Faecal Incontinence

Investigating the Causes of Faecal Incontinence, a Hidden Problem

Toileting habits and problems with bowel control are not considered socially acceptable topics of conversation so when someone has a problem and seeks help they struggle to discuss the issues. Consequently there is much silent suffering leading to social isolation.

A recent New Zealand study revealed a prevalence rate of 13% for faecal incontinence defined as “leakage of liquid or solid stool >1/month”. The majority of those affected are female. Anal incontinence can result directly from poor sphincter function, altered rectal sensation and altered rectal compliance. For women a vaginal delivery, even uncomplicated is the most common time for injury or damage to occur.

It is recognised that for all women following a vaginal delivery approximately 30% will have occult damage to the anal sphincters. Of those who have had an assisted delivery (forceps/ventouse) studies report a prevalence of 49-73%. Hidden injuries can also involve the puborectalis muscle and the rectum. Many of the women are young and can compensate for any injury. For many, problems do not become apparent until the women are peri-menopausal.

Continued on page 3
Message from Acuity Health Group

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

Welcome to the first edition of Health Matters for 2016, one of three planned for this year. We look forward to bringing you informative and relevant information, provided by specialists consulting at Acuity hospitals and other medical professionals along with information about new procedures and the latest technology to help you provide the best possible care for your patients.

GP Conference
Registration is now open for the Acuity GP Conference: Connect 2016 a conference proving to be bigger, better and bolder than ever before. We have an exciting array of speakers, sponsors and exhibitors all looking forward to sharing their knowledge with you. Once again we have included the “quick fire” lightning talks that proved very popular last year and a wide selection of concurrent sessions for you to choose from. Turn to the centre of this publication for a current programme (correct at print) and a list of sponsors and exhibitors. Hope to see you at Te Papa on Friday 6th and Saturday 7th May. Visit www.acurity.co.nz/connect to register for the Acurity GP Conference: Connect 2016, and for up to date information.

Feedback
Happy reading and, as always, please do let me know if there’s anything specific you would like to see us cover in future issues of Health Matters.

Paul Quayle,
Chief Operating Officer,
Acuity Health Group Limited

Wakefield Hospital – New General Manager
Dorothy Paton as Wakefield Hospital’s new General Manager. Dorothy comes to us from Forte Health in Victoria as shown here or as a wave can be recorded in colour ultrasound showing defect (between the two arrows) in the internal anal sphincter on the right is the recording of pressure at rest and on the left the reconstruction from this pressure measurement.

Dorothy is a highly experienced General Manager who will be responsible for leading Wakefield Hospital into the future.

It is my pleasure to introduce Dorothy Paton as Wakefield Hospital’s new General Manager. Dorothy comes to us from Forte Health in Christchurch, and is a highly experienced General Manager who will be responsible for leading Wakefield Hospital into the future.

Faecal Incontinence

A significant proportion of these women can be helped with simple treatments such as anti-diarrhoeal medication or pelvic floor retraining. At the other end of the spectrum a minority may need a permanent stoma. However, in order to help these women information about the structure and function of the anorectal continence mechanism is beneficial.

Faecal incontinence can be passive (damage to the internal anal sphincter), urgent (damage to the external anal sphincter or rectum) or a mixture of both. A focused clinical exam of the anorectum can identify the problem in the majority. There is a small role for the use of colonoscopy or proctography in the investigation of these patients but the real advances have been in the use of anorectal physiological studies (manometry and pudendal nerve testing) and endoanal ultrasound.

The ability to perform these studies has been available at Acurity’s Wakefield Hospital since 2004 though the diagnostic ability of the equipment was limited. Recently the hospital upgraded its equipment to state of the art high resolution anal manometry including for the first time nerve stimulation in order to test pudendal nerve function. Mucosal sensitivity testing is also possible but currently not performed.

An anal ultrasound allows us to look at the structure of the anal canal, to identify any defects within the sphincter complex.

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Ultrasound of a normal anal canal (EAS – external anal sphincter, IAS – internal anal sphincter)

Dr Elizabeth Dennett

Ultrasound showing defect (between the two arrows) in the internal anal sphincter

Three dimensional reconstruction of the anal canal based on pressure measured at rest and on the left the reconstruction from this pressure measurement.
Faecal Incontinence

Continued from page 3

One of the simpler operations for incontinence is a direct repair of the external anal sphincter. There is however no value in knowing there is a defect in the sphincter if you don’t know if the nerves work otherwise surgery will fail.

