

# Health Matters

## Mirena – Horror Device or Miracle Cure



Wakefield  
Hospital

Gynaecology

Mr Simon McDowell & Mr Nick Bedford,  
Gynaecologists, ph (04) 381 8120

"My body rejected the  
Mirena, and I started  
having contractions"



Pharmac failure to fund  
effective contraceptive  
'embarrassing'

"I will never forget  
the absolute torture  
I have experienced"



"Vomiting, weight gain  
and immense pain"

*Continued on p3*

### What's inside

Mirena – Horror Device or  
Miracle Cure > 3

Message from Acurity Health > 2

Colon and Rectal Cancers  
– Pre and Post-Operative  
Treatment Pathways > 5

Clinical Diagnosis of Carpal  
Tunnel Syndrome > 10

Connect 2019 > 11

Paediatric Surgery and Paediatric  
Urology at Wakefield > 14

Reducing the Morbidity > 15

Cervical and Lumbar Disc  
Replacements. Maintaining  
Mobility in the Spine > 16

Endorsed CPD Activities > 17

New Consultants > 18

Contact Us > 20

Health Matters articles  
next to this symbol,  
qualify for CPD credits.  
Full details on page 17



**BOWEN**  
HOSPITAL

**ROYSTON**  
HOSPITAL

**WAKEFIELD**  
HOSPITAL

### Clinical Diagnosis of Carpal Tunnel Syndrome

Mr Justin Chou > 10



### Cervical and Lumbar Disc Replacements

Maintaining Mobility in the  
Spine. Mr Austin Enright > 16




### Paediatric Surgery & Paediatric Urology at Wakefield


Mr Brendon Bowkett  
> 14



# Message from Acurity Health

 Acurity Health

 Dr Jonathan Coleman, Chief Executive Officer

 (04) 920 0131

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



**June has seen exciting progress in the Wakefield redevelopment, with the turning of the sod ceremony for the new hospital. Wellington Mayor Justin Lester was on hand with a spade to assist, and there are now very real signs of construction activity on the site.**

In just over 18 months' time your patients will be seeing specialists and having their investigations in the brand new Wakefield consulting suites as Stage one is completed. Shortly after, work will commence on Stage two, consisting of the ward and perioperative block. In three years' time we will have the most modern private hospital in New Zealand, completed to the highest environmental and building standards.

At the same time the redevelopment of Royston hospital in Hastings is progressing with a new layout that enables better patient flow, and additional operating theatres to better meet patient demand as pressure grows on the DHB facility.

We are also opening our new private mental health facility in Auckland in September. This will be a first for New Zealand – a private day clinic with extensive day programmes aimed at those with mild/moderate disorders

who are currently not well catered for in the public system. It is located in Nicholls Lane, on the site of the old Carlaw Park in Auckland, and will be a state-of-the-art facility providing evidence-based treatment.

Every patient will be under a supervising psychiatrist and will have access to a full range of ancillary treatments including art therapy, yoga and physical activity, to complement their treatment and the group programmes available

to them. We will also be offering Transcranial Magnetic Stimulation (TMS), an evidence-based treatment which is only just starting to emerge in NZ.

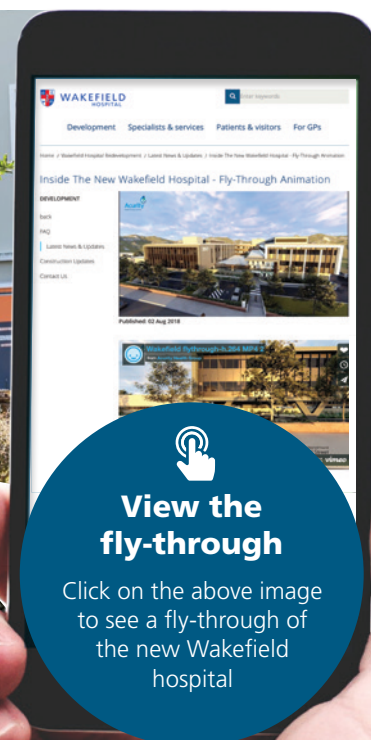
As you can see, Acurity is continually investing in facilities and services; we are committed to the continued evolution of the range of treatment options for you and your patients.



**Dr Jonathan Coleman**  
Chief Executive Officer  
Acurity Health Group Limited



Marg Jenner, GM Wakefield Hospital, Dr Jonathan Coleman, CEO of Acurity Health Group, and His Worship the Mayor of Wellington Justin Lester turned the sod at Wakefield hospital on Wednesday 19 June, marking the start of construction.





# Mirena – Horror Device or Miracle Cure

Mr Simon McDowell  
& Mr Nick Bedford



Wakefield Hospital Gynaecology

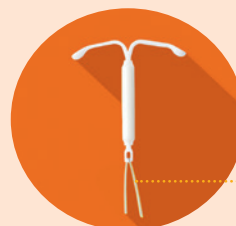
Mr Simon McDowell &  
Mr Nick Bedford, Gynaecologists

(04) 381 8120

www.wakefield.co.nz

**2018 yielded a number of emotive headlines regarding the Mirena intrauterine device. Is Mirena an aggressively-marketed and over-hyped uterine nic-nac, or god's gift to aging uteri?**

**What is the Mirena?** It is a T-shaped plastic device that sits inside the uterus (an IUD). It measures 32 x 33mm, with two blue strings attached to its base. The stem contains 52mg of Levonorgestrel. 20mcg is released every day, which gradually declines to 10mcg per day at five years. The manufacturers consider the lifespan of a Mirena to be five years.



The stem contains 52mg of Levonorgestrel

Lifespan = 5 Years

**Mirena nightmare – "I will never forget the absolute torture I have experienced"<sup>5</sup>**  
(Stuff, Oct 4, 2018)

This was an arresting headline from Stuff last year. In this case the author had a Mirena placed to help with dysmenorrhoea. The most common indications are heavy and/or prolonged menstrual bleeding, and contraception. Mirena is fully funded by Pharmac for women with anaemia (Hb <120g/L and/or ferritin <16mcg/L) related to abnormal uterine bleeding and who either cannot tolerate oral medications, or where oral medications are unsuccessful. It is less successful in our experience for irregular bleeding or spotting, as many women will experience this side effect after placement. However, up to 20% of women will have amenorrhoea (no periods at all) which for many will be a welcome effect. Studies show a 71 to 95% reduction in the amount of bleeding, which is similar to the effect of an endometrial ablation.

At a population level, Mirena is the most cost-effective solution compared to oral therapies, endometrial ablation or hysterectomy. In selected cases it may be used to treat endometrial hyperplasia or endometrial malignancy. It has been shown to reduce dysmenorrhoea including in women after endometriosis resection. The evidence regarding lowered recurrence of endometriosis is extremely weak. Mirena is a very effective contraceptive. Studies show that the chances of pregnancy are similar to a sterilisation procedure, and at 10 years after sterilisation Mirena is more effective overall.

Anxiety, depression, low libido, headache and breast tenderness are reported in around 5% of users. An abrupt change in mood after insertion should be carefully evaluated. It is interesting in this case that the anxiety was so sudden and several months after placement.<sup>5</sup> We have seen women in whom their anxiety took many months to be attributed to the Mirena, and resolved after removal. An index of suspicion should be maintained.

**Endometriosis: My body rejected the Mirena, and I started having contractions<sup>6</sup>**  
(Stuff, May 10, 2018)

Expulsion of Mirena is a documented issue; all practitioners who insert Mirena will have had a number of patients with this problem. Literature quotes a 3 to 6% expulsion rate in the first year of use. It is uncommon for Mirena to be expelled after the first year. Expulsion appears to occur more commonly in women with very heavy menstrual bleeding,

postpartum, and those with severe dysmenorrhoea.

Symptoms indicating potential expulsion of Mirena include new cramping, vaginal discharge and bleeding. Many women are not aware it has been expelled; this seems to occur in those women with passage of large clots.

If a woman has had one Mirena expelled, the risk of a further one being expelled is 14%. Placing the Mirena using ultrasound guidance (to check it is at the fundus) may be of help to ensure correct positioning. We routinely perform a trans-vaginal ultrasound following Mirena insertion to confirm correct positioning.



**My Mirena 'miracle':  
Vomiting, weight gain  
and immense pain?**

(Stuff, Dec 14, 2018)

Annoying bleeding is the most common problem after a Mirena insertion. Most women will have some spotting or bleeding in the first few weeks. Irregular bleeding and cramping may continue for up to three to six months, and can be prolonged in up to 59%. Twenty-three to thirty-one percent may have occasional spotting. Women are encouraged when possible to give a Mirena some time to see if these symptoms settle. Women will need support and reassurance.

As with most contraceptives, there is often a 'trade-off' – if their regular period is steadily becoming lighter and less painful, hopefully they can 'put up with' the irregular light bleeding. In most cases this will eventually settle. In women where irregular/unscheduled bleeding persists, options can include some supplemental oestrogen, or a course of Doxycycline, which has endometrial repair effects. We are happy to discuss such patients and strategies.

Other complications include infection, lost strings, pelvic inflammatory disease (including with *Actinomyces* species) and perforation of the uterus during insertion.

Hormonal side effects are far less common than orally ingested hormones. Systemic hormone levels are 20% of measured levels in women using oral contraceptives. Most women have no hormonal side effects, but there is a wide range of patient experience. This may be due to quite variable binding and clearance of the many metabolites. There is no evidence to prove an increase in weight post Mirena insertion; there are likely confounding factors.

Some women are very sensitive to hormones, and Mirena-related complaints include acne, headache, nausea, mood disturbance and hirsutism. Women should be listened to, and their issues dealt through reassurance and finding an agreed approach.

