

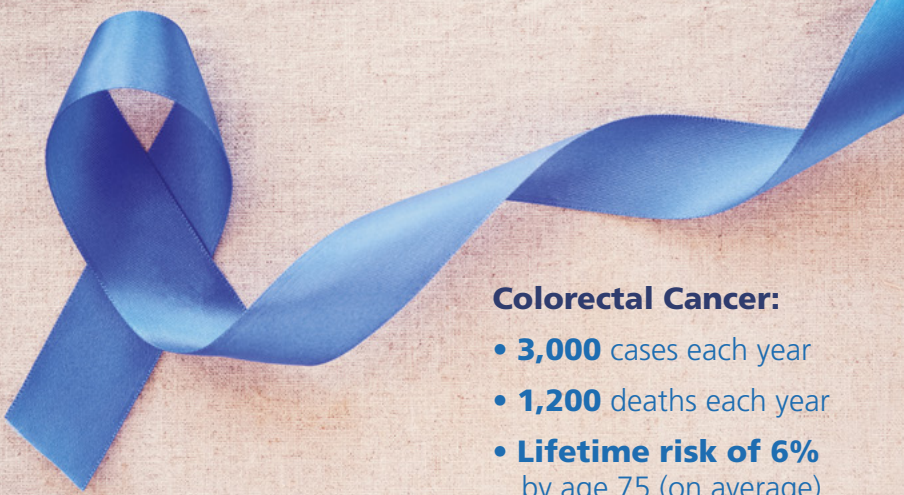
Health Matters

Hereditary Colorectal Cancer

Dr Ben Griffiths




📍 Bowen Hospital ⚙️ Gastroenterology 👤 Dr Ben Griffiths, P: (04) 381 8110



Colorectal Cancer:

- **3,000** cases each year
- **1,200** deaths each year
- **Lifetime risk of 6%** by age 75 (on average)
- **1 in 18** people



Connect 2021 GP CONFERENCE

Health through the ages:

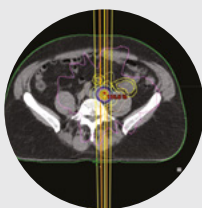


Connect 2021 GP CONFERENCE

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Endorsed CPD Activity

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Welcome to Health Matters.

Keeping you up to date with services that are relevant to your patients.

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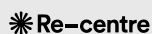
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Welcome Message

from Acurity Health Group and Evolution Healthcare



Acurity Health Group
and Evolution Healthcare



Sue Channon,
Chief Executive Officer



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www.acurity.co.nz



Kia ora, and welcome to our latest Health Matters publication. I am delighted to provide you all with my first update as CEO of Acurity Health Group and Evolution Healthcare.

It has been busy across our New Zealand and Australian businesses since commencing my role a few months ago. Our organisation continues with significant investments and developments to drive excellence in patient care and health outcomes.

In July, we launched our **eAdmissions patient portal** for our surgical hospitals in New Zealand. eAdmissions is a first of its kind in New Zealand and represents a significant step toward our digital standardisation. Patients are now able to complete their admission forms online,

providing them with a fast, simple and convenient method of sending these important forms to our hospitals.

Wakefield Hospital redevelopment is progressing well, with our Stage One building being fitted with windows, cladding, and the roof nearing completion.

Continued over

About Acurity Health Group

One of New Zealand's leading private providers of healthcare services, Acurity owns and operates Wakefield and Bowen Hospitals in Wellington, Royston Hospital in Hawke's Bay, and Re-centre, a private mental health facility in Auckland.

Through a partnership with Icon Group based in Brisbane, Australia, Acurity delivers private oncology services at Bowen Icon Cancer Centre in Wellington.

They also have investments in Grace Hospital Tauranga, Proactive, Birthcare and Endoscopy Auckland.

Acurity aims to be the preferred provider of private healthcare services, chosen by leading specialists, major health insurers, patients and their families. This is demonstrated through Acurity's commitment to developing and growing their hospitals and continuously investing in the latest technology, while being a leader in their sector.

"These patients are benefiting from a complex operation through minimally invasive incisions which provides for a shorter hospital stay, significantly less pain and a faster recovery."

Once completed, patients who come for specialist appointments at our Specialist Medical Centre or Heart Centre, Imaging services, or physiotherapy, will be going into our new building. We look forward to inviting our Wellington primary practitioners to tour our new building.

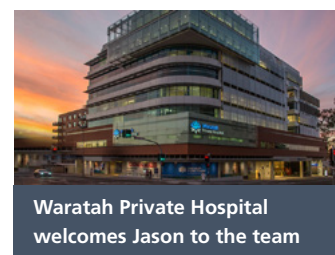
We are seeing more patients who require prostatectomies opt to have their procedure via the **da Vinci robotic surgery** technologies since launching this at our Wakefield Hospital. These patients are benefiting from a complex operation through minimally invasive incisions which provides for a shorter hospital stay, significantly less pain and a faster recovery.

Continuing to lead in advanced technologies, we are the first private hospital in New Zealand to have invested in the **latest technology for ophthalmic procedures**. Bowen Hospital's Ophthalmologists are now operating with the highly

specialised technology, NGenuity® 3D Visualisation System, which allows procedures to be viewed in 3D not only by our specialists, but our theatre team too on a large 4K OLED display. We also acquired the Alcon Centurion Active Sentry™ system, which monitors and maintains optimum pressure during cataract procedures, automatically detecting flow rate, irrigation pressure and vacuum to maintain target interocular pressure.

The Alcon Centurion Active Sentry™ system will soon be available at Royston Hospital for ophthalmic procedures.

The **Royston Orthopaedic Day Surgery construction** is well underway since celebrating a turning of sod ceremony on Friday 26 June. This is a significant development for our Hawke's Bay community, which aims to continue improving access for patients to dedicated orthopaedic surgical services.



Royston Day Surgery – fly-through

Royston Hospital has also secured a **new private-public-partnership with Hawke's Bay DHB**, which will see people in the region having access to a further 200 hip and knee joint replacement elective procedures from now until June 2021. This brings a 25% increase in access to these surgeries for the Hawke's Bay community.

That's not all for Royston developments, with some of the developments to our Hospital now completed. Upon arrival, patients can enjoy a new modern reception and foyer, including a new lift service.

Across the Tasman we welcomed Jason Penberthy as General Manager of Waratah Private Hospital. Jason has held several senior management positions within the private healthcare sector. Not only does Jason bring a wealth of experience to his management positions, he has also completed a Bachelor of Nursing, Graduate Diploma of Midwifery (with distinction), Graduate Diploma of Intensive Care Nursing and recently completed a Master of Business Administration (MBA).

"...continuing to lead in advanced technologies"

"...also has specialists who are contracted by ACC to deliver mental health services"

Since our first lockdown earlier this year, our specialists at **Re-centre** have been equipped to provide private mental health care to Kiwi's nationwide.

After the first lockdown our clinic had an increase in people seeking mental health support for a number of issues such as anxiety. We want to let you know our specialists are available for your patients, and are available to take direct referrals through our GP Hotline – 0800 854 905.

Re-centre is a NIB Health Insurance First Choice Provider, and a Southern Cross Affiliated Provider, and also has specialists who are contracted by ACC to deliver mental health services.

We are committed to providing you with **Continued Medical Education meetings**. Whether by webinar, in one of our facilities or at our annual conference, we look forward to seeing you and providing you with the opportunity to network with your colleagues, meet our specialists, and take away key messages and learning outcomes that will benefit your primary care practice.

Whilst our **Connect GP Conference** was postponed due to Covid earlier this year, we are delighted to confirm this is to be held across Friday 19 and Saturday 20 March 2021 at Te Papa Museum, Wellington. Our theme, Health Throughout the Ages remains the same, with some new speakers.

You will find more information about Connect in this edition, including how to register if you haven't done so yet. I look forward to meeting many of you at our Conference next year.



Re-centre.co.nz



It is our drive to provide excellence in the care and recovery of our patients through superior health care services using the best technologies available to promote health and wellbeing. We see this through our Net Promoter Score across our hospitals with a rating of nine out of ten. Comments we receive from patients leave us very proud of the quality of care we provide.

I want to thank you for your ongoing trust and support in our organisation to care for your patients seeking private health care.

Yours sincerely

Sue Channon
Chief Executive Officer
Acurity Health Group
and Evolution Healthcare



www.royston.co.nz

Royston Hospital is the number one provider of private surgical services in the Hawke's Bay region. With highly qualified and experienced specialists and nursing professionals, welcoming facilities and the latest in equipment and surgical techniques, at Royston you are in great hands.



Part of the Acurity Health Group
and Evolution Healthcare



Rapid Advances in Radiotherapy

Dr Han Kim



📍 Bowen Hospital

🌟 Oncology

👤 Dr Han Kim,
Radiation Oncologist

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🌐 www.bowen.co.nz
www.boweniconcancercentre.co.nz

Figure ① Left scapular bone metastasis

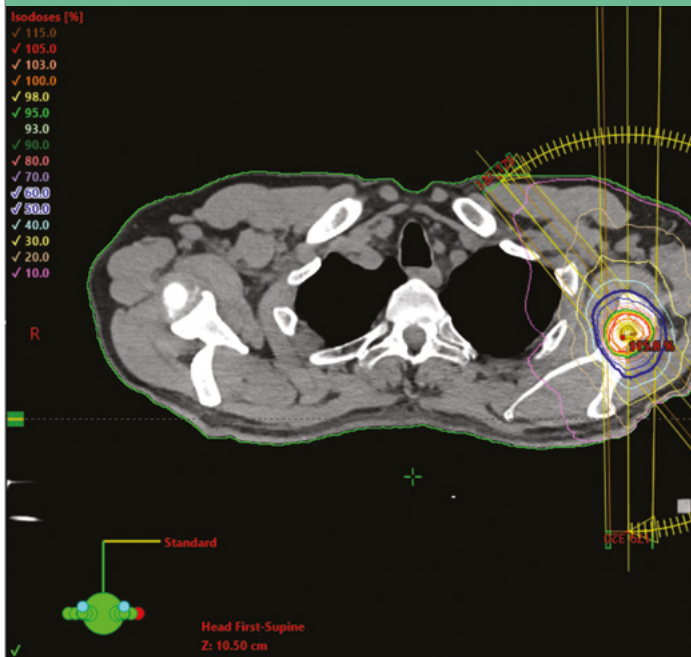
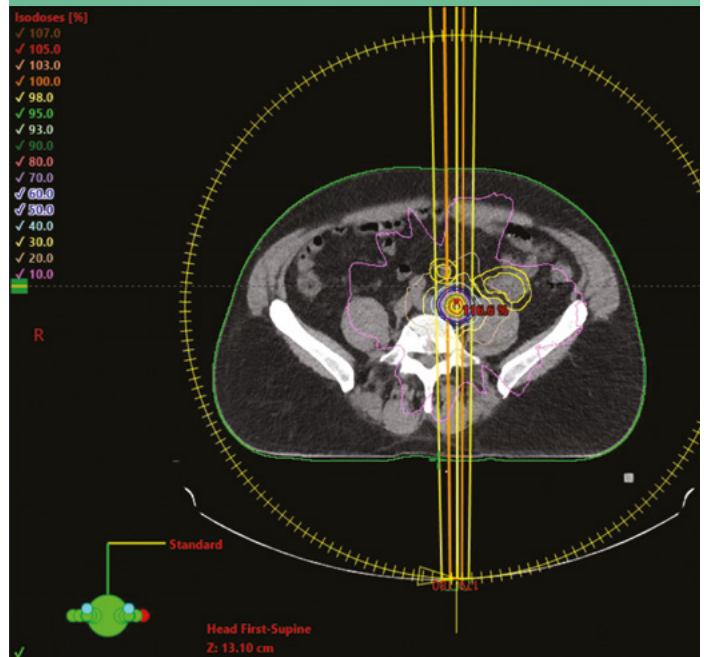