All of these tests are simple to perform, they require no prior preparation by the patient and can usually be completed in less than 30 minutes. They can provide a wealth of information in order to treat people with incontinence and in many cases give them their lives back.

References

Manometry provides a list of useful information about the function of the anorectum but investigation is not complete without knowing if the pudendal nerves work.

The universally standard way to measure terminal motor latency in the pudendal nerves is to use a St Marks electrode while performing a PR examination.

Image 1: Dr Elizabeth Dennett

Acuity Health Group is delighted to host a variety of Continuing Medical Education (CME) sessions for GPs throughout the coming year.

Register today by emailing pg@acurity.co.nz
For an updated list, visit www.acurity.co.nz and search events.
For more information, contact Sarah Malone, Business Development Manager, P. 04 920 0158, E. sarah.malone@acurity.co.nz

Upcoming CME Sessions – 2016

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<th>Date</th>
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<th>Title</th>
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<tr>
<td>15 March</td>
<td>Dr John Beaumont, Dr Alex Bullar, Muhammad Khalid, Ophthalmologists</td>
<td>Ophthalmology Update on Ophthalmology 2016</td>
<td>Roxton Centre Seminar Room</td>
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<td>17 March</td>
<td>Mr Fred Phillips, Orthopedic Surgeon</td>
<td>Orthopaedics Osteoarthritis of the Hip and Knee in Young Patients</td>
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<td>22 March</td>
<td>Mr Nick Bedford, Mr Simon McDowell, Gynaecologists</td>
<td>Gynaecology Update Beyond That Time of the Month</td>
<td>Kapiti Lindale Conference Centre, Paraparaumu</td>
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<td>23 March</td>
<td>Drs John Beaumont, Alex Bullar, Muhammad Khalid, Ophthalmologists</td>
<td>Ophthalmology Update on Ophthalmology 2016</td>
<td>East Pier Hotel 50 Nelson Quay Ahuriri, Napier</td>
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<tr>
<td>31 March</td>
<td>Dr Jess Gale, Ophthalmologist</td>
<td>Pelvic Floor Dysfunction Pelvic Floor Dysfunction: Related to Defecation and Incontinence</td>
<td>Wakefield Hospital Education Centre</td>
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<tr>
<td>5 April</td>
<td>Dr Elizabeth Dennett, General Surgeon, Liz Childs, Pelvic Health Physiotherapist</td>
<td>Gynaecology Endometriosis and Chronic Pelvic Pain (Dr Jeremy Maeta), Musculoskeletal aspects of Pain (Leanne Wait)</td>
<td>Kapiti Lindale Seminar Room</td>
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<td>6 April</td>
<td>Mr Jeremy Maeta, Obstetrician and Gynaecologist, Leanne Wait Physiotherapist</td>
<td>Gynaecology Endometriosis and Chronic Pelvic Pain (Dr Jeremy Maeta), Musculoskeletal aspects of Pain (Leanne Wait)</td>
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<td>13 April</td>
<td>Mr Jeremy Maeta, Obstetrician and Gynaecologist, Leanne Wait Physiotherapist</td>
<td>Gynaecology Endometriosis and Chronic Pelvic Pain (Dr Jeremy Maeta), Musculoskeletal aspects of Pain (Leanne Wait)</td>
<td>East Pier Hotel 50 Nelson Quay Ahuriri, Napier</td>
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<td>6 &amp; 7 May</td>
<td>Multiple speakers</td>
<td>Connect 2016: Acurity GP Conference For enquiries, email <a href="mailto:connect@acurity.co.nz">connect@acurity.co.nz</a></td>
<td>Te Papa, Wellington</td>
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<td>15 June</td>
<td>Wakefield Heart Centre</td>
<td>Cardiology Cardiology Update</td>
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<td>29 June</td>
<td>Wakefield Heart Centre</td>
<td>Cardiology Cardiology Update</td>
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<td>6 July</td>
<td>Dr Alex Popadic, General Surgeon</td>
<td>General Surgery Breast Cancer and DCCS – What’s New?</td>
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<td>24 August</td>
<td>Mr John Groom Gastrointestinal and Colorectal Surgeon</td>
<td>Gastroenterology The Bottom Half of the Body</td>
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<td>September</td>
<td>Mr AH Shekouhi, Consultant General and Colorectal Surgeon</td>
<td>General Surgery TBC</td>
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<td>October</td>
<td>Dr Leopold Lourens, Vascular and Endovascular Surgeon</td>
<td>Vascular Surgery TBC</td>
<td>Kapiti Lindale Conference Centre, Paraparaumu Wakefield Hospital Education Centre</td>
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Glaucoma and its Treatment

Bowen Hospital

Glaucoma is an insidious disease with minimal symptoms until it is advanced, so most patients are diagnosed as an incidental finding by their optometrist. For this reason it is important that the treatment for glaucoma does not worsen quality of life more than future visual loss from glaucoma itself.

