

# Health Matters

## Ophthalmology in Primary Practice.... a few pearls

Dr John Beaumont



Royston Hospital

Area: Ophthalmology  
Article written by: Dr John Beaumont,  
Ophthalmologist, phone (06) 873 1152



With the very full medical school curriculum and often limited clinical exposure to ophthalmology in general and emergency practice it remains for some a dark art. "Refer to Ophthalmologist" being the final year mantra often remembered. It is a truism that "experience is what you have just after you need it".

Experience can also be shared in the best Hippocratic tradition. Ophthalmology need not be difficult and here are a few pearls to hopefully keep it simple and successful.

*Continued on page 3*

## What's inside

Ophthalmology in Primary Practice.... a few pearls > **1, 3 & 4**

Message from Acurity > **2**

Cardiac Catheterisation Laboratory > **5**

Radial is Preferred for Percutaneous Coronary Intervention > **6 & 7**

Peripheral Neuropathy: From the Routine to the Extreme > **8 & 13**

'Connect 2015' insert > **9, 10, 11 & 12**

How to do an Endos fascial Axillary Lymphadenectomy > **14 & 15**

Nursing in the Endoscopy Unit > **16 & 17**

New Consultant:  
– Dr Matthew Webber > **17**

Specialist updates:  
– Dr Richard Carroll > **18**  
– Reece Hall > **18 & 19**

Hawke's Bay Health Awards 2014 > **19**

Contact Us > **20**



**Cath Lab**  
Facilities update  
Page 5 >



**Neurology**  
Dr Jeremy Lanford  
Page 8 >



**Save the date**  
GP Conference: Connect 2015  
8 & 9 May 2015

**Register  
Today**

# Message from Acurity

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



Welcome to the first edition of Health Matters for 2015, this is the first of three editions planned for this year. It is our pleasure to bring you this publication designed to inform and educate on the latest techniques and major news within the medical field.

## What's happening in our world?

### GP Conference

Our annual Acurity GP Conference: Connect 2015 is coming together well. Our programme is looking exciting and appealing with a wide variety of interesting speakers. Alongside our clinical presenters, we have New Zealand entrepreneur, international speaker, and

number one best-selling author, Sam Hazledine as our keynote speaker on day one. Sam is regarded as one of the brightest young business minds in the country, and believes that success lies at the intersection of mindset and action, he is passionate about lifting people's sights so they can see what's possible, and sharing the lessons he has learned to get anyone into that sweet spot, where success becomes inevitable.

## Updated Websites

I am delighted to announce the recent launch of the new Acurity and Hospital websites. A key focus in the development was to provide user-friendly navigation and present the latest information about what we do, who our specialists are and the services we deliver.

With added subspecialty functionality and easy-to-find search tools, the process of selecting a specialist has been simplified and is more targeted. Thank you to all of you who took the time to tell us what you wanted in a specialist directory, your feedback and suggestions were important in the development of this new tool.

Take a look around and get to know our new websites, try the specialist search tools, and tell us what you think.

## Cath Lab

In the last edition of Health Matters I mentioned that our new cath lab was under construction at Wakefield Hospital. I'm proud to say this is now complete and proving very popular with our cardiologists and radiologists, all of whom are seeing first hand the benefits of a substantial investment in modern technology. A full feature on the new lab can be found on page 5.

## O-Arm...

Continuing on the technological theme, we are also the proud owners of a Medtronic O-Arm Surgical Imaging System – a device which allows 3D imagery to be gained intraoperatively, and can be linked to our, also



new, StealthStation guidance system allowing internal fixtures and implants to be placed with pinpoint accuracy in all three dimensions.

There are a number of procedures, most notably those involving the spine, in which the O-Arm will add substantial value, minimising clinical risk and maximising patient outcomes. We are the only hospital in the region with this technology, and our specialists welcome referrals for patients who will benefit from this enhanced capability.

## Continuing Medical Education

Our Continuing Medical Education (CME) calendar is filling up quickly for the first half of this year. Please refer to our website [www.acurity.co.nz](http://www.acurity.co.nz) for a list of CME events. We also advertise on the Royal College of General Practitioners website and NZ Doctor under events.

I hope to see you all at our upcoming conference. In the meantime, I hope you get an opportunity to take advantage of the stunning weather we have had this summer.

**Paul Quayle,**  
Chief Operating Officer,  
Acurity Health Group Ltd

**Enrol today**

**Connect 2015**

More inspiring and informative than ever before.  
To enrol now, visit [www.acurity.co.nz/connect](http://www.acurity.co.nz/connect)

# Ophthalmology in Primary Practice... a few pearls

Continued from page 1

Dr John Beaumont



## 1 Take a good history

"What was the first event or symptom" is a useful start. If the examination is not making sense take the history again.

## 2 Record visual acuity

The best corrected acuity is recorded with contact lens, distance or progressive glasses when available. Check the testing distance on the chart 6, 4 or 3 metres. Record the testing distance over the smallest line of letters read, eg. 6/18. If the room is not long enough use a 6m chart at 3m distance and record 3/9 for the same patient. It is the fraction that remains constant. A pinhole overcomes defects of refraction and some media opacities. It indicates macular and optic nerve integrity and is invaluable.

## 3 The red reflex

Set the ophthalmoscope to zero and have the patient fix on it at arm's length. The pupil should be uniformly bright, (the colour may vary) and this indicates a clear optical path without cataract, corneal opacity, hyphaema or vitreous haemorrhage or extensive retinal detachment.

## 4 The Bruckner reflex

Is a most under used test and invaluable in paediatrics. It is the binocular red reflex and when equal both eyes are fixing and focussing on the target light. It excludes manifest strabismus, significant refractive errors and media opacity.

## 5 Afferent pupil defect

The swinging flash light test. Keep the torch on each pupil for equal intervals to avoid adaptation. An afferent pupil will dilate with the light (reduced direct reflex) and constrict when not lit (intact consensual reflex). It indicates significant loss of retinal and optic nerve function and is especially useful in central retinal artery occlusion, optic neuritis and optic nerve trauma.

## 6 The unilateral red eye

Covered well in every text book the following points may assist.

