

Health Matters

Coccydynia – A Right Old Pain in the Butt!



Bowen and Wakefield
Hospitals

Area: Orthopaedics. Article written
by: Mr Jonathon L. Richards, Orthopaedic
and Spinal Surgeon, ph (04) 464 0035

Coccydynia is a painful condition that is often exacerbated by sitting for prolonged periods of time especially on firm hard surfaces. It is more common in females¹ and accounts for 2000 admissions per year in the US health system.

Patients will often complain of pain deep between the buttock cheeks on sitting for long periods of time and especially worse on harder surfaces. A good discriminatory question for simple coccydynia is the patient will often not have it while sitting on the toilet seat as this has no pressure on the coccyx. Bearing down to pass a bowel motion can exacerbate the pain commonly.



1 Bony destruction of sacrum/coccyx suggestion a pathological cause

First described by Simpson in 1859, causative aetiological factors have included trauma, repetitive injury, local tumours, degenerative disc disease and idiopathic causes. Fractures of the coccyx are in fact quite rare and commonly x-rays of suspected injuries are misinterpreted as this rather than the normal morphological variation that is present. *Continued on p2*

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Message from Acurity Health

Chief Operating Officer's Message
Paul Quayle, Chief Operating Officer, ph (04) 920 0146



With the cooler weather setting in it seems fitting to give a warm welcome to Edition 18 of Health Matters.

Inside this issue you will find interesting and informative articles from our specialists along with a feature on the Acurity GP Conference: Connect 2017 held mid-May. We also have a number of new consultants to introduce to you who have recently joined our hospitals.

Wakefield Hospital New General Manager
It is my pleasure to introduce Marg Jenner as Wakefield Hospital's new General Manager. Marg is well known to those within Wakefield, and in the broader market following her extensive experience across Wakefield – most recently as the Practice Manager at Wakefield's Specialist Medical Centre. Marg is a great leader and I have no doubt in my mind that she will confidently lead Wakefield Hospital into the future.

With Marg moving into the General Manager role Lee White, formerly the ICU/HDU Charge Nurse at Wakefield Hospital, steps into the role of Practice Manager within the Wakefield Specialist Medical Centre. Lee is always available and happy to hear from you and will assist you with any queries you may have.

I wish both Marg and Lee all the best in their new roles.

GP Conference 2017
It was fantastic to see so many new faces at the conference this year along with a strong contingent of

returning delegates. I enjoyed the opportunity to chat with a number of you over the course of the conference and appreciated the positive feedback about our event. As I mentioned at the opening of each day, your feedback is very important to us, and is used to form the following year's programme and to continually improve the event.

I'd like to thank all of the speakers, sponsors and exhibitors who travelled from across the country to be a part of the event. Without their strong support it certainly wouldn't have been the overwhelming success that it was.

Congratulations to all of our prize winners and my sincerest thanks to the sponsors and exhibitors for providing these prizes. The Acurity Health Group Practice Prize this year was won by Dr Reshmi Gounder, who takes back to Upper Hutt Health Centre a surgical treatment bed.

Save the Date
Next year is a very special year for the GP Conference as we will be celebrating its 20th year running. Please lock the date in your diaries for Friday 25th and Saturday 26th May 2018, at Te Papa, Wellington. We already have lots of great ideas for the conference but we would appreciate if you have any suggestions that you share them with us so we can

do our best to include them. Keep an eye out in future editions of Health Matters and on our website www.acurity.co.nz for details.

Bowen Icon Cancer Centre
The Bowen Icon Cancer Centre is the first private cancer care facility in the Wellington region and is the result of a partnership between Acurity and the Icon Group (a specialist provider of cancer care in the Asia/Pacific region). The new centre will initially focus on chemotherapy, with radiation oncology expected in 2018. The Centre is a Southern Cross affiliated provider and will be accepting referrals from late July.

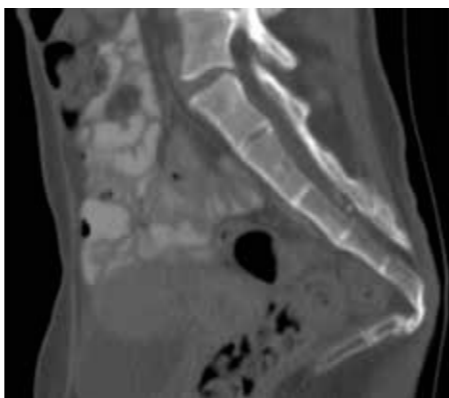
CME (Educational Events)
Our CME sessions continue to be well attended. The purpose of these meetings is to introduce you to new consultants and to update you on any new developments in their specialties. Once again we use your feedback to develop the CME programme and bring you what you have asked for. We advertise our CME meetings on our website, the Royal New Zealand College of General Practitioners website and also in NZ Doctor online. If you would like to receive email notifications of upcoming CME meetings please email your details to events@acurity.co.nz

Enjoy our latest Health Matters edition.

Paul Quayle
Chief Operating Officer
Acurity Health Group Ltd

Coccydynia – A Right Old Pain in the Butt!

