

Health Matters

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Look out for this symbol. Full details > 13



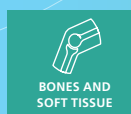
Connect 2019



WOMEN'S HEALTH



HEAD HEALTH



BONES AND
SOFT TISSUE



SKIN


**Final call for
registrations**

29-30 March 2019


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Royston Hospital:

– Dr Melinda Parnell

– Mr Ciaran Thrush

Bowen and Wakefield Hospital:

– Mr Giles Foley

Wakefield Hospital:

– Professor Mark Stringer

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Message from Acurity Health

 Acurity Health

 Dr Jonathan Coleman, Chief Executive Officer

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 www.acurity.co.nz



Kia ora and welcome to the first edition of Health Matters for 2019. The Christmas break probably already seems like a long time ago, but I hope you've taken the chance to recharge for a busy year ahead in your clinical practice.

Acurity's hospitals and clinics are back in full swing, and we have a range of exciting developments ahead of us.



We've kicked off the year with the commencement of radiation oncology treatment at the Bowen Icon Cancer Centre, located at Bowen Hospital in Wellington. Now patients in Wellington and the lower North Island have access to private radiation oncology services close to home for the first time ever. Demand for the service is high, and it complements the existing medical oncology service at Bowen to form a comprehensive cancer centre.



The long awaited redevelopments at Wakefield and Royston hospitals will be making significant progress over the coming year, with the \$14m works at Royston having commenced in early January. The \$100m plus investment in a total rebuild of Wakefield Hospital starts next month.

The focus throughout the delivery of these projects will be continuity of service for all our patients, and plans are in place to ensure that this happens.

"The long awaited redevelopments at Wakefield and Royston hospitals will be making significant progress over the coming year..."

We are also broadening our range of services with the leasing of premises for a private mental health outpatient service in Auckland that is due to open later in the year.



Also at the end of March we will once again be hosting our GP conference at Te Papa. We really hope you will join us for an interesting and engaging programme that will keep you up to date with the latest developments and innovations in head health, women's health, bones and soft tissue and skin. Anyway here's to 2019!



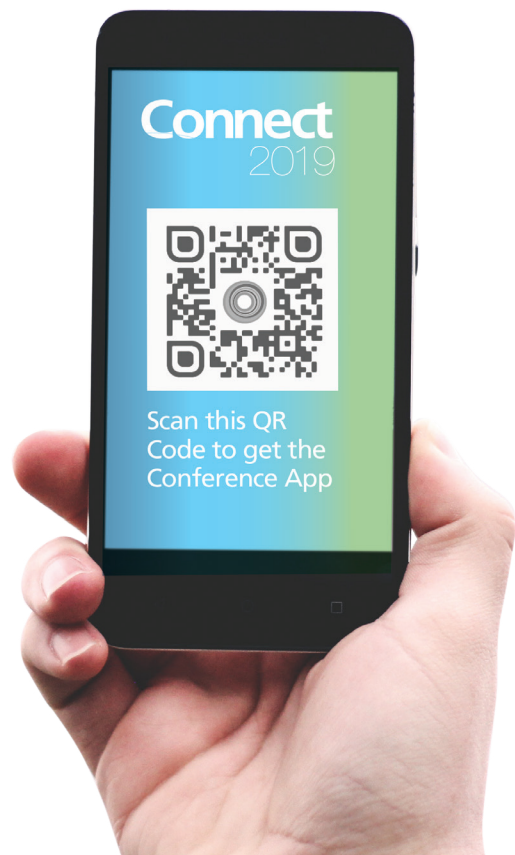
Jonathan Coleman
Chief Executive Officer
Acurity Health Group Ltd



Connect 2019 is going digital

You're invited to download the Conference App before the event. The App will enable you to participate in audience polling, interactive sessions, debates, and so much more.

Download the App via the QR code below. Full details on p10.



The Treatment of Benign Disorders with Radiation Therapy

Dr Han Kim



Bowen Hospital

Radiation Oncology,
Bowen Icon Cancer Centre

Dr Han Kim, Radiation Oncologist,
ph (04) 896 0200

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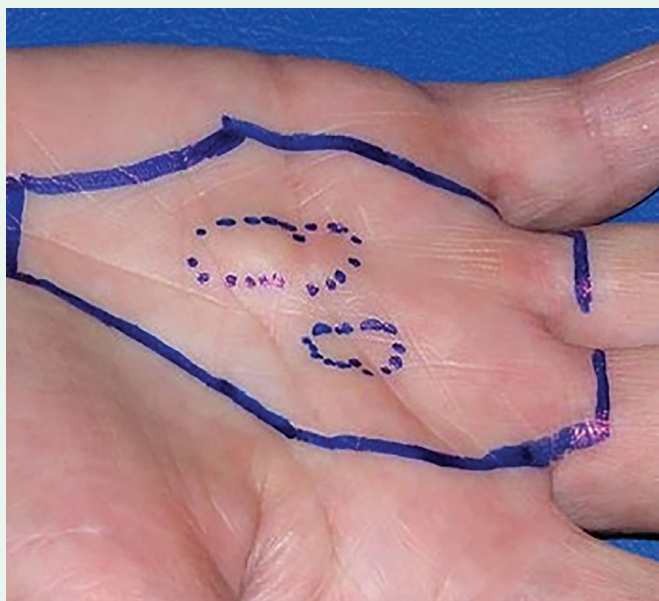


Figure (a) Small nodules in the palm of the hand (dotted lines). No contracture of fingers (the full line indicates the field for radiotherapy).