Medication: drops drops drops

Drops are often the first and last treatment for glaucoma. Prostaglandin drops are popular because they are more effective, they are best tolerated, and they are applied once daily. Prostaglandins alter the expression of metalloproteinases, which makes the extracellular matrix more permeable and allows outflow of fluid through an unconventional route. They can make the eyes red, and sometimes worsen ocular surface irritation. An interesting side effect is known as prostaglandin-associated periorbitopathy, with increased eye-lashes (number and length), sometimes increased eyelid pigmentation, and atrophy of the periorbital fat resulting in a deep sulcus on the upper lid and even epinephthalmas. These side effects are partly reversible when the drop is stopped (figure 2).

Timolol is our next most popular drop, and is fairly effective but can sometimes cause the systemic side effects of beta-blockers. I warn patients about breathlessness, dizziness, lethargy, poor concentration, depression and loss of sex drive, and so many refuse to take it! We now use a low dose 0.25% gel-forming XE drops once daily, which seems to lower the pressure as much as 0.5% drops twice daily but with fewer side effects.

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Summary

As yet the only treatment to reduce the risk of blindness in glaucoma is lowering the IOP, and yet all treatments have some risk too. Each incremental attempt to lower IOP remains a trade-off between these risks.

Surgery

Unlike cataract surgery, glaucoma surgery does not improve vision and still has significant risks of vision-threatening complications. In some patients it is the only way to avoid blindness, while in others the risks are acceptable in order to avoid intolerable side effects of drops. Surgery is more effective than laser and drops, but the benefit of this is only found after careful long-term follow up.

Several different lasers are used in ophthalmology and in treating glaucoma. Two types that can specifically lower the IOP are known as Argon Laser Trabeculoplasty (ALT) and Selective Laser Trabeculoplasty (SLT). In both types a green laser is applied directly to the drainage structure of the eye (the trabecular meshwork) using a thick mirrored contact lens to visualise the irido-corneal angle (figure 3). In ALT small high energy focal burns create discrete scars, resulting in improved function between the scars, while in SLT large low energy pulses are applied which stimulate or irritate the meshwork cells to function better. Both lasers have similar effect on IOP, and the effect is additional to drops (or can be an alternative), and there are also theoretical advantages because improving trabecular outflow may reduce diurnal variation. The main advantages of SLT is that it can be safely repeated indefinitely for as long as it remains effective, but the disadvantage is that SLT is not widely available in public hospitals at this point.

Dr Jesse Gale consults at Capital Eye Specialist, 148 Cuba Street, Wellington, and operates at Bowen Hospital, 98 Church Drive, Crofton Downs, Wellington.
Evolution of the Practice Management System

More than just patient management – a business efficiency and analytical tool

Primary care in New Zealand is passing through a critical transition time. On one hand there is increasing expectation and shifting focus from secondary to primary care, support for increased patient participation and a threat on general practice quality and performance. On the other hand there are considerable workforce and financial sustainability challenges looming. We are now challenged to dramatically increase our productivity and capacity to cope with increasing workloads and cost pressures. One way to address our challenges is to embrace a powerful information technology platform to support these objectives.

To support a changing health care model a Practice Management Systems (PMS) needs to be flexible enough to address the myriad of variations in primary care practices that exist today, while being robust enough to meet the needs of the future. This includes the ongoing drive to increase productivity, meet sustainability challenges and maintain financial stability.

The Patient Centered Model of Care is a boundary between primary care, community care, and self-care. (Where personal health records, shared care records and practice based electronic health records evolve into an integrated interoperable information system that can be used by the care team (including practice BTI’s and whanau) from anywhere under appropriate authority and controls.)

As the complexities of the operating environment continue to increase it’s paramount that the PMS must continue to evolve. Not only to absorb these requirements, but also to become a more comprehensive tool supporting business requirements of the practice.

Analytics Medtech’s Clinical Business Intelligence tool is a fully integrated clinical and financial analysis tool designed to report business growth and provide improved business growth and income analysis tools then talk and to the Medtech at the ‘Connect 2016’ Acury GP Conference. Alternatively contact us – via phone (09) 358 1123 or email sales@medtechglobal.com

Recognising Adverse Pain Behaviour in Low Back Pain Patients

Steve Jacobs (not his real name) is a successful CEO who has just booked an appointment to see you!