Continued from page 1



2 A long sacrum with significant angulation of the sacro-coccygeal junction



3 A ring or cutout cushion. Available at most pharmacies.

Recent CT² and MRI³ studies of both normal and symptomatic coccygeal morphologies have demonstrated a shorter, straighter more retroverted coccyx in females. There is also an associated higher rate of sacro-coccygeal and intercoccygeal fusion in females as well as a higher incidence of a bony spicule which may make women more prone to coccydynia.

The usual anatomical morphology in the sacro-coccygeal region involves five fused sacral segments and three to four coccygeal segments that articulate at the sacral/coccygeal cornu. This can be either fused, a synovial joint or a symphysis⁴. Having a longer sacral segment due to either transitional anatomy or extra sacral segments creates a longer lever placing the sacro-coccygeal joint in a more vulnerable position to pressure while sitting. The coccyx may also adopt a series of more angulated position as described by Postacchini and Massobrio⁵. This has the effect of placing the sacro-coccygeal articulation at a more prominent position. (figure 2).

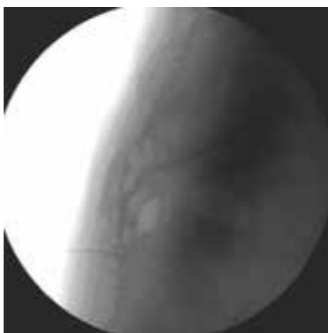
My management of coccydynia involves a three step process to try and relieve the patient's symptoms. The first stage which can easily be performed in primary practice is regular analgesic management and pressure relief. I will commonly give my patients regular paracetamol + NSAIDs (if not contra-indicated) with nortriptyline or amitriptyline.

The second important treatment is to provide some type of pressure relief. A ring or cutout cushion (figure 3) can be purchased from most pharmacies and can be used at times when hard surfaces can't be avoided (work). If the patient is a keen cyclist then I try and convince them to park the bike in the garage for a few months. Just like any inflamed area, rest is a very important treatment.

Plain x-rays and bloods to rule out infection should always be performed if ongoing symptoms are encountered. I would commonly give this management six months duration before proceeding to the next level of treatment.

Routinely I will MRI the coccyx and the lumbar spine on referral, looking for any of the rare causes of coccydynia that may have been missed on the plain x-rays. Occasionally lumbar pathology will be found that can contribute to the overall disability but the vast majority of the time the MRI will be normal.

If the patient has ongoing disabling symptoms despite maximal non-operative therapy I would next perform an EUA and steroid injection under GA. This allows me to assess the mobility of the sacro-coccygeal articulation and then provide an injection of local anaesthetic and cortisone. This is used as both a therapeutic and diagnostic injection. It helps me confirm the pain generator is the sacro-coccygeal articulation.



If the pain is relieved with the injection and returns and is disabling despite maximal non-operative treatment the final treatment option is a surgical coccygectomy.

This procedure involves removing the coccyx and rounding off the distal end of the sacrum through a small incision in the natal cleft.

Results of this procedure can be summarised in a series I analysed while away on fellowship of one surgeon's results over a 40 year career. By condensing the satisfaction rates as described by Bayne⁶ (excellent, good, fair, poor) into two groups those satisfied and those unsatisfied 32/39 were satisfied with the outcome and 7/39 were unsatisfied⁵. There was one revision case in the unsatisfied group. This equated to only one coccygectomy per year out of his average 600 cases per year⁷. The complication rate was 8% with wound infection being the only complication encountered.

References

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* Images are authors own.

Learning points

- Coccydynia is commonly relieved by sitting on the toilet seat as no pressure on the sacro-coccygeal junction is present
- It is more common on women who have a longer sacrum putting the sacro-coccygeal junction in a more vulnerable position
- Good regular analgesic regime and activity/sitting modification is the first line
- Coccygectomy is rarely needed and if patients are carefully selected satisfaction rates are approximately 75%.

Wellington Orthopaedic & Sports Surgeons

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Mr Jonathon L. Richards

Lymphoedema in Breast Cancer

Wakefield Hospital

Area: General Surgery
Article written by: Dr Alex Popadich, Endocrine, Breast & General Surgeon, ph (04) 381 8120

Lymphoedema is swelling caused when protein-rich fluid accumulates^{1,2} in the interstitial tissue due to impaired function of lymphatic tissues.

When lymph stasis prevails, inflammation and fibrosis cause entrapping of the superficial vessels and accelerate insufficiency of lymphatic channels. During lymph stasis, activated macrophages respond to accumulations of lipoperoxidase caused by free radicals not absorbed by compromised lymphatics and cause further inflammation and fibrosis.

