks associated with this technique.

Laryngeal Surgery
Coblation also has uses in the larynx and trachea for de-bulking soft tissue lesions such as papillomata, polyps and tumours.

Coblation benefits:
For the patient this includes less pain and faster return to normal function.
New Consultants

Acurity Health welcomes the following consultants to our Royston and Wakefield hospitals. Please contact them directly if you would like more information about their specialties.

Mr Alistair Dray
FRACS (Ortho)
Orthopaedic Surgeon
P: (06) 873 8804
F: (06) 873 8005
W: www.draytonorth.co.nz
Alistair is a consultant orthopaedic surgeon at Royston Hospital in Hastings, and Hawke’s Bay DHB. He was brought up in Warkworth and graduated from Auckland Medical School in 1993. After finishing his orthopaedic training in New Zealand he worked as a consultant at Waikato DHB for two years, focusing on hip and knee arthroplasty and major trauma, before being appointed to the Surrey Foot and Ankle Fellowship, undertaking a year of surgical training at the Royal Surrey County Hospital and Frimley Park Hospital, with four full-time specialist foot and ankle surgeons. He returned to New Zealand in 2010 to settle permanently in sunny Hawke’s Bay with his family.

His practice is divided between lower limb joint replacement (hip, knee and ankle) and foot and ankle surgery, with a special interest in arthroscopy, sports injuries and general orthopaedics.

Mr Andrew Dowley
MB ChB, DLO, F.R.C.S, ORLHNS (Ed)
Otolaryngologist
P: (06) 873 1162
F: (06) 873 1163
E: ent@airnet.net.nz
Specialty
Ear, Nose and Throat Surgery, Otolaryngology
Training
Andrew did his training in the south Trent region, UK, including two years in Queen’s Medical Centre, Nottingham and a Rhinology Fellowship in Plymouth.

Background
Prior to coming to New Zealand, Andrew was a consultant in Cheltenham and Gloucester Hospitals where he was Programme Director for the Junior Doctors. He is also a reviewer for Emergency Medical Journal. He is chair of the local Non-Melanoma Skin Cancer Group.

Andrew has a special interest in:
• Endoscopic sinus surgery and its applications
• Septoplasty, functional and cosmetic, including complex nasal reconstruction
• Otology and ear disease
• Facial skin lesions and skin cancer.

Mr Dowley consults at the Royston Centre, 325 Prospect Road, Hastings, 4122, and operates at Royston Hospital.

Dr Rees Cameron
FRACP MSc (Hons)
Gastroenterologist
P: (04) 381 8110
F: (04) 381 8111
E: rees.cameron@wakefield.co.nz
Rees is a Gastroenterologist who consults at the Wakefield Gastroenterology Centre, Rintoul Street, Wellington and operates at Wakefield Hospital, Florence Street, Newtown, Wellington.

Specialty
Gastroenterology
Training
Rees is a graduate of University of Auckland Medical School. He trained in Gastroenterology at Christchurch Hospital, and completed a Hepatology Fellowship at Freeman Hospital Liver Transplant Unit, Newcastle-upon-Tyne, and Advanced Interventional Endoscopy Fellowship at California Pacific Medical Center, San Francisco.

Specialising in:
• Therapeutic / interventional endoscopy
• Chromoendoscopic evaluation of colon and upper GI tract
• Endoscopic management of dysplasia in Barrett’s oesophagus
• Inflammatory bowel disease
• Irritable bowel syndrome and the management of chronic abdominal pain
• Viral hepatitis.

Dr Cameron’s intention is to establish a world-class endoscopic ultrasound service in Wellington.

Dr Nick Bedford
MB ChB, Dip Obst, FRANZCOG
Gynaecologist
P: (04) 381 8120
F: (04) 381 8121
E: specialists@wakefield.co.nz
Rees is a gynaecologist who consults at the Wakefield Specialist Medical Centre, 99 Rintoul Street, Newtown, Wellington and operates at Wakefield Hospital, Newtown, Wellington.

Specialty
Gynaecology
Training
Trained at the Otogo Medical School during 1993 to 1999 and received his Diploma in Obstetrics and Medical Gynaecology Otago in 2002, RANZCOG Training Program 2003-2008. His sixth year of training was completed at Monash Medical Centre in Melbourne, followed by a two year Fellowship in Laparoscopic Surgery and Pelvic Floor Repair at Flinders Medical Centre in Adelaide, South Australia.

Specialising in:
• Laporoscopic and minimally invasive gynaecology, especially laparoscopic hysterectomy, myomectomy (removal of fibroids), treatment of endometriosis and the management of pelvic floor repair
• Vaginal surgery for prolapse and incontinence including native tissue and mesh options when appropriate, and sling surgery for incontinence
• General gynaecology including investigation and management of chronic pelvic pain, heavy menstrual bleeding and infertility.

He will provide comprehensive and sensitive treatment, working collaboratively to achieve the best outcome for his patients.

Dr Latha Vasan
MBBS; FCOG; FRANZCOG; MRM
Gynaecologist
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Dr Vasan is a gynaecologist who consults at the Wakefield Specialist Medical Centre, 99 Rintoul Street, Newtown, Wellington and operates at Wakefield Hospital, Florence Street, Newtown, Wellington.

