

Health Matters

Glaucoma Surgery

Dr Alex Buller



Royston Hospital

Area: Ophthalmology
Article written by: Dr Alex Buller,
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The Future's Looking Better and Better



There's a challenge in glaucoma surgery: it's called the 10-10-10 challenge.

That stands for an operation that takes 10 minutes, achieves an intraocular pressure of 10, and lasts for 10 years.

Our current gold standard operation is the trabeculectomy, which using current methods takes one hour to perform, can achieve a pressure of 10 but not in many cases, and 30% fail within three years. That's still a long way short of the 10-10-10 goal. Contrast this with cataract surgery where we've had near perfect results since the turn of the century.

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Save the Dates

Acurity GP Conference
19 & 20 May 2017



Message from Acurity Health

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



Welcome to the 16th issue of Health Matters – our final edition for 2016. I can't believe we're nearly at the end of the year already.

Oncology

Since publically announcing our intent to open oncology services in the Wellington region we have been engaging with the local oncologists to gain their support and ensure that the service delivered is complimentary to that provided by Capital & Coast DHB.

At this stage, we expect to be treating patients in our new medical oncology facility early in the New Year. After discussion with the medical oncologists, we have elected to develop this facility at our Bowen Hospital site in Crofton Downs, ensuring ease of access to the majority of residents in the region.

GP Conference

Planning for next year's conference, Connect 2017 has begun. The programme is developing well with plenty of short sharp presentations along with concurrent sessions to provide you with up to date knowledge and advice that you can take back to assist you with your patients. We have taken into account the feedback you provided and have incorporated topics into the programme that you have asked for.



If you haven't already done so please save the dates in your diaries for Friday 19th and Saturday 20th May, Te Papa, Wellington.

Please visit our website www.acurity.co.nz for more information and keep an eye out in future editions of Health Matters.

I'd like to take this opportunity to wish you a wonderful rest of the year and a lovely break over the Christmas New Year period.

Happy reading...

Paul Quayle,
Chief Operating Officer,
Acurity Health Group Ltd

Glaucoma Surgery

Continued from page 1

Dr Alex Buller



The Future's Looking Better and Better



The reason for the shortfall in performance of trabeculectomy surgery is because of its tiny therapeutic window. This isn't an exaggeration. It works by changing the balance of outflow of fluid from the eye's anterior chamber which has an average volume of 200 microlitres, with a flow rate that averages 2.0 microlitres per minute. If too much extra flow is created, the eye can become blind, sometimes suddenly and painfully. Even if this target window is achieved initially the main reason for the procedure failing is wound healing: we want the newly fashioned outflow passage to continue to achieve the new flow rate without that being influenced by wound changes in the weeks/months/years following.

Advances in techniques, technology and understanding have led to a new wave of approaches developing to overcome these problems. The new kids on the block go by the name of MIGS: Minimally Invasive Glaucoma Surgery.

It's an evolving group of different approaches aimed at achieving lower eye pressure whilst being less invasive surgically. It's a pretty big group too.

Approaches being used include implants to connect the anterior chamber with Schlemm's Canal (including the iStent and Hydrus implants), the suprachoroidal space (for example the Cypass and STARflo implants) and outside the sclera (such as the Xen Gel stent). Others remove a part of the trabecular meshwork (like the Trabectome and Kahook Dual Blade), and others decrease aqueous production by the ciliary body (such as the MicroPulse P3 laser).

The leaders of the pack include the iStent, which has been developed as an add-on to cataract surgery. It's a small titanium implant inserted into the Schlemm's canal at the end of cataract surgery. It takes up to 10 minutes to put in, on average only drops the pressure as much as one eyedrop medication, and is known to last five years so far. They are also now being inserted by glaucoma surgeons in New Zealand.