### Check the pupil:

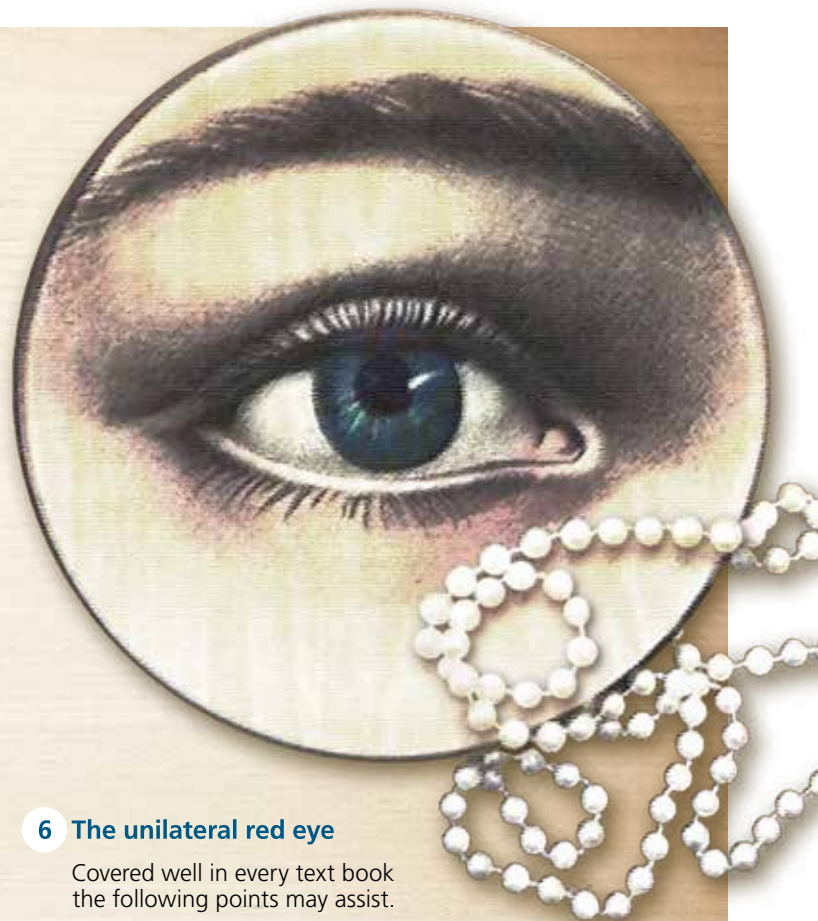
If smaller especially in dim light iritis is likely. When larger, especially in bright light, acute angle closure. Beware pre-existing conditions such as surgery or an Adie's pupil.

### Redness:

When limbal, this is corneal or anterior segment inflammation. When bulbar, think sub conjunctival haemorrhage or extensive infective conjunctivitis. When tarsal think viral for lower and chronic allergy for upper tarsal inflammation.

### Presentation:

Watery	> viral or possibly foreign body
Mucopurulent	> bacterial or dacryocystitis
Chronic (two weeks or more)	> think chlamydia.





# Ophthalmology in Primary Practice... a few pearls

Continued from page 3

Dr John Beaumont



## 7 The irritable red eye

### Scratchy or sandy – think dry eye:

Avoid lubricants with Benzalkonium chloride. QID should be the maximum otherwise further treatment is required. A useful sequence is from drops to gel to ointment at night. Think Sjogren's syndrome and refer those not successfully managed.

### Itchy – think allergy:

Treat with Lomide, Patanol and perhaps one or two weeks of Fluorometholone.

### Burning eyes:

Can indicate either or neither of the above and think refraction and optometric referral.

## 8 Chalazion is a granulomous inflammation of the meibomian gland

(A series of sebaceous glands within the tarsal plate). Antibiotics are ineffective. Treatment with local heat, time and incision with drainage if required. A chalazion that is large, discharging or in the upper lid and affecting vision, will benefit from incision and drainage.



The basic requirements are occluder and pinhole for visual acuity testing, ophthalmoscope and flashlight, and a knowledge of ocular anatomy.

## 9 The driver's licence visual standard

Remember the 6/12 acuity standard is bilateral. The visual field requirement is again bilateral and is 140 degrees without significant defects in the central 20 degrees. This includes homonymous hemianopia although even such cases have been successfully appealed. When in doubt refer for a binocular driver's field by automated perimetry. When visual acuity is less than 6/60 in an eye the patient is regarded as monocular and ineligible to gain Classes 2-5 but may retain them.

## 10 Corneal foreign body removal

A personal bête noir. A metallic corneal foreign body may be removed with the edge of a needle. A rust ring however cannot and a needle tip will lacerate but not remove it. It is best to refer a rust ring for removal with a burr at the slit lamp.

Enjoy your ophthalmology.

**"He who asks  
a question is a fool  
for a minute, he who  
does not ask, remains  
a fool forever."**

Confucius

**Dr John Beaumont** is an ophthalmologist practicing at Royston Hospital, Hawke's Bay, with special interests in refractive cataract surgery and strabismus.  
E: [info@eyesurgeonshawkesbay.co.nz](mailto:info@eyesurgeonshawkesbay.co.nz)  
W: [www.eyesurgeonshawkesbay.co.nz](http://www.eyesurgeonshawkesbay.co.nz)

# Cardiac Catheterisation Laboratory

Wakefield Hospital

Area: Facilities Update



The new Artis Q Cath Lab at Wakefield Hospital is the first of its kind in New Zealand, providing next generation imaging for cardiology, vascular and radiology examinations with a very unique technology. At the heart of this new system is a high powered x-ray tube, and efficient detector system which drastically reduces radiation dose to the patient (and operator) by up to 60% compared to conventional imaging equipment.

This ground-breaking technology brings a new imaging performance, enabling the clinician to ultimately treat the patient faster, with more precision and with added confidence for enhanced patient outcomes. In the fight against one of the most threatening diseases such as coronary artery disease, Artis Q delivers innovative applications offering

precision for enhanced guidance during interventional procedures in cardiology. An example of this is the first ever real-time enhancement of coronary stents, called "CLEARstent Live"; effectively viewing the heart real-time without any motion! This creates added accuracy in the deployment of stents, lessening the potential of future patient complications.