**Pharmac failure to fund  
effective contraceptive  
'embarrassing'**

(Stuff, Apr 27, 2019)

This headline is contrary to the other headlines in this article. The doctors at Aceso Health very much agree that a Mirena should be fully funded in New Zealand. It is an excellent contraceptive, is rapidly reversible, and is an effective treatment for menstrual disturbance, especially heavy bleeding. Where hysterectomy used to be the only option for women with abnormal uterine bleeding, treatments such as Mirena and endometrial ablation have introduced cost-effective and minimally invasive alternatives.

Currently the cost is prohibitive for many women, unless they happen to qualify as outlined earlier. There is no funding for use for dysmenorrhoea or treatment of suspected or proven endometriosis, although DHBs may provide this as a treatment option. Replacement can become a burden on the hospital clinics, and some patients may not get a further device via the public system. Insurance companies may not cover the full cost, and don't usually cover the device if placed solely for contraception. All of this introduces uncertainty for women and practitioners. The benefits of long-acting, reversible contraceptives are clear however, and are tangibly evident in our falling termination of pregnancy rates.

**"Mirena is like any other  
medication or device:  
it is imperfect, but in most  
cases the benefits outweigh  
the adverse effects."**

Mr Simon McDowell & Mr Nick Bedford

Miracle  
Cure?

Horror  
Device?



P: (04) 381 8120  
F: (04) 381 8121  
E: specialists@wakefield.co.nz

aceso health  
COMPREHENSIVE WOMEN'S CARE

### Summary

Mirena has been extensively studied and is not over-hyped. In our experience most women are satisfied with the Mirena. Many of us will be able to think of a woman initially anxious regarding having a Mirena, but then 'singing its praises' six months later. In saying that, a Mirena is not for everyone. Some women will have significant problems, intolerable side effects, and debilitating hormonal symptoms. Mirena is like any other medication or device: it is imperfect, but in most cases the benefits outweigh the adverse effects.

### References

1. Vercellini, P., Frontino, G., De Giorgini O., et al. (2003). Comparison of a levonorgestrel-releasing intrauterine device versus expectant management after conservation surgery for symptomatic endometriosis: a pilot study. *Fert Steril*, 80(2), 305-9
2. Bayoglu, Y., Dilbaz, B., Altinbas, S., et al. (2011). Postoperative medical treatment of chronic pelvic pain related to severe endometriosis: levonorgestrel-releasing intrauterine system versus gonadotropin-releasing hormone analogue. *Fertil Steril*, 95(2), 492-6
3. Aoun, J., Dines, VA., Stovall, DW., et al. (2014). Effects of age, parity, and device type on complications and discontinuation of intrauterine devices. *Obstet Gynecol*, 123(3), 585-92
4. Lethaby, A., Hussain, M., Rishworth, JR., & Rees, MC. (2015). Progesterone or progestogen-releasing intrauterine systems for heavy menstrual bleeding. *Cochrane Database of Systematic Reviews*, Issue 4. Art. No: CD002126. DOI: 10.1002/14651858.CD002126.pub3
5. Ward, B. (2018, October 4). Mirena nightmare: 'I will never forget the absolute torture I have experienced'. *Stuff*. Retrieved from <https://www.stuff.co.nz>
6. Name Withheld. (2018, May 10). Endometriosis: My body rejected the Mirena, and I started having contractions. *Stuff*. Retrieved from <https://www.stuff.co.nz>
7. Name Withheld. (2018, December 14). My Mirena 'miracle': Vomiting, weight gain and immense pain. *Stuff*. Retrieved from <https://www.stuff.co.nz>
8. Broughton, C. (2019, April 27). Pharmac failure to fund effective contraceptive 'embarrassing'. *Stuff*. Retrieved from <https://www.stuff.co.nz>

# Colon and Rectal Cancers

## Pre and Post-Operative Treatment Pathways

Mr Ali Shekouh



Bowen Hospital  
Wakefield Hospital

General Surgery,  
Endoscopy

Mr Ali Shekouh, General  
Surgeon, Endoscopist

(04) 479 8261

[www.bowen.co.nz](http://www.bowen.co.nz)  
[www.wakefield.co.nz](http://www.wakefield.co.nz)

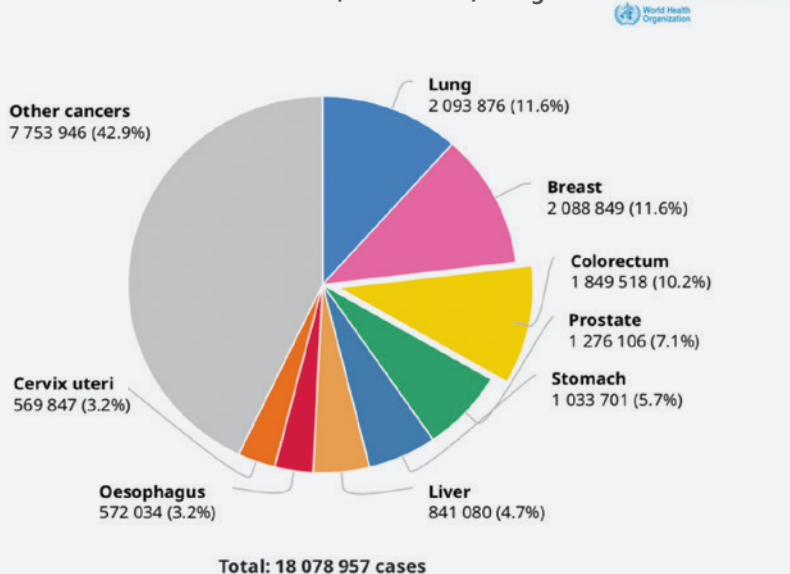
In the 2018 World Health Organization (WHO) published data, colorectal cancer accounts for 10.2% of the number of new cancer cases reported and is responsible for 9.2% of all worldwide cancer deaths (Figure ①)<sup>1</sup>. New Zealand has one of the highest incidences of colorectal cancer worldwide<sup>2,3</sup> compared to some other Western countries such as the United Kingdom and the United States. Hence, knowledge of the treatment pathways for this cancer would aid in our understanding and management of patient care.

The location of the tumour, a colon or a rectal cancer, will determine the treatment pathway. This article aims to provide a brief overview of the pre-operative staging and the treatment pathways for the electively diagnosed colon and rectal cancers as an in-depth discussion is beyond the scope of this short article. The most common histological types for colorectal cancers are adenocarcinomas.

"This article aims to provide a brief overview of the pre-operative staging and the treatment pathways for the electively diagnosed colon and rectal cancers..."

Figure ① World Health Organization 2018  
New Number of cases and number of deaths, both sexes, all ages<sup>1</sup>