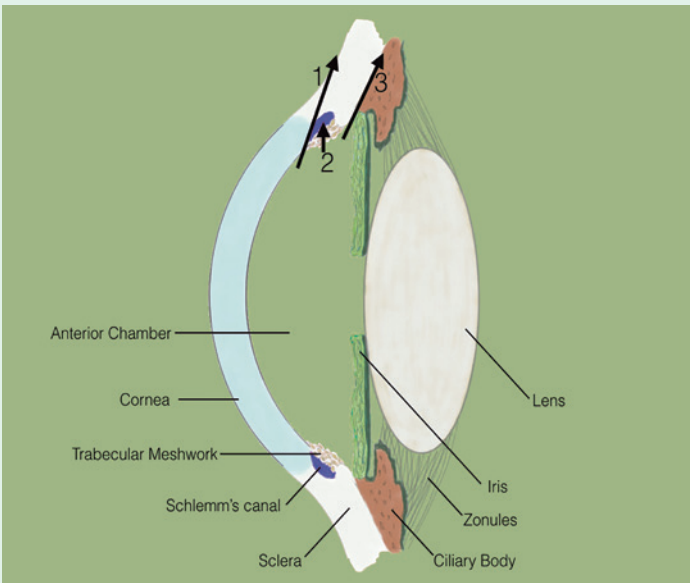


Figure 1. An illustration of the anterior segment of the eye. Aqueous humour is mostly drained out of the anterior chamber through the trabecular meshwork into Schlemm's canal, from where it joins the veins on the external ocular surface.

The arrows indicate MIGS approaches to draining aqueous humour out of the anterior chamber:
1. Into the subconjunctival space,
2. Into Schlemm's Canal, and
3. Into the suprachoroidal space

While these new devices don't yet hit the 10-10-10 standards they do give improved options and safe results. Glaucoma patients have a wide variety of levels for treatment needed to control their disease.

The biggest group of patients use a single eyedrop. An iStent implant at the time of cataract surgery can remove the need for ongoing eyedrops usage, overcoming compliance issues, drug side-effects and the physical challenges of putting in eyedrops.



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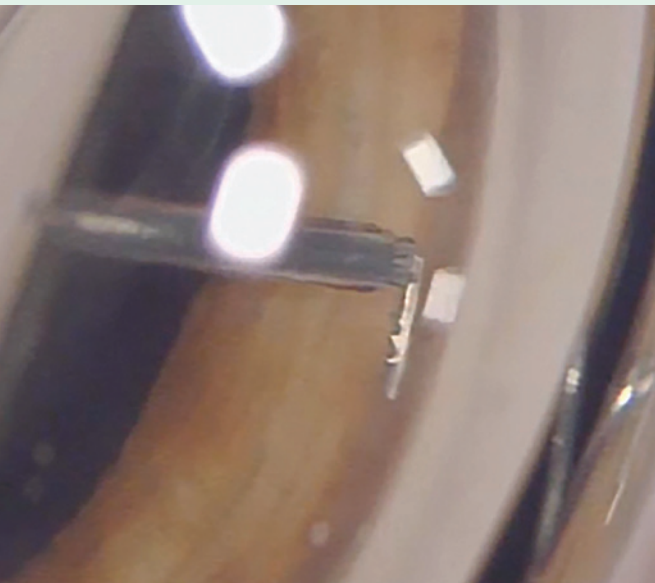


Figure 2. An iStent being inserted into an eye

For those interested in looking further into glaucoma there are some great explanations and factsheets on the websites for Glaucoma New Zealand, www.glaucoma.org.nz, and the International Glaucoma Association, www.glaucoma-association.com



Shoulder Pain Simplified



Mr Rob Rowan

Wakefield Hospital

Area: Orthopaedics
Article written by: Mr Rob Rowan, Orthopaedic Surgeon, ph (04) 381 8100

Patients over 35 commonly present with shoulder pain. It can at times be difficult to identify the source of pain and the most appropriate treatment. Imaging studies and radiology reports can easily confuse the doctor and the patients are frequently miserable!



I present here an algorithm to help you diagnose and manage this disabling and common presentation. The algorithm combines history, examination, investigations and treatment.