# Radial is Preferred for Percutaneous Coronary Intervention

Wakefield Hospital

Area: Cardiology

Article by: Dr Anil Ranchord, Interventional Cardiologist, Wakefield Heart Centre, ph (04) 381 8115



Figure 1 TR Band

In contemporary practice the radial approach for Percutaneous Coronary Intervention (PCI) is preferred by most patients<sup>1</sup> and cardiologists in New Zealand. Patients who have undergone radial access prefer it in 90% of cases for their next procedure compared to 49% with femoral access.<sup>1</sup>

There are several reasons for this observation. The radial artery is superficial and is not associated with major nerves making access more comfortable. After the procedure haemostasis is rapidly achieved with a TR band (see figure 1), avoiding the need for uncomfortable groin compression. Patients can sit up immediately afterwards and early ambulation is possible. Reductions in nursing intensity are self-evident with this approach. Earlier return to work is also feasible as there are less concerns about lifting or straining causing bleeding. Finally, same day discharge is

more likely to be achieved for elective cases and is associated with the added benefit of improved cost effectiveness for hospitals.

Patient preference aside, trial data has demonstrated reduced access site complications and vascular bleeding compared to the femoral approach in the elective and acute setting. The benefit is most apparent in patients with ST elevation myocardial infarction (STEMI) where major vascular access site complications have been reduced by 65% and major bleeding by 49% with radial access.<sup>1</sup>

In the RIFLE-STEACS (Radial versus Femoral Randomised Investigation in ST Elevation Acute Coronary Syndrome) trial these benefits were associated with a reduction in 30 day mortality (9.2% vs. 5.2%,  $p = 0.020$ ).<sup>2</sup> Experienced operators can achieve these results with similar use of contrast and radiation dose compared to femoral procedures.

Patients with previous Coronary Artery Bypass Grafting often undergo angiography via femoral access, however radialists can achieve similar success via the left radial approach. The LIMA is readily accessible because it is "on route" and in fact the same catheters as from the femoral approach are often used. Furthermore, it is now possible to perform right heart studies from the arm using the brachial vein at the same time as

coronary angiography, thereby avoiding the leg altogether in many cases.

Radial access is by no means a panacea as there are unique challenges to using this approach. Radial artery spasm can be uncomfortable and variations in arterial anatomy including radial loops and a short aorta are challenges for the radialist to master. However, experienced operators will cross over to the femoral approach in less than five percent of cases. Radial artery spasm can usually be mitigated by attention to appropriate patient sedation, pre-treatment of the artery with intra-arterial nitrates or verapamil, by minimising catheter manipulation and patience. The advent of "slippery catheters" (the Eaucath) can often permit PCI even when spasm has occurred despite these measures.



Figure 2 Allen's Test

Techniques to overcome anatomical variations become familiar with experience.

There are, of course, times when the radial approach may not succeed, most often due to spasm or tortuosity, or when it should be avoided such as in renal patients who may require a fistula for dialysis and perhaps in patients who demonstrate poor ulnar artery flow when radial artery occlusion may cause hand ischemia. However, persistent radial artery occlusion is uncommon and usually asymptomatic. This can be minimised by attention to "patent haemostasis" techniques, where the minimum of pressure in the patients TR band is used for radial artery compression after the procedure.

Suitability for the radial approach can be assessed in the office by doing an Allen's test.

Ask your patient to make a fist and then apply digital pressure over the radial and ulnar arteries to occlude them (see figure 2). The patient then opens their hand, which should now appear blanched. Release the ulnar artery while keeping the radial occluded. The test is normal if colour returns to the hand in less than seven seconds. If it does not the patient may have impaired ulnar arterial flow, which means radial artery occlusion post procedure could cause hand ischaemia. These patients may not be suitable for a radial approach using this hand. Additional assessment using alternative techniques may be made by the cardiologist prior to angiography in these cases.

## References

- 1 Jolly SS, Yusuf S, Cairns J, et al. RIVAL trial group. Radial versus femoral access for coronary angiography and intervention in patients with acute coronary syndromes (RIVAL): a randomised, parallel group, multicentre trial. *Lancet* 2011; 23:377(9775):1409-20
- 2 Romagnoli E, Biondi-Zoccai G, Sciahbasi A, et al. Radial versus femoral randomised investigation in ST-segment elevation acute coronary syndrome: the RIFLE-STEACS (Radial Versus Femoral Randomised Investigation in ST-Elevation Acute Coronary Syndrome) study. *J Am Coll Cardiol* 2012; 18:60(24):2481-9.

In summary,  
radial PCI is safer,  
preferred by patients  
and in the setting of  
STEMI is associated with  
reduced mortality.

**Dr Ranchord** is an Interventional Cardiologist based at the Wakefield Heart Centre, Rintoul Street entrance, Newtown, Wellington.

P: (04) 381 8115  
F: (04) 381 8116  
E: heart@whc.co.nz



# Peripheral Neuropathy: From the Routine to the Extreme



Dr Jeremy Lanford

Wakefield Hospital

Area: Neurology  
Article written by: Dr Jeremy Lanford, Neurologist, ph (04) 381 8115



## A Red Flag Approach to Evaluating Peripheral Neuropathies

Peripheral neuropathy can be considered a grab bag diagnosis encompassing many different diseases, presentations, and treatments.

The prevalence of patients with a peripheral neuropathy being seen in a GP's office can be up to eight percent for those over 55 years of age. However, in the general community the prevalence is around two percent (see Table 1).

As you can see in Table 1, the aetiology of peripheral neuropathy is rather daunting. However, an easy approach can be made with most patients that present with symptoms of a peripheral neuropathy.

## Neuropathy Characterisation

For the evaluation of peripheral neuropathy we will consider a "red flag" system. When red flags are seen that likely indicates a rare or more concerning feature to the neuropathy and requires further specialist assessment. As with any new medical presentation a detailed history and examination is required in evaluating peripheral neuropathy. The focus will be on the what, where, when, and in what setting aspects of a peripheral neuropathy (see Table 2). Table 2 outlines the red flag features of a peripheral neuropathy.