### Number of new cases in 2018, both sexes, all ages



### Number of deaths in 2018, both sexes, all ages

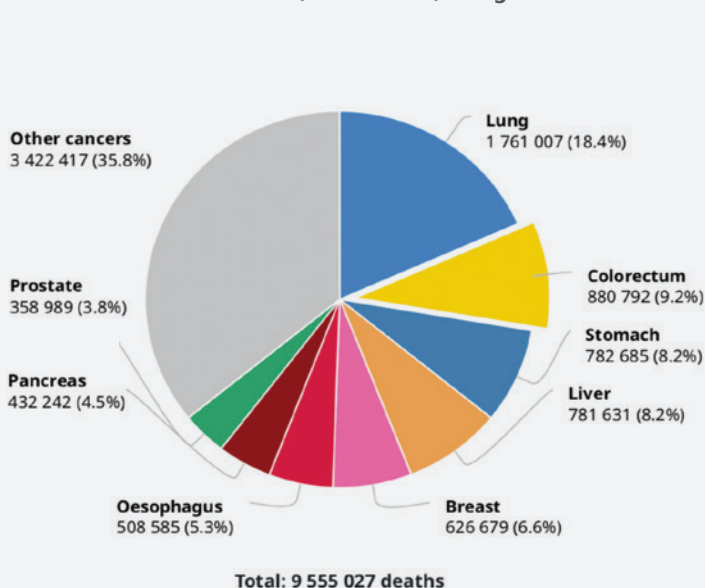


Figure 2a Colon and Rectal Cancer Pre-Operative Treatment Pathway<sup>5</sup>

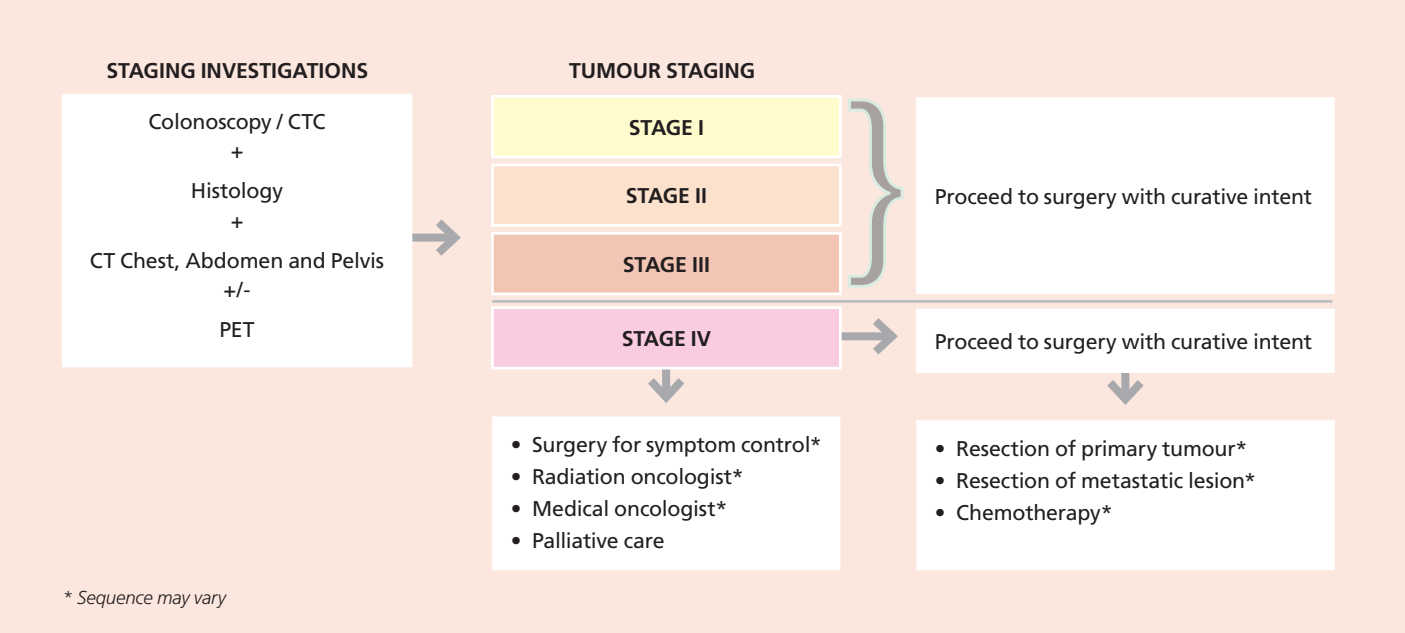
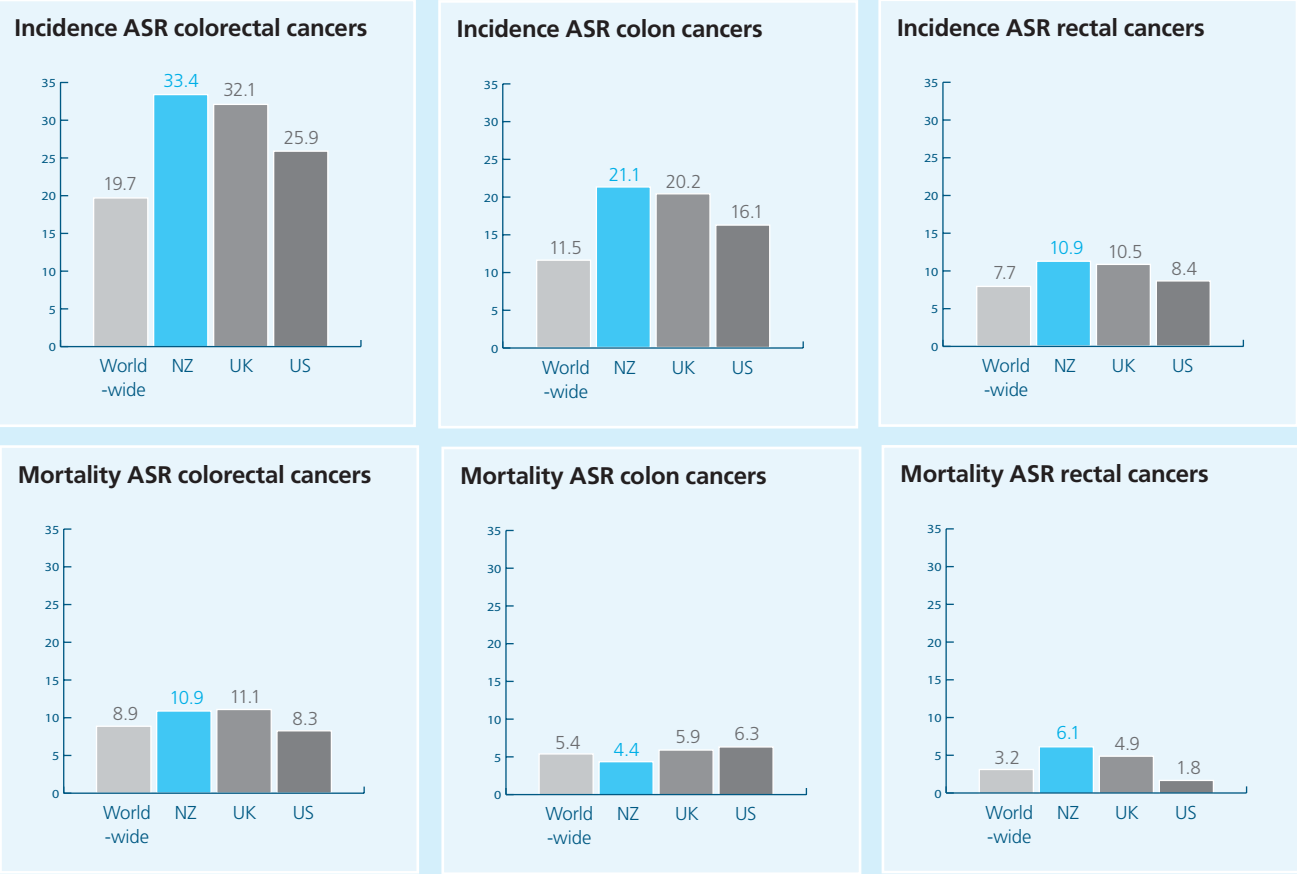


Table 1 2018 Table of Comparison of the Incidence and Mortality ASR for Colorectal Colon and Rectal Cancers Worldwide, in New Zealand and the United Kingdom<sup>2</sup>

ASR = Crude and Aged Standardised Rates per 100,000 population





Definition of colon versus rectal cancer

A colon cancer is a tumour arising from the large intestine. A rectal cancer is located within 15 centimetres from the anal verge. Anatomically, the rectum starts at the level of the third sacral vertebra and ends at the anal verge – the location is usually confirmed by the combination of clinical examination, endoscopy and magnetic resonance imaging (MRI) scan. Rectal cancers can be further subdivided into upper, mid or lower rectal cancers.

Pre-operative staging

When a colorectal cancer is suspected, the definite diagnosis is confirmed by colonoscopy/computed tomography colonography (CTC) and histological confirmation. The patient will undergo a

further computed tomography (CT) scan of the chest, abdomen and pelvis staging. Patients with rectal cancer will have an additional MRI scan which would determine the local staging. Selected patients may also undergo positron emission tomography CT (PET) scans if there are any lymph node/s or distant lesion/s which require further characterisation and confirmation. Once the diagnosis is confirmed, the management of the patient is discussed in a multidisciplinary meeting (MDM) – the recommended gold standard in cancer patient care. Table (2) summarises the pre-operative staging indications and Table (3)<sup>4</sup> shows the staging of colorectal cancer. Figure (2b) shows an endoscopic image of a rectal adenocarcinoma and Figure (3) illustrates a T3 rectal cancer MRI image.

Table (2) Pre-Operative staging for colon and rectal cancers

TUMOUR LOCATION	IMAGING	INDICATION
Colon and Rectum	CT abdomen, chest and pelvis	<ul style="list-style-type: none"><li>To assess the size and infiltration of the tumour, extension into adjacent structures and whether nodal involvement is present.</li><li>To detect any distant lung and liver metastatic disease.</li><li>To identify if obstruction or perforation is present/pending.</li></ul>
Rectum	MRI	<ul style="list-style-type: none"><li>For T staging of rectal cancers.</li><li>To determine the length of the tumour and whether the tumour is high, middle or low rectum.</li><li>To detect locoregional extensions.</li></ul>
Colon and Rectum	PET CT	<ul style="list-style-type: none"><li>Only for selected patients.</li><li>To determine the nature of suspicious nodal or distant lesions if they cannot be confidently determined on CT and MRI.</li></ul>

Table (3) Colorectal cancer staging<sup>4</sup>

STAGE I	Primary tumour into but not through muscularis propria and no metastases.
STAGE II	Primary tumour grown through to serosa and peritoneal surface but no metastases.
STAGE III	Any size of primary tumour with lymph node metastases.
STAGE IV	Presence of distant metastatic disease.

Figure (2b) Endoscopic image of a rectal adenocarcinoma



Figure (3) MRI scan image of rectal cancer

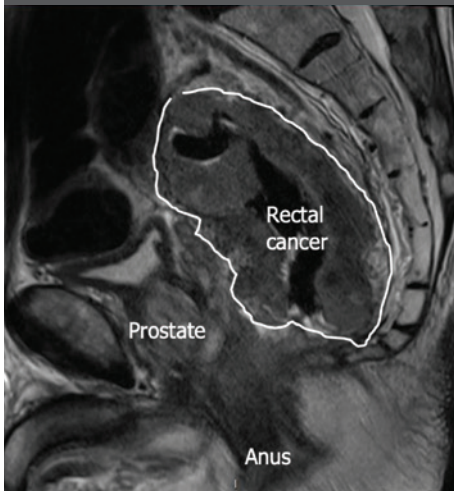


Figure ④ Rectal Cancer Pre-Operative Staging and Neoadjuvant Treatment Pathways<sup>6,7</sup>