Three guiding principles underly this and should not be forgotten

- a. Common things occur commonly
- b. The KISS principle (Keep it Simple!)
- c. Identifying a frozen shoulder if it exists is key to success

Step 1. Pain Location

Pain arising from the rotator cuff (RC), subacromial space (SAS) and shoulder joint/capsule is commonly referred to the lateral aspect of the arm and deltoid. It can also be felt over the anterior shoulder, occasionally the posterior shoulder and very occasionally radiates to below the elbow. This pain location does not help differentiate between a frozen shoulder and RC/SAS pathology.

Pain from the Acromioclavicular Joint (ACJ) is usually felt over the ACJ but it can on occasion radiate into the trapezius, and be felt over the anterior shoulder. If the patient has pain in the paraspinal muscles or midline of the cervical spine it is not arising from the shoulder.

Step 2. Does the Patient have a Frozen Shoulder?

Assess shoulder internal and external rotation. This is easiest done by standing behind the patient and assessing passive external rotation and active internal rotation (placing arm up behind back). This is critical. Adhesive capsulitis (frozen shoulder) is common and can be severely disabling. It can occur spontaneously or after injury. It can complicate the picture in patients with other RC/SAS pathology. It is more common in diabetics. If the patient has lost passive external or internal rotation in the shoulder they either have a frozen shoulder or osteoarthritis of the shoulder. An x-ray should be undertaken to exclude osteoarthritis. Then proceed to **frozen shoulder treatment**, skip other steps.

Patients with a frozen shoulder will have pain at extremes of motion and with arm elevation. This gets confused with impingement pain. The most important differentiating sign is loss of shoulder rotation with the arm at the patient's side. This typically does not occur in patients with RC/SAS pathology.

Patients with a frozen shoulder often have had an ultrasound suggesting subacromial bunching +/- partial thickness rotator cuff tear. These findings are not relevant if the patient has clinical signs of a frozen shoulder.

Step 3. Does the Patient have RC/SAS Pathology?

Patients with RC/SAS pathology typically present with impingement pain. This is pain over the lateral arm or anterior shoulder which occurs with arm elevation through the range of 60 to 150 degrees. They will have a full passive range of internal and external rotation in the shoulder. It is appropriate to investigate with an ultrasound scan and x-ray of the shoulder. Many of these patients can be helped by non-operative treatment.

If the x-ray is normal and the ultrasound shows a partial thickness rotator cuff tear or no rotator cuff tear. Proceed to **Non-operative treatment of RC/SAS pathology**.

Patients with a full thickness rotator cuff tear will in most circumstances have a better long term result with surgical treatment and referral should be initiated. These patients can be broadly placed into three categories.

- a. Active patients with normal x-ray. Typically patients 40 to 75 years of age. These patients have a better long term result with surgery
- b. Patient not a candidate for surgery because of choice or medical comorbidities. Proceed to **Non-operative treatment of RC/SAS pathology**
- c. Patients with an irreparable cuff tear. If the x-ray shows a high riding humeral head with loss of Acromiohumeral distance the cuff is not repairable. MRI scans are also useful in determining if the cuff is repairable in patients where this is unclear. These patients can benefit from non-operative management. If non-operative treatment fails surgical treatment such as a reverse shoulder arthroplasty can be considered.

Patients with partial thickness rotator cuff tears on the ultrasound should be managed non-operatively initially. If non-operative management fails surgical referral is appropriate. Be aware of a possible frozen shoulder.

Step 4. Does the Patient have AC Joint Pathology?

Typically pain is over the ACJ or anterior shoulder and can radiate into the trapezius. Pain is made worse by high arm elevation and forced internal rotation. This can be treated with analgesia, nonsteroidal anti-inflammatory drugs (NSAID), and/or ACJ cortisone injection. Surgical treatment is reliable if non-operative treatment fails.

Treatment of frozen shoulder

The natural history is resolution over 18 months in most patients. However the symptoms can be severe and some patients are left with residual stiffness without treatment. The most effective initial treatment is an intra-articular injection of 40mg kenacort into the shoulder joint. This will improve symptoms for most. If symptoms continue, a repeat injection is reasonable. If this fails manipulation under anaesthetic or arthroscopic release are the next step.