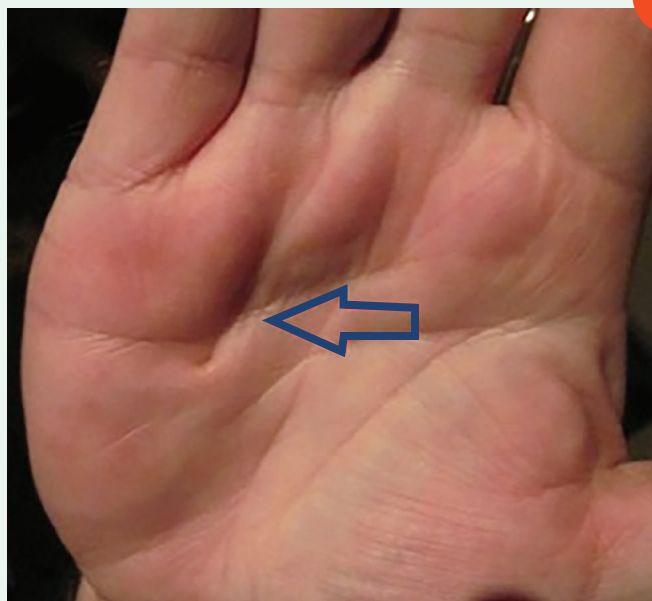


Figure (b) The skin in the palm starts pulling in. Originally there had been a nodule that now begins the "convolution phase".

Radiation therapy plays a pivotal role in cancer management. It provides a substantial improvement in the quality of life for symptomatic cancer patients and often the treatment is well tolerated with minimal impact on their daily activities. Depending on the goal of the treatment, the course can be as short as a single fraction, to multiple fractions over a number of weeks. Each radiation session comprises approximately 20 minutes in a radiation department. Radiation therapy can also be offered in benign disorders and many clinicians are not aware of this.



Approximate
length of each
radiation session
in a radiation
department.

There are several benign disorders that radiation is indicated for. Some of these include; keloid, heterotopic ossification, Graves' eye disease, as well as Dupuytren's contracture. For these disorders, radiation is used for its anti-proliferative and anti-inflammatory effect and acute toxicity is generally not an issue as only low dose radiation is required.

There has been a big surge of interest in treating Dupuytren's contracture with radiation. The radiation treatment has shown high efficacy of preventing 80% of patients requiring contracture release surgery if they are treated in their early phase¹.

Early is defined as contracture of less than 10-15 degrees or otherwise known as clinical stage N/1. This is when it is in the proliferative phase where radiation is most effective. Majority of patients also report improvement in their local symptoms arising from fibrotic nodules and fascial cord formation. In some cases, reirradiation can be offered to prevent worsening of contractures post initial treatment and soften the hard-painful nodules. For patients with existing contracture, the best approach is to consider radiation treatment immediately after their release post surgery.

Continued over.



Figure **c** Ledderhose disease.



Figure **d** Example of Dupuytren's and Ledderhose nodules at hand and foot, respectively. Early stage (stage N of Dupuytren's), no finger contraction and Ledderhose nodules still relatively small.

Morbus Ledderhose is a similar disorder found in feet of patients who often suffer from Dupuytren's contracture. It can cause pain and impact on their mobility as some of these nodules can grow significantly larger than Dupuytren's. Radiation is effective to soften these painful nodules and slow down or even completely halt the disease's progression². Beneficial results may take a few months to a year to become apparent.

The treatment course for these conditions requires less than 10 sessions³. Patients are

expected to spend about 20 minutes in the department for each session, but the actual delivery of radiation takes less than 5 minutes. The delivery of radiation is painless, and patients can continue their daily activities including working. Skin reaction for this type of radiation is very mild and there are no associated systemic side effects. Comfortingly, there are no published reports of secondary malignancy for treating Dupuytren's or Ledderhose disease. This treatment is available in Wellington.

Dr Han Kim's specialist interests include breast, genitourinary (prostate), head and neck, and skin cancers

References

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- Figures a, b and d: Images and captions credited to www.dupuytren-online.info/dupuytren's_contracture.html
- Figure c: Image retrieved from www.medicalnewstoday.com/articles/319187.php and credited to Herecomesdoc, 2013.