Background
Latha qualified in medicine in India and completed a specialty Training Programme in Obstetrics and Gynaecology in Cape Town, South Africa. Her post graduate masters in reproductive medicine (MRM) is from the University of New South Wales.

Latha is available to see patients with any gynaecological condition and has a particular interest in disorders of the lower limb.

His special clinical interests are:
• Hip and knee arthroplasty
• The use of computer navigation for knee replacement surgery
• Foot and ankle surgery.

Gareth is a Fellow of the Royal Australian College of Surgeons, and a member of the New Zealand Orthopaedic Association.

Gareth is an orthopaedic surgeon who consults at the Wakefield Specialist Medical Centre, 99 Rintoul Street, Newtown, Wellington and operates at Wakefield Hospital, Florence Street, Newtown, Wellington.

Gareth qualified in medicine in 1999 and completed the Orthopaedic Training Programme in New Zealand. He post graduate clinical and research fellowships in Primary Revision Arthroplasty and Foot and Ankle Surgery were in Perth and Melbourne, Australia.

Gareth is available to see patients with any orthopaedic conditions and has a particular interest in disorders of the lower limb.

His special clinical interests are:
• Hip and knee arthroplasty
• The use of computer navigation for knee replacement surgery
• Foot and ankle surgery.

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Gareth is an orthopaedic surgeon who consults at the Wakefield Specialist Medical Centre, 99 Rintoul Street, Newtown, Wellington and operates at Wakefield Hospital, Florence Street, Newtown, Wellington.

Gareth qualified in medicine in 1999 and completed the Orthopaedic Training Programme in New Zealand. He post graduate clinical and research fellowships in Primary Revision Arthroplasty and Foot and Ankle Surgery were in Perth and Melbourne, Australia.

Gareth is available to see patients with any orthopaedic conditions and has a particular interest in disorders of the lower limb.

His special clinical interests are:
• Hip and knee arthroplasty
• The use of computer navigation for knee replacement surgery
• Foot and ankle surgery.

Mr Latha Vasan
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Dr Vasan is a gynaecologist who consults at the Wakefield Specialist Medical Centre, 99 Rintoul Street, Newtown, Wellington and operates at Wakefield Hospital, Florence Street, Newtown, Wellington.

Background
Latha qualified in medicine in India and completed a specialty Training Programme in Obstetrics and Gynaecology in Cape Town, South Africa. Her post graduate masters in reproductive medicine (MRM) is from the University of New South Wales.

Latha is available to see patients with any gynaecological condition and has a particular interest in disorders of the lower limb.

His special clinical interests are:
• Hip and knee arthroplasty
• The use of computer navigation for knee replacement surgery
• Foot and ankle surgery.

Gareth is a Fellow of the Royal Australian College of Surgeons, and a member of the New Zealand Orthopaedic Association.
Update on Pelvic Mesh in 2012

It's been a bad year for the manufacturers of uro-gynaecological mesh. These materials that have become incorporated into repair of pelvic organ prolapse (POP) and management of urinary incontinence (UI) are being re-examined for their safety.

POF and UI affect a large proportion of our aging population. Some 11% of women undergo surgical treatment for these problems, many of whom also require revision surgery. This represents a major market and in the world of medical devices, specific meshes and surgical kits for prolapse repair and incontinence treatment have been keenly promoted to both clinicians and directly to patients. But in July 2011, with increased awareness of mesh-related complications, the Food and Drug Administration, FDA, the body responsible for authorising medical products in the United States, updated their safety warning on a number of commercially available pelvic mesh kits, and reviewed the device classification for several of these products. The change requires several currently available products to undergo more rigorous scientific assessment, or be withdrawn from the market. The process surrounding approval of new surgical devices, and how this relates to pelvic meshes, is interesting. So is the extent of the problems and the challenges that remain for pelvic floor reconstruction.

Why Mesh? – Problems with Native Tissues

Despite the prevalence of POP and UI, our understanding of causative risk factors and long-term outcomes is relatively poor. We recognise the importance of parity and delivery, of age and oestrogen status, of obesity, chronic cough and constipation. Underlying this, deficient pelvic tissues are thought to predispose women to the problem, and moreover to treatment failure. Pelvic tissue from women with stress urinary incontinence and pelvic organ prolapse show a genetic predisposition to abnormal extracellular matrix remodelling, altering normal tissue architecture and mechanical properties. Vaginal repair of POP using native tissues is associated with significant rates of prolapse recurrence; some 30% of these patients undergo repeat prolapse surgery, often with multiple procedures, with progressively shorter intervals between surgeries. Repair using deficient tissues therefore seems counter-intuitive.

Borrowing from abdominal wall and inguinal hernia surgery, reinforcing surgical repair by incorporating graft materials into POP and UI surgery makes sense. Likely options for grafts include native tissues (harvested from another site), biological materials and monofilament polypropylene mesh. Sufficient native fascia is readily available for UI surgery, but not for POP repair. Biologics, either cadaveric or porcine, have demonstrated significant medium-term failure. Monofilament polypropylene mesh, widely used in hernia surgery and spectacularly successful as an anti-incontinence sling treatment, seemed the obvious choice for prolapse repair.