The unique function of lymphatic vessels involves intrinsic contractions resulting in continual transport of fluid regardless of level activity or limb position. Lymph uptake relies on continuous, uninterrupted emptying of

proximal vessels and nodes, disruption of the afferent vessel at the node results in lymph vessel hypertension, valvular incompetence with reflux. Destruction of lymphatic vessels by cancer, axillary surgery, axillary radiotherapy, and infection are all known causes of lymphoedema in patients with breast cancer. Lymphoedema presents a serious problem for many breast cancer survivors, with documented rates of six to 40%. Since the advent of sentinel node biopsy the rates of lymphoedema have decreased to seven to 22%. Average time to lymphoedema development is seven months, but can develop years after the operation/treatment.

Low Level Laser Therapy (LLLT) has been around since the 1960s and has been used for treatment of lymphoedema since 1995. LLLT reduces fibrosis and scarring by affecting fibroblasts and macrophages. It also stimulates development of new lymphatic pathways (lymphogenesis).

Low Level Laser Therapy for Lymphoedema is used in the grid pattern in the axilla and arm as shown in Figure 1 and 2. It usually consists of multiple six to 12 sessions lasting around 30 minutes. Several double blinded² and randomised controlled trials^{3,4,5,6} have all shown positive and sustained effects and improved patient outcomes.



Table 1: Stages of Lymphoedema		
Stage 0	Latency stage	Reduced lymphatic transport and functional capacity. No visible, palpable oedema, subjective complaints
Stage 1	Reversible	Reduces with elevation, pitting when present, no fibrosis
Stage 2	Spontaneously irreversible	No resolution, may fluctuate, pitting more difficult, fibrosis present
Stage 3	Lymphostatic Elephantiasis	Dermal hardening, non-pitting, papillomas, hyperkeratosis, extreme girth

Table 2: Symptoms and Characteristics of Lymphoedema	
<ul style="list-style-type: none">• Slow, gradual progression• Pitting in early stages• Distal to proximal advancement (may spare the hand)• Loss of bony contours• Dorsal "buffalo hump" if hand involved• Normal skin colour• History of infection• Ulcerations are rare• Rarely painful• Asymmetric if bilateral	

Dr Alex Popadich



Treatment consists of:	
1	Manual lymphatic drainage/massage ^{1,6}
2	Compression bandaging/garments ¹
3	Exercise ¹
4	Skin and nail hygiene ¹
5	Low level laser therapy ^{1,2,3,4,5,6}

Low level Laser Therapy is also used for treatment of scars and contractures as well as muscle injuries. Some practitioners also use it to minimise post-operative pain related to muscle tightness. There are no reported complications from LLLT.

Lymphoedema is a chronic and incurable condition. Early identification and management will improve quality of life and minimise all complications including cosmetic, functional, psycho-emotional and potentially life threatening.

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* Images supplied by RianCorp Pty Ltd

Dr Popadich runs clinics at:

Wakefield Specialist Medical Centre
99 Rintoul Street
Newtown, Wellington

Waikanae Specialist Medical Centre
Marae Lane, Waikanae

Ropata Medical Centre
577 High Street, Avalon
Lower Hutt

For all appointments please contact the Wakefield Specialist Medical.
P: (04) 381 8120
F: (04) 381 8121
E: specialists@wakefield.co.nz

Bowen Icon Cancer Centre



Cancer Treatment to be offered at Bowen Hospital from July.

From July, the Bowen Icon Cancer Centre will be providing private cancer care for the Wellington and surrounding community. The centre includes a six chair day hospital, delivering chemotherapy and other treatments for blood cancer and disorders.

- Supported by a dedicated, experienced team of local specialists, the centre offers patients:
- The ability to choose their own oncologist and see them consistently
 - World-class facilities with an experienced clinical team providing consistent care for your patients
 - Access to non-PHARMAC approved medicines
 - Consultation and treatment in a timely manner.

With sweeping views of Trelissick Park, the centre provides an intimate, serene and supportive environment for patients seeking a private treatment alternative.

Referrals can be made to one of the below oncologists:



Dr Anne O'Donnell, Medical Oncologist



Dr Brendan Luey, Medical Oncologist



Dr Kate Clarke, Medical Oncologist

Additional specialists will be joining the centre in the coming months.

Please send your referral to:
P: (04) 896 0200
F: (04) 896 0201
E: admin.bowen@oncnz.team



Upcoming CME Meetings

Acurity Health Group host a variety of Continuing Medical Education (CME) sessions for GPs throughout the year. Each session is formatted to give you an opportunity to meet consultant physicians and surgeons, receive expert feedback and discuss topics in an interactive environment. We aim to deliver practical sessions with a primary healthcare focus and learning outcomes based on general practice diagnosis, management and investigation.