### 2 Neuropathy Characterisation

Neuropathy Characterisation	Red Flags
"What" type of nerve fibre is involved?	<ul style="list-style-type: none"> <li>Motor (weakness)</li> <li>Autonomic (syncope)</li> <li>Large fibre (areflexia, proprioception and vibratory loss, sensory ataxia)</li> <li>Small Fiber (pain and temperature loss)</li> </ul>
"Where" is the nerve damage?	<ul style="list-style-type: none"> <li>Proximal</li> <li>Distal</li> <li>Asymmetric</li> <li>Symmetric</li> </ul>
"When" did the symptoms start?	<ul style="list-style-type: none"> <li>Acute</li> <li>Sub-acute</li> <li>Chronic</li> <li>Insidious</li> </ul>
In "What Setting" did the neuropathy occur?	<ul style="list-style-type: none"> <li>Weight loss</li> <li>Smoking</li> <li>Autoimmune Disease</li> <li>Bariatric Surgery</li> <li>Toxins/Medications</li> <li>Alcohol Use</li> <li>Family History</li> </ul>

Continued on page 13

### 1 Differential Diagnosis of Peripheral Neuropathy

Hereditary	Hereditary Charcot Marie Tooth Hereditary Sensory Neuropathy Adrenomyeloneuropathy
Metabolic	Diabetes Vitamin B12 deficiency Vitamin B1 deficiency Hypothyroidism Uremia Alcoholism Copper deficiency Medications
Infectious	HIV Hepatitis C Leprosy West Nile Virus
Neoplastic	Paraneoplastic Monoclonal Gamopathy of Undetermined Significance Multiple Myeloma
Immune	Guillane Barre Syndrome CIDP Sarcoid Connective Tissue Disorder Associated Amyloidosis

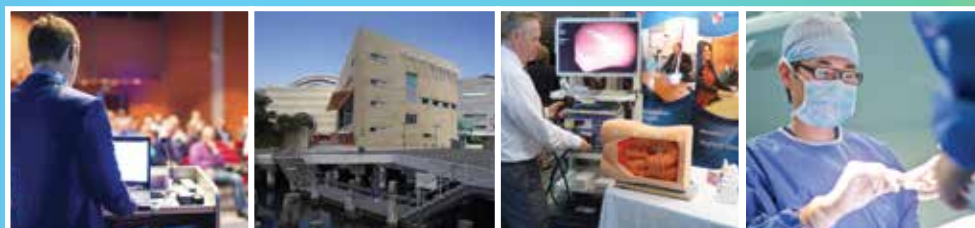


Conference  
programme  
enclosed.

Te Papa,  
8 & 9 May 2015

# Connect 2015

**Join the biggest annual conference for General Practitioners in the lower North Island. Connect with other GPs and be inspired by the latest techniques and technology. Engage with some of New Zealand's finest Specialists. The 'Connect 2015' GP Conference (brought to you by Acurity Health), will be an inspiring and informative event.**



## **Introduction From Acurity Health Group**

We are pleased to announce the 2015 Acurity Health GP Conference. Now in its 17<sup>th</sup> year, this exciting event (previously under the Wakefield banner) will return to Te Papa, on 8<sup>th</sup> and 9<sup>th</sup> May 2015. Presented by Wakefield and Bowen Hospital's in association with the Department of Primary Health Care and General Practice, University of Otago, Wellington, the 2015 conference has a new format, more speakers and a fast-paced, exciting programme highlighting what's new and relevant in clinical practice.

Designed around the theme "Connect", the programme promises to deliver an engaging and informative two days of workshops, lectures, discussions, quick fire presentations and opportunities to network with peers and

leading industry players, including some of New Zealand's finest surgical and medical specialists.

Invitations are open to all General Practitioners, Registrars, Registered Nurses and Practice Managers.

We look forward to welcoming you to our 2015 event. To register, go online to [acurity.co.nz/connect](http://acurity.co.nz/connect) or contact Sarah Malone on (04) 920 0158. Please also call Sarah if you have any questions about the conference.

Paul Quayle,  
Chief Operating  
Officer, Acurity  
Health Group Ltd

Sarah Malone,  
Business Development  
Manager, Acurity  
Health Group Ltd

**[www.acurity.co.nz/connect](http://www.acurity.co.nz/connect)**

# Programme

Connect  
2015

This year's programme covers – in depth – four relevant topics. Below is an outline of this programme. For more current information, please visit [www.acurity.co.nz/connect](http://www.acurity.co.nz/connect)

## Friday 8 May 2015 – Day One

0800 - 1730	Registration Desk Open
0845	<b>Official Conference Opening Remarks</b> Dr Ian England, Chief Executive, Acurity Health Group Ltd Dr Sue Pullon, University of Otago, Wellington
	<b>Cardiovascular Health</b>
0900	<b>Presentations</b> • Update in Structural Heart Disease <b>Adj. Professor Alex Sasse</b> , Cardiologist
0935	• EP Ablation <b>Dr Matthew Webber</b> Cardiologist/Electro-physiologist
1005	• EVAS – A New Way of Treating AAA <b>Mr Richard Evans</b> , Vascular and Transplant Surgeon
1035	Morning Tea and Exhibition
1115	<b>Concurrent Workshops</b> • Tackling Obesity – Principles and Practice <b>Lesley Gray</b> , University of Otago • Implementing ABC Alcohol (Practical Skills) <b>Dr Helen Moriarty</b> , University of Otago • Tackling Challenging Conversation <b>Sue Paton</b> , Health Promotion Agency <b>Dr Maria Stubbe</b> , University of Otago
1155	Workshops Repeated
1225	Lunch and Exhibition
	<b>Orthopaedics</b>
1325	Helping Your Patients Control Their Low Back Pain – Four Key Exercises <b>Rodney Ford</b> , TBI Health
1335	<b>Lightning Talks</b> • Shoulder Pain – A Working Guide <b>Mr Jon Cleary</b> , Orthopaedic Surgeon
1350	• Hips and Knees <b>Mr Gareth Coulter</b> , Orthopaedic Surgeon
1405	• What is “True” Sciatica <b>Mr Chris Hoffman</b> , TBI Health
1420	• Direct Access Carpal Tunnel Release Scheme <b>Professor Alan Thurston</b> , Orthopaedic Surgeon
1435	• Questions and Discussion
1450	Afternoon Tea and Exhibition
1520	<b>Concurrent Workshops</b> • Case Discussions <b>Mr Chris Hoffman</b> , TBI Health <b>Steven Livingston</b> , ACC Porirua Branch • The role of Hand Therapy Prior to Surgery <b>Matt Beal</b> , Hand Therapist, Hand Rehabilitation • Referral Pathways for Hip and Knee Replacements <b>Mr Grant Kiddle</b> , Orthopaedic Surgeon
1600	Workshops repeated
1640	<b>Keynotes Speaker</b> “Dream Big” The Three Foundations of Success <b>Sam Hazledine</b> Doctor, Entrepreneur, Athlete, Father
1730	<b>Networking Function</b> Hosted by Acurity Health Group Ltd