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Bowen
icon cancer centre



10 sessions
(or less)
of treatment
required



20 minutes
in a radiation
department
per session



5 minutes
(maximum)
of delivery of
radiation



The Role of Sleep

in Optimising Rehabilitation and the Recovery from Injury

Brendon Tod



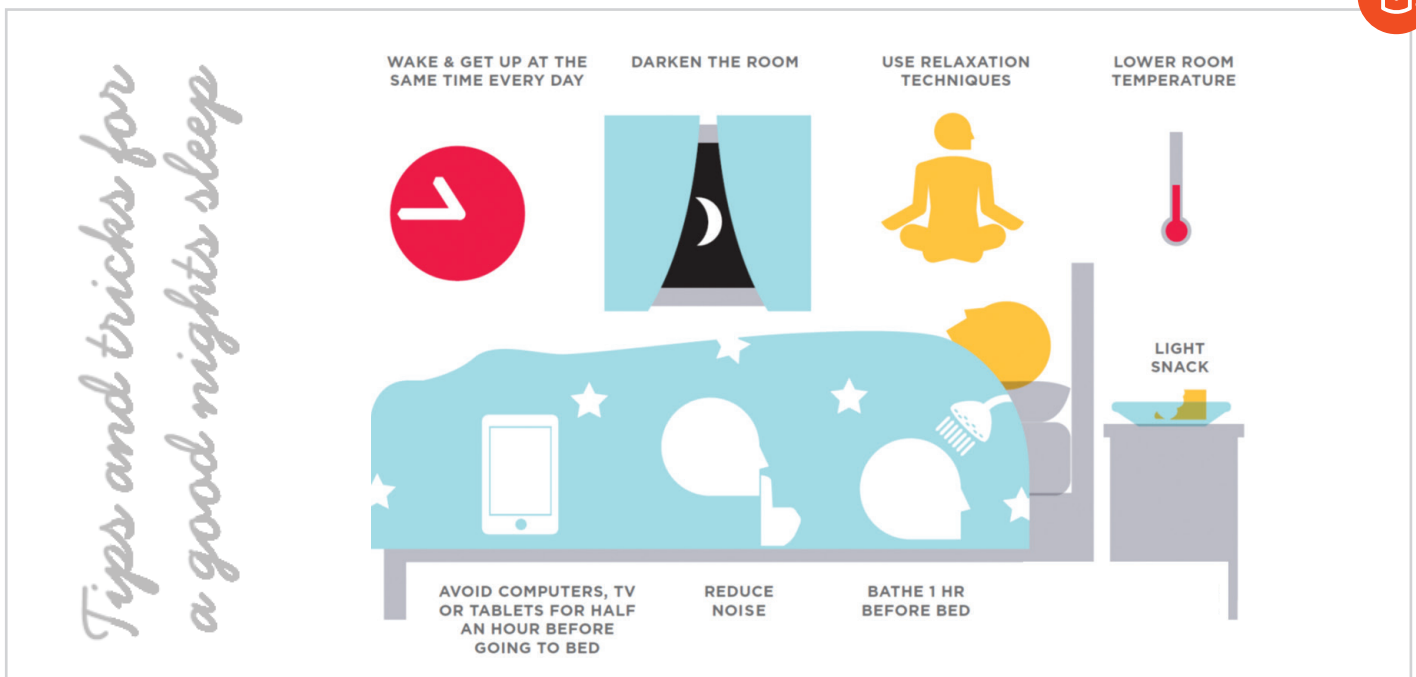
Proactive

Physiotherapy

Brendon Tod, Chief Executive Officer

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While there is still much to be determined regarding the physiological mechanisms of sleep, it is well established that an adequate quantity and quality of sleep is essential for human health and wellbeing^{1,5}. But what about sleep's role in recovery from an injury?

While there is a growing body of evidence pointing to sleep's role in the recovery from traumatic brain injury¹⁰, wound healing, surgery, and in the inhibition of chronic pain⁷ – sleep and its role in improving rehabilitation outcomes are not well documented.

However, based on what we do understand about sleep, it would stand to reason that helping to improve a patient's sleep should be a big part in any rehabilitation programme with a view to helping enhance the recovery process and in improving their ability to cope.

So, what can we do to enhance sleep in patients following injury or illness that will require a sustained period of recovery?

A proactive approach to rehabilitation will aim to improve sleep in participating patients by:

- A** Improving the patient's understanding of the importance of sleep through education
- B** Screening for sleep disorders that may be impacting on recovery or coping mechanisms, and then referring for medical input to help address the disorders
- C** Helping a client to establish good sleep hygiene practices.

Continued over.





IMPROVING THE PATIENT'S UNDERSTANDING OF THE IMPORTANCE OF SLEEP THROUGH EDUCATION



Educating a patient regarding the importance of sleep on their health, wellbeing, and recovery will involve explaining the role of sleep in a range of physiological functions. This may include education in regards to sleep's role in tissue growth and renewal, hormonal balance, neurotransmitter replenishment, and inflammatory mediation^{1,2,3,4,5,7,8}. It will also help a patient to understand the negative effects of sleep deprivation on mood, motivation, and coping mechanisms^{3,10}. In helping the patient to understand the importance of sleep on the outcome of their rehabilitation, we aim to increase their motivation to improve their sleeping habits.



SCREENING FOR SLEEP DISORDERS THAT MAY BE IMPACTING ON RECOVERY OR COPING MECHANISMS, AND THEN REFERRING FOR MEDICAL INPUT TO HELP ADDRESS THE DISORDERS



Screening for sleep disorders requires rehabilitation health professionals to be current in their knowledge of the range of different sleep disorders that a patient may present with and to be able to recognise signs and symptoms of sleep disorders in their patients. This will generally involve referral back to a patient's GP or a specialist sleep clinic for further investigation.