Consultants are often able to provide updates on the latest research and cutting edge treatments and procedures. Our sessions are endorsed for CME and MOPS purposes by the RNZCGP. If you would like to suggest a topic of interest or require more information please contact Sarah Malone, Business Development Manager, P: (04) 920 0158, sarah.malone@acurity.co.nz To register, please email events@acurity.co.nz For updated information, visit www.acurity.co.nz

Upcoming CME Meetings – 2017					
Date	Speaker	Speciality	Topic/Details	Venue	CME endorsed
4 July Tuesday	Mr John Groom, Gastrointestinal and Colorectal Surgeon/ Endoscopist	Gastrointestinal and Colorectal Surgery	Gastroenterology 101 Top and Bottom: A Surgeons Perspective	The Dowse, James Coe 2 Room, Lower Hutt	2 credits
26 July Wednesday	Dr Ken Romeril, Dr Anup George, Haematologists	Haematology	Topic to be confirmed	Wakefield Hospital, Education Centre	2 credits
3 August Thursday	Wakefield Heart Centre, Speakers to be confirmed	Cardiology	Cardiology Update 2017	Kapiti Lindale, Conference Centre, Kapiti Coast	2 credits
8 August Tuesday	Dr Lupe Taumoepeau and Mr JK Wicks, Vascular and Endovascular Surgeons	Vascular	Topic to be confirmed	Wakefield Hospital, Education Centre	2 credits
15 August Tuesday	Dr Lupe Taumoepeau and Mr JK Wicks, Vascular and Endovascular Surgeons	Vascular	Topic to be confirmed	Kapiti Lindale, Conference Centre, Kapiti Coast	2 credits
16 August Wednesday	Wakefield Heart Centre, Speakers to be confirmed	Cardiology	Cardiology Update 2017	Wakefield Hospital, Education Centre	2 credits
22 August Tuesday	Mr Grant Broadhurst, General Surgeon	General Surgery	General Surgery Update: Colonic Problems, Thyroid Nodules, Melanoma in General Practice, Benign Breast Disease	East Pier Hotel, Napier	2 credits
29 August Tuesday	Mr Grant Broadhurst, General Surgeon	General Surgery	General Surgery Update: Colonic Problems, Thyroid Nodules, Melanoma in General Practice, Benign Breast Disease	Royston Centre, Hastings	2 credits
13 September Wednesday	To be advised	Musculoskeletal	Manual Musculoskeletal Diagnosis Techniques (practical session)	Wakefield Hospital, Education Centre	2 credits



Thanks to everyone who participated in the Acurity GP Conference **Connect 2017**. We are truly appreciative of your support, and with more of you attending than ever before, this conference continues to grow in popularity. The event which was held over a fabulous two days at Te Papa, explored four main themes: Health Challenges in our Communities; Health for the Over Fifties; Oncology Update and Management of Long Term Conditions.

Themes were structured around topics you wanted us to present and started with Dr David Graham motivating the audience to tackle childhood obesity through practical tools and approaches. The Oncology Update session on Saturday morning was another highlight covering new treatment and therapies within this fast moving field. With over thirty speakers and a variety of plenary and concurrent sessions to attend,

delegates were spoilt for choice. Lightning talks continued to be a highly regarded part of the conference programme and many enjoyed the important message behind Nigel Latta’s witty, light hearted talk on Communicating with Humans. Within the busy programme there was also plenty of time to relax and catch up with colleagues, presenters and sponsors and it was great to see familiar faces and to meet those attending for the first time.

Our sponsors and exhibitors help make this conference possible each year and we are especially grateful for their ongoing support. Equally important is your feedback which helps to shape future conferences and we appreciate the time you take to share this with us. **We hope to see you again next year, 25th – 26th May 2018 at Te Papa.**

“It has been one of the best run high quality conferences I’ve been to”

Special thanks



Special thanks to the following speakers

Mr Chris Adams
Plastic Surgeon
Mr Campbell Baguley
Otolaryngologist
Dr Angela Ballantyne
Senior Lecturer in Bioethics,
Department of Primary Health
Care and General Practice,
University of Otago
Dr Richard Carroll
Endocrinologist
Dr Ian Courtts
Dermatologist
Dr Ben Darlow
Musculoskeletal Physiotherapy
Specialist and Senior Lecturer,
University of Otago, Wellington
Dr Andy Davies
Respiratory and Sleep Physician

Dr Joe Feltham
Diagnostic & Interventional
Radiologist
Dr Cathy Ferguson
Otolaryngologist
Dr Jesse Gale
Ophthalmologist
Dr David Graham
Paediatrician
Dr Justine Lancaster
Cancer Pathway Clinical
Editor, CCDHB
Nigel Latta
Psychologist
Dr Phillip Matsis
Interventional Cardiologist
Dr Lynn McBain
GP, Director at Compass Health,
Senior Lecturer, University of
Otago, Wellington
Mr Bernard McEntee
General Surgeon

Darien Montgomerie
Oncology Site Manager,
Bowen Icon Cancer Centre
Dr Anne O'Donnell
Clinical Leader Medical
Oncology, Wellington Blood
and Cancer Centre, CCDHB
Jake Pearson
Sports and Exercise
Medicine Specialist
Mr Fred Phillips
Orthopaedic Surgeon
Dr Jessica Povall
Physiotherapist
Professor Sue Pullon
Professor and Head of
Department, Primary Health
Care and General Practice,
University of Otago, Wellington
Dr Anil Ranchord
Interventional Cardiologist
Mr Robert Rowan
Orthopaedic Surgeon