Additional MRI Local Staging for Rectal Cancer Pre-Operative Pathway

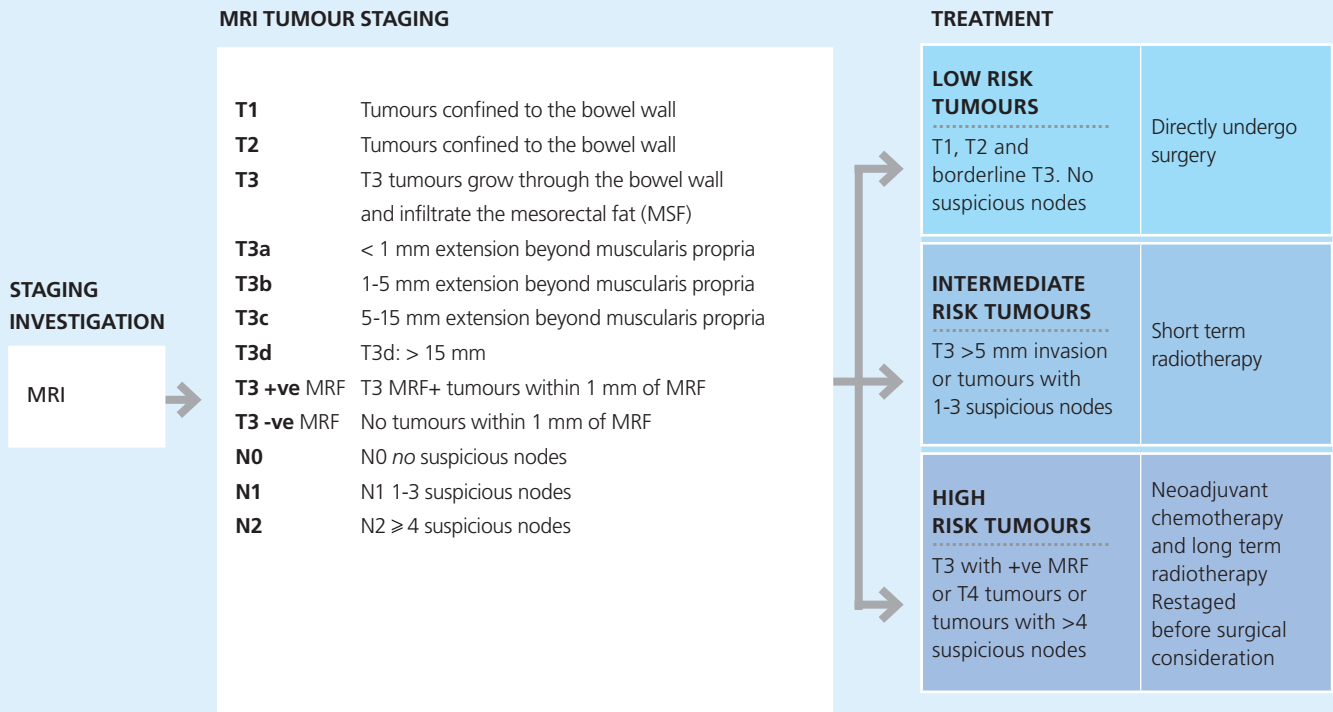
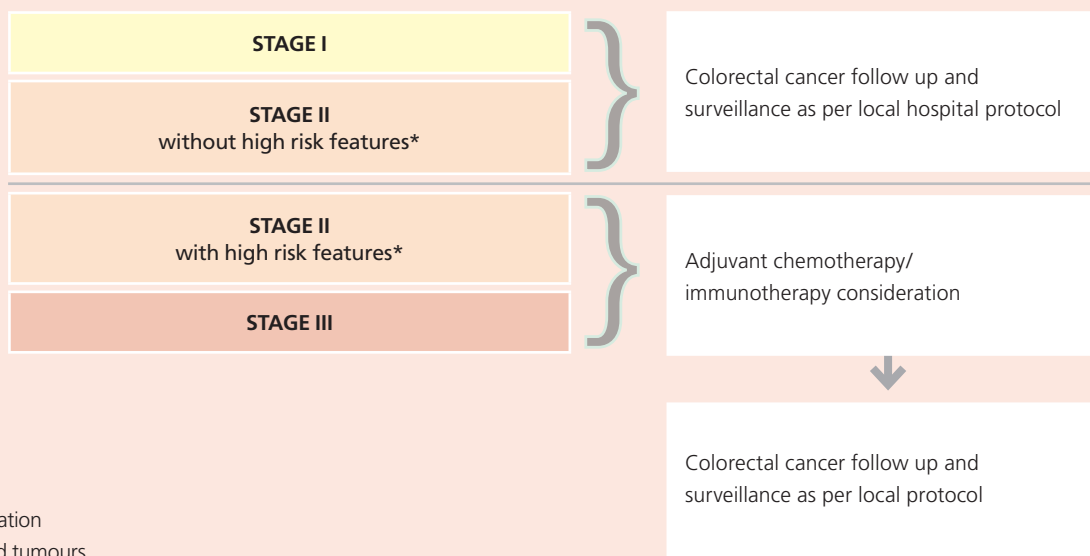


Figure ⑤ Colon and Rectal Cancer Post-Operative Treatment Pathway<sup>6</sup>

Pathological Tumour Staging

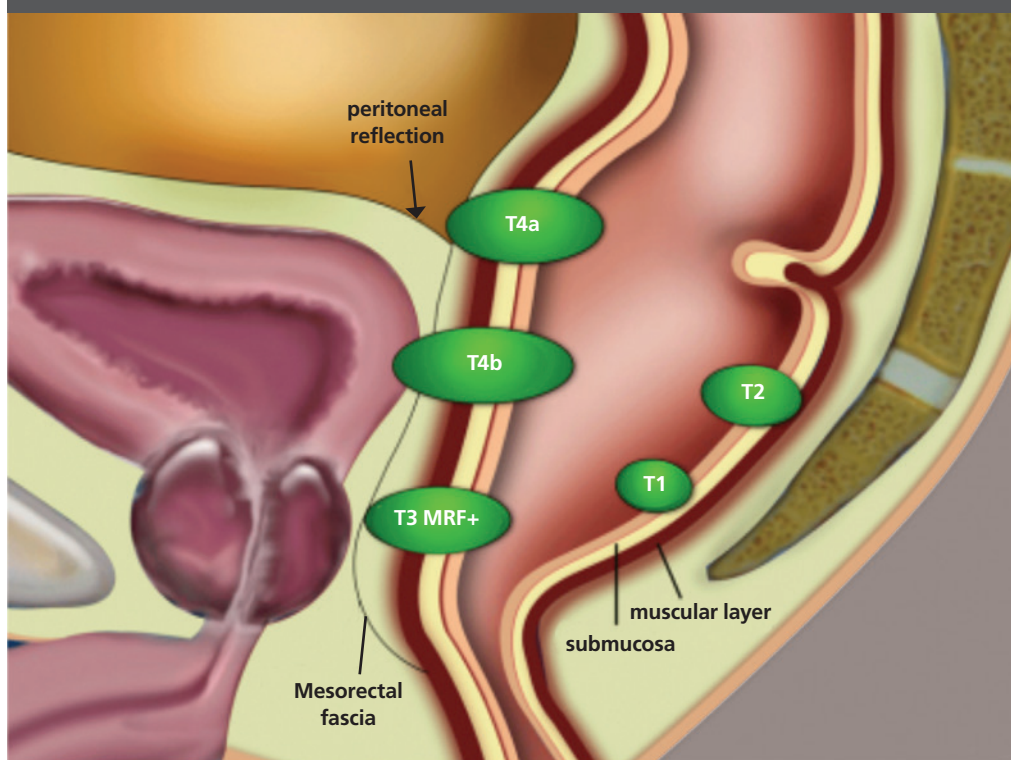


\* High Risk Features

- pT4 tumours
- Emergency presentation
- Poorly differentiated tumours
- Inadequately sampled nodes (<12)
- High levels of microsatellite instability



Figure 6 Schematic diagram of rectal cancer staging<sup>7</sup>



### Pre-Operative and Post-Operative Treatment Pathways

Once the pre-operative staging is completed, the MDM panel would discuss and recommend treatment options – surgery with/without neoadjuvant treatment – radiotherapy with/without chemotherapy for patients with rectal cancers or systemic chemotherapy for patients with advance/metastatic colorectal cancers. The treatment pathway may vary – taking into account patient choice to undergo the recommended treatment/s, general health, morbidities and tumour staging. Figures 4 – 6<sup>5</sup> summarise the pre-operative staging and the possible treatment pathways for colon and rectal cancers – which may vary depending on the national and local hospital policies. Currently, there is a national trial in New Zealand to assess the consistency of the MDM decision-making process.

### Conclusion

In the past ten years, there have been vast advances in the management of local, advanced and metastatic colorectal cancer. Neoadjuvant and adjuvant chemotherapy, radiotherapy and immunotherapy in advanced and metastatic disease cases have been shown, in some patients, to reduce local recurrence rates in rectal cancers and stall disease progression and increase overall survival in advanced and metastatic colorectal cancers. With the introduction of bowel cancer screening, the anticipated detection of early polyp cancer detection and the increasing number of treatment options, the role of MDM is becoming an integral part of the patient care pathway – to recommend the best gold standard treatment for such a common cancer.