HELPING A CLIENT TO ESTABLISH GOOD SLEEP HYGIENE PRACTICES

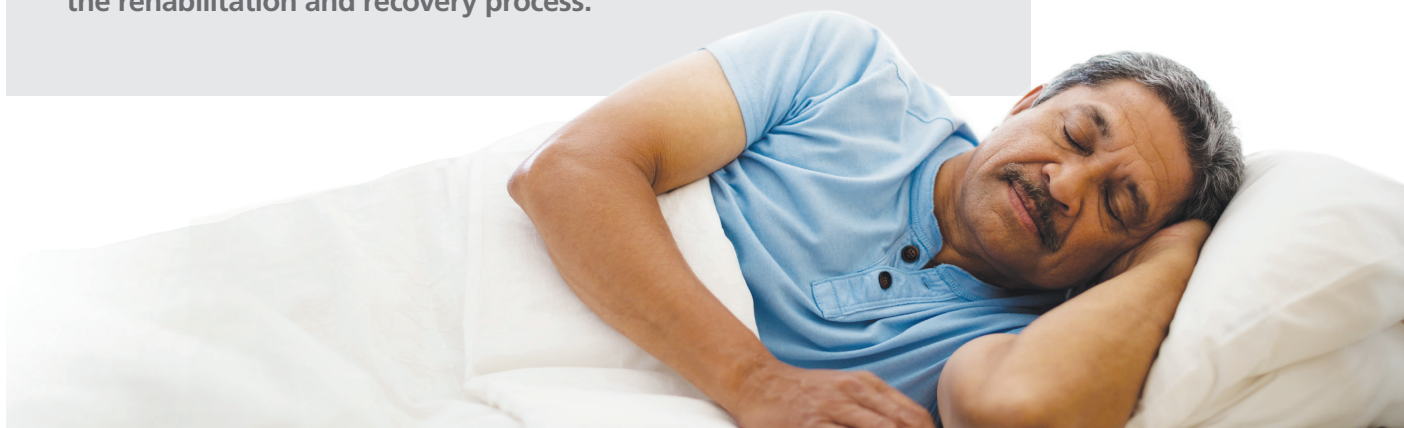


Sleep hygiene refers to the habits and practices that are conducive to sleeping well on a Regular basis^{9,10}. The establishment of good sleep hygiene practices is different for every patient and requires an understanding of the patient's current bedtime routine. It can include the introduction of relaxation techniques, establishing consistent wake times, refraining from screens and bright lights, and reducing bedroom noise; amongst other things. From time to time this may require the prescription of sleep medication to aid in the establishment of a consistent sleep-wake cycle.

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In summary, sleep plays a vital role in human health and wellbeing, however addressing sleep issues or promoting sound sleep is often overlooked in the recovery process. Educating patients regarding the importance of sleep, addressing sleep disorders, and promoting sleep hygiene practices are all options in taking steps to optimise the rehabilitation and recovery process.



Connect 2019

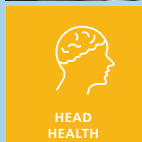



The Royal New Zealand
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Te Whare Tohu Rata o Aotearoa
Endorsed CPD Activity

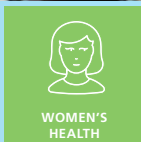


**29-30
March 2019**

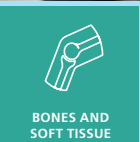
Programme Preview
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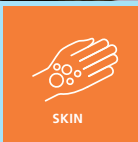
HEAD
HEALTH



WOMEN'S
HEALTH



BONES AND
SOFT TISSUE



SKIN



2019 marks the 21st year this conference has been held and Acurity Health Group, in partnership with the Department of Primary Health Care and General Practice, University of Otago, Wellington, are proud to continue to support the medical profession with this annual event.

The positive feedback we receive from the Connect conference every year inspires us to make each one better than the last and this year is no exception. With more audience polling, more interactive sessions and more ethical debates, our aim for 2019 was to take the programme to a new level of excellence – we hope you agree we achieved this.

Various topics will be explored under the broad themes of skin, head health, women's health, and bones and soft tissues. Some of the best presenters, world leading researchers, highly skilled specialists and expert healthcare professionals have been invited to provide

updates on conditions you see commonly and some less well known. Sessions are designed to have practical tips and take home messages that are applicable to the better diagnosis and care of your patients.

We invite you to discover what the programme has to offer and look forward to welcoming you to Connect 2019.





Sarah Malone
Business Development Manager
Acurity Health Group Limited

Friday Programme (preview)
















0800	Registration Desk Open (until 1730)		Oceania Room
0840	Official Conference Opening Remarks	 Dr Jonathan Coleman Chief Executive Officer, Acurity Health Group Ltd  Associate Professor Lynn McBain Head of Department, Primary Health Care and General Practice, University of Otago,	
 STRAND 1: HEAD HEALTH			
0900	Primary Care Mental Health: From There to Here to Where?	 Professor Tony Dowell	
0940	 Lightning Talks:		Soundings Theatre
	Assessment of Medico-Legal Capacity – From a GP Perspective	 Ms Kay Cunningham Clinical Psychologist / Neuro Psychologist	
	Stroke	 Dr John Denton Radiologist	
	Q & A		
1020	New Auckland Mental Health Service and Latest Applications and Tools	 Ms Lyn Dawson Mental Health Clinician	
1055	Youth Well Being Study – Outcomes and How we Can Help	 Professor Marc Wilson Victoria University of Wellington	
1115	Morning Tea and Exhibition		Oceania Room
1150	 Concurrent Session A:		
	Separation of Craniopagus Twins: A Clinical, Legal and Ethical Conundrum	 Mr Reuben Johnson Neurosurgeon	● Yellow: Level 3 Rangimarie Rm 2
	Community Care of Epilepsy	 Dr David Abernethy Neurologist	● Green: Level 2 Icon Theatre
	Oral and Maxillofacial Diagnoses	 Mr Manish Patel Oral & Maxillofacial Surgeon	● Red: Level 3 Rangimarie Rm 1
1225	 Concurrent Session B:		(Repeat of Concurrent Session A)
1255	Lunch and Exhibition		Oceania Room