Adj. Professor Alex Sasse
Cardiologist
Anna Sisley
Cancer Information Nurse
Dr Nicola Smith
Respiratory Physician
Mr Rod Studd
Urologist
Dr Lupe Taumoepeau
Vascular and
Endovascular Surgeon
Kim Tottenham
Podiatrist
Dr Richard Trendle
Clinical Exercise Physiologist
Dr Amanda Tristram
Consultant in
Gynaecological Oncology
Mr JK Wicks
Vascular and
Endovascular Surgeon
Dr Ian Wilson
Gastroenterologist

“Lightning
talks are great –
to the point
and useful”



Winner of the Practice Prize

Congratulations to Dr Reshmi Gounder of Upper Hutt Health Centre, winner of the Acurity GP Conference Practice Prize. Above: Dr Reshmi Gounder and Maire Mackle, Nurse Manager, enjoying the Amtech E327T Jago 2 Section Treatment Table.

“Superb
conference
as usual”

“Very enjoyable
and constructive
conference”

“Great speakers”

“Excellent
and relevant
sessions”



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Seqirus
Sound Business Systems
Southern Cross Health Society
Specialist Vein Health
University of Otago, Wellington
Wakefield Heart Centre
Wakefield Hospital

But My Sleep Just Isn't Normal Doc

Dr Andrew Davies



Bowen Hospital

Area: Sleep

Article written by: Dr Andrew Davies, Sleep and Respiratory Physician, ph (04) 479 2019

Sleep is a universal phenomenon. Everybody does it and consequently patients who have sleep disturbance have already had all sorts of advice, some good and some terrible, by the time they seek a medical opinion.

There is a huge variation in what is "normal" sleep and the layperson's perception of when and how they should sleep is often significantly at odds with biology. The perception of a "normal" sleep pattern being one where you rapidly drift off to a deep and restful uninterrupted sleep, gradually waking to a state of razor sharp alertness eight hours later is grossly incorrect but very pervasive.

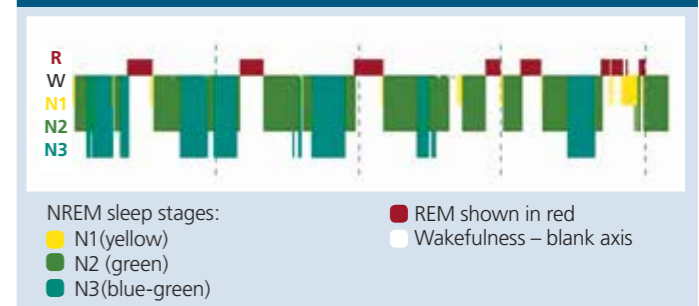
The normal sleep latency (time from attempting to sleep to actually falling asleep) is said to be 20 – 40 minutes, the normal sleep duration is said to be five and a half to eight and a half hours, the range of normal is very broad and there are many who happily exist in the extremes of this range although dementia and cardiovascular disease have both been associated with very long and very short sleep durations.

cycling back through the sleep stages. These cycles last 40 to 90 minutes and we tend to have longer cycle lengths and more NREM at the beginning of the night and shorter cycles with more REM towards the end. This REM predominance in the morning, with resultant loss of accessory muscle use, is partly why the calls between three and 5am as house officers on nightshift were so often about decompensating COPD/ Asthma patients.

It is thought that NREM sleep, when the brain is less active, exists so the very metabolically active neurons can clear the buildup of metabolites from the day and REM sleep has a role in memory processing and retention. Patients who lack the deeper stages of NREM sleep more commonly report fatigue whereas a lack of REM sleep has been linked to cognitive symptoms. The cyclical sleep pattern is probably evolutionary as at any point in the night a small social group of about eight would have one or two individuals who would be easily woken by approaching dangers. Given the cyclical nature of our sleep awareness of two or three awakenings a night is still within the range of normal.

Our sleep phase (the time of day during which we sleep) is as much a social construct as it is biological. Again the range of "normal" is very broad with some societies in the

A normal Hypnogram from one of our recent PSGs showing the sleep cycles



Mediterranean and Middle East commonly having two sleep periods with one after lunch then staying up late in to the night. In most of the English speaking world we have compressed our opportunity for sleep into a smaller and smaller window interfering with our circadian rhythm with artificial light, bright screens and alarm clocks.

Our sleep phase also drifts later during adolescence, commonly returning to its baseline during our mid to late 20s. This may be evolutionary with the most fertile age group being awake later into the night. It also explains why teenagers can be so useless in the morning and why children in their late teens perform better when the school day is shifted back a few hours.

As well as being concerned about sleep duration and quality, patients may also want to discuss some of the strange phenomena that occur around sleep. Seemingly bizarre phenomena such as hypnic jerks, hypnopompic hallucinations, sleep paralysis and sleep walking can all affect us very occasionally and are not necessarily a sign of a sleep disorder when they are

infrequent. Often peoples anxious reaction to a very occasional episode of sleepwalking or sleep paralysis is the problem rather than the symptoms themselves being harmful or abnormal.