As with many health conditions, the sooner the condition is identified (and appropriate treatment initiated), the better the outcome. A number of studies have tried to identify the key factors associated with the development of persistent back pain.1,2 Be wary if your back pain patient appears very worried about their pain, has poor sleep, difficulty returning to normal daily activities, and is involved in litigation and/or has poor social or vocational support. More recently, researchers at Keele University in the UK have developed and validated a screening tool (Keele STARTBack) for use in primary care to help identify LBP patients that are at risk of developing a heightened level of pain behaviour.3

Within our network of clinics, we provide a dedicated multi-disciplinary programme to help patients that are not coping with their back pain. The programme is run by a team of physiotherapists, occupational therapists and psychologists and is designed to help people to better understand their situation and provide a staged and supported return to activity, work and independence.

The outcomes of the results are achieved when there is a consistent and continuous effort from everyone involved – including the patient, the GP, their whanau and friends, and the rest of the rehab team.

References:
2. McIntosh G, Frank JW, Hogg-Johnson S, Bombardier C, Hall HH. Prognostic factors associated with low back pain (including disability) at 12 weeks after treatment initiated), the better the outcome. A number of studies have tried to identify the key factors associated with the development of persistent back pain.1,2 Be wary if your back pain patient appears very worried about their pain, has poor sleep, difficulty returning to normal daily activities, and is involved in litigation and/or has poor social or vocational support. More recently, researchers at Keele University in the UK have developed and validated a screening tool (Keele STARTBack) for use in primary care to help identify LBP patients that are at risk of developing a heightened level of pain behaviour.3

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Programme preview

Friday 6 May 2016 – Day One

0800 Registration Desk Open

OPTHALMOLOGY / NEUROLOGY

1010 Concurrent Sessions A:

1015 Concurrent Sessions A:

MUSCULOSKELETAL

1110 Concurrent Sessions A:

1255 Lunch / Exhibition

Saturday 7 May 2016 – Day Two

0800 Registration Desk Open

RENSAL DISEASE / CARDIOLOGY

1330 Concurrent Sessions G:

1355 Concurrent Sessions E:

1405 Concurrent Session H (repeat of G)

1410 Prize Draw

1440 Men’s Health

1310 Concurrent Sessions C:

1350 Concurrent Session D (repeat of C)

1400 Concurrent Sessions E:

1410 Men’s Health

Legend

Planetary sessions (Soundbites Theatre)
Questions for lightning speakers
Concurrent sessions (you pick two for each session)

For the most current programme, please visit www.acurity.co.nz/connect/
New Initiatives for Vascular Ultrasound

Wakefield Hospital

Area: Vascular Ultrasound, Referral and Reporting. Article content supplied by:
Dr Richard Evans, Vascular Surgeon, Specialist Vein Health, ph (04) 389 4999

Vascular ultrasound covers a range of areas from lower limb and pelvic vein DVT assessment, to complex arterial assessments.

At the core of a vascular study is: What is the underlying disease process, and what vascular surgical input will be required to manage the problem?

At Specialist Vascular Ultrasound, we have developed several new initiatives which increase the efficiency of managing vascular patients for general practitioners and other specialists.

Firstly, we have introduced the SR – Specialists and Referrals programme on Medtech. This enables referrers to request vascular scans directly via the Specialist Vein Health Medtech entry, see the dropdown menu below.

If your practice does not have the SR programme, referrals can also be sent in the usual fashion via the Veinspec EDI, or using an editable PDF document form available on our website.

The next new initiative is a prompt specialist vascular opinion on management of the patient’s problem. This takes the form of same day reports sent to the referrer via Medtech, or a phone call from a vascular surgeon if the problem is urgent – such as a DVT which may be suitable for thrombolysis, or a large AAA or severe carotid stenosis which may require urgent intervention.

Ease of referral process, timely reports and direct vascular specialist input to patient management are all key features of our new service.

Specialist Vein Health
Specialist Vascular Ultrasound
P: (04) 389 4999
F: (04) 389 4970
E: reception@svh.co.nz
W: www.svh.co.nz

For more details, go to www.acurity.co.nz/connect/
In January this year, President Obama gave his final State of the Union address to the American people. Drawing parallels to John F. Kennedy’s moon-shot speech, he announced a lofty goal to see “America cure cancer once and for all”. The statement may be ambitious, but we are at a time of rapid progress for cancer therapies.