 STRAND 2: WOMEN'S HEALTH			
1355	PCOS and Infertility	 Mr Nick Bedford and Mr Simon McDowell Gynaecologists 	Soundings Theatre
1440	 Concurrent Session C:		
	Pelvic Pain – A Framework for Management	 Mr Jeremy Meates Gynaecologist	● Purple: Level 2 Icon Theatre
	Menopause – Prescribing HRT	 Professor Bev Lawton	● Blue: Level 3 Rangimarie Rm 1
	Breast	 Dr Christine Mouat	● Orange: Level 3 Rangimarie Rm 2
1515	 Concurrent Session D:		(Repeat of Concurrent Session C)
1545	Afternoon Tea and Exhibition		Oceania Room
1620	Acute Porphyria – Our Not So Rare Disease	 Dr Cindy Towns Physician	
1635	Panel discussion		
	Should I get Pregnant? An Ethical Debate	 Dr Malcolm Abernethy Cardiologist  Dr Andrew Aitken Cardiologist  Dr Kate Neas Geneticist  Dr Peter Abels, Obstetrician Gynaecologist	Soundings Theatre
	Q & A		Oceania Room
1730	Closing Remarks for Day One		
1735	Networking Function Hosted by Acurity Health Group Ltd		

Legend

-  Lightning talks (short, sharp sessions)
-  Concurrent sessions (you pick two for each session)

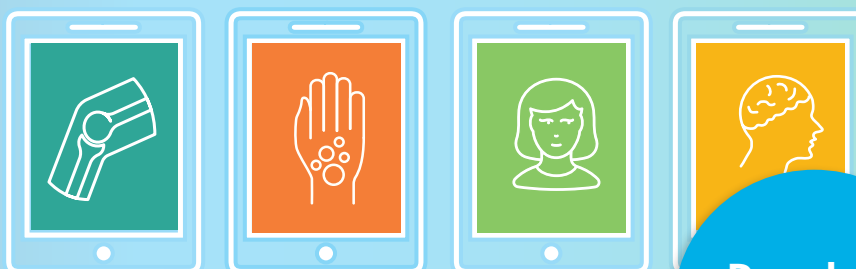
Saturday Programme (preview)

0800	Registration Desk Open (until 1600)	Oceania Room
 STRAND 3: BONES AND SOFT TISSUE		
0840	Welcome Day 2	Soundings Theatre
0845	There's Never Been a Better Time to get Rheumatoid Arthritis: How Practice Improvements and Better Drugs Have Transformed the Long Term Outcome of RA	
	 Associate Professor Andrew Harrison Rheumatologist	
0925	Shoulder Labral Tears – A Clinical Presentation	
	 Mr Jamie Belesky Physiotherapist	
0935	 Lightning Talks:	
	Calcaneal Apophysitis, Also Known as Sever's "Disease"	
	 Kim Tottenham Podiatrist	Soundings Theatre
	Hip Labral Tears, Separating Fact from Fiction	
	 Mr Fred Phillips Orthopaedic Surgeon	
	Common Sports Injuries in Adolescents	
	 Mr Vijay Vallabh Physiotherapist	Soundings Theatre
	Q & A	
1030	Morning Tea and Exhibition	Oceania Room
1105	 Concurrent Session E:	<p> Green: Level 3 Rangimarie Rm 1</p> <p> Yellow: Level 3 Rangimarie Rm 2</p> <p> Red: Level 2 Icon Theatre</p>
	Bone Health and the Older Adult – What's New?	
	 Mr Andrew Linton Geriatrician	
	Total Hip & Knee Arthroplasty. The Past, the Present, and What's Coming!	Red: Level 2 Icon Theatre
	 Mr Peter Devane Orthopaedic Surgeon	
	Acute Hand Presentations – Trauma & Infection	Red: Level 2 Icon Theatre
	 Dr Sarah Usmar Plastic Surgeon	
1140	 Concurrent Session F: (Repeat of Concurrent Session E)	

 STRAND 4: SKIN				
1215	Overview of Leg Ulcers Management		Mr Albert Lo Vascular Surgeon	Soundings Theatre
1245	Lunch and Exhibition			Oceania Room
1340	Dermatology Pearls		Dr Giri Raj Dermatologist	
1415	Designing Vaccines for Cancer Therapy		Prof Ian Hermans Head of Cancer Immunotherapy Programme, Malaghan Institute	
1450	Prize Draw			
1455	Chronic Urticaria		Dr Nicholas Kennedy Rheumatologist & Immunologist	
1515	Scarring and Scar Management		Mr Chris Adams Plastic Surgeon	Soundings Theatre
1535	From Vascular Anomalies to a Paradigm Shift on the Understanding and Treatment of Cancer		Dr Swee Tan Executive Director Gillies McIndoe Research Institute	
1630	Close of Conference – Final Remarks			

Ways to register





Online: www.acurity.co.nz/connect
Email: connect@acurity.co.nz
(we will contact you)
Questions: Call Sarah Malone
on (04) 920 0158



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it before
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<p>On your smart phone, click on the relevant app store link below to download the ShowGizmo App:</p> <p> ShowGizmo for Android</p> <p> ShowGizmo for iPhone</p> <p> Mobile web App</p>	<p>Once inside the App find 'Connect 2019'</p>  <p>Accept the T&Cs, click sign in, and complete the following:</p> <ul style="list-style-type: none"> – Email address used when registered to connect – Your name – Create a password 	<p>Once you're logged into the App, select "Your Profile" from the left hand menu, which will allow you to edit your personal information.</p>

Alternatively, you may prefer to scan this QR code. Once it's downloaded, select 'Connect 2019' then go to Step 2.