Sleep physicians spend a significant amount of time explaining the broad range of normal sleep to patients. Sometimes finding out that their sleep latency of 30 minutes alongside three awakenings a night with the very occasional hypnic jerk is well within the normal range is all people need to feel less anxious about their sleep.

Dr Davies consults at the Bowen Specialist Medical Centre and also at Wellington and Hutt Hospitals.

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Does Eating Low FODMAP Food Relieve IBS Symptoms?

Wakefield Hospital

Area: Dietetics
Article written by: Vicki Robinson, Dietitian, ph (04) 381 8110

Some food, such as milk and milk products, legumes, vegetables and fruits and grains known as ‘gas producing’ have long been identified as triggers for gastrointestinal symptoms associated with irritable bowel syndrome (IBS). Researchers at Monash University have classified the problematic components of these foods as slowly absorbed or poorly digested short-chained carbohydrates, now known as FODMAPs or Fermentable, Oligosaccharides, Disaccharides and Monosaccharides and Polyols¹.

Over the past 10-12 years clinical and observational trials² have associated low FODMAP eating with a reduction in symptoms especially abdominal pain, bloating and diarrhoea in up to 75% of those diagnosed with IBS. A low FODMAP diet may also provide relief for those with inflammatory bowel disease³ and children experiencing IBS like symptoms⁴, although careful supervision is necessary to mitigate nutritional risks. This article summarises Monash University research shared at an international meeting in 2015 and outlined in the March 2017 Journal of Gastroenterology and Hepatology⁵.

What are FODMAPs?

Oligosaccharides are the longest FODMAP carbohydrate found naturally in wheat, rye, legumes, nuts, onions and garlic⁶. Lack of an enzyme to break down oligosaccharides makes them poorly absorbed by all humans. Lactose is the main disaccharide that is poorly absorbed by those lacking the enzyme lactase. While people of Asian and Mediterranean backgrounds are more likely to be lactase deficient, those with intestinal inflammation such as active Crohns disease may also be deficient. Many others will have

sufficient lactase and will not require a lactase restriction. Apples, pears, watermelon, mango, honey, some vegetables and commercial sweeteners (such as high corn fructose syrup) contain the monosaccharide or single sugar, fructose. Polyols, mannitol and sorbitol, are found in apples, pears, stone fruit, cauliflower, mushrooms, snowpeas and artificial sweeteners such as xylitol, an ingredient of some gums and mints. All of the FODMAPs are both poorly absorbed and rapidly fermented. The smaller molecules such as fructose, mannitol and sorbitol are also osmotically active in the small bowel which can lead to fluid changes in the large bowel, excess flatus, altered bowel habit and typical IBS symptoms⁷.

Implementing the Low FODMAP Diet

A low FODMAP eating pattern is not a one size fits all, nor is it a diet for life or a cure⁸. Assessment and prescription needs to be individualised based on IBS symptoms, severity, frequency, usual meal pattern, suspected trigger foods and FODMAP and fibre intake. Dietary recommendations

need to consider nutrition adequacy especially fibre and calcium, which can be lowered when FODMAPs are restricted. If a low FODMAP diet is deemed necessary and an individual is interested (but not too interested such as being at risk of an eating disorder), then a four to six week restriction is necessary to assess the impact on symptoms.

Re-challenging FODMAPs

Despite the effectiveness of restricting fermentable carbohydrates or FODMAPs on IBS symptoms, this restrictive diet can also negatively impact nutritional adequacy and quality of life. The composition and concentration of bacteria, such as beneficial Bifidobacteria, can also be altered on the diet⁹, which may impact gut microbiota and health. Consequently, long-term FODMAP restriction is not recommended, necessitating systematic re-introduction of individual FODMAPs to assess tolerance¹⁰. The re-challenge will help identify specific dietary triggers. A more relaxed FODMAP regime based on tolerance can continue to support symptom relief but with improved nutritional adequacy and microbiota. Alternately, those who do not improve

are recommended to assess inadvertent intake of FODMAPs, food intolerances or chemicals, or other non-diet-related approaches such as psyllium, antispasmodics, or psychological therapies to alleviate symptoms.

Optimising Success with Low FODMAPs

The implementation of the low FODMAP diet and re-challenging process is complex. To support the success of this strategy, research recommends supervision by a dietitian with expertise in the management of gastrointestinal disorders, along with the use of up-to-date patient resources¹¹. However, with increasing interest in the diet as an IBS therapy but limited understanding of long term impacts, authors suggest further research and surveillance into its outcomes is needed¹².

Vicki is a NZ trained Dietitian with many years' experience working with both individuals and on public health approaches to make healthy food choices readily available where we live work and play.