## Saturday 9 May 2015 – Day Two

0800 - 1600	Registration Desk Open
	<b>Oncology</b>
0900	<b>Presentations</b> • Patient Pathways and Information for GPs <b>Dr Anne O'Donnell</b> , Oncologist, Capital Coast & District Health Board (CCDHB)
0925	• PET CT Scans <b>Dr Trevor FitzJohn</b> , Pacific Radiology
1000	<b>Concurrent Workshops</b> • Brain Cancer <b>Mr Martin Hunn</b> , Neurosurgeon • Bladder Cancer Detection <b>Mr Rod Studd</b> , Urologist • GI Cancer <b>Dr Ian Wilson</b> , Gastroenterologist
1030	Morning Tea and Exhibition
1100	Workshops repeated
1140	<b>Presentations</b> • Technology in Medical Practice <b>Sanjeewa Samaraweera</b> , Medtech • Patient Portal in Primary Care (bringing our Practice into the 20 <sup>th</sup> Century). <b>Dr Richard Medicott</b> , GP, Island Bay Medical Centre
1205	Lunch and Exhibition
	<b>Women's Health</b>
1305	<b>Concurrent Workshops</b> • Pelvic Floor Dysfunction – What Can You Do About It? <b>Liz Childs</b> , Pelvic Health Physiotherapist • Fertility <b>Mr Simon McDowell</b> , Gynaecologist • Contraception / Implants <b>Dr Sandy Morris and Dr Beth Messenger</b> , Family Planning Association
1340	Workshops repeated
1415	<b>Presentation</b> • The Role of Imaging in Staging Gynaecological Cancer <b>Dr Mark Leadbitter</b> , Pacific Radiology
1435	<b>Lightning Talks</b> • Endometriosis – An Enigma <b>Mrs Hanifa Koya</b> , Gynaecologist
1445	• Overview of Vulvar Pruritus <b>Mr Fali Langdana</b> , Gynaecologist
1455	• Initial Workup for Prolapse and Incontinence <b>Mr Nick Bedford</b> , Gynaecologist
1505	• Panel Discussion
1525 - 1530	Close of Conference – final remarks

# Speakers

Connect  
2015

This year's conference includes an outstanding selection of speakers. Here are a few of them. For a more comprehensive list, please visit [www.acurity.co.nz/connect](http://www.acurity.co.nz/connect)

## Guest Speaker

### Dr Sam Hazledine

Doctor,  
Entrepreneur,  
Athlete, Father.



Young entrepreneur of the year recipient, best-selling author and GP Sam Hazledine will inspire you with his vision that anything is possible.

In his presentation *"Dream Big"* Sam will share what he sees as the three foundations of success in any endeavour, business or otherwise. He shows how it's possible for anyone to achieve great things when these are applied.

Audiences have described him as inspirational and motivational. Sam's version of success is real and relevant to anyone who knows there's more to life than where they are currently at.

"What would you do if you knew you ultimately couldn't fail? How big would you dare to dream?"

Dr Sam Hazledine

## Other Key Speakers Include:

### Cardiovascular Health

**Adj. Prof. Alex Sasse**  
Update in Structural Heart Disease



**Dr Matthew Webber**  
EP Ablation



**Mr Richard Evans**  
EVAS – A New Way of Treating AAA



### Orthopaedics

**Mr Grant Kiddle**  
Referral Pathways for Hip and Knee Replacements



**Mr Chris Hoffman**  
Case Discussions



**Prof. Alan Thurston**  
Direct Access Carpal Tunnel Release Scheme



### Oncology

**Dr Trevor FitzJohn**  
PET CT Scans



**Mr Rod Studd**  
Bladder Cancer Detection



**Mr Martin Hunn**  
Brain Cancer



### Women's Health

**Mrs Hanifa Koya**  
Endometriosis – An Enigma



**Mr Fali Langdana**  
Overview of Vulvar Pruritus



**Mr Nick Bedford**  
Initial Workup for Prolapse and Incontinence





# Registration details

# Connect 2015

## Registration fees

		Both days	One day
GPs:	Before 31 March (Earlybird discount.) You could also win your fee back!	\$480	\$300
	After 31 March (Standard)	\$540	\$340
Nurses:	Before 31 March (Earlybird discount.) You could also win your fee back!	\$200	
	After 31 March (Standard)	\$250	

## How to register

- Online: [www.acurity.co.nz/connect](http://www.acurity.co.nz/connect)
  - Email: [connect@acurity.co.nz](mailto:connect@acurity.co.nz) (we will contact you)
  - Fax: Fax your contact details to 04 3818102, with the subject: 'Connect'
- Questions – please call Sarah Malone on 04 920 0158.



Register today  
Hurry – the Earlybird  
discount ends soon

Presented by //



In association with //

THE DEPARTMENT OF PRIMARY  
HEALTH CARE AND GENERAL PRACTICE,  
UNIVERSITY OF OTAGO, WELLINGTON

POSTGRADUATE STUDIES



WELLINGTON

We gratefully acknowledge the support of our sponsors //

GOLD SPONSORS



SILVER SPONSORS



LANYARD SPONSOR



TEA BREAK SPONSOR




# Peripheral Neuropathy: From the Routine to the Extreme

Continued from page 8

Dr Jeremy Lanford



## Evaluation of Peripheral Neuropathy

 In the absence of red flags you are left with a chronic distal symmetric, primarily sensory painful neuropathy. There is typically a metabolic cause for the neuropathy which requires only a few simple tests. The highest yield laboratory evaluations include a fasting glucose or two hour glucose tolerance test, vitamin B12 level, and serum protein electrophoresis. In particular though, a two hour glucose tolerance test may be of a much higher yield as it has been shown to identify an abnormality in 25-36% of patients who had previously been diagnosed as having an idiopathic neuropathy based on a normal HgA1C (see Table 3).

### 3 Peripheral Neuropathy Evaluation

#### Routine Evaluation

Complete Blood Count

Comprehensive Metabolic Panel

TSH

Vitamin B12

Fasting Glucose (two hour glucose tolerance if negative)

Serum Protein Electrophoresis

\*Ask About Alcohol\*

## A Word on Electrodiagnostic Testing

Nerve conduction tests are commonly ordered and used to evaluate peripheral neuropathies. The study can help to determine the fibre type involved, type of nerve injury (demyelinating versus axonal), severity of the nerve injury and distribution (distal symmetric). However, the study is limited by only being able to evaluate large fibres. In the setting of a distal symmetric small fibre neuropathy the study will be normal. This is a key point as a normal study doesn't necessarily rule out the presence of a neuropathy.