Medical Devices and the Food and Drug Administration (FDA)

Use of surgical mesh for abdominal hernia repair began in the 1950s and preceded FDA device regulation. This was progressively used as a precedent for pre-configured mesh products for treatment of UI and POP to circumvent more rigorous processes of evaluation of safety and efficacy, prior to general marketing. Where a manufacturer believes a device is ‘substantially equivalent’ to an existing and legally marketed device, approval may be sought under a submission entitled 510(k). For devices classified as Class I or II, there is no requirement for independent pre-market assessment of safety and effectiveness. Unfortunately, all mesh is not equal, mesh may behave differently placed into different sites in the body, and delivery systems may represent novel surgical technique themselves. One notable and well-used product “Prolift”, now being withdrawn, was marketed for three years without FDA approval; the manufacturer’s believing the device too similar to an existing approved product to warrant an independent application for approval. ‘Prolift’ was subsequently used as the precedent for yet another new and modified device, so transferring and evolving the precedent.

Why Kits? – Office, Vaginal

The trend in many branches of surgery is towards more minimally invasive approaches, and to particular to office-based procedures performed under local anaesthetic. This has driven shorter pieces of sling for treatment of UI; vaginal rather than abdominal surgery for treatment of POP; and custom-delivery systems for vaginally-placed mesh at POP surgery. Marketing has encouraged general use of never devices and touted a short-learning curve for their execution. Consequently, large numbers of trans-vaginal mesh procedures are being performed, many outside of the operating theatre environment. It is estimated that one in three POP surgeries uses mesh and three of four POP procedures are done trans-vaginally. For UI surgery more than 80% are done trans-vaginally with mesh.

Continued on page 12
beneath the incision, and Placing mesh trans-vaginally mesh sheet such as ‘Prolift’. placing mesh into this narrow bladder is narrow. Correctly skin and the urethra and remove and removal may be resolution generally requires eroded, it is infected, and can trigger a foreign body with polypropylene is that is it integrates with tissues and Polypropylene is an excellent with few complications, using via this approach. Mesh contraction may cause vaginal shortening, tightening, and/or vaginal pain and is increasingly reported in the literature. Further to this FDA review and the Advisory Committee, who met in September, a number of devices currently in use have been recalled. These include Prolift and Prostar, the most commercially successful kits for mesh repair. Other companies are reviewing their devices in the context of the FDA warning and associated US litigation against mesh manufacturers.

Current Options – Back to the Future

So how will we continue to manage POP and UI in 2012 and beyond? Happily, sling surgery using TVT for treatment of UI has demonstrated long-term safety and efficacy and it seems unlikely our approach will, or needs to change. Whilst slings placed using a transobturator (TOT) rather than retro-pubic (TVT) approach are considered equally safe and efficacious, complete removal of TOT sling, if required, is more difficult than removal of TVT sling. Consideration of feasibility of mesh excision may become increasingly important in the future. For management of POP, a return to more traditional vaginal repair using native tissues seems likely. But is there a better solution? The experiment with vaginal mesh kits has not addressed the problems of poor tissue integrity and the need for frequent revision procedures, which dog traditional vaginal prolapse repair. Hysterectomy treats uterine prolapse by removing the uterus, without specifically addressing defects in pelvic floor support. Hysterectomy has been associated with increased risk of subsequent POP and UI and the role of hysterectomy for management of POP may be questioned.

Sacrocolpopexy is an abdominal approach to POP repair, first described in 1957 by Young and Swan and modified in 1962 by Lane. It may be performed laparoscopically with the usual advantages of early return to normal function and early discharge from hospital that is associated with laparoscopic surgery, but the technique is otherwise similar to the original descriptions. Mesh is used to suspend the apex of the vagina, uterus and cervix, to the sacral promontory. The support mimics normal anatomical support by the uterosacral ligaments and preserves the normal vaginal axis. Hysterectomy is unnecessary for success. Indeed, it is preferable to avoid an associated vaginal incision. The mesh is commonly extended down the back of the vagina to the pelvic floor and perineal body. Anteriorly it is extended to the level of the bladder trigone. These extensions treat the components of cystocele and rectocele, in addition to effective apical support. Compared to traditional vaginal surgery without mesh, sacrocolpopexy repair with mesh (sacrocolpopexy) results in less recurrent prolapse.

Compared to transvaginal POP surgery with mesh, there is a lower rate of mesh complications with sacrocolpopexy. Pelve mesh placed abdominally at sacrocolpopexy appears safe and use of mesh for this procedure is considered appropriate by the FDA, following their review. Abdominal sacrocolpopexy, either open or laparoscopic, restores pelvic anatomy and provides durable repair of prolapse, with resolution of prolapsed related symptoms. My own experience over the past ten years with this procedure, performing it laparoscopically, parallels published results: resolution of symptoms and satisfaction rates are high (95%), success is durable, and mesh erosion is rare (two percent).