Surgical Treatment of Stress Incontinence

Mr Nick Bedford



Wakefield Hospital Gynaecology

Mr Nick Bedford, Gynaecologist

(04) 381 8120

www.wakefield.co.nz

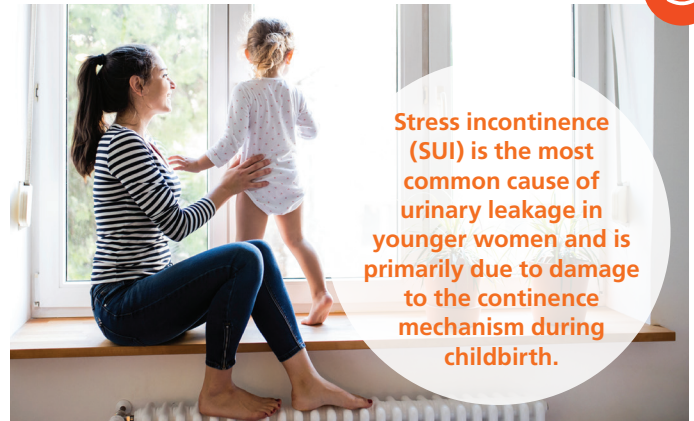
Mesh use in gynaecology for incontinence and/or prolapse has become highly contentious. Many practitioners may have been faced by women and their families with a high degree of anxiety about their options for treatment, either that which has been proposed, or potentially already undertaken.

It is my feeling that in the last 2 years in particular, women have become a lot 'warier' of surgical approaches such as the retropubic or transobturator mid-urethral slings, even though they are some of the most studied and well-validated surgical techniques available. So, what is the current situation around mesh use for incontinence, and what are the other options?

Stress incontinence (SUI) is the most common cause of urinary leakage in younger women and is primarily due to damage to the continence mechanism during childbirth. Childbirth can damage the pelvic floor, as well as the delicate support tissues that surround the mid-urethra and attach it to fascia behind the pubic bone. It is worth noting that pelvic floor exercises when taught by a specialist pelvic floor physiotherapist, and practised regularly, can lead to improvement or cure in more than 70%¹. It is also evident that up to one in four women are doing something OTHER than contracting their pelvic floor muscles effectively when they demonstrate a pelvic floor contraction, so never take their word for it! First line management should always include a visit to a good pelvic floor physio, as

well as lifestyle advice and medication review. However, a long-term cure is difficult to sustain, so surgical options are also worth discussing.

Broadly speaking there are three main techniques: the fascial sling, the Burch colposuspension, and the synthetic mid-urethral sling (MUS). The first report of the use of MUS was published in 1996² and built on an expanded theory of pelvic floor support termed the 'Integral Theory'. The aim was to recreate the dynamic fascial support of the urethra, without causing the voiding dysfunction inherent to the other techniques. The TVT was also designed to be an ambulatory procedure and to be done under local anaesthesia to allow a 'cough test' during the operation, aiming to avoid over-tightening the mesh. The first RCT was published in 1998³ and follow-up data are available to 17 years from this original cohort⁴. Early reports did note complications such as retropubic haematoma, bladder perforation, and bowel injury, so in 2001 a different approach was reported, taking the mesh out through the obturator foramen rather than into the retropubic space⁵. In many places during my training in the 2000s, this was the procedure of choice for gynaecologists.




Stress incontinence (SUI) is the most common cause of urinary leakage in younger women and is primarily due to damage to the continence mechanism during childbirth.

In both cases, it can be a day-stay procedure with a quick return to usual function and low morbidity.

The 2000s saw an explosion in innovation in mesh procedures in gynaecology, particularly transvaginal mesh placement for prolapse. With MUS the developments were to try to reduce the amount of mesh needed, refine the weave and 'weight' of the material, devise new mesh delivery systems, and introduction of 'mini-slings' which were placed through a single sub-urethral incision and anchored into the obturator internus fascia, avoiding mesh passage into the groin. However, the brakes were firmly applied in 2011 when the FDA released a second warning about mesh use⁶. In the years following, a number of jurisdictions (NZ included) have undertaken government-level reviews of mesh use, including MUS. In New Zealand, a Health Select Committee reported in 2016⁷, while the Australian Senate Inquiry released their findings in 2018⁸. Consistent recommendations include:

- Improving informed consent processes

- Credentialling and training of surgeons for mesh placement and removal
- Creation of registries to facilitate mandatory reporting of all mesh use and complications.

 In Scotland, the process went further, with mesh use halted while their review took place. After an extensive review, the Scottish Inquiry⁹ recommended the use of retropubic slings over transobturator, citing a slight performance advantage over time, but also noting a significantly lower rate of pain complications.

 In New Zealand, further developments followed the Australian Therapeutic Goods Authority¹⁰ ruling on the sale of mesh products in gynaecology surgery in December 2017. This required re-labelling of MUS products and removed 'mini-slings' and vaginally-placed mesh for prolapse; MedSafe quickly followed. This led to a lot of confusion, with many media outlets reporting that mesh had been 'banned', and a lot of practitioners and patients were left confused.

We now have several products available which all meet the new requirements.

There were a number of recommendations from the Australian Senate Inquiry, and one was to improve patient information and consent, which led the Australian Commission on Safety and Quality in Health-care (ACSQHC) to develop patient centred guidelines. These* are excellent resources for patients, and I direct all women contemplating surgery for SUI or prolapse to them. They also developed credentialling guidelines and the New Zealand Ministry of Health has directed all private and public hospitals to implement these for surgeons who wish to continue to place MUS. How this will affect women in those smaller centres (and caseload in the bigger centres) remains to be seen.