## Symptomatic Treatment of Neuropathic Pain

Despite identifying and even treating common causes of peripheral neuropathy many patients are still left with neuropathic pain. Treatment of neuropathic pain is rather limited and discussing realistic expectations with your patients is essential as many have very unrealistic goals. When generalising the results from diabetic neuropathic pain trials the efficacy of common medications used in reducing neuropathic pain range from 11-63% reduction in pain compared to placebo (see Table 4). This is far from the perception that many patients have of becoming pain free on these medications.

### 4 Medication Management of Neuropathic Pain

#### Common Medications to Treat Neuropathic Pain

Medication	Dose Range	Pain Reduction
Gabapentin	900-3600 mg/d	11%
Amitriptyline	25-100 mg/d	20-63%
Venlafaxine	75-225 mg/d	18-23%
Sodium Valproate	500-1200 mg/d	27-30%

### Summary

1. Characterise the neuropathy using the what, where, when, and in what setting approach
2. In the absence of red flags a simplified evaluation is all that is needed
3. Keep realistic goals with your patients when treating neuropathic pain.

### References

- 1 Martyn CN, Hughes RAC. Epidemiology of Peripheral Neuropathy. Journal of Neurology, Neurosurgery, and Psychiatry. 1997; 62:310-318
- 2 Burns J, Mauermann M, Burns T. An Easy Approach To Evaluating Peripheral Neuropathy. The Journal of Family Practice. 2006 Vol 55. No 10. 853-861
- 3 England JD, Gronseth GS, Franklin G et al. Practice Parameter: Evaluation of Distal Symmetric Polyneuropathy: Role of Laboratory and Genetic Testing (an evidence-based review). Neurology. 2009; 72:185-192
- 4 Bril V, England J, Backonja M et al. Evidence-Based Guideline: Treatment of Painful Diabetic Neuropathy. Neurology. 2011; 76:1758-1765.

**Dr Lanford** is a consultant neurologist and is based at the Wakefield Heart Centre, Rintoul Street entrance, Newtown, Wellington.

P: (04) 381 8115  
F: (04) 381 8116  
E: heart@whc.co.nz



# How to do an Endofascial Axillary Lymphadenectomy

King B, Meredith I. How to do an endofascial axillary lymphadenectomy. *ANZ J.Surg.* 2015; 85: 85

Bowen Hospital

Area: General Surgery

Article written by: Mr Burton King, Breast and General Surgeon, ph (04) 891 0575

Axillary lymph node dissection remains a standard part of the operative management of breast cancer for women with clinically or histologically positive axillae. There are several published descriptions of the axillary dissection, perhaps the most comprehensive being that of Ung *et al.* in 2006.<sup>1</sup> Our intent is to perform a level two dissection and the technique is similar to that of Ung *et al.*, except that the anterior laminae of the clavipectoral fascia (CPF) are preserved and reconstituted.

The average patient age was 58 years (38–77,  $n = 18$ ), an average of 16 nodes were procured (6–26) and two patients required aspiration of axillary seromas and 11 out of 18 patients had positive nodes (range 1–11).

We have previously described the laminated, three-dimensional structure of the CPF that is evident during axillary insonation and dissection.<sup>2</sup> Using this procedure, we have dispensed with axillary drains and only a minority of our patients required axillary seroma aspiration. Following mastectomy or breast conservation surgery, the lateral border of pectoralis major is defined. Here, the medial, anterior lamina of the CPF is identified but not incised. Once the anterior extent of the CPF is displayed, a longitudinal incision is made through the midpoint of the CPF to access the axillary contents. If there is a substantial axillary tail, then the CPF is incised along the perimeter of the tail to include intra-breast lymph nodes. A loose areola tissue plane is encountered; the edges of the CPF are grasped and

elevated and this areola tissue plane developed by blunt and sharp dissection. Medially, this loose areola tissue plane leads directly to a posterior gutter, and the long thoracic nerve on serratus anterior is identified and preserved (Figure 1b).

Superiorly, a deeper lamina of the CPF along the inferior border of the axillary vein has to be incised to find the thoracodorsal nerve. Identification of the intercostobrachial nerves is standard, as is the lateral dissection. Identification of the long thoracic nerve and thoracodorsal bundle results in definition of a vertical sheet, 'the interneural tissue'. This can be grasped between the thumb and index finger. This tissue contains fat, lymph nodes and lymphatic vessels and is lined by thin fascial layers that we consider related to the CPF (Figure 1a).

At this stage, the anterior laminae of the CPF and axilla are carefully palpated for any residual nodes. After haemostasis, the CPF is reconstituted with a running, absorbable 'lymphostatic' suture. No drain is placed in the axilla.

The pathogenesis of seroma formation continues to be poorly understood,<sup>3,4</sup> although it seems that the greater the surgical disruption of the axilla, the higher the incidence of seroma and lymphoedema.<sup>3</sup> It is possible that apart from reducing dead space, reconstituting the CPF may partially restore pressure gradients and facilitate collateralisation to improve lymphatic flow. This 'minimal access' approach to the axilla would also be useful in segregating an axillary seroma from an implant reconstruction and the loculated seroma can be aspirated under ultrasound guidance.

We believe this technique should be given consideration to avoid axillary drains and may reduce the incidence and volume of seroma following axillary dissection.

## References

- 1 Ung O, Tan M, Chua B, Barraclough B. Complete axillary dissection: a technique that still has relevance in contemporary management of breast cancer. *ANZ J. Surg.* 2006; **76**: 518–21
- 2 King B, Shortis A. Functional axillary anatomy: time for a new look at the clavipectoral fascia? *ANZ J. Surg.* 2012; **82**: 576–7
- 3 van Bommel AJ, van de Velde CJ, Schmitz RF, Liefers GJ. Prevention of seroma formation after axillary dissection in breast cancer: a systematic review. *Eur. J. Surg. Oncol.* 2011; **37**: 829–35
- 4 Kuroi K, Shimozuma K, Taguchi T *et al.* Pathophysiology of seroma in breast cancer. *Breast Cancer* 2005; **12**: 288–93.

**Mr King** is a Breast and General Surgeon who is based at the Breast Centre, at Bowen Hospital in Crofton Downs, Wellington.

Mr King has a special interest in breast cancer and breast ultrasound. He has published papers in Breast Surgery and Anatomy.