De novo UI (unmasked UI) occurs in nine to 42% of patients unless an anti-incontinence sling is placed simultaneously with the POP surgery. I have advocated sling placement simultaneously with sacrocolpopexy except in patients with established voiding dysfunction not attributable to prolapse, I have not seen any complications secondary to sling placement in this context. The posterior mesh is routinely extended downward the posterior vaginal wall, between the rectum and vagina, to treat rectocele. This component of sacrocolpopexy is now appearing in colo-rectal literature as laparoscopic anterior/ventral rectopexy, for treatment of rectal prolapse, faecal incontinence and obstructed defecation.

Conclusions

In the management of pelvic organ prolapse (POP) and urinary incontinence (UI) 2012, therefore stems the dawn of an era:

1. Incontinence surgery looks set to return from the office to the operating theatre, with retro-pubic (TVT), and probably transobturator (TOT), polypropylene slings remaining standard treatment,

2. The role for abdominal POP repair using laparoscopic or open sacrocolpopexy will likely increase, in the wake of regulatory and clinical difficulties encountered with vaginally placed pelvic mesh and established limitations of traditional tissue based vaginal repair.

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Epub 2011 Sep 25. Review


9. FDA Medical Devices: Premarket Notification (510(k)). U. S. Food and Drug Administration Silver Spring, Maryland

Mr Andrew Kennedy-Smith is an urologist who operates at Wakefield Hospital and consults from his rooms, Wellington Urology Associates, based at Wakefield Hospital. Mr Kennedy-Smith’s special-interests include laparoscopic approach to urology, the management of prostate and renal cancer, complex urinary tract reconstruction and incontinence management. For further information please contact Mr Kennedy-Smith on phone 381 8344.

Update on Pelvic Mesh in 2012

Continued from page 10
Over two consecutive days, during the April school holidays, Wakefield Health Limited held its 15th annual GP Conference at Te Papa, Wellington. The venue proved to be an excellent choice as it was well received by all who attended.

Dr John Wyeth, 2012’s chairman of the Wakefield Health Conference, along with Andrew Blain, Chief Executive of Wakefield Health Limited, officially welcomed and thanked all the delegates, speakers and sponsors for attending.

Our Changing World
2012’s theme was ‘Our Changing World’. We had a wide and interesting array of speakers, two from across the ‘ditch’ and several from outside of Wellington, delivering topics ranging from Detecting Cancer Symposium, led by Professor Swee Tan, Professor Peter Gibson, Dr Trevor Hitz Joh, Dr Shelly Soo, Associate Professor Parry Guildford, Mr Burton King, Dr Ian Coutts and Dr Ian Wilson. Learning from Recent Disasters Symposium, led by Professor Beverley Raphael, Dr Mark Leadbetter, Dr Adrian Gilliland and Tania Thomas, Deputy Commissioner from the Health and Disability Commissioner’s office. To, Our Future, led by Associate Professor Dawn Elder and Mr Rob Rowan.

Workshops
Delegates were also spoilt for choice by the variety of workshops they could attend given by specialist consultants. These workshops were led by Professor Peter Gibson, Dr Frank Weilert, Dr Alexander Sasse, Dr Dynes McCornell, Dr Justin Travers, Professor Beverley Raphael and Mr Grant Kiddle.

During the course of the conference, delegates, presenters, sponsors and Wakefield Health Limited staff were able to network with fellow colleagues over refreshments.

We thank everyone who attended this year’s conference and appreciate the very positive feedback received. Wakefield Health is totally committed to supporting our medical community, this is why we organise and sponsor these conferences each year.

References:
1. ‘Our Changing World’: http://tinyurl.com/8uxlx6o
2. Detecting Cancer Symposium: http://tinyurl.com/9hjdnua
3. Learning from Recent Disasters Symposium: http://tinyurl.com/9n84q2h
4. Our Future: http://tinyurl.com/9vv7j2m


“We thank everyone who attended this year’s conference and appreciate the positive feedback”
Bariatrics: A Balanced Surgical Approach

1.1 billion people worldwide considered to be overweight, adult morbid obesity has now been recognised as a worldwide pandemic. In New Zealand about 60% of the population is considered overweight, mainly due to our ‘obesogenic environment’ i.e. ready access to poor nutrition combined with reduced physical activity.

Today we follow the journey of ‘Tracy’, a patient who has kindly agreed to share her experiences and interview with Elisabeth Stubbs and Angela Phillips, members of the multi-disciplinary team that support consultants Mr Simon Bann and Mr S Kusal Wickremesekera in their bariatric practice.

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Today we follow the journey of ‘Tracy’, a patient who has kindly agreed to share her experiences and interview with Elisabeth Stubbs and Angela Phillips, members of the multi-disciplinary team that support consultants Mr Simon Bann and Mr S Kusal Wickremesekera in their bariatric practice.

Bariatrics: Patient’s Story

“Eating with the brain, not with the eyes.”

“Tracy’s” story as told to Greg Clarke, former Chief Operating Officer, Acurity Health Group Ltd.