Physiotherapy is not typically helpful for this condition.

Prescribe simple analgesia and NSAID's as appropriate.

Injections can be placed under x-ray or ultrasound guidance by a radiologist. Alternatively one member of your practice can easily learn to do these injections and can act as a resource in your practice to provide timely, cost effective treatment for your patients. I would be happy to teach any of you who are keen.

Non-operative treatment of RC/SAS pathology

Physiotherapy is important and useful. Therapy should focus on reducing inflammation and maintaining range of motion initially and then quickly progress to a strengthening program. Subscapularis and Infraspinatus are humeral head depressors. Strengthening these muscles with resisted internal and external rotation exercises can be very effective and has been shown to work as well as a subacromial steroid injection if continued for six weeks.

Prescribe simple analgesia and NSAID's as appropriate.

Subacromial space injection of 40mg of kenacort can be very effective in relieving pain. Again these can be placed by a radiologist, however placing these injections is straight forward and rewarding for both the doctor and patient. I would be happy to teach you how to do these injections.

Other points

Other causes of shoulder pain include benign and malignant tumours, osteoarthritis, inflammatory arthritis, polymyalgia rheumatica, cervical pathology, and chest/ cardiac pathology.

If the history is not typical consider these other conditions.

An ultrasound alone will not identify many of the above conditions. If investigations are being undertaken I strongly recommend an x-ray and ultrasound are done. Blood tests may also be indicated depending on the presentation.

If patients have rotator cuff pathology and a frozen shoulder, treat the frozen shoulder first.

"I would be happy to teach you how to do these injections"

Upcoming CME Meetings – 2016/17



Acurity Health Group host a variety of Continuing Medical Education (CME) sessions for GPs throughout the year.

Each session is formatted to give you an opportunity to meet consultant physicians and surgeons, receive expert feedback and discuss topics in an interactive environment.

We aim to deliver practical sessions with a primary healthcare focus and learning outcomes based on general practice diagnosis, management and investigation.

Consultants are often able to provide updates on the latest research and cutting edge treatments and procedures.

Our sessions are endorsed for CME and MOPS purposes by the RNZCGP. If you would like to suggest a topic of interest or require further information please contact Sarah Malone, Business Development Manager, P: 04 920 0158, E: sarah.malone@acurity.co.nz

To register please email Persephone pg@acurity.co.nz

Visit www.acurity.co.nz to keep up to date with educational events at Acurity.


Upcoming CME Meetings – 2016/17					
Date	Speaker	Speciality	Topic/Details	Venue	CME endorsed
27 October Thursday	Mr John Groom, Gastrointestinal & Colorectal Surgeon / Endoscopist	Gastroenterology	The Bottom Half: Including Bowel Screening	Kapiti Lindale Conference Centre, Paraparaumu	2 credits
2 November Wednesday	Dr Ian Wilson, Gastroenterologist	Gastroenterology	Diagnostic Dilemmas and Clinical Cases	Wakefield Hospital Education Centre, Wellington	2 credits
3 November Thursday	Wakefield Heart Centre, Cardiologists	Cardiology	To be advised	Kapiti Lindale Conference Centre, Paraparaumu	2 credits
15 February 2017 Wednesday	Lissa Judd, Dermatologist	Dermatology	To be advised	Bowen Hospital, Seminar Room, Wellington	2 credits
	Mr Richard Evans, Vascular Surgeon	Vascular Surgery	Laser Treatment for Vascular Skin Conditions		
March	Mr Simon Johnson, Orthopaedic Surgeon	Orthopaedics	Shoulders (TBC)	Royston Centre, Seminar Room, Wellington East Pier Hotel, Napier	2 credits
March	Mr Reuben Johnson, Neurosurgeon	Neurosurgery	To be advised	Wakefield Hospital Education Centre, Wellington	2 credits
12 April Wednesday	Mr Nigel Willis, Orthopaedic Surgeon	Orthopaedics	Foot and Ankle	Bowen Hospital, Seminar Room, Wellington	2 credits
19 & 20 May Friday & Saturday	Acurity GP Conference: Connect 2017			Te Papa, Wellington	TBA



Save the Date
19 and 20 May 2017

Connect 2017

Providing the most relevant medical information – with a personal touch.