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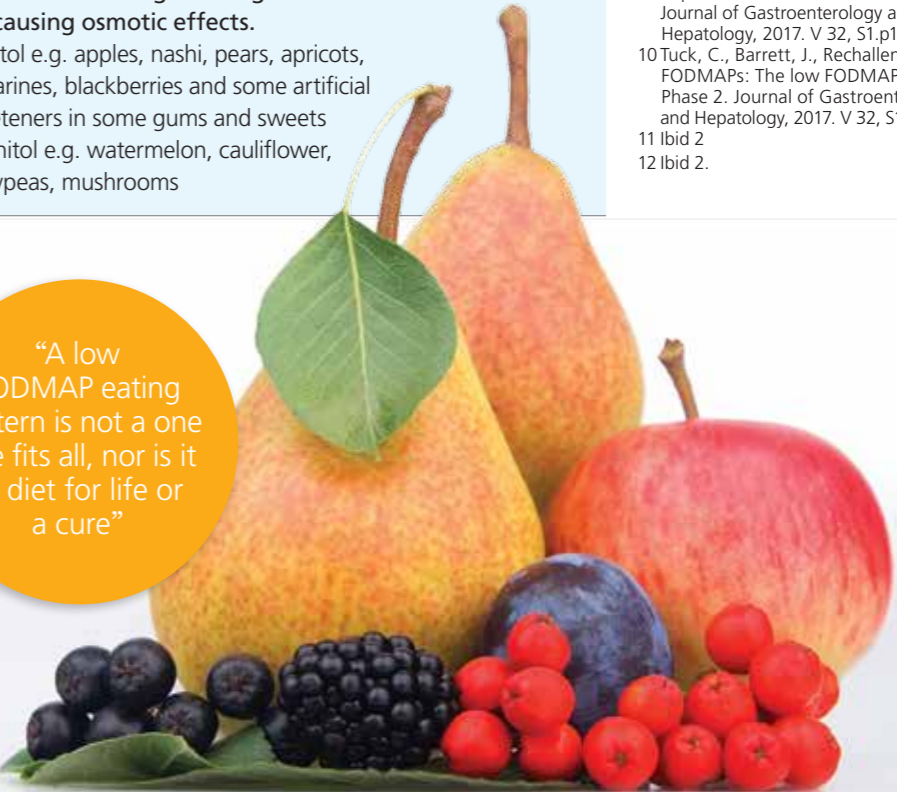
Table 1: The FODMAP carbohydrates, their action and sources

F	Fermentable	
O	Oligosaccharides (longer chain sugars)	Poorly absorbed by humans and highly fermentable. <ul style="list-style-type: none">• Fructans, FOS (chains of fructose) e.g. some fruit, vegetables (onions, garlic), wheat, rye products• Galactans, GOS (chain of the sugar galactose) e.g. legumes, lentils, some vegetables and nuts
D	Disaccharides (two sugars)	Malabsorbed when the enzyme lactase is deficient. <ul style="list-style-type: none">• Lactose or milk sugar (galactose + glucose) in milk and milk products• (Sucrose or table sugar (fructose + glucose) – rarely causes problems)
M	Monosaccharide (single sugar)	Slowly absorbed across the length of the small intestine causing osmotic effects (not necessarily malabsorbed). <ul style="list-style-type: none">• Fructose e.g. apples, pears, watermelon, honey, juice, dried fruit and sweetener, high corn fructose syrup
A	And	
P	Polyols (sugar alcohols)	Slowly absorbed along the length of the small bowel causing osmotic effects. <ul style="list-style-type: none">• Sorbitol e.g. apples, nashi, pears, apricots, nectarines, blackberries and some artificial sweeteners in some gums and sweets• Mannitol e.g. watermelon, cauliflower, snowpeas, mushrooms

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- 12 Ibid 2.

“A low FODMAP eating pattern is not a one size fits all, nor is it a diet for life or a cure”



New Consultants



Dr Brenda Breidenstein
MD

Ophthalmologist
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Speciality
Ophthalmology

I am an Ophthalmologist consulting at Harbour Eye Specialists in Thorndon, Wellington. I operate at Bowen Hospital.

Training

- Doctor of Medicine at University of Virginia
- General Ophthalmology Residency at University of South Florida
- Fellowship in Paediatric Ophthalmology and Adult Strabismus at University of California, San Diego and University of Auckland.

Special interests

- Comprehensive Ophthalmology
- Paediatric Ophthalmology
- Adult Strabismus.

Background

- American Board of Ophthalmology – Board Certified
- Medical Council of New Zealand – Vocational Registration as Specialist Ophthalmologist.



Dr Giri Raj
MBChB FRACP

Dermatologist
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Speciality
Dermatology

I am a Dermatologist, practicing at the **Bowen Specialist Medical Centre**, 98 Churchill Drive, Crofton Downs, Wellington. The last four years have been spent running dermatology services in New Plymouth.

Training

My training has been at Auckland University; Auckland Hospital; Liverpool, UK; London St Johns; and in Glasgow.

Special interests

My special interests include skin cancer, skin cancer surgery, psoriasis, eczema and acne.

Background

- Dux of Auckland Grammar School, 1995
- Extensive post fellowship experience in dermatology in the UK.



Dr Andrew Aitken
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Interventional Cardiologist
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Speciality
Cardiology

I am an Interventional Cardiologist with considerable experience in the management of all aspects of coronary heart disease. I consult at the Wakefield Heart Centre, Rintoul Street, Newtown in Wellington.