I’d had enough of feeling sick all the time, of collapsing at the end of the day exhausted. The year leading up to my gastric sleeve surgery in particular was hard going – I had constant nausea, was tired and felt like I wasn’t keeping up with things. At 53 I weighed 118kg and had a BMI of 46. I had diabetes and high blood pressure. But more than anything I wanted to be able to keep up with my new grandson.

It wasn’t an easy decision but one that I pretty much kept to myself. Even my husband was unaware of what I was doing until I started the optifast diet. By then I had taken out a personal loan and nothing, and I mean nothing, was going to stop me. I had to do a lot of work on myself, it wasn’t just about the weight, but also about being mentally prepared. It’s about a mindset fixated certainly helped!

“IT’s not about the operation – it’s about what I do with it.”

My husband was not happy, in fact it would be fair to say that he was really not happy. He thought “oh well it’s another try yah yah yah” and then there was the cost. He made an appointment to see the surgeons but once I went on the diet and he realised how pedantic I was about it, he knew it wasn’t going to be a five minute wonder. He could see it was important to me, and he was very encouraging. I did a lot of research, spoke to my GP who was supportive but didn’t know a lot about the procedure so did some more investigation after talking to me. As part of the preparation I met with the surgeons, a dietician and a counsellor. The counsellor focused on the psychological side of things and could see that my personality made me a good candidate for it.

The dietician covered off what kinds of food I would be able to eat afterwards. I started preparing meals and freezing things. My friend bought me a little plate smaller than a saucer, I also bought little dishes for afterwards. On the diet I dropped weight so quickly at times I was freezing. I had to wear layers tighter than normal clothes. My surgery took place at Wakefield Hospital in August 2011. I came in on a Monday and was discharged on theWednesday. The surgeons were great, very supportive and there for me if I needed anything. The Wakefield Hospital staff were wonderful and very caring. I am not normally a good patient (ironically I am a nurse), but I did okay.

I stayed at home for a week then went on a prearranged trip for a few days. I took it in stages. I stayed home for two weeks and started back at work part time for four hours a day. The plan was to get back to full time work after four weeks but it took me six because I was still very, very tired. Looking back I did return too early. I couldn’t help myself – I was trying to squeeze a full time job into four hours.

One of the things about the op is that you can get anxious afterwards and I did. I’m not a needy person but I became quite clingy (my husband thought it was great). I hadn’t really been prepared for the anxiety of thinking “oh my god, what if I eat this and it stuffs up my stomach?” and undoing all the good work that had just been done. My motto became “eating with the brain, not with the eyes”.

One of the reasons I didn’t tell people is that a lot of people make negative comments such as “you took the easy way out”. Nothing could be further from the truth – it is NOT an easy process, it’s a hard option. For me it’s an everyday thing focusing on what I am eating and asking yourself is this going to support what I am doing? For the first six weeks I ate a lot of pureed food and gently introduced other foods. It took a while to eat meat and fish.

At about five and a half months I was eating normally although I no longer eat bread or eggs as they tend to sit uncomfortably with me.

I have adapted what I eat to where I am now. I eat smaller portions but more often. I really struggle to drink water as I never used to. Also am eating a lot more protein which was really hard work.

I do go out and eat but tend to be more choosy. I go for entrees rather than big meals now. I don’t do the high fat stuff of course – just can’t. There is no value in the food. I’m always asking myself “what is valuable for my body?”

Continued on page 18
There have been other changes – my diabetes is dormant, my blood pressure is down and I don’t feel constantly sick. One of the biggest differences is that I can go to the shops now. I really enjoy shopping which can be a bit disastrous! I can go into those shops I wouldn’t have gone into before. I now wear different colours, not just black anymore. My energy levels are up. I still run around like a tornado at work but the difference is that I don’t crash at the end of the day feeling like death warmed up. Instead I’m off for a walk.

My family and friends notice the difference and are stoked with what I have achieved. People who didn’t know, don’t need to know.

It’s been a year now. I have lost around 30kg and maintain my weight within a 2kg range. Surgery is not an easy option; it’s now up to me to make it work. Best of all I can now chase my grandson around!

I recommend the op but with the following provisos:

1. Attitude
   You must have the right attitude – are you prepared to change your lifestyle?

2. Balance
   You must have balance in your life. You can’t work all the time and then rush out and grab something if you put work ahead of home life or health then it’s not going to work. Are you prepared to make changes? If not, then you are not ready.

3. Organisation
   Be organised – freeze meals, get smaller clothes in advance, keep some money aside so you can buy yourself things as required.

4. Programme
   Follow the programme with support from the doctors, dietitian and counsellor.

5. Focus
   Focus on what you eat.

6. Monitor
   Watch for anxiety.

There was a financial impact – I went down four bra sizes in less than six weeks, and at $70 a bra it added up.
Bariatrics: Nutritional Support

When patients start the process of consideration for a Sleeve Gastrectomy, the first step is for patients to undergo a nutrition assessment to gather background information to ensure any medical or lifestyle concerns can be addressed prior to surgery.