HEALTH CHALLENGES
WITHIN OUR
COMMUNITIES

50

HEALTHCARE
FOR THE
OVER FIFTIES



ONCOLOGY
UPDATE



MANAGEMENT
OF LONG TERM
CONDITIONS

We're delighted to invite you to 'Connect 2017'.

This conference is growing from strength to strength and is gaining a reputation as the 'best little GP Conference' in New Zealand. Here's your chance to join in and discover the latest clinical updates in primary and secondary healthcare through a variety of interactive speaker presentations, case studies, lightning talks and practical demonstrations.

Discover the latest in oncology treatment and services

Explore the management of long term conditions including anxiety and depression, CVD and skin disorders

Focus on the diagnosis and treatment of age related conditions in the over fifties including joints, rehabilitation, vascular disease and urology

Examine health challenges within the community from childhood obesity to sleep disorders

Guest speaker Nigel Latta will provide an entertaining and insightful look into contemporary health issues facing New Zealand communities.

Save the date 19 and 20 May 2017. Te Papa, Wellington

Registration details

Registrations open Friday 10th February 2017

Please check the website for updates www.acurity.co.nz/connect

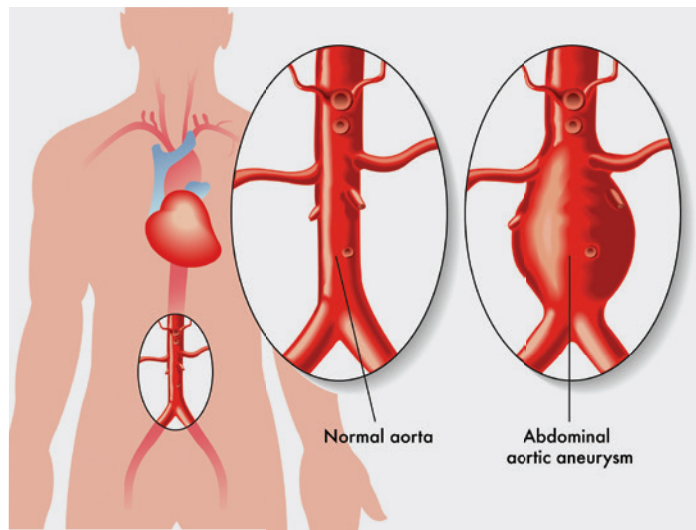
Aortic Aneurysm Screening – Catching Those at Risk

Janine Ahearn



Wakefield Hospital

Area: Vascular
Article written by: Janine Ahearn, Vascular Sonographer, ph 0800 83 46 43



Annual Rupture Rate for AAA		Earnshaw, J.J., Wyatt, M.G. (2012)
AAA diameter (cm)	Rupture Risk (% / year)	
<4	<0.5	
4.1 – 4.9	0.5 – 5	
5.0 – 5.9	3 – 15	
6.0 – 6.9	10 – 20	
7.0 – 7.9	20 – 40	
>8.0	30 – 50	

Vascular surgeons Mr Kes Wicks and Dr Lupe Taumoepeau joined to form Specialist Vein Health in early 2015. Based at Wakefield Hospital and supported by a team of vascular sonographers, nursing and administration staff, they have extended their reach to include clinics in Nelson, Palmerston North, Kapiti and Lower Hutt, giving patients outside the large cities an opportunity to access specialist vascular services.

In July this year they made one specific area of vascular importance even more accessible, by launching the first AAA screening programme in the greater Wellington area, under the name SHARP – Specialist Health Aneurysm Reach Programme.