Training

I studied medicine at the University of Otago, qualifying in 1987. As a junior doctor in the Wellington region I pursued cardiology, achieving FRACP in 1998. My post-fellowship training was spent in Edinburgh. I returned to New Zealand in 2000 and have been a full time cardiologist in the Wellington region since then.

Special interests

In addition to being an interventional cardiologist I have a specific interest in looking after children and young adults with congenital heart disease. I also have expertise in the management of pulmonary hypertension and the oversight of cardiology conditions for women during pregnancy.

Background

I was born in the UK but most of my childhood was spent in Nelson. I've been a Wellingtonian since 1985. I am a keen but far from competitive, runner and cyclist.



Mr Simon Harper
MA MB BChir FRACS

Endocrine and General Surgeon
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Speciality

Endocrine and General Surgery

I am a New Zealand trained specialist Endocrine and General Surgeon consulting at the Wakefield Specialist Medical Centre and operating at Wakefield Hospital.

Training

My specialist training in endocrine surgery was carried out in the UK.

- Endocrine Surgery Specialist Fellowship – Sheffield, UK
- Higher Surgical Training – NZ
- Basic Surgical Training – UK
- Medical Degree – Cambridge University, UK.

Special interests

Thyroid: thyroid nodules, ultrasound guided FNA, surgery for malignant and non-malignant thyroid disease including lymph node dissections. **Parathyroid:** minimally invasive and bilateral parathyroid surgery including the work-up and organisation of localisation studies. **Adrenal:** investigation and surgery for adrenal incident-alomas, functional and non-functional adrenal tumors. **Abdominal. Endocrine:** including thyroid, parathyroid, adrenal as above but also, NET and familial endocrine disease. **Gall bladder surgery. Hernias:** laparoscopic and open, groin and abdominal. **Laparoscopic surgery:** General. Lumps and bumps.



Dr Kate Tietjens
MBChB FANZCA FCICM

ICU (Intensivist)
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Speciality
Intensive Care

Kate is a newly qualified specialist in intensive care and practices at Wakefield Hospital, Newtown in Wellington.

Training

Kate has her FCICM, and has also completed her anaesthetic training (FANZCA). She completed most of her training in Wellington, and has just returned from a paediatric intensive care fellowship in Brisbane. She also has a clinical diploma in palliative care medicine.

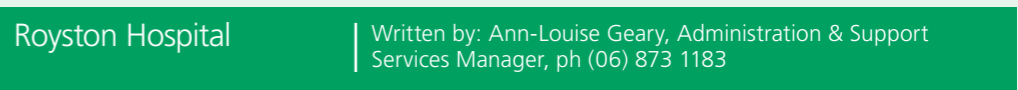
Special interests

Kate is particularly interested in medical education and holds a teaching position with the University of Otago, Wellington School of Medicine.

Background

Keeping Kate busy are two very active young boys.

Automated Texting to Royston Patients



Royston Hospital initiated a quality improvement project to improve a very manual and time-consuming process of chasing up outstanding admission forms from patients who had not returned them within the timeframe of a week prior to their admission.

Frequently, admission forms were not received back from patients prior to their admission which lead to delays in relation to both clinical and administration aspects of their admission process.

In 2015 Royston successfully implemented texting reminders for patient to follow fasting instructions, which reduced fasting-related postponements and delays by 95%. Following this success, Royston looked to technology to automate the admission form return process to improve patients' preparedness for surgery and reduce administration anomalies on a patient's admission.

As the use of mobile phones is now so widespread, testing a messaging functionality with the assistance of staff members proved very helpful. A variety of scenarios were tested using the Acurity Patient Management System, Trak. An indicator field was used to highlight patients who had returned their admission forms. An icon associated with this field enabled staff to visually see which patients were yet to return their forms.

An automated text reminder is sent one week prior to the patient's admission date. If their form remains outstanding three working days prior a further reminder text will be sent. As a limited number of patients don't have a cell phone number, their details are visible in the text files and they are contacted by telephone.

Return rate averages per week:



Prior to the system change, the return rate of documentation ranged from 20 – 25 forms missing per week equating to considerable staff time spent in follow up calls, admission delays and inaccuracies in patient details, unrecognised until their admission. These last minute changes were often unsettling for the patient at what is for most an anxious time.

The return rate has improved to an average of only two missing forms per week. The process has significantly reduced the workload for reception and booking staff. This system of texting patients has been well received by patients who have commented positively on receiving a reminder prompt. The admission process for patients has been considerably enhanced since these changes. Royston is now further testing the system to automate reminders to patients to notify of any recent hospital admissions that may have changed their health status including the possibility of requiring screening for MRSA pre-operatively. This initiative won the Quality Improvement Award at Royston in 2016 and recognised in the Acurity Health Quality Awards.



Contact Us

Acurity Health Twilight Golf



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Earlier this year, in March, we held our annual golf tournament at the Miramar Links Golf Course. Attendees were a mix of GPs, Consultants and Management. Lovely evening had by all.



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