The nutrition pre-assessment includes identifying any nutrient deficiencies, as up to as many as 60-80% of morbidly obese patients have micronutrient deficiencies pre-operatively. Pre-assessment helps identify any current or previous history of eating disorders, and determines the patients ability to make lifestyle changes based on previous weight loss attempts and eating patterns. At this stage education is provided on pre and post surgery nutrition to ensure a clear understanding of changes required and the need for life-long healthy eating and lifestyle patterns. At this time individualised recommendations are made based on eating behaviours. These changes should commence prior to surgery to assist with post surgery behaviour.

For two to six weeks, prior to surgery, patients go on the Optifast Very Low Calorie Diet (VLCD). Optifast VLCD is a complete meal replacement, and the programme entails three Optifast VLCD products, two cups of low starch vegetables and one serving of fruit. This is generally well tolerated; some tiredness in the first week can occur but feedback from patients is generally positive. The purpose of the programme is to shrink liver size to enhance the safety of their procedure. Surgery reduces the size of the stomach, and reduces the production of Ghrelin (appetite-stimulating hormone) therefore patients are assisted to reduce their quantity of food long-term to facilitate significant weight loss. During the first six weeks post surgery, patients progress from puree textures to a regular healthy diet high in protein, including small quantities of complex carbohydrates, low fat dairy, fruits and vegetables. Due to high protein requirements (60-120g protein/day) and the significant reduction in food quantity following surgery a protein supplement is usually required during the initial six to twelve weeks. It is important to ensure food quantities remain reduced long term, and foods are low in calorie density. If not then weight re-gain can occur.

The reduced quantity of foods post surgery results in a reduction in vitamin and mineral intake, therefore a multivitamin needs to be taken daily as micronutrient deficiencies can occur. A common post-operative complication is constipation due to reduced fibre intake and inadequate fluid intake. This is ideally treated with increased fluids, a fibre supplement and/or Kixxcrush but if necessary a laxative is used.

Research shows food tolerance and gastrointestinal quality of life post Sleeve Gastrectomy was ranked superior to the laparoscopic adjustable gastric banding (LAGB) and Roux-en-Y gastric bypass (RYGB). Foods commonly identified by our patients as being poorly tolerated are meat, chicken, fatty or rich foods and bread although most patients can return to a full intake with no intolerance. Food intolerance is often associated with non-compliance, in particular eating too quickly.

The expected long-term weight loss following a Sleeve Gastrectomy is equivalent to RYGB and LAGB. We aim for weight loss of 60-75% of excess body weight based on research to date. Regular exercise and a high protein intake are important to assist with long-term weight loss maintenance. Our patients are seen by our Lifestyle Coach to provide them with an individualised exercise programme that works for them. Patients have five post surgery consultations over the first year. Additional consultations are undertaken on an individual basis if required or requested.

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Example of a typical intake long-term after surgery:

**Breakfast**
- 1 x weetbix plus 1/2 cup calc–trim milk plus 100g yoghurt
- 1 x poached egg on toast

**Morning Tea**

**Lunch**
- 120g tuna with 2 crackers
- Chicken salad (100g chicken plus 1/2–1 cup salad)

**Afternoon Tea**

**Dinner**
- 120g chicken / one small chicken breast
- 1/3 small / medium potato
- 1/3 cup vegetables
- 120g salmon
- 1/3 small dinner roll
- Saled 1/2 cup

References
Enhanced Recovery After Surgery (ERAS) Coming to a Hospital Near You

Bowen Hospital

A growing understanding of the importance of evidence based guidelines in all aspects of the management of patients undergoing elective colon and rectal surgery has been reined into a reproducible package of care aimed at optimising patient outcomes with the benefit of fewer complications and reduced length of hospital stay.

How does ERAS Work in Practice?

When patients are scheduled for elective colon or rectal surgery in the outpatient clinic they are given a much clearer explanation of what will happen in hospital and what is expected of them on the ward. A patient is asked about their achievements of the recovery milestones.

Prior to surgery no bowel preparation is given apart from an enema for rectal surgery and patients are allowed to have a clear 'pre-op' carbohydrate drink up to two hours before surgery. They arrive in the operation room in a ‘fed’ rather than fasted state which is associated with a faster recovery.

The intra-operative and post-operative fluid management is important as excess 'soft' containing intravenous fluids are associated with an increased cardiovascular morbidity and surprisingly also surgical morbidity. Fluids are given in a goal directed manner rather than according to a fixed formula. Patients are offered protein and carbohydrate drinks on return to the ward, and food the day following surgery.

A surgical care into a coherent components of peri-operative has led the field in refining autonomy and an evidence based approach to all aspects of surgical and anaesthetic requirements. Wound infusion catheters, of long acting local anaesthetic, are routinely used although some protocols require a high thoracic epidural for 48 hours on the basis that it reduces post-operative ileus.

Multi walks, from day one, are encouraged and intravenous fluids and the urinary catheter are removed on the first post-operative day. Increasing mobility and resumption of a normal diet is fast becoming an integral part of colorectal surgery and will likely be adopted by other surgical specialties.

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2. Opiate analgesia is minimised following surgery.