SHARP
SPECIALIST HEALTH
ANEURYSM REACH PROGRAMME

SHARP is being gradually rolled out to GPs by Specialist Vein Health, to offer low cost

ultrasound examinations in order to detect aneurysmal disease in patients 60+ with one or more of the following risk factors:

- High blood pressure
- Family history of vascular disease
- Smoker
- COPD (Chronic Obstructive Pulmonary Disease)

While AAAs may occur within any segment under the diaphragm, >80% of AAAs are seen infra-renally, between the renal arteries and the aortoiliac bifurcation⁴. The usual diameter of the aorta in this area being 1.5 – 2.4cm¹, the aorta is considered aneurysmal when it reaches a diameter of 30mm.

With AAA prevalence ranging from three to 10% in men to 54 years of age and up to 12.5% in the 75-84 year age group⁴, AAA is both common and life threatening. The risk of rupture increases as diameter expands, seen in the table above, with a high mortality rate of 85 – 90% from rupture¹.

The SHARP programme aims to detect and then monitor and/or treat aneurysms, catching these at risk patients in time to make a difference.

Vascular Surgeon Mr Kes Wicks reports that he has had a very positive response from local GPs so far regarding the SHARP aneurysm screening programme, with comments including one GP saying they were “grateful for its availability”. With their highly experienced team of vascular sonographers reporting results directly to the vascular surgeons – Mr Wicks notes that their service is unique, thorough and life-saving.

Charges for the AAA scan through the SHARP programme are \$45.00 for community services card holders and \$90.00 for non-community services card holders. Specialist Vein Health are excited to be extending this valuable service to those at risk at a fraction of what it would normally cost the patients.



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References

- 1 Earnshaw, J.J., Wyatt, M.G. (2012) *Complications in Vascular and Endovascular Surgery: How to Avoid Them and How to Get Out of Trouble* (1st ed.) Harley, UK: tfmPublishing Ltd
- 2 Haase, J. Schafers, H-J. et al. (2010). *Cardiovascular Interventions in Clinical Practice*. Blackwell Publishing Ltd; Online ISBN: 9781444316704
- 3 Nair, N., Shaw, C. et al. (2012) *Abdominal Aortic Aneurysm Disease in New Zealand: Epidemiology and Burden between 2002 and 2006*. NZMJ volume 125. Number 1350
- 4 Wakabayashi, I. & Groschner, K. (2014) *Interdisciplinary Concepts in Cardiovascular Health*. Switzerland; Springer International Publishing.

* Body image from SHARP Dreamstime.

Intrusive Dental Injuries in Adolescent Patients

Dr Mohammad Alansary



Bowen Hospital

Area: Dentistry
Article written by: Dr Mohammad Alansary, Paediatric Dentist, ph (04) 499 8608



Figure 1: Clinical presentation of intruded upper front permanent teeth with fractured crowns and alveolar bone fracture

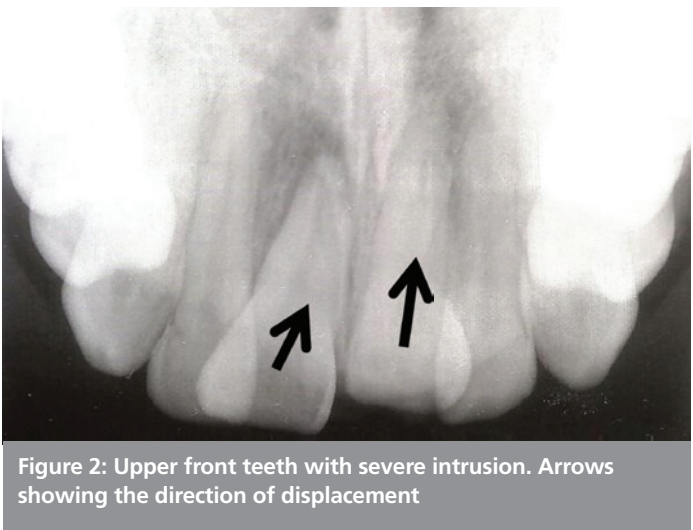


Figure 2: Upper front teeth with severe intrusion. Arrows showing the direction of displacement

Dental injuries are the second most common body injury in preschool children and the fourth among seven to 30 year olds (Eilert-Peterson, 1997). The peak incidence of dental trauma in the primary dentition are found at two to three years of age where motor coordination is developing and the children start moving around on their own.