Figure ② Lymph node SBRT



Radiotherapy has been advancing rapidly. The concept of stereotactic ablative radiotherapy (SBRT/SABR) has been around since the late 1990s, with clinical trials starting in early 2000.

The concept is to deliver an extremely high dose of conformal radiation therapy to a target with rapid dose fall-off around the surrounding area to minimise the treatment-related side effects. The technique has been optimised with improved diagnostic imaging, patient immobilisation, image guidance, and faster radiation delivery.

SBRT has confirmed its efficacy in early lung cancers¹ and limited brain metastasis and is regarded as a standard of care.

With dose escalation beyond what traditional treatments can achieve using conventional radiotherapy technique, as well as rapid treatment delivery over a shorter treatment course (i.e. three to five fractions vs up to 39 fractions), it has shown long-term local control rates of up to 90%. The concept of the treatment is similar to surgical metastasectomy without the morbidities associated with it. Possible consideration for SBRT currently includes limited (1-5 mets) brain metastasis, lung, lymph nodes, bone including

spine, and other visceral organs such as adrenal gland, kidney, liver (met + HCC), pancreas, and prostate.

In the era of immunotherapy and more advanced systemic treatment options available, SBRT shows real benefit in oligometastatic/metastatic directed therapy settings. This could extend the use of current systemic treatment by maximising the duration of each systemic treatment. It could also be used to achieve local control relieving symptoms, or ablating the limited metastatic disease to avoid or delay systemic treatments.

SBRT also allows retreatment to delicate areas around

the spinal canal safely whilst minimising the risk of myelopathy and preventing tumour progression leading to spinal cord compression. This technique also allows safer re-irradiation to a higher dose for longer-term disease control. A common example of the treatment includes oligometastatic disease in breast and prostate cancers to the bone, ultimately enabling strategies to either delay systemic treatment therapies such as androgen deprivation treatment (ADT deferral strategy) or to extend the use of more tolerable treatment such as endocrine treatment while ablating and controlling oligoprogressive disease.

Figure ③ Spine SBRT

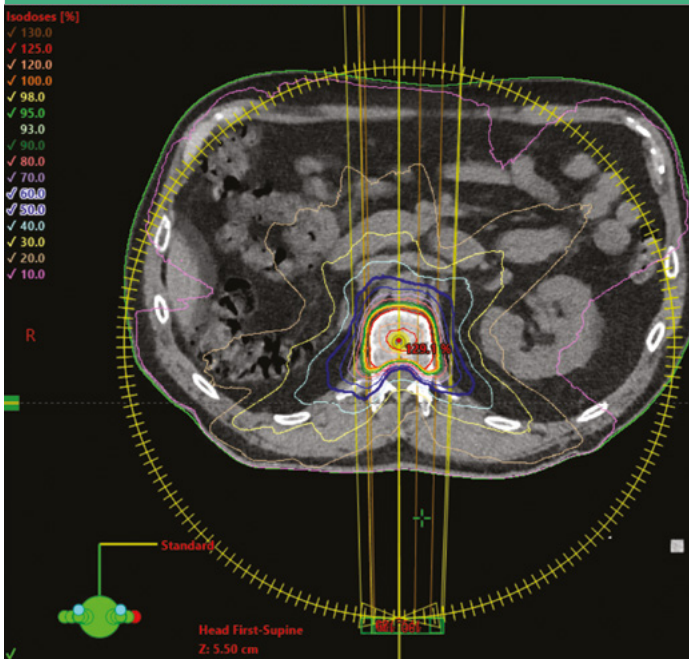
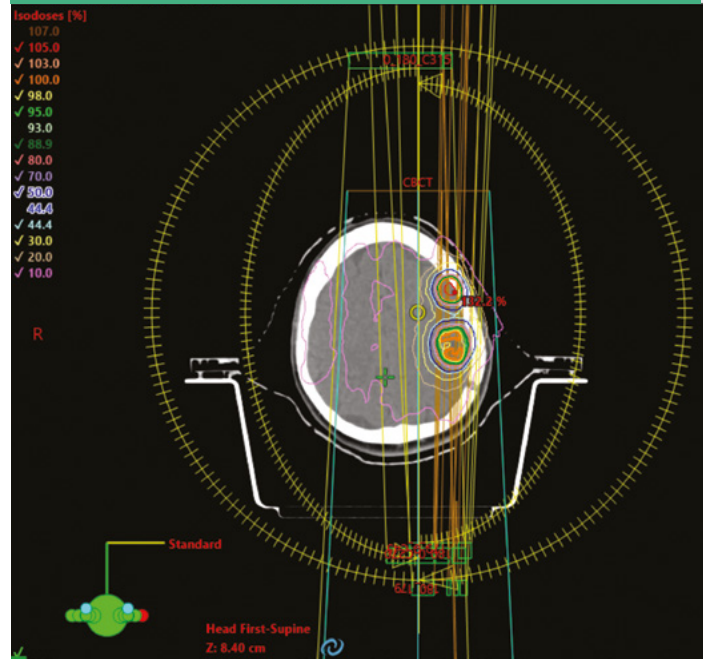


Figure ④ Multiple brain metastasis HyperArc SBRT



With randomised control evidence available supporting the clinical advantage of utilising SBRT, as well as an acceptable side effect profile, this is a valid treatment option for both curative and palliative cancer patients. Recently published long-term outcome data from the COMET trial² suggests up to 22 months of median survival gain in some malignancies.

The quality of life of patients are generally well maintained as the treatment-related side effects are often well-tolerated and requires less frequent visits to the hospital are required as the treatment fractionation is considerably reduced.

One of the exciting new available areas of the treatment includes patients with newly diagnosed low to intermediate-risk prostate cancer, who can complete their curative treatment course in five fractions of radiation instead of up to 20-39 treatments³.

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* Image source: Author's own.

Bowen
icon cancer centre

About Bowen Icon Cancer Centre

We are proud to provide world-class private cancer treatment in a friendly and supportive environment for our patients and loved ones. Our experienced team work as one from diagnosis to treatment to ensure patients receive personalised, exceptional care every step of the way.

SBRT services are currently available at Bowen Icon Cancer Centre.

For further information or referrals, contact han.kim@onc.nz.team or ph (04) 896 0200.

Menopause Hormone Therapy

Dr Elaine White & Dr Kirsten Gaerty



Gynaecology

Dr Elaine White – Gynaecologist
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Eighty percent (80%) of women experience symptoms around menopause that typically last about four years but can continue up to 12 years in 10% of women.

This can have a significant effect on their quality of life and daily functioning, and for some these symptoms are debilitating. An effective but under-utilised treatment is available in menopause hormone therapy (MHT).

Menopause – what happens and when?

Menopause occurs when the ovaries fail to produce the hormones oestrogen and progesterone. This can happen naturally with aging, after treatment such as chemotherapy or radiotherapy, or when the ovaries are removed (surgical menopause). If it happens prior to age 40 it is defined as premature menopause. This hormonal change, particularly the reduction of oestrogen, is thought to be the cause of menopausal symptoms and hormonal levels can fluctuate for many years before periods stop completely.

Table ① Menstrual stages

Premenopausal From menarche to the beginning of menopausal symptoms
Perimenopausal From beginning of menopausal symptoms to the last menstrual period
Postmenopausal More than 12 months with no periods in a woman who has her ovaries/an ovary, or immediately following their surgical removal.

The perimenopausal period is a normal but complex physiological and psychosocial time in a woman's life. This starts on average at age 47 and can take four – seven years. It ends with the menopause at around 51 years, and by age 55 nearly all women are postmenopausal¹. Symptoms include shorter and irregular cycles, and the physical and psychological symptoms of menopause.

How to make the diagnosis

- **Perimenopause:** based on vasomotor symptoms and irregular periods
- **Menopause:**
 - No periods for more than 12 months in women not using hormonal contraception
 - Menopause based on symptoms in women without a uterus.

FSH should not be used to diagnose menopause in women over 45².

This features as one of the RANZCOG Choosing Wisely statements in 2019. FSH can fluctuate so doesn't give a definitive answer.

As clinicians we need to treat the woman in front of us not the number. FSH may be useful if menopause is suspected in women less than 45, particularly those less than 40 (i.e. early or premature menopause).

Table ② Symptoms of menopause

Physical symptoms	Psychological symptoms
Vasomotor symptoms: hot flushes, night sweats	Mood swings
Insomnia	Irritability
Palpitations	Anxiety
Musculoskeletal: joint aches and muscle pain	Difficulty coping
Headaches	Forgetfulness
Urogenital: vaginal dryness, dyspareunia	Difficulty concentrating
Sexual dysfunction	



Vasomotor symptoms

These are due to altered function of the body's temperature control. They can occur without warning, but may be precipitated by a hot drink, change in room temperature, alcohol, and stress. They typically last one – five minutes. Headaches, palpitations and dizziness may be associated. Insomnia or disturbed sleep may in part be due to night sweats.