Mr John Keating is a General Surgeon, who consults and operates at Bowen Hospital.

Mr Keating specialises in:

- Colon and rectal surgery
- Laparoscopic surgery
- Colonoscopy
- Pseudomyxoma Peritonei.

For further information please contact Mr Keating, P: (04) 479 8261.

Age Related Macular Degeneration (ARMD)

Bowen Hospital

A small percentage of patients with both an aggressive subset of disease and those who could afford Private Photodynamic Therapy (PDT) had a chance of slowing progression of central blindness. Imaging the excitement when we were able to offer to all exudative ARMD patients, treatment which preserved the presenting vision in 80% and actually improved vision in 25%. The issue of monthly injections inside the eye for two years seemed inconsequential, in comparison to the possibility of having something better to say than "The key to good results, however, is ‘the presenting vision’. So often, patients notice a change of vision in one eye on a chance closing of the good eye, or a routine optometry check, and by then the natural history of bleeding, scarring and photoreceptor damage has already occurred. Earlier detection gives better outcomes. So as the excitement settles and we realise the truths – that some patients will not benefit that ARMD is a chronic disease requiring ongoing invasive treatment, and that the burden of observational treatment is massive – we now turn toward improving outcomes by education.

The Macular Degeneration New Zealand (MDNZ) was formed in 2009/10 with a view to providing both public education and a voice to lobby New Zealand Government to ensure equitable treatment nationwide and obtain adequate funding. In New Zealand and Australia, ARMD is found to be the leading cause of blindness, see figure 1, and this data is being used to drive awareness programmes and justifying resource demands.

What Can Primary Carers Do?

Facilitate optometry review at three to four times, however, we were able to offer to all exudative ARMD patients, treatment which preserved the presenting vision in 80% and actually improved vision in 25%. The issue of monthly injections inside the eye for two years seemed inconsequential, in comparison to the possibility of having something better to say than "The key to good results, however, is ‘the presenting vision’. So often, patients notice a change of vision in one eye on a chance closing of the good eye, or a routine optometry check, and by then the natural history of bleeding, scarring and photoreceptor damage has already occurred. Earlier detection gives better outcomes. So as the excitement settles and we realise the truths – that some patients will not benefit that ARMD is a chronic disease requiring ongoing invasive treatment, and that the burden of observational treatment is massive – we now turn toward improving outcomes by education.

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What Can Primary Carers Do?

Attend to modifiable risk factors:

- Smoking
- Glucose
- Control control blood pressure, cholesterol and encourage exercise
- Diet

Attend to modifiable risk factors:

- Smoking
- Smoking increases ARMD risk three to four times, however, this reduces with cessation
- Control control blood pressure, cholesterol and encourage exercise
- Diet
- Diet – increase omega 3 and fluids. Eat fish two to three times per week, dark green leafy vegetables and fresh fruit daily and a handful of nuts per week.

Excellent dietary information is available on the MDNZ website.

Dr Helen Long

Age Related Macular Degeneration has changed since the introduction of Anti-Vascular Endothelial Growth Factor (VEGF) intravitreal agents. Prior to 2004 – 2006 we saw only the tip of the iceberg in terms of ARMD patients.

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Septorhinoplasty
Changing the Face of ENT

Royston Hospital
Area, Ear, Nose and Throat Surgery, Otolaryngology
Article written by: Mr Andrew Dowley, ENT Surgeon, phone (06) 873 1162

This surgery is tremendously rewarding as each nose is different and there is a lot of creativity dealing with the various individual aspects of each nose. It can also be terribly frustrating; you are dealing with the most prominent feature on the face and any slight imperfection is there for all to see. This is especially true when one considers the fact that the scarring that comes with the healing contracts, potentially causing an unpredictable result.

There are two main aspects to a septorhinoplasty: function and form. There are also two viewpoints, the patient’s and the surgeon’s. None of these things are independent of each other – a bent nose is also likely to have some degree of obstruction.

Form
This is the aspect that really excites both surgeon and most patients, however, it is also the one that is most subjective and therefore requires an honest conversation between surgeon and patient about what is possible and what is perceived to be an issue by both parties. Thus a formalistic approach is inappropriate.

“...the patient will have their own idea of what is important to them.”

An accurate pre-operative diagnosis is vitally important in order to inform the patient of their issues, as they will frequently know that things are wrong but are unable to define what or why. This must start with the underlying structure of bone and cartilage, followed by an assessment of the soft tissue covering including skin. Everything should be taken in the context of the face as a whole, ensuring any changes are in keeping with the overall structure.

In many patients their bony or cartilaginous anatomy has been so badly damaged that tissue has to be taken from elsewhere. The patient’s own nasal septum can be used, however it is rigid and brittle so it is best to be limited to correcting deformities of the septum itself. The cartilage in the pinna is strong and flexible, giving a natural feeling nose. However, to avoid affecting the appearance of the ear, only lateral crurae (dome of the right lower lateral cartilage) were later cartilage were malpositioned high on the nasal dorsum giving a flattened profile and causing nasal obstruction. Careful dissection and repositioning have improved the situation, but of course the scars remain.