The notion of using the body’s immune system to fight malignancy is not new. Spectacular but rare cases of spontaneous tumour regression have long been documented and attributed to the immune system. In the 1890s, Dr William Coley injected patient’s tumours with live bacteria, and observed dramatic regressions among some of those who survived his ministrations.

Bone marrow transplant, effectively an immune system transplant, prevented lymphoma and leukaemia recurrence, and we now know that this protection is due to lymphocytes (specifically T cells) from healthy donor recognising and attacking the recipient’s cancer.

Current immune therapies for cancer can be divided into two types: passive and adaptive immunotherapies. Passive immune therapies, such as the monoclonal antibodies Herceptin® and rituximab, avidly bind to the surface of cancer cells and label them for destruction by the innate immune system. Although effective and in widespread clinical use, these treatments do not lead to long-lasting immunological memory – they only work for as long as the antibodies are present. In contrast, the adaptive immune system has the capacity for ‘immunological memory’ – it can learn to recognise abnormal cells and keep attacking them whenever they appear. Training T cells to identify tumour cells as foreign, and to destroy them is the goal of many experimental immunotherapy trials.

Our immune system has inhibitory pathways, called ‘immune checkpoints’, which prevent undesirable autoreactivity. Inhibitory pathways in our T cells are often triggered in the vicinity of normal tissues. Molecules that block these inhibitory pathways can ‘unlock’ T cell function against cancer cells. Interestingly, it was a surprise to many when the first of these ‘checkpoint inhibitors’ (pembrolizumab (anti-PDL1), or anti-CTLA4) led to dramatic regressions in cancer patients. Since then, many checkpoint inhibitors have been approved and are now in clinical practice.

The Malaghan Institute of Medical Research in Wellington, New Zealand is working on cancer vaccination approaches, designed to stimulate T cell activity against cancer. Developed through a joint research venture between the Ferrier Institute and the Malaghan Institute, one of our approaches has been patented and a company called Avalia Immunotherapies formed to progress this research. Our approach is as they are employing the immune system in a way that it is able to attack the cancer tissue.
Plantar Calcaneal Spurs: What is the Research Telling Us?

Heel pain is a common condition that podiatrists see on a regular basis. There are many different causes of heel pain. This article will focus on what the evidence is telling us about the role of heel spurs in plantar heel pain.

Based on the reportedly high prevalence of spurs in the asymptomatic population, the role of subcalcaneal spurs in heel pain has been questioned in musculoskeletal medicine, leading to an emerging view that the finding has limited diagnostic value. The association between a spur formation and heel pain have not been adequately investigated.

Plantar calcaneal spurs are common. It is estimated that 11% to 16% of the general population have radiographic evidence of spurs. Evidence of spurs are over represented in particular sub groups such as older people, females, people with osteoarthritis, and those with previous or current heel pain. The pathophysiology of spurs is poorly understood. There are risk factors for a symptomatic heel spur. These include increased age (usually over the age of forty years), athletes (usually runners), obesity and increased hours of standing usually on hard unyielding surfaces. Up to 65% of patients complaining about heel pain have signs of a plantar spur. It is a common finding in plantar heel pain. There are to be a correlation between heel spurs and plantar heel pain. However it is unclear whether the spur is the cause of the heel pain or just a correlation. Many people have a spur but no pain.

Functional problems have long been suggested as a cause. There is some evidence for this but it is very weak. These factors include decreased ankle joint and 1st MTP dorsiflexion, and increased pronatory forces. Heel spurs were unrelated to radiographic measures of foot posture. However we must remember that those radiographs were static and do not represent dynamic movement.

What causes heel spurs?

One theory for spur formation is the mechanical overload theory where a series of stresses continue to push the fascia or plantar heel past a “critical limit”. The repetitive traction of the insertion of the plantar fascia into the calcaneus leads to inflammation and reactive ossification of the enthesis. There is also the longitudinal traction hypothesis (Figure A) where the plantar fascia lengthens with lowering of the medial longitudinal arch and that people with heel pain are more likely to be flat footed. However, studies have shown that most spurs are located deep to the plantar fascia (in deep intrinsic muscles) and also within fibrocartilage and loose connective tissue. Histological evidence shows no sign of inflammation and the bony trabeculae of spurs are not aligned in the direction of the soft tissue traction. It also showed that many spurs could reform after the release of the plantar fascia. The vertical compression theory (bone adaption, increasing the heel surface area to adapt to load) (Figure B) suggests that plantar calcaneal spurs are an adaptive response to vertical compression of the heel rather than longitudinal traction of the plantar fascia (they are not traction spurs). Fibrocartilaginous outgrowths which form in response to calcaneal stress fractures in an attempt to protect the calcaneus against micro cracks.