Sexual dysfunction

Sexual problems may be caused by vaginal dryness due to low oestrogen levels, resulting in dyspareunia. As men and women get older, interest in sex may decrease but this particularly affects women as oestrogen levels are directly related to libido, as evidenced by research³. Treatment of other menopausal symptoms may indirectly improve libido by improving feelings of wellbeing and energy levels. It is reported that hypoactive sexual desire disorder (HSDD) is present in 12.3% of women aged 45 to 64 years, and 7.4% of those over 65; however, it is underdetected and undertreated⁴.

How did we get from HRT to MHT?

Hormone replacement therapy (HRT) was widely used for many improvements in women's health including menopause symptoms until 2002 when the Women's Health Initiative (WHI) Study was published⁵ and changed the way society and medical professionals viewed its use. The WHI study found that while HRT prevented osteoporotic fractures and colon cancer, it increased the risk of having a cardiovascular event as well as the incidence of breast cancer. It raised serious concerns about HRT and almost overnight women were advised by health professionals to stop, or stopped of their own accord. But this research needed closer examination: the WHI had set out to investigate HRT and its role in reducing cardiovascular

risk in women; the average age of women participating was 63 years old; and logically the risk of both cardiovascular disease and breast cancer would be higher in women who were older. When the data is reanalysed for women in the age group who need management of symptoms, these results did not apply. In 2016, two of the authors of the WHI study published an apology⁶ for the misinterpretation of the study and admitted that this misunderstanding had denied many women MHT and the benefits from it.

The change of name to menopause hormone therapy reflects its primary use to relieve the debilitating symptoms that many women experience. It also reflects the fact that, from all of the up-to-date resources, there is confidence that if a woman takes MHT early in the menopause, she is likely to experience an overall benefit to her health, compared to a woman of the same age, with the same background risks, who does not.

The menopause consultation

- Explanation of the stages of menopause
- Common symptoms and diagnosis
- Lifestyle changes and interventions that could help general health and wellbeing
- Benefits and risks of treatment of menopausal symptoms
- Long-term health implications of menopause
- Osteoporosis: Advice on bone health.

Management of symptoms

Treatment options:

- Menopause hormone therapy
- Non-hormonal
- Non-pharmaceutical e.g. CBT

It is important to optimise lifestyle factors for each woman, regardless of whether you will recommend MHT.

Management of vasomotor symptoms

MHT is the first line treatment for vasomotor symptoms and low mood/anxiety related to menopause after discussing the short-term and long-term benefits and risks.

Non-hormonal options

SSRI/SNRIs including Citalopram, Paroxetine, Venlafaxine as well as Clonidine and Gabapentin are proven effective options. The doses tend to be lower than those for the treatment of depression (e.g. Venlafaxine 75mg slow/sustained release and Gabapentin 900mg/day). Non-hormonal alternatives that have been studied but have shown no proven benefit include black cohosh, phytoestrogens, isoflavones and red clover extract. Bioidentical hormones are also not recommended as they may contain varied strengths, dosing and components.

Atrophic vaginal symptoms/ urogenital symptoms

Offer vaginal oestrogen to women with urogenital atrophy (including those on systemic MHT).

Discuss that:

- Symptoms return when treatment is stopped
- Adverse effects are rare
- Don't recommend monitoring of endometrium
- Advise to report any unscheduled PV bleeding.

Consideration of other life stressors

Other life events such as worry over teenage children, elderly relatives and stresses of work may also contribute to such "symptoms" around the time of the menopause.



Table 3 HRT Risk

Risk	Age range (years)	Background incidence per 1000 women in Europe not using HRT		Additional cases per 1000 women using oestrogen only HRT (estimated)		Additional cases per 1000 women using combined (oestrogen-progestogen) HRT (estimated)	
		Over 5 years	Over 10 years	For 5 years' use	For 10 years' use	For 5 years' use	For 10 years' use
Breast cancer	50–59	10	20	2	6	6	24
	60–69	15	30	3	9	9	36
Endometrial cancer	50–59	2	4	4	32	NS	NS
	60–69	3	6	6	48	NS	NS
Ovarian cancer	50–59	2	4	<1	1	<1	1
	60–69	3	6	<1	2	<1	2
Venous thromboembolism	50–59	5		2		7	
	60–69	8		2		10	
Stroke	50–59	4		1		1	
	60–69	9		3		3	
Coronary heart disease	70–79	29–44		NS		15	

Note: Where background incidence or additional cases have not been included in the table, this indicates a lack of available data. NS indicates a non-significant difference.



See original source

Menopause Hormone Therapy

The gold standard for treatment of menopausal symptoms is MHT and, after risk assessment and proper counselling, for the majority of symptomatic women the benefits of MHT outweigh the risks.

Key risks and benefits

Provide information on the benefits and risks of MHT to help women make an informed choice about which treatment to use for menopausal symptom. Risks vary by age and route of administration. It is important to remember that, for the majority of symptomatic women, the benefits of MHT outweigh the risks.

Key points

Baseline risk depends on individual risk factors.

VTE: Risk increased above baseline by oral MHT but not transdermal.

Cardiovascular disease

(Coronary heart disease and stroke):

- Risk is not increased when started in women under 60 years
- Cardiovascular risk factors are not a contraindication if they are optimally managed

Breast cancer: Increased risk is related to treatment duration and reduces after stopping MHT. While a progestogen increases the risk of breast cancer, different progestogens have different risk ratios⁷. Levonorgestrel releasing IUS is thought to have the lowest risk.

Osteoporosis: Risk is reduced while taking MHT, but this only continues while on treatment.

MHT: What to prescribe

The Australasian Menopause Society (AMS) has a fact sheet for MHT preparations and equivalent doses for Australia and for New Zealand⁸ to assist in prescribing.

- If a woman still has her uterus (has not had a hysterectomy), a progestogen must be prescribed as unopposed oestrogen places her at risk of endometrial hyperplasia and malignancy.
- If commencing treatment less than 12 months since the last menstrual period, cyclical MHT is recommended and after 12 months this can be changed to a continuous preparation.
- Given the variable response to MHT dosage, adjustment should be guided by the clinical response – review every three months using the lowest dose possible to get control of symptoms.
- Risk over benefit using MHT becomes more prevalent after five years of use.



download factsheet



Transdermal MHT (patches)

Transdermal MHT has not been associated with an increase in the risk of venous thromboembolic disease whereas oral MHT has⁹, so is preferable in those at risk of VTE including BMI >30kg/m². It has been funded in New Zealand since 2016.

Testosterone

Testosterone contributes to libido, sexual arousal and orgasm by increasing dopamine levels in the central nervous system. Testosterone also maintains normal metabolic function, muscle and bone strength, urogenital health, mood and cognitive function. NICE Guideline 232 suggests considering testosterone supplementation for menopausal women with low sexual desire if HRT alone is not effective. Maximising the oestrogen dose should be the first line treatment before considering testosterone.

Remember:

Oestrogen and progestogen to women with a uterus

Must not give unopposed oestrogen to women with a uterus

Oestrogen alone to women without a uterus

Premature ovarian insufficiency

is diagnosed when periods spontaneously stop under the age of 40 years. Early menopause is defined as periods spontaneously stopping between 40 and 45 years. In these groups of women, MHT should be initiated and continued to the age of 50 years. 75% of UK women stated that the menopause caused them to change their life and more than 50% said it had a negative impact on their lives¹⁰.

Table 34 Practical trouble shooting

Common side effects:	Dealing with the side effects:
Oestrogen <ul style="list-style-type: none"> Fluid retention Breast tenderness Bloating Nausea / Dyspepsia Headaches 	Oestrogen <ul style="list-style-type: none"> Reduce dose Change route Change type Which hormone is causing the side effect?
Progestogens <ul style="list-style-type: none"> Fluid retention Breast tenderness Headaches Mood swings PMT-like symptoms 	Progestogens <ul style="list-style-type: none"> Change type Reduce dose if available Change route Alter duration

When to refer to a health professional with expertise in menopause

- If treatment doesn't improve symptoms
- High risk of MHT and not responded to non-hormonal alternatives
- Troublesome ongoing side effects
- Menopausal symptoms and contraindication to HRT e.g. breast Cancer
- Uncertainty about most suitable treatment for menopausal symptoms.

After a thorough risk assessment and discussion, it may be that the symptoms are so debilitating that a trial of MHT is warranted.

MHT is just one part of helping a woman adjust to the symptoms, sometimes distressing and debilitating, that the menopause causes. As well as lifestyle and behavioural modifications, MHT can significantly improve a woman's quality of life and we should as medical professionals not deny any future generations this opportunity.

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* Table 3 source: MHRA/CHM (Drug Safety Update 2007; 1 (2): 2-6) available at www.gov.uk/drug-safety-update.

Bowen Hospital Expands to Four Operating Theatres

 Bowen Hospital

 Media Release

 (04) 479 2069

 www.bowen.co.nz



A new specialised operating theatre at Bowen Hospital has been supporting the Wellington community since May to help meet the backlog of cases since Covid-19 Alert restriction levels have lowered.

Elective surgeries will now utilise the advanced theatre, and three existing surgical theatres at Bowen Hospital with governance from the Ministry of Health, the local District Health Board, and specialist college and societies guidelines.

The theatre is one of the first integrated facilities in New Zealand offering the latest breakthroughs in medical technology, including advanced imaging capabilities that go beyond clear and concise higher image resolution.

Dorothy Shaw, General Manager of Bowen Hospital, says the completion of the theatre is in line with the hospital's commitment to meet the increased needs of the wider Wellington community, particularly during this challenging time.

"We know it has been difficult for our patients and their families who have been waiting for surgery. Our new theatre means additional operating capacity as our surgical teams begin to

operate more frequently, and tackle a backlog of surgical cases," said Ms Shaw.

"With a total of four theatres at the ready, we have the capacity to meet the demands of our surrounding region."

Ms Shaw said the community now has access to the latest in medical technology with the introduction of fluorescence imaging, a game changer in active surgery.

"The new imaging technologies means a surgeon can see live blood perfusion, tumour margins, lymphatics and other critical anatomical structures through the press of a button. It's quite amazing."

Bowen Hospital, operated by Acurity Health Group and Evolution Healthcare, has undergone a number of major developments since 2009.

The new theatre at Bowen comes at a time of significant investment for Acurity Health Group, with the Wakefield Hospital redevelopment in Wellington, Royston Hospital developments including a new private Orthopaedic Day Surgery Unit in Hawke's Bay, and developments at Grace Hospital, Tauranga.

Hereditary Colorectal Cancer



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Gastroenterology

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Colorectal cancer (CRC) is one of the most commonly reported cancers in New Zealand, with approximately 3,000 cases and 1,200 deaths each year, and an average lifetime risk of 6% by age 75 (1 in 18 people).