Approximately one third of five year old children have suffered traumatic dental injuries involving primary teeth. Most often represented as tooth displacement (luxation). In 12 year old children, 20-30% have suffered dental injuries with boys more frequently affected. Peak incidences for boys are found at nine to 10 years due to vigorous playing and sports activities.

One of the most severe forms of luxation injuries are intrusions which produces catastrophic effects to the alveolar bone, shears and destroys periodontal ligament fibres and cells, and

crushes the apical vascular system (Kenny et al. 2003). It should be noted that a large degree of force is required to intrude permanent incisor teeth into the alveolar bone and the possibility of other injuries to the head and facial region should be investigated.

Prognostic factors that may affect healing and tooth survival include the degree of displacement of intruded teeth, concomitant tooth crown fractures, and the stage of root maturity. The best prognosis is seen in teeth where root development is most complete.^{1,2,3}

Depending on the severity of intrusion, there is a high risk of dental pulp necrosis. The crushing injury to the periodontal ligament and root surface is so severe that progressive root resorption and replacement by bone (Ankylosis) is not an uncommon sequela with figures that vary from 38% to 52%⁴ resulting in the loss of the affected tooth eventually.

The dental management for intruded teeth involves surgical, endodontic, and restorative interventions. The treatment aim is to preserve the alveolar bone support surrounding the tooth while providing good aesthetics and function. If root resorption complicates the healing process, a planned loss of the affected tooth in the appropriate timing will provide a healthy supporting bone that can accommodate replacement by a dental implant or auto-transplanted premolar tooth as a definitive long-term treatment option.

Repositioning of the tooth into its original position will decompress the injured tissues and re-establish the normal relationship between the tooth and bone. Repositioning can be performed immediately by surgical reduction, or by using orthodontic traction (active repositioning). A third option for mild intrusions is by passive repositioning and waiting for the tooth to return to its preinjury position.⁵

Continued on page 10.

Dr Mohammad Alansary is a Paediatric Dentist consulting at Capital Dental, 1 Murphy Street, Thorndon, Wellington and operating at Bowen Hospital, 98 Churchill Drive, Crofton Downs in Wellington.

Intrusive Dental Injuries in Adolescent Patients

Continued from page 9

Dr Mohammad Alansary



Figure 3: Splinting for repositioned intruded teeth



Figure 5: Final restoration of intruded teeth at 20 months follow-up visit



Figure 4: Root canal treatment for intruded teeth

Intruded teeth that are surgically repositioned require appropriate splinting. It is recommended to use a non-rigid splint that allows functional tooth movement and minimise the chances of “ankyloses” (tooth to bone union). The splinting time for intrusive injuries can vary from one week to two weeks and can be extended for four weeks in case of associated alveolar bone fracture.

In such teeth, early endodontic treatment is required hoping to suppress the “inflammatory root resorption” that may result from necrotic pulp tissue. However, “ankylosis” may still occur because of irreversible damage to the periodontal ligament due to the severe crushing injury.

Long term treatment considerations

Intrusive luxation injuries produce severe damage to the tooth, periodontal ligament, supporting bone and the dental pulp. Healing outcomes are usually complicated by root resorption, ankylosis, marginal bone loss, pulp canal obliteration and pulp necrosis. In a growing pre-adolescent patient, ankylosis will result in an “infra-occluded” tooth that will appear embedded in the alveolar bone with a resultant gingival disharmony.

In case of this unfavourable healing, the tooth can be expected to last for two to ten years depending on the speed of alveolar bone turnover. The current management will provide a medium term solution to preserve aesthetics and allows for controlled loss of the tooth while preserving its supporting

alveolar bone that will allow further orthodontic treatment or tooth replacement by implants or tooth auto-transplantation.