What of the other options for SUI? Since the MUS became popular, fascial slings have been less commonly performed. This is for a number of reasons, including it being a significantly larger procedure, requiring harvesting of fascia from either the thigh or the rectus sheath, and a Pfannenstiel-type incision to attach the sutures to the rectus sheath. Infection, length of stay and postoperative catheterisation rates are higher than MUS. De-novo urgency symptoms may arise in as many as 20% of women, but graft complications are much reduced. These have more commonly been used as a second (or even third) procedure where MUS has been unsuccessful or for

women with intrinsic sphincter deficiency or neurogenic incontinence¹¹. The other first-line procedure is the Burch colposuspension. This is a retropubic procedure to fix the paraurethral tissues to the iliopectineal line. Traditionally an open operation, it can be performed laparoscopically, but care has to be exercised to avoid over-correction of bladder neck support. Postoperative voiding dysfunction is relatively more common than the MUS, as are complications related to the more significant surgery required, longer hospital stay, and denovo posterior compartment prolapse¹². It is important to emphasise that neither of these procedures are complicated by some of the particular issues with transvaginal mesh, but equally a lot of the research is considerably older and pain outcomes, in particular, may not have been as rigorously recorded. Other options such as peri-urethral bulking agents are available and undergoing a resurgence of interest, especially in the UK. A durable and non-obstructive option remains the goal.

Despite the controversies and the occasional severe and life-changing complications (particularly pain-related) that can be seen with MUS, it remains the procedure of choice for most women in view of the long-term success and minimally invasive nature of the procedure. Due to the reduction in the potential for pain complications, I have opted to move to retropubic MUS. An alternative option is the laparoscopic Burch colposuspension, although women need to appreciate the differences in terms of postoperative effects and complications.



"These* are excellent resources for patients, and I direct all women contemplating surgery for SUI or prolapse to them."

***Australian Commission on Safety and Quality in Healthcare (ACSQHC) resources:**

<https://www.safetyandquality.gov.au/wp-content/uploads/2018/12/Treatment-Options-SUI-Consumer-Info.pdf>



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aceso health
COMPREHENSIVE WOMEN'S CARE

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Endorsed CPD Activities



Acurity Health

CPD Activities

Sarah Malone,
Business Development Manager

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www.acurity.co.nz

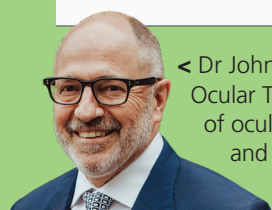
Acurity Health Group is proud to provide a wide variety of CPD endorsed events and publications.

Upcoming CME Meetings

Acurity Health Group 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 or request information, please contact Sarah Malone (details above). To register, email marketing@acurity.co.nz

Date	Speaker	Specialty	Topic/Details	Venue	CME endorsed
21 March Thursday	Dr John Beaumont	Ophthalmology	Ocular Trauma	Napier	2 credits
9 April Tuesday	Mr Brendon Bowkett and Professor Mark Stringer	Paediatrics	Neck Lumps, Lesions and Common Paediatric Gastrointestinal Problems	Wakefield	2 credits
2 May Thursday	Mr Tony Phang and Dr Jeremy Krebs	Hyperthyroidism and Osteoporosis	Hyperparathyroidism and the Surgical Management of it	Wakefield	2 credits
May	Wakefield Heart Centre	Cardiology	Cardiology Update	Wakefield	2 credits
21 May Tuesday	Mr Austin Enright	Orthopaedics	Discussion on the Latest Spinal Updates	Havelock North	2 credits
22 May Wednesday	Mr Austin Enright	Orthopaedics	Discussion on the Latest Spinal Updates	Napier	2 credits
		Ophthalmology	Update in Ophthalmology	Bowen	2 credits



< Dr John Beaumont is speaking in Napier on 21 March.
Ocular Trauma learning outcome: 'To recognise the signs
of ocular trauma to enhance diagnosis, assess severity
and provide management to achieve best outcomes.'

**2 CPD
credits
per session**

Reading Health Matters – educational articles



Time spent reading Health Matters is an approved individually planned learning activity recognised by the RNZCGP for continuing professional development (CPD) purposes. Time can be claimed on the basis of 1 credit for 1 hour of reading and reflection.

**.25 CPD
credit**
for every 15 minutes
of reading and
reflection

Connect 2019 GP Conference

This conference has been endorsed by The Royal New Zealand College of General Practitioners (RNZCGP) and has been approved for up to 12.25 CME for the General Practice Educational Programme (GPEP) and Maintenance of Professional Standards (MOPS) purposes.

up to
**12.25 CPD
credits**

**Connect
2019**

What Paradigm Shift?

Mr JK Wicks



Wakefield Hospital Vascular Surgery

Mr JK Wicks, Vascular Surgeon

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There is a paradigm shift in vein treatment that has happened over the last decade.

Veins! "Don't worry about them. They are just cosmetic. The fix is worse than the problem. You're a vein surgeon Kes you think they should all be fixed." That's what I've heard many times from doctor friends and acquaintances. The last comment was the most recent one from a GP friend of mine insinuating that vein treatment is only performed so that vein surgeons can pay for the new bach or boat and that somehow all veins are cosmetic and never really cause serious problems.



Case study from Mr JK Wicks:

Let me tell you a story of a patient that I recently dealt with in my public practice. Let's call him Mr SOS. His history is one of an athlete, who, in his teens and early twenties, held Wellington records both track and field. As he got older he became increasingly busy with his family and work. He was a landscaper and remained active but was overweight. He noticed about two years before he came to the clinic that his legs would swell by the end of the day and be painful. But what was alarming was that the skin around his calves was discoloured with brownish pigment and quite thickened. He saw his GP but was reassured that he didn't need to get anything done.