It is the second highest cause of cancer death after lung cancer. Unfortunately, prior to national bowel cancer screening, 21% of cases presented with distant disease spread and 25% were diagnosed following a visit to the emergency department. Luckily, CRC is a preventable cancer due to the time course of the polyp to cancer sequence and the presence of an easily removable precursor lesion (polyps).

Hereditary risk

An estimated 35% of CRC is due to heritable factors and among patients with CRC, 29% have a family history that has placed them at increased risk.

In New Zealand we have classified familial risk to determine appropriate recommendations. “Moderate” risk patients are those with one first-degree relative (FDR) with CRC diagnosed before the age of 55 years or two first-degree relatives with CRC diagnosed at any age. Any weaker family history than this is considered “average” risk and any stronger is considered “high” risk.

In general terms, average risk patients should participate in a national screening programme (a work in progress in New Zealand), moderate risk patients should have colonoscopic surveillance five yearly from age 50 (or 10 years younger than the earliest CRC in the family), and high risk patients should be referred both for colonoscopy and to the New Zealand Familial Gastrointestinal Cancer Service (NZFGCS) for further assessment.

CRC only in distant relatives or in a single FDR >55 years confers a slightly increased risk of CRC, but this is generally not considered high enough to warrant intensive (i.e. colonoscopic) screening. Even having a FDR with an advanced polyp increases a patient’s risk of CRC and some guidelines (not New Zealand’s) suggest counting these as you would a cancer in determining family history based recommendations. Patients with no family history of CRC at all actually have a lower risk than average.

Figure ① Increased risk of colorectal cancer based on family history

Family history of colorectal cancer	Colorectal cancer risk relative to the average population risk
No family history	0.86 ^[11] (14% decrease)
One or more first-degree relative diagnosed at any age	1.4 ^[10] – 2.1 ^[8] , 2.05 ^[11] (40–110% increase)
One first-degree relative diagnosed before age 50	3.3 ^[11] (230% increase)
One first-degree relative diagnosed between ages 50 and 60	2.2 ^[10] to 2.5 ^[11] (120–150% increase)
Two or more first-degree relatives	3.0 ^[11] (200% increase)
No first-degree relative, at least one second-degree relative	1.1–1.5 ^[11] (10–50% increase)

Results from cohort studies published since 2005.

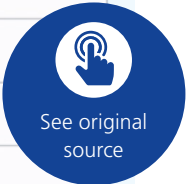
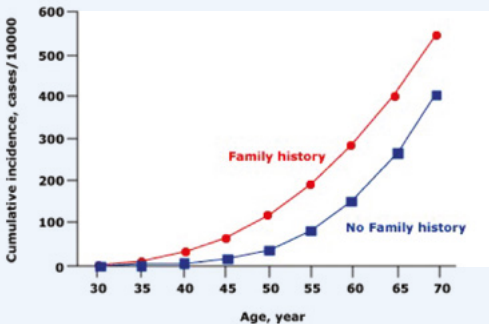
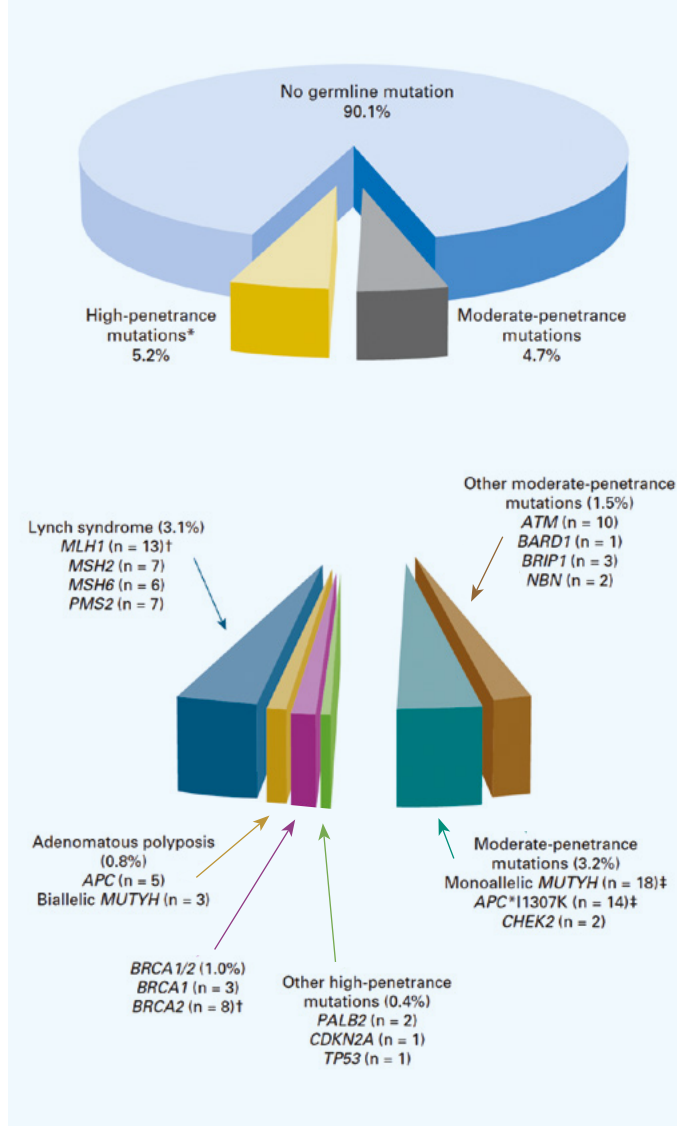


Figure ② Incidence of colorectal cancer according to age and family history



Graphic representation of the cumulative incidence of colorectal cancer demonstrates that in people with a family history, colorectal cancers occur earlier in life, not uncommonly in the 40s or even the 30s.

Figure 3 Cancer Susceptibility Gene Mutations in Individuals with Colorectal Cancer



Familial CRC Syndromes

Highly penetrant syndromes such as Lynch Syndrome (LS), familial adenomatous polyposis (FAP) and others account for only 5-10% of all CRC diagnoses. Advances in genetic diagnosis, endoscopy, surgery, and medical and lifestyle interventions provide the means for CRC prevention and effective treatment in susceptible individuals.

Colonoscopy is the gold standard diagnostic and

preventative method of surveillance for people with hereditary risk of CRC and studies consistently report that high quality colonoscopy screening and surveillance services result in a reduction in CRC incidence and mortality in individuals with LS and FAP. There is insufficient evidence to recommend other methods of surveillance for those with familial CRC risk such as Faecal Immunochemical Testing or CT colonography.

Lynch Syndrome (LS)

LS is an autosomal dominant condition caused by defects in DNA mismatch repair (MMR) and is the most common cause of inherited colorectal cancer. Individuals who carry a MMR gene mutation are at a significantly increased risk of developing cancers at multiple sites, most notably colorectal and endometrial carcinomas. The prevalence of LS is estimated to be 1/280, and 95% of people who carry a LS mutation are unaware of the fact. LS is often suspected when special histologic staining of tumours reveals the absence of one of the MMR proteins. This special staining is now carried out routinely on all colorectal and endometrial cancers, which is helping to increase the pick-up rate for LS. Colonoscopy is generally performed at one to two intervals in patients with LS.

Familial adenomatous polyposis (FAP)

FAP is an autosomal dominant condition caused by mutations in the tumour suppressor gene APC, characterised by the presence of multiple colorectal adenomas (usually hundreds). Colorectal cancer occurs in nearly 100% of patients at an average age of 39 if left untreated and therefore prophylactic colectomy is performed, usually between 14-18 years of age.

Other polyposis syndromes

There are many other rare polyposis syndromes that require specialised assessment and management including, but not limited to: Peutz-Jeghers, Juvenile Polyposis, MUTYH-associated polyposis, PTEN hamartoma tumour syndrome etc.

Serrated Polyposis Syndrome

"Serrated class" polyps include sessile serrated polyps, hyperplastic polyps and traditional serrated adenomas. Patients with multiple serrated class polyps may meet the criteria for Serrated Polyposis Syndrome (SPS).

SPS most probably comprises a phenotypically and genetically heterogeneous group of diseases and a single causative gene has not been identified. The prevalence in the West is generally considered to be around 1:3000 in screening populations; however, this is changing as awareness of the condition increases.

The overall lifetime risk of CRC in SPS is elevated but unknown, with estimates ranging from 7-70%; this risk can be reduced with one-to-two yearly colonoscopy. There is also an increased risk of CRC in FDRs of patients with SPS and they are recommended to undergo five-yearly surveillance colonoscopy.

"Red flags"

When enquiring about a family history of CRC there are certain features to be aware of that may suggest a familial colorectal cancer syndrome, including: >2 close relatives with CRC, CRC <50 years old, multiple CRCs in one person, other Lynch cancers (endometrial, gastric, urinary tract etc), and a personal or family history of multiple polyps.

Reduction of CRC risk in primary care

Individuals at increased familial risk of CRC should be strongly encouraged to quit smoking, maintain a normal BMI, moderate their consumption of red and processed meat, and to exercise regularly.

Screening for *H. pylori* (with stool antigen testing) in patients with Lynch Syndrome and subsequent eradication therapy is recommended to reduce the risk of gastric cancer.

Aspirin is associated with a reduction in the risk of adenomas and CRC in individuals at average risk of CRC, but its use for primary prevention must be weighed against the potential gastroduodenal toxicity. There is also uncertainty in regard to the importance of chemoprevention in the context of a national CRC screening programme. The 2017 Australian Cancer Council clinical practice guidelines state that for all those between 50-70 years with no contraindications, 100mg of enteric-coated aspirin daily should be "actively considered" to prevent CRC. At least two-and-a-half years' treatment is required with benefit only evident after 10 years (shorter for cardiovascular benefit).

In the specific case of Lynch Syndrome, there is good evidence from the CAPP2 trial that 600mg of aspirin daily reduces CRC risk by approximately half. The benefits of regular aspirin take at least three to five years to become evident, and taking aspirin for less than two years does not seem to confer any benefit. There is uncertainty about the optimum dosage of aspirin and the CAPP3 trial is ongoing to address this. In the interim, clinicians are strongly advised to consider low dose aspirin (at least 100mg enteric-coated) in Lynch Syndrome patients unless contraindicated.

New Zealand Familial Gastrointestinal Cancer Service (NZFGCS)

Individuals with a family history of CRC that meets the NZGG category 3 referral criteria should be referred to the NZFGCS. This is crucial, not only for proper diagnosis and care of the individual but perhaps even more importantly, for the relatives/whanau who otherwise may not have been aware of their risk, and can then be given appropriate surveillance recommendations.