### References

1. The Global Cancer Observatory. (2018). *Colorectal cancer*. Retrieved from [http://gco.iarc.fr/today/data/factsheets/cancers/10\\_8\\_9-Colorectal-fact-sheet.pdf](http://gco.iarc.fr/today/data/factsheets/cancers/10_8_9-Colorectal-fact-sheet.pdf)
2. The Global Cancer Observatory. (2018). *Estimated number of new cases in 2018, worldwide, both sexes, all ages*. Retrieved from [http://gco.iarc.fr/today/online-analysis-table?v=2018&mode=cancer&mode\\_population=continents&population=900&populations=900&key=asr&sex=0&cancer=39&type=0&statistic=5&prevalence=0&population\\_group=0&ages\\_group%5B%5D=0&ages\\_group%5B%5D=17&nb\\_items=5&group\\_cancer=1&include\\_nmsc=1&include\\_nmsc\\_other=1](http://gco.iarc.fr/today/online-analysis-table?v=2018&mode=cancer&mode_population=continents&population=900&populations=900&key=asr&sex=0&cancer=39&type=0&statistic=5&prevalence=0&population_group=0&ages_group%5B%5D=0&ages_group%5B%5D=17&nb_items=5&group_cancer=1&include_nmsc=1&include_nmsc_other=1)
3. Ministry of Health. (n.d.). *Cancer: New registrations and deaths – series*. Retrieved from <https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/cancer-new-registrations-and-deaths-series>
4. Poston, G.J., Tait, D., O'Connell, S., Bennett, A., Berendse, S., on behalf of the Guideline Development Group. (2011). *Diagnosis and management of colorectal cancer: summary of NICE guidance*. *BMJ*, 343, 1010-12. Retrieved from <https://www.bmj.com/bmj/section-pdf/187375?path=/bmj/343/7831/Practice.full.pdf>
5. Guideline Development Group (GDG). (2011). *Clinical Guideline. Colorectal cancer: the diagnosis and management of colorectal cancer. Full Guideline (draft)*. Retrieved from <https://www.nice.org.uk/guidance/cg131/documents/colorectal-cancer-full-guideline2>
6. American Joint Committee on Cancer. (2009). *Colon and Rectum Cancer Staging*. Retrieved from <https://cancerstaging.org/references-tools/quick-references/Documents/ColonSmall.pdf>
7. van Loenhout, R., Zijta, F., Lahaye, M., Beets-Tan, R., & Smithuis, R. (2015). *Rectal Cancer – MR staging 2.0. Radiology Department of the Medical Centre Haaglanden in the Hague, The Netherlands Cancer Institute in Amsterdam and the Alrijne Hospital in Leiderdop, the Netherlands*. Retrieved from <http://www.radiologyassistant.nl/en/p56195b237699d/rectal-cancer-mr-staging-20.html>

- Figure 1: Credited to World Health Organization 2018 [http://gco.iarc.fr/today/data/factsheets/cancers/10\\_8\\_9-Colorectal-fact-sheet.pdf](http://gco.iarc.fr/today/data/factsheets/cancers/10_8_9-Colorectal-fact-sheet.pdf)
- Figure 2a: Colon and Rectal Cancer Pre-Operative Treatment Pathway credited to <https://cancerstaging.org/references-tools/quick-references/Documents/ColonSmall.pdf>
- Figure 2b: Endoscopic image of a rectal adenocarcinoma
- Figure 3: MRI scan image of rectal cancer
- Figure 4: Rectal Cancer Pre-Operative Staging and Neoadjuvant Treatment Pathways<sup>6,7</sup>
- Figure 5: Colon and Rectal Cancer Post-Operative Treatment Pathway<sup>6</sup>
- Figure 6: Schematic diagram of rectal cancer staging<sup>7</sup>
- Table 1: 2018 Table of Comparison of the Incidence and Mortality ASR for Colorectal Colon and Rectal Cancers Worldwide, in New Zealand and the United Kingdom<sup>2</sup>. (\*ASR = Crude and Aged Standardised Rates per 100,000 population)
- Table 2: Pre-Operative staging for colon and rectal cancers
- Table 3: Colorectal cancer staging<sup>4</sup>

# Clinical Diagnosis of Carpal Tunnel Syndrome

📍 Bowen Hospital

★ Orthopaedics

👤 Mr Justin Chou,  
Orthopaedic Surgeon

☎ (04) 464 0035

🌐 www.bowen.co.nz

**Carpal tunnel syndrome is the most common compressive neuropathy in the upper limb. It is a condition that responds well to treatments, if diagnosed correctly. However there has been no well-established diagnostic tools for carpal tunnel syndrome thus far.**

Consequently missed diagnosis can delay prompt treatment and functional recovery. False positive diagnosis can also lead to unnecessary surgery, treatment complications, and increased burden on the health sector overall.

Recent orthopaedic literature has investigated the accuracy of various diagnostic tools for carpal tunnel syndrome. There are several clinical based diagnostic criteria<sup>1</sup>, as well as ultrasound or nerve conduction studies. The underlying cause of this diagnostic dilemma is the wide-ranged spectrum of clinical presentations of carpal tunnel syndrome. Some patients present with mainly nocturnal discomfort while others present with activity related pain and weakness during the day. Furthermore several other clinical conditions can mimic or co-exist with carpal tunnel symptoms, namely diabetic neuropathy, cervical radiculopathy or general arthritic conditions of the thumb and wrist. Because of these variables, the clinician's clinical assessment is critical to formulate a treatment plan specific to the patient's presenting complaints, with supplementary diagnostic studies to exclude other potential causes.

**CTS-6** is a simple clinical assessment for carpal tunnel syndrome that has been validated and used worldwide. These six items diagnostic

criteria include two symptomatic questions and four clinical examinations. This can be easily performed in the office setting with on average five to ten minutes to complete. The two questions relate to neurological symptoms in the median nerve distribution and nocturnal symptoms.

The four examinations are:

- 1 Sensory testing in the median nerve innervated digits
- 2 Strength testing of thenar eminence
- 3 Tinel's test
- 4 Phalen's test.

An overall score of 18 on CTS-6 has a 99% specificity for carpal tunnel syndrome. We have investigated the inter-observer variability of CTS-6 in a local population of 60 patients and found a high degree of correlation between the surgeon and qualified hand therapists.

**Neurophysiology testing** is a great tool to 'rule-out' vague clinical presentations due to its high sensitivity. However several studies have indicated its poor specificity (50%) and cautioned its use as a general screening tool for carpal tunnel. High rate of 'false-positive' diagnoses can subject the patient to unnecessary treatment, treatment complications, and dissatisfaction.

FINDING	POINTS*
Numbness predominantly or exclusively in median nerve distribution	3.5
Nocturnal symptoms	4
Thenar atrophy or weakness	5
Positive Phalen's test	5
Loss of 2-point discrimination (>5 mm)	4.5
Positive Tinel sign	4

\* The corresponding point values for all positive findings are added together to obtain a total score. A score  $\geq 12$  was defined as positive for carpal tunnel syndrome.



A recent retrospective audit of 114 Wellington patients and 128 wrists which received carpal tunnel release surgery based only on positive neurophysiology results showed 21% reporting minimal or no symptomatic improvement. Although not ideal as a general screening tool, neurophysiology testing still plays a vital role in identifying other causes of neurological symptoms in the hand, as well as monitor nerve functional recovery after surgical release in severe cases.

The key to successfully treating carpal tunnel syndrome is an accurate diagnosis based on the clinical assessment. Several treatment modalities can be employed in the initial consultation. Nocturnal symptoms of short duration

can often benefit from using night-time wrist splint, therefore avoid the need for surgery. Cortico-steroid injection can provide long lasting therapeutic effects. Hand therapy is particularly useful in managing weakness and functional modifications. Ultimately surgical release is the treatment for longstanding, severe carpal tunnel symptoms. However the surgical outcome is heavily dependent on a clinician's thorough review of patients' signs and symptoms.

## References

1. Fowler, JR., Munsch, M., Tosti, R., Hagberg, WC., & Imbriglia, JE. (2014). Comparison of ultrasound and electro-diagnostic testing for diagnosis of carpal tunnel syndrome: study using a validated clinical tool as the reference standard. *J Bone Joint Surg Am*, 96(7), e148. doi: 10.2106/JBJS.M.01250.



## The Acurity GP Conference has been connecting GPs with primary and secondary healthcare experts for 21 years.

On 29<sup>th</sup> and 30<sup>th</sup> March, over 350 individuals from across NZ met at Te Papa on the stunning Wellington waterfront to embrace the themes of Head Health, Bones & Soft Tissue, Women's Health and Skin.

Each theme had a particular focus on practical tips and take-home messages and was structured to foster learning and discussion.

An expert body of more than 30 speakers presented on their specialist areas. Some focused on what's new and what's still relevant in common everyday

problems and others delivered useful advice on current resources, applications, new tools and ideas. Your feedback shows speakers really delivered onsite with some informative and thought-provoking sessions.

A highlight was former All Black and campaigner for mental health awareness Sir John Kirwan's moving account of his personal battle with depression. During the Friday networking function, JK was funny and engaging as he delivered a strong message about removing the stigma around mental health.

Mixing with guests in his relaxed and easy-going style, JK set the scene for an evening of conversation and shared experiences.

Thank you to everyone who attended this year's conference. The work you carry out is of enormous importance and Acurity is committed to supporting the medical community by continuing to organise this conference each year.

We look forward to welcoming you again in 2020.