Function
The most important of these is patency of the airway and as such improving pre-operative history. The nose is affected by poor airflow but it may also have been irreparably damaged by a previous injury so it should be recorded in the pre-operative history. The nose is the first part of the common airway and as such improving airflow here can have a positive impact on the lower airway.

Viewpoints
As surgeons an intricate knowledge of the anatomy and how that affects form and function can give us a good idea of the issues that are problematic and how to deal with them. This is all very well but the patient will have their own idea of what is important to them. I am often surprised at how patients will not notice or will happily accept what I consider to be a major issue and be delighted that what they consider to be the presenting complaint has been dealt with. It can be quite a journey to the point where the nose has healed and the final result is known, often 12 months or more, and if the patient is pleased with the result, that is what is most rewarding.

Mr Dowley is an ENT Surgeon who consults and operates at Royston Hospital.
For further information please contact Mr Dowley, phone (06) 873 1162.
Chronic sinusitis is prevalent. About ten percent of the population are thought to be affected by this condition. Chronic rhinosinusitis can be broadly classified into chronic rhinosinusitis with or without polyps.

Following assessment, including nasendoscopy, patients with chronic sinusitis often undergo imaging with computerised tomography (CT). Patients are usually treated medically initially. This can include topical and/ or systemic corticosteroids, antibiotics and nasal saline douching.

Endoscopic sinus surgery is offered to patients who have failed to respond to maximal medical therapy. The aim of surgery is to open the natural ostia of the sinuses to facilitate mucociliary clearance and allow access of topical treatments to the sinuses and to enhance the effect of systemic medical treatment.

Anatomical variations can result in technical difficulties during surgery. Balloon Sinuplasty has become a useful tool in the management of sinusitis over the last decade. It has particular value in the management of frontal sinusitis. The frontal sinus is the most inaccessible of the sinuses and correspondingly failure rates after surgical intervention are the highest for the frontal sinus.

The development of Balloon Sinuplasty was inspired by coronary angioplasty and involves balloon dilatation of the sinus ostium. It can be carried out under local or general anaesthesia. An illuminated guide wire is passed into the sinus and successful cannulation is confirmed by observing trans-illumination of the sinus. The balloon catheter is passed over the guide wire, the balloon is dilated and the sinus ostium is enlarged. Dilatation treats micro-fractures in the surrounding air cells but essentially it preserves the integrity of the mucosa. Bleeding and pain are therefore minimal and length of stay in hospital can be reduced.

Large published series have confirmed the safety of the technique and also confirmed high rates of ostial patency at two years post-op.

References:

An Overview of Lymphoproliferative Malignancies

The last decade has witnessed significant advances in the diagnosis and treatment of lymphoid related blood cancers. The lymphomas, and chronic lymphatic leukaemia (CLL), together account for a large proportion of haematological malignancies seen in the clinic.

There are over 30 different types of lymphomas according to the World Health Organisation (WHO) classification. It is important to make a precise diagnosis to plan for optimal treatment. The haematologist is well placed to investigate and organise treatment because of the combined training in pathology and internal medicine.

Lymphomas may have a protein presentation and can arise in any part of the body. They can range from an indolent follicular type that can be simply observed, to a highly aggressive Burkitt type that will require urgent therapy to avoid a fatal outcome. The usual manifestation of high-grade lymphoma will be a palpable nodal mass, often accompanied by concomitant symptoms such as night sweats and weight loss. Patients may present to any subspecialty, i.e. with an abdominal mass to a general surgeon or to ENT with a tonsilar mass.

The use of CT imaging is necessary in staging the extent of disease and PET/CT is now standard for Hodgkin disease staging. The amount of standardised uptake value (SUV) or intensity tends to correlate with the activity and proliferation rate. The PET scan is also occasionally used in CLL to diagnose large cell transformation that can occur in late stages. Serum lactate dehydrogenase (LDH) is also used in staging to indicate disease burden. Levels as high as 8000 may be found in very aggressive cases.

Lymphomas are often managed by chemotherapy or immunotherapy, surgery, radiotherapy, stem cell transplantation and in some cases autologous transplant. The lymphomas are often refractory to the current range of treatment options.

There is some evidence that the addition of Rituximab improved both progression free survival and overall survival. However, there is still much to do before we can cure lymphoma.

“CLL is very common in the elderly population but the disease course is often chronic and indolent.”

In summary, the advent of Rituximab as targeted therapy against CD20 positive B-lymphocytes has seen improved outcomes with time and overall survival. However, there are second generation monoclonal antibodies, and other new drugs which target the B cell receptor, being trialled to improve the outcomes of those with relapsed or refractory disease.

Autologous transplants are carried out in haematology units at the major cancer centres and can provide long-term disease control. In selected younger patients an autologous marrow transplant can be a potentially curative option. CLL is very common in the elderly population but the disease course is often chronic and indolent. Younger patients tend to have more rapidly progressive disease and will need more potent therapy such as FCR (Fludarabine, Cyclophosphamide and Rituximab), now funded by Pharmac and regarded as the gold standard.

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