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BOWEN

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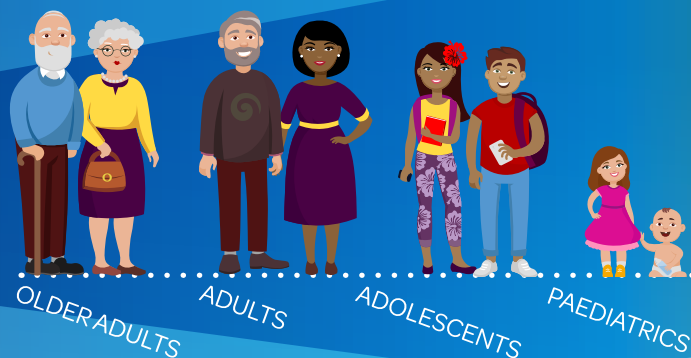
Bowen's modern, conveniently located private surgical hospital offers the best in private healthcare services Wellington has to offer. With our team of highly trained and dedicated medical specialists, and the very latest in equipment and techniques, we have a proud reputation for the quality of our care.




Part of the Acurity Health Group and Evolution Healthcare




Connect 2021 GP CONFERENCE



Kia Ora, Welcome to Connect 2021

On behalf of the organising committee, Acurity Health Group and Evolution Healthcare are delighted to invite you to join us at Connect, the leading lower North Island annual GP Conference, to be held over Friday 19 and Saturday 20 March, at Te Papa Museum, Wellington.

With a growing popularity year-on-year, we anticipate Connect 2021 will reach capacity for registrations. The positive feedback we receive every year, and the majority of delegates who transferred their 2020 registrations to our new dates in 2021, has inspired us to make our conference even greater than what was already planned.

Connect 2021 will continue with the theme Health Through the Ages. From Older Adults right through to Paediatrics, various topics will be explored with some of the best presenters, world leading researchers, highly skilled specialists and expert healthcare professionals helping you stay up-to-date for primary care practice.

We are delighted to have keynote speakers presenting on various topics such as Family Violence, Mindfulness for GPs, and LGBTQIA+ Gender Affirming Healthcare and GP Cultural Competence.

We look forward to you joining us over two days of networking, education, skills development, debate and discussion. There will be numerous opportunities to enhance your knowledge, widen your network, and help shape the future of primary health care.

Organising Committee | Connect GP Conference
Acurity Health Group and Evolution Healthcare.

If you are a delegate who had registered for the original May 2020 dates, please be assured your registration and payment have automatically been transferred to our new March 2021 dates. If you would like to discuss your registration details, please contact us by email: connect@acurity.co.nz



Event Partners





Connect 2021 GP CONFERENCE



ELDERLY

**FRIDAY
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WE'LL EXPLORE:

- dementia
- menopause
- rheumatoid arthritis
- community therapies

ADULTS

**FRIDAY
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WE'LL EXPLORE:

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- fertility
- presentations from our keynote speakers (below)

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- sleep disorders and digital disruption
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- sexual health

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WE'LL EXPLORE:

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- failure to thrive
- paediatric surgeries and when to refer
- ophthalmology
- gastroenterology and infants

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Holly Carrington,
DVFREE & Policy Adviser for SHINE
Presenting: GPs' vital role in addressing
NZ's epidemic of domestic violence



Dr Fiona Moir, MBChB, MRCP, PhD,
Director Connect Communications
Presenting: Mindfulness
for Health Professionals

**A number
of relevant
topics will be
covered**



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Register now

Connect 2021: Health through the Ages

Registration fees		Super Early Bird (closes 31 Oct)	Early Bird (closes 31 Dec)	Standard
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	Day	\$150	\$200	\$250
Other Health Professional	Full	\$200	\$250	\$300
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GP Registrar and student	Full	\$200	\$250	\$300
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Breast cancer treatment has become increasingly complex over the last 20 years or so. As well as improvements in adjuvant (or neoadjuvant) chemotherapy, targeted therapy (such as Herceptin) and radiation therapy (e.g. hypofractionation), the surgical options have changed.

Not so long ago the only decision was whether to pursue wide local excision or mastectomy. If a patient had a large tumour or a small breast, then mastectomy was the only option. This was traditionally considered for cases requiring more than 25% of the breast to be removed for adequate cancer treatment or for T3 disease (>50mm). Some women chose to undergo breast reconstruction, which was usually performed as a delayed procedure by plastic surgeons some time after completion of cancer treatment. Wide local excision was traditionally performed by excising an ellipse of skin over the tumour and the only decision to be made was how best to orient that ellipse.

As the specialty of oncoplastic breast surgery has developed, techniques have evolved and women with breast cancer now have more surgical options to consider. As well as increasing access to breast reconstruction after mastectomy, it is possible to conserve breasts with a higher tumour-to-breast ratio using volume displacement or volume replacement techniques. Volume displacement combines

wide local excision with breast reduction – the therapeutic mammoplasty. This usually requires a contralateral breast reduction to maintain symmetry. Volume replacement uses local tissue from outside the breast to replace the excised breast tissue. Various options can be used, including crescent flaps, LICAP flaps and TDAP flaps (Figure 1). For even greater volume replacement even a Latissimus dorsi (LD) flap can be used. The decision around which option to choose depends on several interrelated factors. Tumour size to breast volume ratio is important, but the position of the tumour within the breast also plays a role. The size and shape of the breasts, as well as surrounding subcutaneous tissue, will impact on which options are suitable. And, perhaps most importantly, the individual woman's attitude to her breasts and the cancer. It is really important to establish this during the consultation to help women select the best option for them. And it is important to remember that for the majority of tumours, a simple wide local excision with glandular closure is all that is required.

Figure 1 Volume replacement techniques



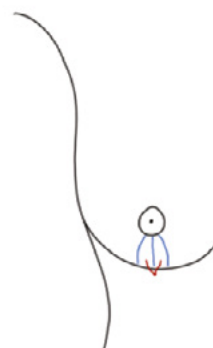
A. Thoracodorsal artery perforator (TDAP) flap



B. Lateral intercostal artery perforator (LICAP) flap



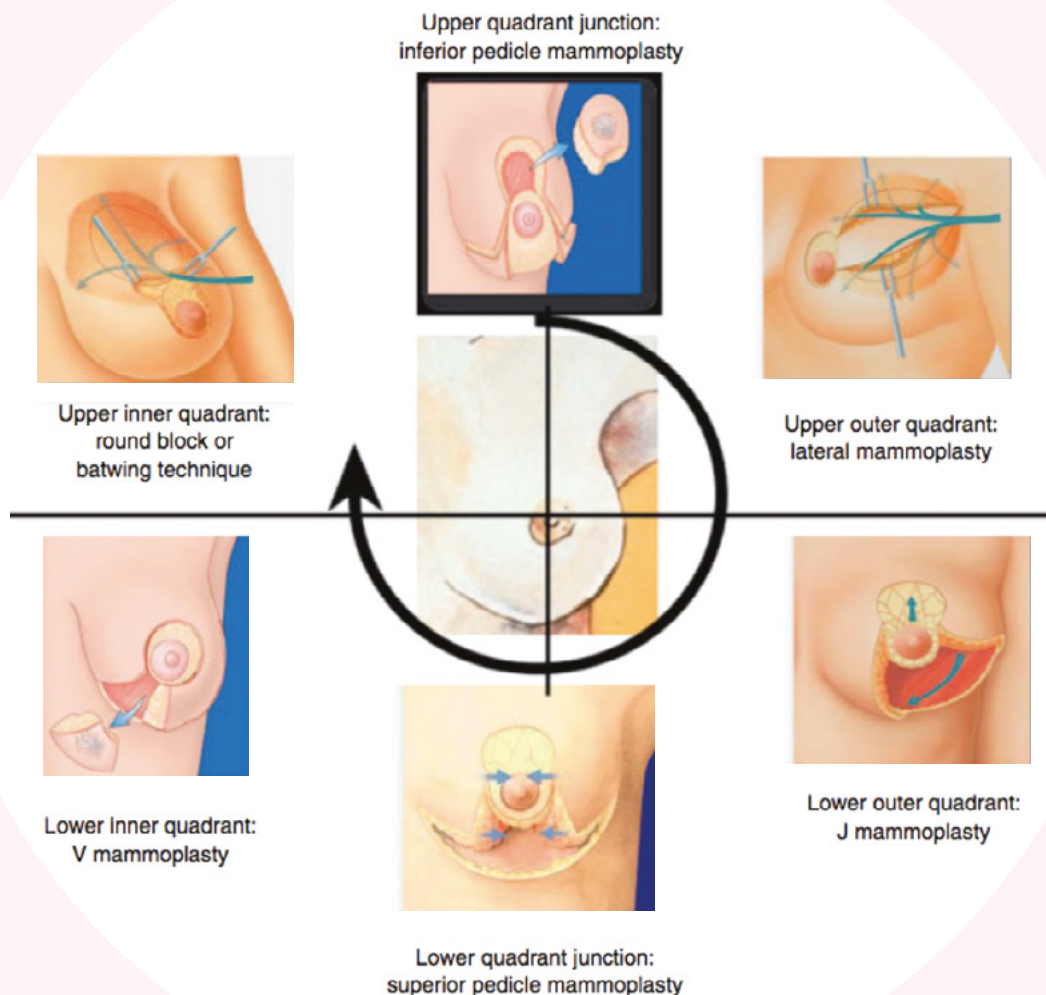
C. Crescent flap – marked out



D. Crescent flap – mobilised into inferior pole defect



Figure 2 A quadrant-based approach to therapeutic mammoplasty suggested by Clough *et al*(3). The position of the cancer is an important factor in determining which options are available.