"This is the  
best conference  
for GPs"

Conference attendee



# Special thanks



## Special thanks to the following speakers

### **Mr Peter Abels**

Obstetrician Gynaecologist

### **Dr David Abernethy**

Neurologist

### **Dr Malcolm Abernethy**

Interventional Cardiologist

### **Mr Chris Adams**

Plastic Surgeon

### **Dr Andrew Aitken**

Cardiologist

### **Mr Nick Bedford**

Obstetrics and Gynaecology

### **Mr Jamie Belesky**

Physiotherapist

### **Ms Kay Cunningham**

Clinical Psychologist / Neuro Psychologist

### **Ms Lyn Dawson**

Mental Health Clinician

### **Dr John Denton**

Radiologist

### **Mr Peter Devane**

Orthopaedic Surgeon

### **Professor Tony Dowell**

Professor of Primary Health Care and General Practice, Obstetrics, Gynaecology and Women's Health

### **Associate Professor**

**Andrew Harrison**

Rheumatologist

### **Professor Ian Hermans**

Head of Cancer Immunotherapy Programme, Malaghan Institute

### **Mr Reuben Johnson**

Neurosurgeon

### **Dr Nicholas Kennedy**

Rheumatologist and Immunologist

### **Professor Bev Lawton**

Professor

### **Dr Andrew Linton**

Geriatrician

### **Mr Albert Lo**

Vascular Surgeon

### **Mr Jeremy Meates**

Obstetrician and Gynaecology

### **Mr Simon McDowell**

Obstetrics and Gynaecology

### **Dr Christine Mouat**

Breast and General Surgeon

### **Dr Kate Neas**

Clinical Geneticist, and the National Clinical Director for Genetic Health Service NZ

### **Mr Manish Patel**

Oral & Maxillofacial Surgeon

### **Mr Fred Phillips**

Orthopaedic Surgeon

### **Dr Giri Raj**

Dermatologist

### **Dr Swee Tan**

Founder and Executive Director, Gillies McIndoe Research Institute

### **Ms Kim Tottenham**

Podiatrist

### **Dr Cindy Towns**

Physician

### **Dr Sarah Usmar**

Consultant Plastic & Reconstructive Surgeon

### **Mr Vijay Vallabh**

Physiotherapist

### **Professor Marc Wilson**

Professor at Victoria University of Wellington





**Practice Prize  
Winner**

**Congratulations to  
Dr Richard Newman** from  
Riccarton Medical, winner of the  
Acurity GP Conference Practice prize,  
the E304 Instrument Dressing Trolley  
and Welch Allyn G5600 Minor  
Procedure Light with  
Mobile Stand.

## Special thanks to the following sponsors

### Platinum Sponsors:



### Gold Sponsors:



### Silver Sponsors:



### Bag Sponsor:

Vital Healthcare Property Trust

## Special thanks to our conference partners

The Department of Primary Health  
Care and General Practice, University  
of Otago, Wellington



## Special thanks to the following exhibitors

- Medtech Limited
- Sanofi
- Boehringer Ingelheim (NZ) Limited
- University of Otago, Wellington
- Specialist Vein Health
- Bank of New Zealand (BNZ)
- Pacific Radiology Group
- Wakefield Heart Centre
- Bowen Icon Cancer Centre
- Dilworth Hearing
- Cancer Society
- SR e-Learning & SR Specialists & Referrals – Cervin Media
- Proactive Rehab
- Acurity Health Group Limited
- GSK
- Novartis New Zealand Limited
- Roche Products (NZ) Limited
- Southern Cross Health Society
- Voice Power NZ Ltd
- Medora
- Seqirus (NZ) Ltd
- Pacific Edge Diagnostics Ltd
- Bay Audiology
- Aspen Pharmacare
- Bowen Hospital, Royston Hospital, and Wakefield Hospital
- Bayer New Zealand Limited

# Paediatric Surgery and Paediatric Urology at Wakefield



Mr Brendon Bowkett

Wakefield Hospital

Paediatrics

Mr Brendon Bowkett, Paediatric Surgeon and Paediatric Urologist

(04) 381 8120

[www.wakefield.co.nz](http://www.wakefield.co.nz)

**As a paediatric surgeon and paediatric urologist at Wakefield Hospital and Specialist Medical Centre, it has been my pleasure to work with a very dedicated, child-focused surgical team and to deliver a high level of service including advanced laparoscopy for children. Both paediatric general surgery and paediatric urology are available. The service now integrates also with paediatric specialist endoscopy provided by my colleague Mr Mark Stringer.**

There has been a consistent effort to offer the most advanced procedures for children including the highest level of laparoscopy for such indications as gastroesophageal reflux and obstructive renal pathology. Whilst urinary reflux seldom requires surgery, when it does this can be done non-invasively. Such an approach dramatically improves the child's experience of surgery.

Some of the recent advances in urology for unstable bladders include Botox injection therapy on rare occasions for those who don't respond to bladder programmes and multi modal pharmaceutical options. With any diagnosis the emphasis for children is always on non-invasive or non-surgical techniques as the first line of specialist care. For example, children with day time bladder symptoms can often be managed by obtaining a non-invasive bladder urodynamic assessment without the need for more invasive investigations or surgery.

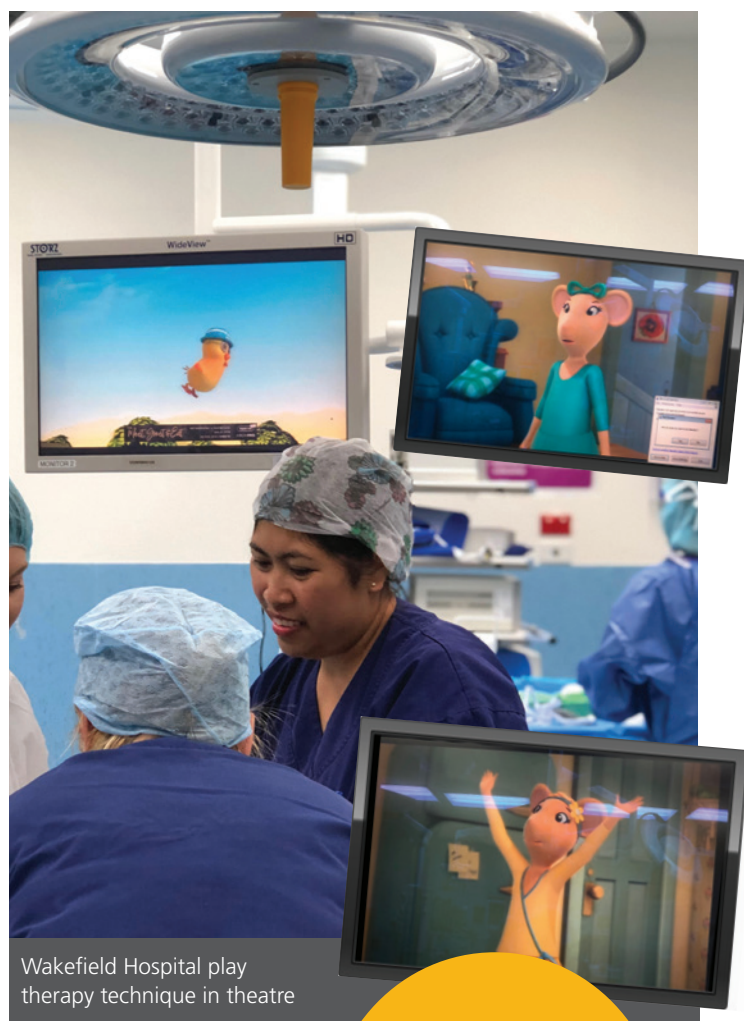
What is also a key part of the service is to provide integrated care including close liaison with other specialities both public and private. Many paediatric surgical conditions are associated with other anomalies or associations that are important to define and this is a key part of the service.

This includes pathways for rapid diagnosis of head and neck lumps and a focused approach to timely diagnosis of unusual skin lumps and lesions is available.

Another component of integrated care is the availability of specialist paediatric anaesthesia. This maximises the ability of the child to receive procedures as pain free as possible.

A good example of child-focused care at Wakefield is a play therapy technique used in our theatres for many children. Currently I believe only the Wakefield campus offers this approach. The laparoscopic theatre screens are integrated to play an age appropriate video with sound, which captures the child's imagination at the time of anaesthetic induction. From the time the child arrives into theatre several screens work together to create a digital playground effect. This has been developed by the nurses who regularly work in the paediatric theatre. Younger children will see a story that they are used to. My favourite is Bob the Builder.

We are hopeful the play therapy techniques are developed even further and possibly in other locations of the new Wakefield Hospital rebuild.



Wakefield Hospital play therapy technique in theatre

Such an approach dramatically improves the child's experience of surgery.



# Reducing the Morbidity

## Ongoing Evolution of Breast Cancer Treatment

Mr Bevan Jenkins



Mr Bevan Jenkins, General,  
Laparoscopic and Breast Surgeon

(06) 873 1169

[www.royston.co.nz](http://www.royston.co.nz)

### The management of breast cancer continues to evolve and become less surgically aggressive.

Considered almost uniformly fatal until the late 19<sup>th</sup> Century, the operation promoted by W.S. Halsted in 1894 of removing the breast, pectoralis major and minor along with a full axillary nodal dissection became the standard of care for several decades. This operation was associated with a much-improved survival rate, albeit with a high morbidity burden. With improvements of radiotherapy, hormone treatment, cytotoxic chemotherapy and targeted novel agents for adjuvant management increasing the survival rates of breast cancer patients, surgery has become less aggressive. Partial Mastectomy and Sentinel Lymph Node Biopsy (SLNB) have become mainstream options and the morbidity of surgery has decreased<sup>1,2,3</sup>.

The latest change in management has been the reduction in clinical recommendations for Axillary Lymph Node Dissection (ALND). A decade ago, a woman with a positive sentinel node (metastatic deposit) would have been advised to have an ALND performed, with the concomitant long-term post-operative risks of chronic pain and lymphoedema. The Z11<sup>4</sup> trial published in 2010 compared the outcomes of women who did or did not have an ALND as part of a partial mastectomy for T1 or T2 cancers (primary tumour up to 5cm in size) with

positive SLNB; otherwise the patients had the same management per treatment team's recommendations of radiotherapy, and systemic treatment of either chemotherapy, hormone suppression or both. The median follow-up of 6.3 years showed there was no significant difference in survival or local recurrence between the two groups, while the ALND group had (expectedly) significantly higher lymphoedema, paraesthesia, wound seroma and infection rates. Of note, the ALND group had further positive nodes found in 27% of ALND specimens, so the corollary is for those patients in whom ALND was omitted, a similar burden of positive nodes remained in situ. Although these were surgically untreated metastatic deposits, they didn't affect the overall outcome. One presumes that the adjuvant radiation +/- chemotherapy or hormone suppression treated the remaining nodes sufficiently to prevent recurrent clinical disease. North American practice embraced this new paradigm enthusiastically, while there was some hesitancy in the Australasian context.