He is also a Major in the Royal New Zealand Army Medical Corps and an examiner for the Royal Australasian College of Surgeons.



## The Breast Centre

Level B1, Bowen Centre,  
98 Churchill Drive, Crofton  
Downs, Wellington  
P: (04) 891 0575  
F: (04) 891 0577  
E: [info@thebreastcentre.org.nz](mailto:info@thebreastcentre.org.nz)





**Figure 1 (a-b)**  
Photographs depicting  
endofascial axillary  
lymphadenectomy

- a** long thoracic nerve;
- b** thoracodorsal bundle; and
- c** cut edge of interneural tissue.

### Endofascial Axillary Lymphadenectomy – towards a “drain-less” protocol.

Axillary lymph node dissection is still an important part of breast cancer management. It has become less necessary in the era of sentinel node biopsy and following the Z11 trial, axillary lymph node dissection is not always required even for micrometastases found in sentinel nodes. However, there is still a place for the axillary dissection in the local control of breast cancer.

The traditional way of performing an axillary dissection involves the use of a drain to the axilla. This is an uncomfortable appliance, disliked by patients. It requires nursing supervision for emptying and increases the risk of wound infection. At The Breast Centre we have refined the axillary dissection procedure to preserve the clavipectoral axillary fascia. This is sewn back together after surgery and no drain is needed. As small number of patients require ultrasound guided aspiration of the accumulated postoperative axillary seroma but the majority do not. In this way we have dispensed with axillary drains and improved our patients quality of life.

The rationale for the endofascial axillary lymphadenectomy has also been described from The Breast Centre. We have noted that the axillary fascia is a complex three dimensional structure. It makes sense to reduce the surgical impact and damage on the axillary mechanism. It seems to have benefit for reducing seromas and overall patient satisfaction.

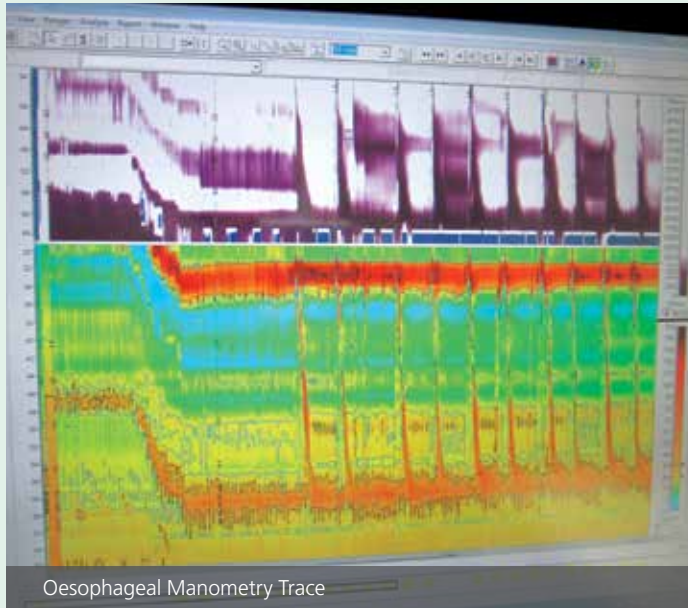
King, B. and Shortis, A. (2012), Functional axillary anatomy: time for a new look at the clavipectoral fascia? *ANZ Journal of Surgery*, 82: 576–577. doi: 10.1111/j.1445-2197.2012.06162

# Nursing in the Endoscopy Unit

Wakefield Hospital

Area: Procedures Update

Article written by: Marie Verschoor, Clinical Charge Nurse Endoscopy



Traditionally the role of the nurse in the Endoscopy unit was to support the patient and assist the Endoscopists, making sure the bowel prep is good and the equipment is at the ready. **Over the past 10 years the role of the endoscopy nurse has changed.** There is much discussion on the role of nurse endoscopists and these positions are common in the UK and Australia. We now have specialist nursing roles within Gastroenterology, Inflammatory Bowel Disease nurses, Irritable Bowel Disease nurses etc. In our unit here at Wakefield Hospital we have nurses taking on many roles traditionally done by the Gastroenterologist.

## Oesophageal Motility Studies

We have recently upgraded our Oesophageal Manometry studies equipment to the Sandhill High Resolution Impedance Manometry. This allows us to observe bolus transit and muscular activity to accurately assess oesophageal function in one simple swallow test.

## 24hr pH Test

Our new ZepHr® Impedance/pH Reflux Monitoring System allows us to detect all reflux activity over a 24 hour period and categorise each episode as acid or non acid.

Currently we have two nurses being trained in these procedures under the supervision of Dr Ian Wilson, Gastroenterologist. They are learning to pass and position the manometry and 24hr pH catheters and carry

out the assessment with the aim of eventually doing this test independently.

## Hydrogen Breath Testing

This test is used for the diagnosis of mal absorption of certain sugars, bacterial overgrowth and measuring gastric transit time. In humans, only bacteria – specifically, anaerobic bacteria in the colon – are capable of producing hydrogen. The bacteria produce hydrogen when they are exposed to unabsorbed food, particularly sugars and carbohydrates, not proteins or fats. Although limited hydrogen is produced from the small amounts of unabsorbed food that normally reach the colon, large amounts of hydrogen may be produced when there is a problem with the digestion or absorption of food in the small intestine, that allows more unabsorbed food to reach the colon.



# New Consultant

Wakefield Hospital



**Dr Matthew Webber**

FRACP MBChB

**Cardiologist/  
Electrophysiologist**

P: (04) 381 8115

F: (04) 381 8116

E: heart@whc.co.nz

Matthew is a Cardiologist/  
Electrophysiologist  
practicing at the Wakefield  
Heart Centre, Rintoul Street,  
Newtown, Wellington.

## Specialty

Cardiology/Electrophysiology

## Training

- Electrophysiology fellowships in Waikato 2011 – 2012, Liverpool (UK) 2013 – 2014.
- Cardiology physician training in Wellington (2006 – 2010).
- Matthew undertook his earlier training in Dunedin and Christchurch.