Breast reductions have long been performed to treat women with symptomatic macromastia as well as for more cosmetic reasons. There are three key elements to a breast reduction: skin resection, glandular resection and nipple vascularity (pedicle). These elements can be tailored to excise a breast cancer with wide margins and conserve the breast despite removing a

larger proportion of breast tissue (Figure 2). And for women with macromastia and breast cancer, therapeutic mammoplasty can achieve dual outcomes of both cancer treatment and symptomatic (or cosmetic) improvement. The amount of breast tissue and skin removed depends on the preoperative size and shape of the breast as well as the size and position of



Figure 3 Different scars from breast reduction surgery

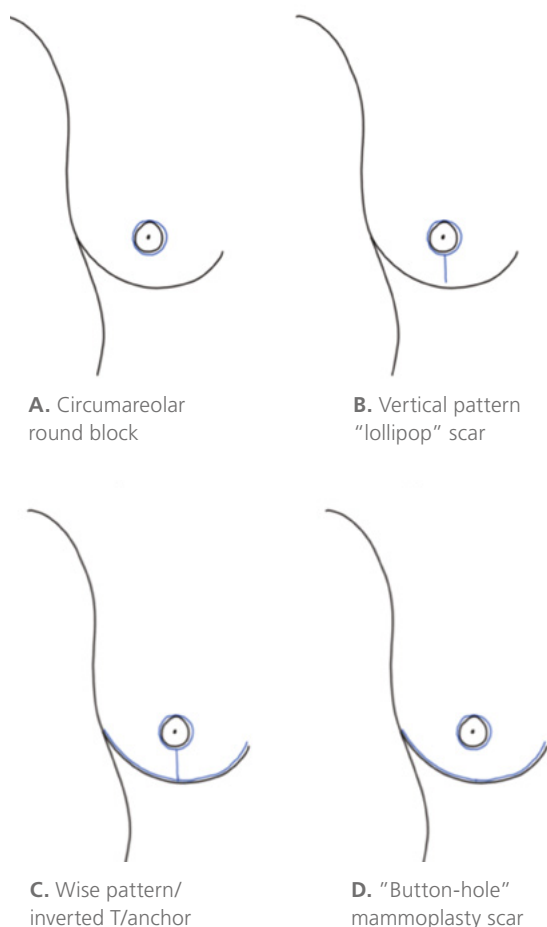
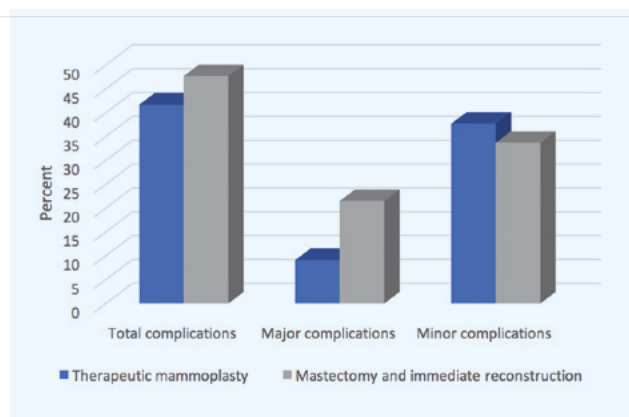


Figure 4 Complications

Major and minor complications after breast cancer surgery from Stein et al(2)



the cancer and the women's desired postoperative breast size. The scars left on the breast are defined by the incisions used (Figure 3). For small reductions, the round block mammoplasty can be used and just leaves a circular scar around the areola. A vertical pattern can be used for a moderate reduction and leaves a "lollipop" scar around the areola and down towards the inframammary fold (IMF). For the biggest reductions, the Wise pattern is usually needed and leaves an anchor, or inverted T-shaped scar. The most common complication is some wound breakdown at the T-junction which usually requires simple dressings for a couple of weeks to resolve. Sometimes the vertical limb can be avoided ("button-hole" mammoplasty). It is important to explain the scars and the reasons why they are needed to each patient. Therapeutic mammoplasty has been shown to be effective and safe for the treatment of large breast cancers¹ and a recent paper demonstrated that as well as being a safe and effective alternative, therapeutic mammoplasty has better surgical and patient-reported outcomes than mastectomy and reconstruction (Figure 4)².

The most crucial part of modern breast surgery is helping to guide women through their diagnosis and treatment options at a stressful and frightening time. Establishing the relevant tumour factors, breast factors and patient factors, and discussing these fully with each patient helps ensure the optimal approach for each woman. It is this complexity of decision-making and crucial communication that makes oncoplastic breast surgery such a challenging and rewarding specialty.

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World-leading scalp cooling technology now available at Bowen Icon Cancer Centre

 Bowen Hospital

 Media Release

 (04) 896 0200

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Bowen Icon Cancer Centre now provides local cancer patients with access to the Paxman Scalp Cooling system to help minimise chemotherapy-induced hair loss.

Bowen Icon Cancer Centre, located onsite at Bowen Specialist Medical Centre now offers scalp cooling technology as an added service for patients undergoing chemotherapy treatment. The Paxman Scalp Cooling system is a recognised world leader in minimising hair loss caused by chemotherapy treatment.

This innovative technology helps to minimise hair loss by reducing the temperature of the patient's scalp by a few degrees immediately before, during and after the administration of chemotherapy. The cooling effect reduces blood flow and the amount of chemotherapy drug reaching hair follicle cells, therefore minimising hair loss.

Bowen Icon Cancer Centre Medical Oncologist Dr David

Okonji is delighted that local patients can now access this treatment approach on-site during their cancer treatment.

"In recent years we have seen significant development in supportive treatments to improve outcomes for our cancer patients. These advancements extend from clinical trials, an increased understanding of cancer and treating medications, and the technology available to help support patients throughout their treatment.

"For suitable patients, this system can reduce the emotional distress associated with this side effect of cancer treatment and have a positive impact in maintaining a patient's self-esteem and dignity."

This technology can be considered for patients receiving certain chemotherapy drugs such as docetaxel, cyclophosphamide and doxorubicin, for breast and other solid tumour malignancies.

The effectiveness of the system varies from patient-to-patient and is dependent on an individual's cancer type and treatment, in addition to other factors such as prior chemotherapy regimens, age and ethnicity," Dr Okonji said.

Bowen Icon Cancer Centre is committed to providing exceptional cancer care, ensuring our patients are supported in every aspect of their treatment. To discuss existing patient eligibility or to make a referral, please contact Bowen Icon Cancer Centre using the details below.

Bowen Icon Cancer Centre

Level B3, Bowen Specialist
Medical Centre,
98 Churchill Drive,
Crofton Downs, Wgtn 6035
P (04) 896 0200, F (04) 896 0201
referrals.bowen@oncnz.team
boweniconcancercentre.co.nz



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All too often we review adolescents who have developed insidious overuse injuries seeking our help, support, and direction so that they can stay on the sports field and keep playing with their friends. By the end of this article I would hope to provide you with two valuable resources to help facilitate recovery and promote injury prevention in adolescence.

I would like to acknowledge that there are many factors in contributing to overuse injuries. Some examples are:

- Inadequate footwear
- Type of playing surface
- Congenital abnormalities
- Too much, too soon.

These factors, along with various others, can be addressed by many of our allied health professionals.

The benefits of physical activity on mental health are immense and beyond the scope of what this article is addressing. However, we need to collectively provide guidance in ensuring young athletes do not miss sport due to preventable injuries.

THE QUESTION I ASK MYSELF TODAY IS THIS:

If I have 10 minutes to address this young athlete, what would my advice be?

I would have two answers...

- 1 Monitoring how much you do will help prevent these overuse injuries from happening – identifying your Chronic Load (four-to-six weeks) and appropriately addressing the Acute Load (one-week spike in activity)
- 2 Educate adolescents about FIFA 11+ and FIFA 11+ for Kids, regardless of what sport they play.

According to the Australasian College of Sport and Exercise Physicians' Position Statement, 5-17-year olds should accumulate 60 minutes of moderate to vigorous exercise daily. Most of this should be aerobic, which provides many health benefits.

Vigorous exercise that helps with bone growth should be performed three times a week. Examples of these exercises can be found in FIFA 11+ and FIFA 11+ for Kids.

To determine intensity, use the Ratings of Perceived Exertion Tool.

By providing your patients with these simple resources, we can start the process of injury prevention and allow them to really benefit from uninterrupted sporting seasons.

Children as young as 10 can be torn between playing and giving 100% for their school, club, and representative teams. In these scenarios, the risk of overload and subsequent injuries can be high.

Overuse injuries occur when the load placed upon the structure is greater than the structure's ability to adapt to that load. Therefore, any time an overuse injury occurs it should be considered a loading error.

Research shows that the best way of reducing incidence of overuse injury rates in this age group, in fact all age groups, is monitoring the athlete's load.



**FIFA 11+
for kids**

[Click to see link](#)



FIFA 11+

[Click to see link](#)

Figure ① Chronic vs Acute Loads – RPE x Time

Example: 15-year old Female Hockey Player



Weeks 1-8	
• Day 1 = RPE 7 x 100mins	Day 1 = RPE 8 x 120mins
• Day 2 = RPE 9 x 60mins	Day 2 = RPE 9 x 120mins
• Day 3 = RPE 5 x 90mins	Day 3 = RPE 8 x 120mins
• Day 4 = RPE 9 x 90mins	Day 4 = RPE 3 x 60mins
• Day 5 = RPE 2 x 60mins	Day 5 = RPE 8 x 120mins
• Day 6 = RPE 7 x 120mins	Day 6 = RPE 9 x 120mins
• Day 7 = RPE 5 x 60mins	Day 7 = RPE 9 x 120mins
Week 9 – Tournament	
• Ave RPE – 6.3 x 83mins	Ave RPE – 7.6 x 111mins

RPE Scale	Rate of Perceived Exertion
10	Max Effort Activity: Feels almost impossible to keep going. Completely out of breath, unable to talk. Cannot maintain for more than a very short time.
9	Very Hard Activity: Very difficult to maintain exercise intensity. Can barely breath and speak only a few words.
7-8	Vigorous Activity: Borderline uncomfortable. Short of breath, can speak a sentence.
4-6	Moderate Activity: Breathing heavily, can hold short conversation. Still somewhat comfortable, but becoming noticeably more challenging.
2-3	Light Activity: Feels like you can maintain for hours. Easy to breathe and carry a conversation.
1	Very Light Activity: Hardly any exertion, but more than sleeping, watching TV, etc.

Using a simple formula of Minutes Played (mins) x Ratings of Perceived Exertion (RPE) and averaging this for the week can be insightful in how much or how little you do in a week. Athletes should be encouraged to record their load in a diary format – see Figure ①.

If you repeat this process for four-to-six weeks, then you can obtain what is a snapshot of a Chronic Load. Once you have a spike in this diary, also known as an Acute Load, research shows that the risk of injury in the next 8-21 days is much higher than normal.

During the 8-21 days, encourage your patients to:

- Perform more recovery techniques post-spike

- Reduce the load on the body by performing pool-based exercises
- Increase the amount of foam rolling and prolonged stretching
- Increase the amount of sleep
- Ensure good nutrition and hydration.

Most importantly, educate them about the value of rest on the growing body. This education will clear the young athlete's mind and they will begin to understand that it is **OK to rest**.