References

1. Flores MT, Andreasen JO, Bakland LK (2001). Guidelines for the evaluation and management of traumatic dental injuries. *Dent Traumatol* 17(4):49-52
2. KOSTOPOULOU & MS DUGGAL (2005). A study into dentists' knowledge of the treatment of traumatic injuries to young permanent incisors. *International Journal of Paediatric Dentistry* 15(10-19)
3. M J Kinirons (1998). Treatment of traumatically intruded permanent incisor teeth in children. *INT J PAED DENT* 8(165 – 168)
4. Andreasen JO, Andreasen FM, Skeie A, Hjorting-Hansen E, Schwartz O (2002). Effect of treatment delay upon pulp and periodontal healing of traumatic dental injuries – a review article. *Dent Traumatol* 18(3):116-128
5. Albadri S, Zaitoun H, Kinirons MJ (2010). UK National Clinical Guidelines in Paediatric Dentistry: treatment of traumatically intruded permanent incisor teeth in children. *International journal of paediatric dentistry / the British Paedodontic Society [and] the International Association of Dentistry for Children* 20 Suppl 1(1-2)

* Author's own images.

Welcome Letter

28 October 2016

Dear General Practitioners

Mr Richard Evans

MBCHB, FRACS (General Surgery), FRACS (Vascular), DDU (Vascular)

Richard Evans, Vascular Surgeon, is now available to see patients at the Bowen Centre and Wakefield Specialist Medical Centre.

Richard has been in practice as a consultant surgeon for nearly 20 years. His areas of expertise include all forms of arterial and venous surgery, endovascular surgery, varicose vein laser and cutaneous vascular laser.

Richard is also a consultant vascular and renal transplant surgeon at Wellington Hospital (CCDHB). He is Vascular Clinical Leader at CCDHB and an honorary senior lecturer at Otago Medical School.

He is happy to be contacted on his mobile by both GPs and patients.

Richard's private practice is based at Bowen and Wakefield Hospitals and he is also available at Boulcott Hospital, Selina Sutherland Hospital in Masterton and the Waikanae Specialist Medical Centre.

Richard is always open to new ways of communicating; bookings can be made on his website and he is happy to do remote consultations via skype.

How to refer:

Bowen Centre, 98 Churchill Drive, Crofton Downs, Wellington 6035.

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Yours sincerely

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Note: new details

New Consultant



Dr Diogo (DJ) Godoy Zanicotti

BDS, Esp(Perio), Esp(Implant),
MCLinDent, PhD

Periodontist Specialist

P: (04) 499 2499

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wellingtonperiodontics.co.nz

I am consulting at Wellington Periodontics and Dental Implants, Level 16, 142 Lambton Quay, Wellington and operating at Bowen Hospital, 98 Churchill Drive, Crofton Downs, Wellington.

I am a fully registered specialist in Periodontics in New Zealand, Australia and Brazil.

Specialty

Periodontics and Dental Implants

Training

I graduated with a BDS from Tuiuti University (Brazil) in 2004, and have been a specialist in Periodontics (2006 – Faculdade de Odontologia de Piracicaba – Unicamp, Brazil) for 10 years. I have a Masters Degree in Clinical Dentistry (Implant Dentistry) from Universidade Positivo, Brazil and a PhD from the University of Otago, New Zealand. For my PhD I studied the regeneration of bone around implants using stem cells.

Special interests

My special interests are in gum disease treatment, plastic surgery of the gums, bone and gum grafting/regeneration and dental implants.

Contact Us

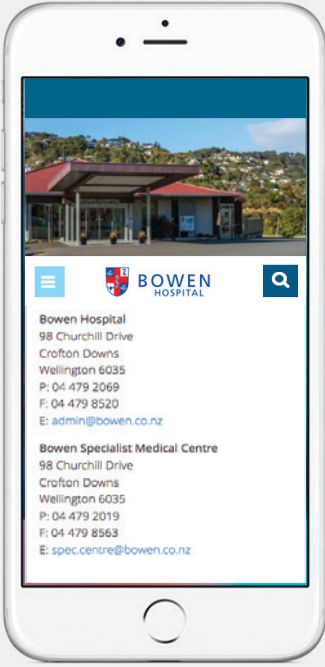


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GP CONFERENCE

Connect 2017


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Te Papa, Wellington // 19 & 20 May 2017 // www.acurity.co.nz




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