## Special interests

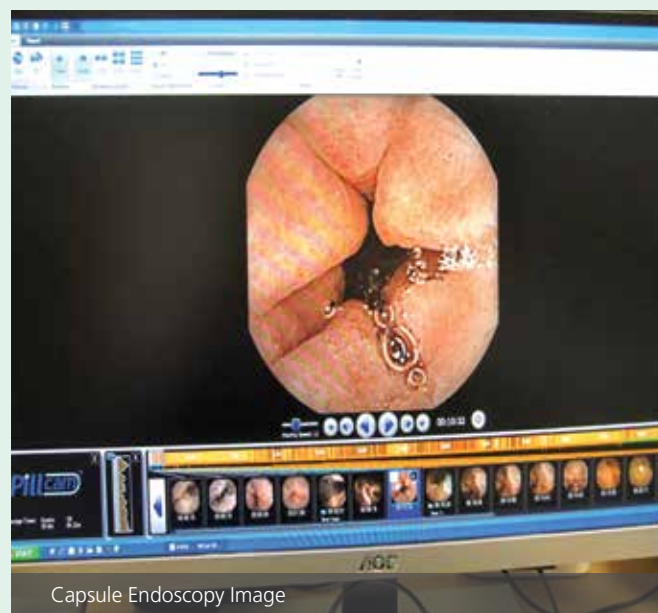
Specialist in cardiac rhythm disturbances including ablation and cardiac pacemaker/defibrillator implantation.

## Background

Matthew had a rural upbringing in the North Island. He is a keen outdoorsman with a particular passion for cycling and hiking.



Breath Test Analyser



Capsule Endoscopy Image

## The Nurses Role

A base line breath sample is taken before the patient is given a challenge dose of the sugar (lactose fructose or sucrose). Lactulose is given when testing for bacterial overgrowth or intestinal transit time.

Breath samples are taken at regular intervals over the next four hours and analysed in the Quintron Breath Analyser. The results are charted and then reported on by the Gastroenterologist.

## Capsule Endoscopy

We have now been doing Capsule Endoscopy (CE) at Wakefield Hospital for 14 years and in that time we have done almost 500 studies. The most common indications for CE is suspected Crohn's disease of the small bowel, iron deficiency

anaemia and obscure bleeding (either overt or occult) not detected by upper and lower endoscopy. The patient must have had a gastroscopy and colonoscopy prior to the capsule endoscopy. The analysis and reporting is done by Dr Wilson and Dr David Edge, Gastroenterologist, but the procedure of setting up the equipment, administering the capsule and monitoring the patient during the day is done by the Endoscopy nurse.

In capsule endoscopy, the small bowel can be viewed through the use of a small camera capsule. The patient is fitted with a sensor belt which is attached to a data recorder. The capsule which takes five images per second is swallowed by the patient. Images are recorded via the sensor belt to the data recorder. The patient can go about their normal

day and return to the unit after eight hours. With a real time viewer the nurse can check if the capsule has reached the large bowel, if so the equipment is removed from the patient and the data is downloaded to the computer. This can take up to three hours. The nurse will check the study the following morning and alert the consultant if urgent reporting is required.

Wakefield Hospital  
Endoscopy Suite, Level 3  
P: (04) 381 8696  
F: (04) 381 8698  
E: Endoscopy@wakefield.co.nz



# Specialist updates



March 2015

Dear General Practitioners

**Dr Richard Carroll**  
MBChB, FRACP

**Endocrinologist now consulting at Wakefield Specialist Medical Centre.**

I am pleased to welcome Dr Richard Carroll to our specialist team at Wakefield. Richard qualified in medicine in 2003 and completed the Endocrinology FRACP Training Programme in New Zealand. He is available to see patients with any endocrine condition.

His special clinical interests are:

- Pituitary tumours and dysfunction
- Neuroendocrine tumours of the pancreas and gastrointestinal tract
- Inheritable endocrine syndromes
- Disorders of the thyroid and adrenal glands
- Endocrine disorders in pregnancy, with a special interest in gestational thyroid dysfunction
- Medical investigation and management of obesity
- Diabetes
- Other general endocrine conditions including disorders of calcium and sodium, metabolic bone disorders including osteoporosis, polycystic ovary syndrome and other menstrual disorders.

Richard is a Fellow of the Royal Australasian College of Physicians, and a member of the New Zealand Endocrine Society (NZSE) and the New Zealand Society for the Study of Diabetes (NZSSD).

**As well as consulting at Wakefield Specialist Medical Centre in Newtown, Richard will have monthly clinics in Waikanae and Masterton.**

For all appointments and enquiries please see contact details at the bottom of this letter or alternatively use our EDI Healthlink: **wakespec**.

Yours sincerely

Marg Jenner  
Practice Manager



March 2015

Dear General Practitioners

I have opened a new eye surgery clinic at the Bowen Centre. Bowen Eye Clinic will offer a comprehensive eye care service including diagnosis and treatment for cataracts, keratoconus, corneal disease, pterygium and refractive laser eye surgery.

Patients will have access to laser eye surgery as a day procedure with the latest FDA approved excimer and femtosecond lasers.

I will continue to consult at clinics in Waikanae, Palmerston North and Nelson.

My telephone, fax and email addresses have changed. For referrals please use the new details listed below.

Ph: (04) 464 0003 or 0800 69 20 20  
F: (04) 464 0004  
E: [info@boweneye.co.nz](mailto:info@boweneye.co.nz)  
W: [boweneye.co.nz](http://boweneye.co.nz)

Bowen Eye Clinic, Bowen Centre, 94 Churchill Drive, Crofton Downs, Wellington 6035.

Thank you for your support.

Regards

**Reece Hall**  
Ophthalmologist

# Hawke's Bay Health Awards 2014

Royston Hospital

By Denise Primrose  
Royston General Manager



Royston Hospital has been delighted to support the Hawke's Bay Health Awards for the past four years.

The Royston Hospital Supreme Award Winner for 2014 was presented by Royston Hospital General Manager, Denise Primrose, to Hawke's Bay DHB's Chief Pharmacist Billy Allan and the Clinical Pharmacist Team. The winning entry was a partnership between primary and secondary health providers and was celebrated at a gala event at the Napier War

Memorial Conference Centre in November 2014.

DHB Health Awards attracted significant entries from throughout Hawke's Bay's primary and secondary health care settings. Eight award category winners were selected with all eligible for the Royston Hospital Supreme award.

Images courtesy of the Hawke's Bay District Health Board.



Reece Hall

# Contact Us



# Connect 2015

Enrol  
today

**More inspiring and informative than ever before.**  
Te Papa, Wellington // 8 & 9 May 2015 // [www.acurity.co.nz/connect](http://www.acurity.co.nz/connect)