I would recommend advising your young athletes to visit the ACC Sport Smart website to learn more about warm-ups, stretching and FIFA 11+. These resources are all free and evidence-based that youth can access, order, and implement as part of their daily habits.

In summary, ask your patients to monitor their loads, prevent injury by becoming stronger using a well-researched evidence-based programme, and the best thing about this is that it is freely available to all.

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P: 0800 868 259

\$10 Million-dollar Royston Day Surgery Development Underway

📍 Royston Hospital

📰 Media release

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🌐 www.royston.co.nz



Reception

The Royston Day Surgery development celebrated the commencement of ground works with a blessing ceremony attended by Sandra Hazlehurst, Mayor of Hastings.

This joint venture is a collaboration between Acurity Health Group and a number of Hawke's Bay's leading orthopaedic surgeons and is a significant investment in the region aimed at improving access for patients to dedicated orthopaedic surgical services.

When fully commissioned, the facility will provide two large state of the art digital operating theatres and supporting services. The development incorporates a modern design that maximises

the use of natural materials and colours with a unique one-way circular patient flow through the generous, light filled patient spaces.

The new facility follows the trend towards day stay procedures enabled through significant advances in technology and surgical practices. The decrease of lengthy recovery timeframes in orthopaedics also provides improved outcomes for patients.



Recovery area

Acurity Health Group Board Director, Dr Jonathan Coleman was onsite to host the blessing. "This is a very exciting time for us and we have been working hard to get our development programmes at Royston restarted after our nation's

Covid lockdown. The multi-million-dollar investment means we can offer the latest in technology and services to meet the growing need for orthopaedic elective surgery capacity."



Theatre



Waiting area



Prospect Road perspective

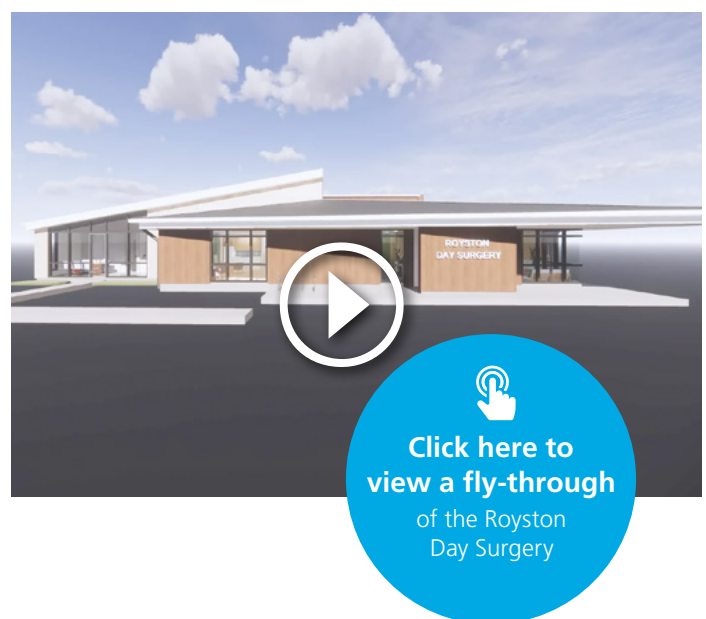
Royston Hospital also commissioned a fifth operating theatre in February and Alexanders Construction are now on site to complete a new reception area, foyer and lift area to improve the patient and visitor experience. A further two operating theatres are also under construction as the hospital invests in expanding its services and capability to meet the growing needs of the local community.

Royston Hospital General Manager, Denise Primrose said, "We are very pleased to have operations back up and running post the Covid shutdown and to be

providing elective surgery services again, after what has been a challenging time for the Health sector".

"We are working hard to scale up our capacity for all services and progressing with our developments to meet the health needs of our communities and support job creation. We are committed to providing the highest standard of healthcare services for the Hawke's Bay region, and the investment at Royston is part of this."

Construction of the Royston Day Surgery will be completed by September 2021.



Endorsed CPD Activities



Acuity Health Group and
Evolution Healthcare

CPD Activities

Acuity Marketing

(04) 920 0131

www.acuity.co.nz

Upcoming CME Meetings

Acuity Health Group and Evolution Healthcare hosts a variety of Continuing Medical Education (CME) sessions for GPs throughout the year. Each session enables you to meet consultant physicians

and surgeons, receive expert feedback and discuss topics. To suggest a topic, request information, or register for a CME, please contact marketing@acuity.co.nz

Date	Speaker	Specialty	Topic/Details	Venue/Format	CME endorsed up to:
16 September Wednesday	Dr Liz Insull and Dr John Beaumonth	Ophthalmologists	Ophthalmology. Update for Optometrists only	Royston Hospital	2 credits
21 September Monday	Dr Ineke Meredith	General Surgery + Breast	Managing a woman after breast cancer: From a young woman in early menopause to a post-menopausal woman undergoing menopause again and everything in between	Webinar 12pm – 1pm	2 credits
29 September Wednesday	Dr Zelda Strydom	Psychiatry	The lowdown on the latest “highs”... Substance Abuse and the Current Trends	Re-centre, Level 3, 12-16 Nicholls Lane, Parnell, Auckland	2 credits
20 October Thursday	Dr Jasminka Milosevic and Ms Avril Scott	Psychiatry	Demystifying Affective Disorders	Re-centre, Level 3, 12-16 Nicholls Lane, Parnell, Auckland	2 credits
22 October Thursday	Dr Liz Insull and Dr John Beaumonth	Ophthalmologists	Ophthalmology. Update for GP's	East Pier, 50 Ahuriri Road, Napier	2 credits
November TBC	Dr Ben Griffiths and Dr Chris Cederwall	Gastroenterology	Gastroenterology Updates	Bowen Hospital, Newtown, Wellington	2 credits
TBC	Dr Liz Insull and Dr John Beaumont	Ophthalmology	Ophthalmology Update – Optometrist only CME	Napier and Hastings venues	2 credits
TBC	Mr James Blackett and Mr Ciaran Thrush	Orthopaedics	Orthopaedic Updates	Napier and Hastings venues	2 credits
TBC	Wakefield Heart Centre	Cardiology	Cardiology Updates	Wakefield Hospital, Newtown, Wellington	2 credits
TBC	TBC	Dermatology and Oncology	Skin Updates	Bowen Hospital, Crofton Downs, Wellington	2 credits



Reading Health Matters – educational articles

0.25 CPD credits for every 15
minutes of reading and reflection.

CME meetings

Each session is
endorsed up
to 2 credits.

Missed a session?

Some of our previous CME
meetings have been recorded,
and are available to view.

For details, email
marketing@acuity.co.nz



Transforming Our Service

Digital Standardisation

Acuity Health Group and
Evolution Healthcare

Digital Standardisation

(04) 920 0131

www.acuity.co.nz

Register online, it's simple

Register and complete your pre-admission forms online via your patient portal. It's fast, easy and once you've created your profile, all your information is there for you to access any time you like.



eAdmissions – Your Patient Portal

From pre-admission through to discharge, our staff are committed to providing excellent care and recovery of our patients through superior healthcare standards, and treating each patient with the highest respect and dignity.

We are pleased to announce that our eAdmissions patient portal has launched for our

hospitals – Wakefield and Bowen Hospitals in Wellington, and Royston Hospital in Hawke's Bay.

eAdmissions is a first of its kind in New Zealand and is a significant milestone for Evolution Healthcare's Digital and IT strategy. Our patients can now click on a link on the hospital website and complete

their admission, insurance and payment forms, and their health questionnaire online. They can then be rest assured that, with the push of a button, their forms have been delivered electronically and instantly to the hospital.

This significant milestone is one of the two major investments in digital and patient management technologies in progress across Acuity Health Group and

Evolution Healthcare which seek to improve our patients' experience. Our Group is focused on completing our WebPAS project, the second major investment across our hospitals in New Zealand. Between WebPas and eAdmissions we continue to pave the way for increased standardisation and a wider digital offering for our patients and clinicians.

Bronchoscopy Services

📍 Bowen Hospital ⚙️ Bronchoscopy 🌐 www.bowen.co.nz



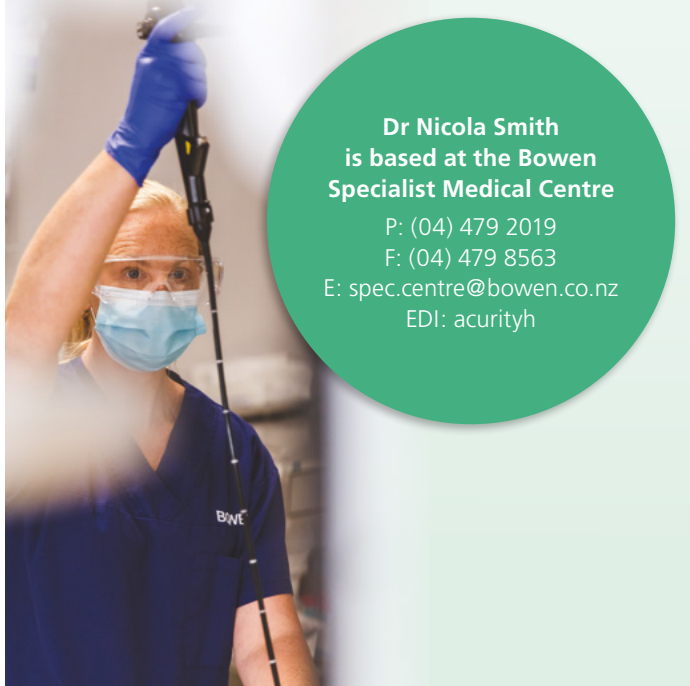
Private Bronchoscopy Service now at Bowen Hospital

Acurity Health Group and Evolution Healthcare are driving excellence in the provision of private bronchoscopy for the lower North Island.

Patients who require bronchoscopy procedures can now be referred privately to Bowen Hospital, where they are able to have their procedure within one-to-two weeks following their initial private consultation with Dr Nicola Smith. Consultations are available in clinic, with follow-up appointments available by telehealth.

Dr Nicola Smith is also available to provide private bronchoscopies for oncology patients receiving treatment and care from our Bowen Icon Cancer Centre, providing continuity of care.

We welcome you to contact us for further information. Referrals can be sent to the Bowen Specialist Centre.



**Dr Nicola Smith
is based at the Bowen
Specialist Medical Centre**

P: (04) 479 2019

F: (04) 479 8563

E: spec.centre@bowen.co.nz

EDI: acurityh

Bowen
icon cancer centre

boweniconcancercentre.co.nz

We are proud to provide world-class private cancer treatment in a friendly and supportive environment for our patients and loved ones. Our experienced team work as one from diagnosis to treatment to ensure patients receive personalised, exceptional care every step of the way.