Things slowly got worse and then he got an infection after a minor trauma to his left leg. This settled with some antibiotics and he was told it's probably just veins and the fix is worse than the problem. So he carried on. While on a family holiday to Samoa, he again had another infection which was poorly dealt with and when he returned to NZ he was admitted to hospital for cellulitis and severe sepsis. He had an area of breakdown of the skin around his left calf but this was small and the infection settled and he was told to follow up with his GP. He did and was reassured. His skin had healed and he was back at work. He waited another six months by which time his leg had become grossly swollen and the skin around his calf had broken down severely. The District

Nurses were called in to help with dressings and they referred him to my clinic.

When I saw Mr SOS in my clinic he had a venous ulcer with a lymphangitic left leg with permanently damaged skin secondary to venous hypertension and lipodermatosclerosis. None of which is reversible with a vein procedure. I knew that I could get his ulcer healed and decrease recurrence by putting him immediately into compression bandaging and treating his veins but this man is now 40 years old with a permanent disability. His left leg will never be normal again despite appropriate treatment.

The problem is that we have to stop saying "veins are just cosmetic, they don't cause bother, the fix is worse than the problem." Varicose veins or venous reflux can have significant and severe consequences. We as doctors cannot predict when and who will go down the severe route of venous hypertension, pigmentation, lipodermatosclerosis and venous ulcers.

Newer endovenous treatments under local anaesthetic are uncomplicated minor procedures that can have huge benefits to prevention of ongoing reflux sequelae. These treatments are

a world away from open varicose veins treatment that is complicated, requires GA and immobilises patients for weeks.

"My question to everyone as a vascular surgeon is why would you not get assessed at the very least? Why wait until you have a SOS. The problem will always get worse. This is a monumental paradigm shift."

New Consultants

Acurity Health welcomes the following consultants. Please contact them directly if you would like more information about their specialties.



Dr Melinda Parnell

MB ChB, PhD, PG Dip
(Sports Medicine), FACSEP

Sport and Exercise Physician

P: (06) 873 8818
F: (06) 873 8819
E: mel@hbsportsmed.co.nz

Mel is a specialist Sport and Exercise Physician. She trained in Wellington and Melbourne, before completing a fellowship year at High Performance Sport NZ, working with elite, carded athletes, from a wide variety of sporting disciplines. Mel has been the Medical Director for Netball NZ and the Silver Ferns team Doctor since 2016.

Specialty

Sports and Exercise Medicine

Special interests

Paediatric and adolescent sports injury, female athlete, knee OA, exercise as medicine, knee and shoulder, tendinopathies.



Mr Ciaran Thrush

BHB, MBChB, FRACS (Ortho)

Orthopaedics

P: (06) 873 1107
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E: reception@ctortho.co.nz

I grew up in Hawke's Bay and gained my medical degree from The University of Auckland. After completing my orthopaedic training I undertook two fellowships in Melbourne, Australia; one at The Alfred Hospital working in the areas of trauma surgery, pelvis and acetabular fracture surgery and hip replacement, and another specialising in sports knee and knee replacement surgery. I have completed a paediatric orthopaedic fellowship at Starship Children's Hospital. I have also undertaken Orthopaedic specialty training in New Zealand.

Specialty

Orthopaedics

Special interests

- Sports knee surgery, especially anterior cruciate ligament reconstruction and meniscal surgery
- Knee replacement surgery, including revision surgery
- Hip replacement surgery, including revision surgery
- Trauma and post-traumatic conditions
- General orthopaedics.



Mr Giles Foley

MB, ChB, FRCS (Tr & Orth)

Consultant Orthopaedic Surgeon

P: (04) 464 0035
F: (04) 479 2217
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Consults at: [Bowen Specialist Centre](#)
Operates at: [Bowen and Wakefield Hospitals](#)

Giles lives and works in Wellington, having been appointed at CCDHB in May 2018. Giles consults on all aspects of hip and knee pathology. He has a particular interest in the management of painful and infected joint replacements.

Specialty

Orthopaedic Surgery

Training

- Graduated from Leeds Medical School in 2004
- Completed orthopaedic training in Manchester in 2014
- Two years Fellowship training in hip and knee replacement at Wrightington Hospital, UK, and Wellington Regional Hospital
- AO trauma fellowship at Hannover Medical School, Germany.

Special interests

Primary, complex primary and revision hip and knee replacement, knee arthroscopy.



Professor Mark Stringer

MS, FRCS, FRACS

Paediatric Surgeon

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Mark qualified in medicine in 1980 and completed Specialist Training in Paediatric Surgery in 1993. He worked as a Consultant Paediatric Surgeon in the United Kingdom until 2006 when he emigrated to New Zealand. He has since worked in Christchurch and Wellington as a general paediatric surgeon, specialising in gastrointestinal and hepatobiliary disorders.

Mark is available to see children with any paediatric surgical conditions and has particular interests in paediatric gastrointestinal endoscopy.

Mark is a Fellow of the Royal Australasian College of Surgeons and a member of the Australian and New Zealand Association of Paediatric Surgeons.

Specialty

Paediatric Surgery

Special interests

Paediatric gastrointestinal endoscopy, paediatric hepatobiliary surgery, general paediatric surgery (other than specialist urology).

Contact Us



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