We now have ten-year published follow-up data from Z11<sup>5</sup> confirming there is still no significant difference in the survival and local recurrence rates, and the practice of Australasian surgeons has been to start adopting this new paradigm. You may have noticed this difference in management

starting to trickle through in your breast cancer patients. The benefits of fewer ALNDs will be less treatment-related morbidities, such as lower rates of lymphoedema and chronic pain, which impact breast cancer patients' quality of life substantially.

#### What's in the future?

We can only apply this data to patients who undergo a partial mastectomy. For those in whom partial mastectomy is not an option or where a total mastectomy is the patient's preference, we would be practising outside of the current evidence base to omit an ALND in the case of a positive SLNB. Fortunately, there is a trial currently underway (POSNO<sup>6</sup>) which is recruiting both partial and total mastectomy patients to answer this exact question. It has almost finished recruiting and by the early 2020s, we should have the answer to whether we can extend this new concept to total mastectomy patients too.

#### References:

1. Halsted, WS. (1898). A Clinical and Histological Study of certain Adenocarcinoma of the Breast: and a Brief Consideration of the Supraclavicular Operation and of the Results of Operations for Cancer of the Breast from 1889 to 1898 at the Johns Hopkins Hospital. *Trans Am Surg Assoc*, 16, 144-181
2. Ghossain, A., & Ghossain MA. (2009). History of mastectomy before and after Halsted. *J Med Liban*, 57(2), 65-71
3. Fisher, B., Anderson, S., Bryant, J., et al. (2017). Twenty-year follow-up of a randomized trial comparing total mastectomy, lumpectomy, and lumpectomy plus irradiation for the treatment of invasive breast cancer. *N Engl J Med*, 347(16), 1233-41
4. Giuliano, AE., McCall, L., Beitsch, P., Whitworth, PW., Blumencranz, P., et al. (2010). Locoregional recurrence after sentinel lymph node metastases: the American College of Surgeons Oncology Group Z0011 randomized trial. *Ann Surg*, 252(3), 426-32
5. Giuliano, AE., Ballman, KV., McCall, L., Beitsch, PD., Brennan, MB., et al. (2017). Effect of Axillary Dissection vs No Axillary Dissection on 10-Year Overall Survival Among Women With Invasive Breast Cancer and Sentinel Node Metastasis: The ACOSOG Z0011 (Alliance) Randomized Clinical Trial. *JAMA*, 318(10), 918-26. doi: 10.1001/jama.2017.11470
6. POSNO. (n.d.). National Institute for Health Research funded trial. **POSitive Sentinel NOde: adjuvant therapy alone versus adjuvant therapy plus Clearance or axillary radiotherapy**. Retrieved from <http://www.posnoc.co.uk>



# Cervical and Lumbar Disc Replacements

## Maintaining Mobility in the Spine

Mr Austin Enright



📍 Royston Hospital

🏥 Orthopaedics

👤 Mr Austin Enright,  
Orthopaedic Surgeon

☎ (06) 876 0167

🌐 [www.royston.co.nz](http://www.royston.co.nz)  
[www.hawkesbayspine.co.nz](http://www.hawkesbayspine.co.nz)

**Spine surgery has advanced rapidly over the last few decades. Surgical interventions continually change to meet the increasing demands of patients and our understanding of spine pathology. Fusion of spinal segments has been a cornerstone of a spine surgeon's arsenal.**

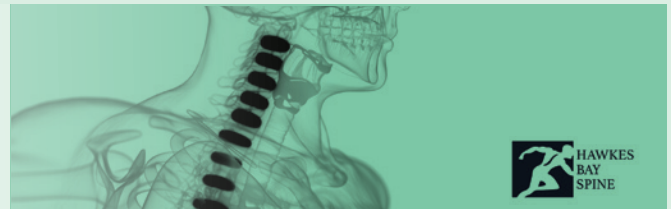
How this fusion is achieved can be highly variable. With the large number of fusions being performed, failure of mobile spinal segments next to the fusion is a significant problem occurring in up to 90% of fusions, depending on the source and cervical or lumbar location of the fusion<sup>1-4</sup>. This process is known as Adjacent Segment Disease (ASD).

Cervical disc replacements (CDR) have been shown to provide at least equivalent patient outcome measures and in many cases, superior results to their equivalent fusion<sup>1,5</sup>. The main advantage of disc arthroplasty over fusion is the decreased rate of ASD. A 2018 systematic review published rates of 86% ASD in anterior cervical fusions (ACDF) versus 42% in CDRs. Subsequent surgeries to address degeneration in the same patient group was found to be 15.2% for ACDF and 4% for CDR<sup>1</sup>. These decreases in revision surgery have been found to make cervical disc replacement surgery a more cost-effective option long term, despite their higher initially implant cost<sup>6,7</sup>.

Lumbar disc replacements (LDR) have had a tumultuous history. They have been present on the market for quite some time, but previous generations of implants were prone to failure. More recently, 3<sup>rd</sup> generation LDR have been developed.

This new generation of implants appears to be far superior to their predecessors in terms of ability to withstand the stresses of the lumbar spine, and the long term functional improvements they give patients<sup>9</sup>. Some studies show that they have improved patient outcomes over all time points versus Anterior Lumbar Interbody Fusion (ALIF)<sup>9</sup>. They have also shown that patients post LDR return to work on average 90 days post-procedure versus patients post ALIF at 155 days<sup>9</sup>. They have also shown measurable decreases in ASD vs ALIF surgery<sup>5,10,11</sup>.

Despite good evidence in favour of disc replacements versus fusion, they are not for everyone. Anterior fusions of both the cervical and lumbar spine are very good operations in their own right. The younger the patient is, the more likely a disc replacement may be advantageous over fusion. Sixty years of age is a typical cut-off for disc replacement, but clinician judgement is paramount. Other clinical and radiographic findings may also make disc replacement surgery a sub-optimum choice for a particular patient. Disc replacements are a growing area of spine surgery and certainly showing increasing promise in specific patients to improve patient outcomes while maintaining segmental mobility.



HAWKES  
BAY  
SPINE

LDR  
post-procedure  
return to work

90

days on average



ALIF  
post-procedure  
return to work

155

days on average

### References

1. Laratta, JL., Shillingford, JN., Saifi, C., & Riew, KD. (2018). Cervical Disc Arthroplasty: A Comprehensive Review of Single-Level, Multilevel, and Hybrid Procedures. *Global Spine Journal*, 8(1), 78-83
2. Hu, Y., Lv, G., Ren, S., & Johansen, D. (2016). Mid- to Long-Term Outcomes of Cervical Disc Arthroplasty versus Anterior Cervical Discectomy and Fusion for Treatment of Symptomatic Cervical Disc Disease: A Systematic Review and Meta-Analysis of Eight Prospective Randomized Controlled Trials. Grasso G, editor. *PLoS One*, Feb 12;11(2):e0149312
3. Szollosi, B., Klemencsics I., & Lazáry, Á. (2015). Adjacent Segment Degeneration after Cervical Disc Surgery: Comparison of One-Level Cervical Disc Arthroplasty versus Anterior Cervical Interbody Fusion: 7-Year Radiological Follow-Up. *Global Spine Journal*, 5(1). (1\_suppl):s-0035-1554290-s-0035-1554290
4. Park, P., Garton, HJ., Gala, VC., Hoff, JT., & McGillicuddy, JE. (2004). Adjacent Segment Disease after Lumbar or Lumbosacral Fusion: Review of the Literature. *Spine*, 29(17), 1938-44
5. Zigler, JE. (2012). Five-Year Results of the ProDisc-L Multicenter, Prospective, Randomized, Controlled Trial Comparing ProDisc-L With Circumferential Spinal Fusion for Single-Level Disabling Degenerative Disk Disease. *Seminars in Spine Surgery*, 24(1), 25-31
6. McAnany, SJ., Merrill, RK., Overley, SC., Kim, JS., Brochin, RL., & Qureshi, SA. (2018). Investigating the 7-Year Cost-Effectiveness of Single-Level Cervical Disc Replacement Compared to Anterior Cervical Discectomy and Fusion. *Global Spine Journal*, 8(1), 32-9
7. Overley, SC., McAnany, SJ., Brochin, RL., Kim, JS., Merrill, RK., & Qureshi, SA. (2018). The 5-year cost-effectiveness of two-level anterior cervical discectomy and fusion or cervical disc replacement: a Markov analysis. *The Spine Journal*, 18(1), 63-71
8. Lazenec J-Y, Aaron A., Brusson A., Rakover J-P, Rousseau M-A. (2013). The LP-ESP® lumbar disc prosthesis with 6 degrees of freedom: Development and 7 years of clinical experience. *European Journal of Orthopaedic Surgery & Traumatology*, 23(2), 131-43
9. Mattei, TA., Beer, J., Teles, AR., Rehman, AA., Aldag, J., & Dinh, D. (2017). Clinical Outcomes of Total Disc Replacement Versus Anterior Lumbar Interbody Fusion for Surgical Treatment of Lumbar Degenerative Disc Disease. *Global Spine Journal*, 7(5), 452-459
10. Guyer, RD., McAfee, PC., Banco, RJ., Bitan, FD., Cappuccino, A., Geisler, FH., et al. (2009). Prospective, randomized, multicenter Food and Drug Administration investigational device exemption study of lumbar total disc replacement with the CHARITÉ artificial disc versus lumbar fusion: five-year follow-up. *The Spine Journal*, 9(5), 374-86
11. Harrop, JS., Youssef, JA., Maltenfort, M., Vorwald, P., Jabbour, P., Bono, CM., et al. (2008). Lumbar Adjacent Segment Degeneration and Disease After Arthrodesis and Total Disc Arthroplasty. *Spine*, 33(15), 1701-1707.