**Part of the Acurity Health Group
and Evolution Healthcare**



New Consultants

Please feel free to contact these consultants directly



Dr Liz Insull

MBChB, BSC, FRANZCO, ANZSOPS

Oculoplastic and Ophthalmic Surgeon

P: (06) 873 1152

F: (06) 873 1153

E: hawkesbay@eyeinstitute.co.nz

Specialty

Ophthalmology

About Liz Insull

Dr Elizabeth Insull is a New Zealand and UK trained Oculoplastic and Ophthalmic Surgeon based at Eye Institute Hawke's Bay in Royston Hospital. Liz is a Consultant at Hawke's Bay Hospital and is involved in Registrar training both locally and nationally.

In addition to cataract surgery, Liz's sub-specialty areas include eyelid surgery, lacrimal (tear duct), orbital (eye socket) surgery and cosmetic eyelid surgery.

She sits on the New Zealand branch executive of the Royal Australian and New Zealand College of Ophthalmology and is a member of the Qualification and Education Committee.

Liz is the only member of the Australian, New Zealand Society of Ophthalmic Plastic Surgeons (ANZSOPS) in Hawke's Bay. Certified ANZSOPS members have unique training in eye surgery and periocular plastic surgery. They have expertise in techniques that address functional and aesthetic

results in orbital, lacrimal and eyelid surgery.

Liz graduated in 2006 from the University of Otago with a Medical and BSC (Neuroscience) degree.

She gained specialist Ophthalmic training in Dunedin and Auckland and sub-specialty fellowship experience at The Royal Devon and Exeter Hospital and the John Radcliffe Hospital, Oxford in the United Kingdom.

Services offered by Dr Liz Insull are:

- Cataract surgery
- Eyelid surgery
- Eyelid malposition including ectropion and entropion
- Tumour excision and eyelid reconstruction
- Cosmetic blepharoplasty
- Same day service to surgically remove lesions occurring on the face and around the eyes (this is particularly helpful for eyelid cysts).
- Botulinum toxin injections
- Lacrimal (tear duct) surgery
- Orbital (eye socket) surgery
- Pterigium surgery
- Laser treatments
- Glaucoma monitoring
- Management of macular and retinal disease
- Intravitreal injections
- Dry eye care
- General Ophthalmology.



Dr Kirsten Gaerty

MBChB, DipObMG, FRANZCOG, DDU

Obstetrician Gynaecologist

P: (06) 281 2797

F: (06) 281 2798

E: office@unityclinic.co.nz

Speciality

Gynaecology and Obstetrics

About Kirsten Gaerty

Kirsten is a consultant Obstetrician Gynaecologist and has obtained both her Medical degree and a Post-graduate Diploma in Obstetrics and Medical Gynaecology from the University of Otago. Subsequent to these accomplishments she embarked upon her Obstetrics and Gynaecology specialist training and completed this in 2014 upon being awarded her Fellowship (FRANZCOG).

She has a special interest in complex obstetrics and completed an 18 month Fellowship (Mater Mothers Hospital, Brisbane) in Maternal-Fetal Medicine. Whilst in Brisbane Kirsten also completed the highly complementary DDU (a post-graduate Diploma in Diagnostic Ultrasound).

Kirsten provides care in all aspects of Obstetrics and Gynaecology. Obstetric interests and expertise are outlined above and areas of interest in gynaecology include pre-conception counselling, fertility assessment and the management of heavy periods. Kirsten is involved in quality

improvement in her role at the DHB and strives to provide up to date evidence based practice and is a senior Clinical lecturer for the university of Otago. Kirsten works closely with Dr Elaine White in their practice ALL WOMEN obstetrics and gynaecology.

In addition to expert pre-conception advice, ante-natal consultations and a small shared care private Obstetric practice. Kirsten also offers professional care and services for general gynaecological problems.

Special interests

- Complex Obstetrics
- Preconceptual counselling
- Fertility
- Menstrual problems.



Jessica Hardley

BA, BSc(Hons), MSc, PgDipClinPsych

Senior Clinical Psychologist

P: (09) 884 8350

F: (09) 282 4872

E: referrals@recentre.co.nz

Speciality

Psychology

About Jessica Hardley

Jessica is an experienced and highly skilled Clinical Psychologist who has worked with children, adolescents and adults. She completed her clinical training in Wellington and has worked across New Zealand and the United Kingdom. Jessica has been with Re-centre since its opening and has been responsible for running group and individual therapy sessions. Jessica believes in using a compassionate, client-centred approach, working in a collaborative manner with people to enable positive outcomes.

She has specialist experience in anxiety, depression, self-harm, PTSD, OCD, stressful life events, self-worth and developing self-identity. She draws from a variety of evidence-based interventions in her practice including Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Acceptance and Commitment Therapy (ACT), Eye Movement Desensitisation and Reprocessing (EMDR), and mindfulness.

Special interests

- Anxiety
- Depression
- Self-harm
- PTSD
- OCD
- Stressful life events
- Self-worth
- Developing self-identity.



Kahn Higgs

B.Psychology (NWU – South Africa),
M.Soc.Sc (NWU – South Africa)

Consultant Clinical Psychologist

P: (09) 884 8350

F: (09) 282 4872

E: referrals@recentre.co.nz

Speciality

Psychology

About Kahn Higgs

Kahn received both his Bachelor of Psychology (2004) and his Masters of Social Science in Clinical Psychology (2008) at the North-West University, South Africa. He went on to work at a psychiatric hospital, where his responsibilities included assessing client needs, working as part of a multidisciplinary team, devising/monitoring appropriate treatment programmes, providing psychotherapy and carrying out applied research.

Kahn has been working in New Zealand since 2017 both in a DHB and private environment, and has been with Re-centre since its opening. During this time he has been responsible for running group and individual therapy sessions.

Kahn specialises in working with clients who might find coping with everyday life challenging – depression, anxiety, loss and grief, relationships and adjustment. He has a cognitive behavioural therapy (CBT) focus and is trained in the integrated technical eclectic approach.

Special interests

- Depression
- Anxiety
- Loss and grief
- Relationships
- Adjustment
- CBT.



Avril Scott

Diploma of Nursing, Bachelor
of Nursing, BSc(Hons)

Clinical Nurse Specialist

P: (09) 884 8350

F: (09) 282 4872

E: referrals@recentre.co.nz

Speciality

Psychology

About Avril Scott

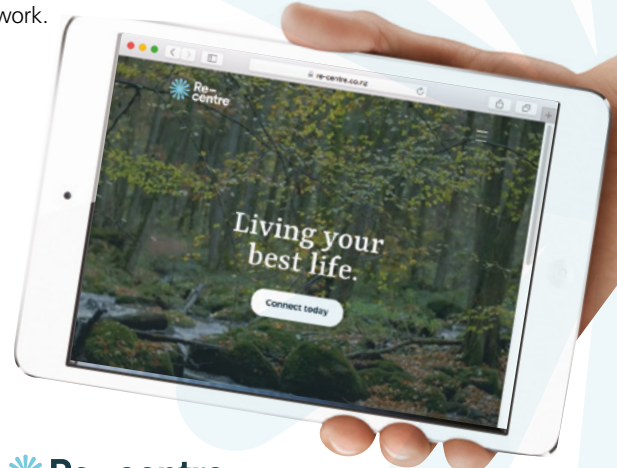
Avril is a Clinical Nurse Specialist at Re-centre with over 20 years' experience working as a mental health nurse in both the UK and New Zealand. She has worked in in-patient and community-based facilities with clients of all ages, experiencing a range of mental health challenges.

Avril has also completed further study in therapeutic interventions including Cognitive Behavioural Therapy, EMDR and family work.

Avril is passionate about supporting people through their personal recovery.

Special interests

- CBT
- EMDR
- Family work.



Re-centre

At Re-centre we have a dedicated **GP 0800 Hotline** available for you to speak directly with one of our specialists. Available Monday to Friday from 8.30am – 4.30pm, you can call us on 0800 854 905 for over-the-phone support and refer your patient directly to us. If we can't answer due to taking another call, please leave us a message and we will contact you.



WAKEFIELD
HOSPITAL



Dr Rita Yang

MBChB, FRACS (Plast)

Plastic and Reconstructive Surgeon

P: (04) 381 8120

F: (04) 381 8121

E: specialists@wakefield.co.nz

EDI: acurityh

Speciality

Plastics and Reconstructive
Surgery

About Rita Yang

Dr Rita Yang is a Plastic and Reconstructive Surgeon with an interest in Breast Reconstruction and Gender Affirmation surgery. She has comprehensive training in microvascular breast reconstruction and Gender Affirmation Surgery. She worked for a year at the prestigious Chang Gung Hospital in Taiwan, followed by training in Gent, Belgium. Rita attended medical school in New Zealand and subsequently trained in Plastic and Reconstructive Surgery in New Zealand. She is originally from Taiwan and is a fluent speaker of Chinese.

Special interests

- Gender Affirmation Surgery
- Breast reconstruction
- Breast augmentation
- Fat grafting
- Reconstruction
- Reduction
- Facial rejuvenation/
Blepharoplasty
- Lymphoedema
management
- Body contouring/
Abdominoplasty
- Skin cancer reconstructions.



Mr Matt Seeley

MHChB, FRACS

Otolaryngologist (ENT)

P: (04) 381 8120

F: (04) 381 8121

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Speciality

Otolaryngologist –
Head and Neck (ENT)

About Matt Seeley

Matt is an Otolaryngologist-Head and Neck (ENT) surgeon based in Wellington. He completed his specialty training in New Zealand, primarily in Wellington and Waikato. He has also completed fellowship training in advanced sinus and skull based surgery with Dr Marc Tewfik at McGill University, Montreal, Canada. He maintains a broad interest in all ENT conditions and has a public hospital position at Wellington Regional Hospital.

Special interests

- Adenoids
- Grommets
- Head and Neck
- Nasal and Sinus Surgery
- Nose
- Throat
- Tonsils
- Head and neck Surgery
- Voice disorders.



WAKEFIELD
HOSPITAL

www.wakefield.co.nz

Based in the heart of Wellington, Wakefield Hospital offers a wide range of high-quality private healthcare services with a team of experienced specialists and the latest in techniques and equipment available. We have a proud history of offering our patients the very best of care in our welcoming and comfortable facilities.



Part of the Acurity Health Group
and Evolution Healthcare



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