# Endorsed CPD Activities



Acurity Health
 CPD Activities
 Acurity Marketing
 (04) 920 0131
 [www.acurity.co.nz](http://www.acurity.co.nz)

## 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, request information, or register for a CME, please contact [marketing@acurity.co.nz](mailto:marketing@acurity.co.nz)

Date	Speaker	Specialty	Topic/Details	Venue	CME endorsed
<b>6 August</b> Tuesday	Dr Malcolm Abernethy, Dr Alex Sasse, Dr Anil Ranchord, Dr Andrew Aitken, Dr Tim O'Meeghan	Cardiology	Cardiology Update	Lower Hutt Events Centre, Lower Hutt	2 credits
<b>14 August</b> Wednesday	Mr Giles Foley	Orthopaedics	Orthopaedics – topic TBA	Bowen Hospital, Crofton Downs, Wellington	2 credits
<b>21 August</b> Wednesday	Dr Anju Basu, Liz Childs	Gynaecology Pelvic Health Physiotherapy	Endometriosis and Pelvic Pain Pelvic and Genital Pain: Conservative Management in Women and Men	Wakefield Hospital, Newtown, Wellington	2 credits
<b>3 September</b> Tuesday	Mr Richard Evans	Vascular	Vascular Telehealth	Bowen Hospital, Crofton Downs, Wellington	2 credits
<b>17 September</b> Tuesday	Brin Williams	Proactive	Return to Work Following Illness or Injury	Wakefield Hospital, Wellington	2 credits
<b>19 September</b> Thursday	Dr Anil Ranchord, Dr Darren Hooks, Dr Alex Sasse	Cardiology	Cardiology Update	Kapiti Lindale Conference Centre, Kapiti Coast	2 credits
<b>25 September</b> Wednesday	Dr Anil Ranchord, Dr Matthew Webber, Dr Alex Sasse, Dr Phillip Matsis	Cardiology	Cardiology Update	Wakefield Hospital, Newtown, Wellington	2 credits
<b>16 October</b> Wednesday	Mr Kes Wickremesekera (JK Wicks)	Vascular	Vascular Update – topic TBA	Kapiti Lindale Conference Centre, Kapiti Coast	2 credits
<b>22 October</b> Tuesday	Mr Kes Wickremesekera (JK Wicks)	Vascular	Vascular Update – topic TBA	Lower Hutt Events Centre, Lower Hutt	2 credits
<b>30 October</b> Wednesday	Dr Ben Griffiths	Gastroenterology	Luminal Gastroenterology Update	Wakefield Hospital, Newtown, Wellington	2 credits
<b>6 November</b> Wednesday	Dr Lupe Taumoepeau	Vascular	Vascular Update – topic TBA	Wakefield Hospital, Newtown, Wellington	2 credits



### 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

### CME meetings – register online

You can find out about the latest CME meetings and book online at [www.acurity.co.nz/our-resources/educational-events](http://www.acurity.co.nz/our-resources/educational-events)



# New Consultants

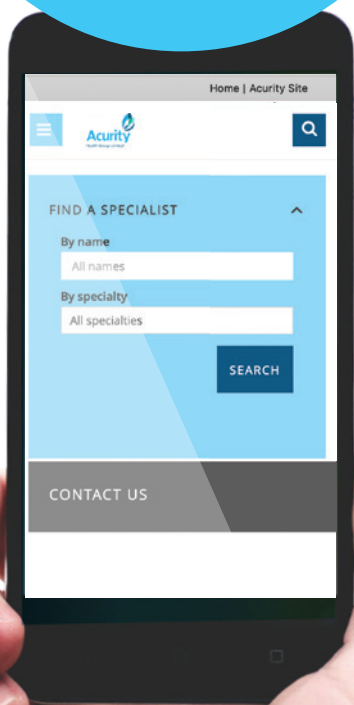
 Acurity Health  New Consultants  [www.acurity.co.nz](http://www.acurity.co.nz), [www.wakefield.co.nz](http://www.wakefield.co.nz), [www.bowen.co.nz](http://www.bowen.co.nz)

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



## See all our consultants online

All of our consultants can be easily viewed on our website – [www.acurity.co.nz](http://www.acurity.co.nz)



**WAKEFIELD**  
HOSPITAL



### Mr Atul Dhabuwala

MBBS, FRACS (Gen Surgery)

#### General Surgeon

P: (04) 570 1421  
F: (04) 560 3737  
E: [wgtnreception@weightlossurgery.nz](mailto:wgtnreception@weightlossurgery.nz)

#### Specialty

General Surgery

#### About Atul Dhabuwala

Mr Atul Dhabuwala is a New Zealand trained general surgeon. He is consulting at Boulcott hospital in Lower Hutt and operates at Boulcott hospital as well as Wakefield hospital. His public hospital commitment is at Lower Hutt hospital and covers a wide range of general surgery practice including Laparoscopic colonic surgery, thyroid surgery, pancreatic surgery, gall bladder and hernia surgery. He also has special interest in Bariatric surgery and performs Laparoscopic Roux en Y Gastric Bypass, Laparoscopic Mini Gastric Bypass and Sleeve Gastrectomy.

Mr Atul Dhabuwala used to be a General Surgical Trainee supervisor and currently is a Royal Australasian College Examiner in General Surgery.

#### Training

General Surgery training in New Zealand and post fellowship upper GI and Pancreatic surgery training in Germany.

#### Special Interests

- Abdominal
- Bariatric Surgery
- Gall Bladder
- Colorectal Surgery
- Hernias
- Thyroid
- Laparoscopy (General Surgery)
- Upper GI (General Surgery)
- Gastrointestinal and Hernia Surgery
- Antireflux and Hiatus Hernia Surgery.



### Dr Neil Avery

FRANZCO, MBChB

#### Ophthalmologist

P: (04) 499 4940

F: (04) 499 0242

E: info@thorndoneye.co.nz

#### Specialty

Ophthalmology

#### About Neil Avery

Neil Avery grew up in Wellington, then attended the University of Otago for undergraduate medical training. While on elective in Jamaica he developed an interest in ophthalmology. Neil completed his internship and general ophthalmology training at Wellington and Dunedin hospitals, followed by two years of fellowship training in retinal diseases and vitreoretinal surgery. He continues to make regular trips to Jamaica to help provide outpatient ophthalmic services and perform small incision cataract surgery and pterygium surgery.

#### Training

- Registrar training in ophthalmology at Wellington Regional Hospital and Dunedin Hospital
- Vitreoretinal fellowship Wellington Regional Hospital 2017
- Graham Lovett Vitreoretinal fellowship Sydney Eye Hospital 2018.

#### Special Interests

- Vitreoretinal Surgery
- Diseases of the Macula
- Cataract Surgery (including complex cataract surgery/sutured lens surgery)
- Pterygium Surgery.



### Mr Justin Chou

MBChB (Otago), FRACS (Ortho)

#### Orthopaedic Surgeon

Wellington Orthopaedics & Sports Surgeons

P: (04) 464 0035

F: (04) 479 2217

E: admin@woss.co.nz

#### Specialty

Orthopaedic Surgery

#### Training

- Otago medical school graduate
- Orthopaedic surgery training in New Zealand
- Fellowship hand surgery St Vincent, Melbourne, Australia
- Fellowship hand training Middlemore, Auckland, New Zealand
- Fellowship training upper limb surgery Sunnybrook, Toronto, Canada.

#### Special Interests

- Arthroscopy
- Elbow
- Joint Replacement
- Shoulder
- Wrist and Hand.

Mr Justin Chou consults & operates at Bowen Hospital.



**Bowen**  
icon cancer centre

### Dr David Okonji

MBBCh (UK), MRCP (UK), MRCPs

(Glas), DTM (R.C.P. & S. Irel.)

#### Medical Oncologist

P: (04) 896 0200

F: (04) 896 0201

E: referrals.bowen@oncnz.team

#### Specialty

Medical Oncology

#### About David

Dr Okonji has a wealth of experience in medical oncology having worked both in New Zealand and internationally over the last 14 years and is actively involved in research as an investigator in clinical trials at Wellington Hospital. He is passionate about empowering patients to make individualised treatment choices through open and clear communication. He invites patient referrals for all cancer types, with a special interest in breast, urogenital and melanoma cancers. David has a particular focus on cancer care in the elderly.

#### Special Interests

- Breast
- Urogenital
- Melanoma.

# Contact Us



**Acurity**

Health Group Limited

GP CONFERENCE

Save the date for next  
year's conference

15 – 16 May 2020

Te Papa, Wellington



98 Churchill Drive  
Crofton Downs  
Wellington 6035  
P: (04) 479 2069  
F: (04) 479 8520  
E: [admin@bowen.co.nz](mailto:admin@bowen.co.nz)



500 Southland Rd  
Hastings 4122  
P: (06) 873 1111  
F: (06) 873 1112  
E: [hospital@royston.co.nz](mailto:hospital@royston.co.nz)



Florence Street  
Newtown  
Wellington 6021  
P: (04) 381 8100  
F: (04) 381 8101  
Toll Free: 0800 WAKEFIELD  
E: [info@wakefield.co.nz](mailto:info@wakefield.co.nz)



Florence Street, Newtown, Wellington 6021  
P: (04) 920 0131, F: (04) 381 8102  
E: [admin@acurity.co.nz](mailto:admin@acurity.co.nz)  
**Newsletter feedback/ideas are welcome:**  
E: [marketing@acurity.co.nz](mailto:marketing@acurity.co.nz)