This is supported by studies that have found that spurs are more common in those who are overweight and those with decreased elasticity of the plantar heel fat pad such as older people. Studies also show that the trabecule of spurs are vertically oriented suggesting that stresses responsible for spur formation may be a result of vertical loading.

Why are some spurs symptomatic?

The presence of a plantar calcaneal spur does not always lead to heel pain. The size of the spur could be an important factor. The larger the spur the more likely to be symptomatic and if there were also fat pad abnormalities this could lead to increased shock transmission to the spur.

It is thought that the following factors may contribute to painful spurs: the size of the spur, presence of concurrent fat pad abnormalities leading to increased shock transmission to the spur, entrapment of the nerve to abductor digiti minimi caused by the spur and fracture of the spur. Extrinsic factors such as footwear, work environment and level of physical activity can contribute to a symptomatic spur. In very painful heel spurs a fracture could be the cause. Histological examination of excised spurs showed that the cortical shell was lacking and endochondral ossification a feature (fracture healing going on). Fracture of the spur itself is a common feature as shown by MRI in a patient I saw recently (Figure C).

Conclusions

Plantar calcaneal spurs are associated with obesity, osteoarthritis, and heel pain. They can be unrelated to foot posture. Plantar calcaneal spurs may primarily be an adaptive response to vertical compression. This may have implications for the management of plantar heel pain in older people. In chronic heel pain clinician’s treatments may be more focused around reducing the vertical stress, using silicone heel cups and contouring orthoses around the arch. In a very painful heel treating the pain like a micro/stress fracture and using a mooreboot for a period of up to four weeks may be a consideration.

References


Clinicians might find of interest the Journal of Foot and Ankle research. It is a free online journal with open access and is peer reviewed relating to the assessment, diagnosis, prevention and management of foot and ankle disorders. www.jfootankleres.com

Kim consults at Wakefield Sports Medicine, Level 4, 99 Pontcliff Street, Newtown, Wellington.

As well as providing general podiatry services Kim has a special interest in sports podiatry, providing a range of services including sports injury and general rehabilitation, running assessments, video gait analysis, footwear evaluations and the provision of orthoses if needed. She can also perform paediatric (children) limb assessments.

Podiatry to Kim is about keeping people active.

E: sportsmed@wakefield.co.nz
**New Consultants**

**Mr Ali R. Shekouh**  
MB ChB, MRCS, MD, FRCS  
(General Surgery), FRACS  
Consultant General and Colorectal Surgeon  
P: (04) 479 2019  
F: (04) 479 8563

I am consulting at the Bowen Specialist Medical Centre and practicing at Bowen Hospital.  
**Specialty**  
Colorectal and General Surgeon  
**Training**  
I graduated at the University of Liverpool, UK in 1995 and trained extensively in all aspects of colorectal and general surgery in Merseyside, UK. I completed two colorectal specialist fellowships in the USA and Singapore. During my training, I undertook a two year laboratory-based research project at the University of Liverpool and researched in the molecular biology of cancer. I developed the proteomic techniques for this research. This resulted in a M.D. higher degree in 2007. I have published several articles in high profile medical and scientific journals. I still retain an active interest in surgical research and am a strong advocate of undergraduate and allied medical teaching.  
**My areas of expertise include all surgical aspects of lower gastrointestinal disease, but in particular, colorectal disease (including inflammatory bowel disease, colorectal cancer, diverticular disease, rectal prolapse, anal incontinence, and anal pathology). My general surgical expertise includes gallstone disease, hernias (including laparoscopic inguinal hernia repair) and endoscopy (gastroscopy and colonoscopy).**  
**Special interests**  
- Laparoscopic colon and rectal cancer surgery  
- Colon and small bowel surgery (open and laparoscopic)  
- Inflammatory bowel disease management and surgery  
- Pelvic floor disorders (including prolapse) and surgery  
- Anorectal diseases (including haemorrhoids, fissures and fistulae)  
- Laparoscopic gallbladder surgery  
- Laparoscopic and open hernia repair (including ventral and abdominal wall repair)  
- Colonoscopy, colonic surveillance and gastroscopy  
- Clinical research and medical education.  
**Background**  
Ali is currently a member of the following professional/other bodies:  
- Fellow of the Royal College of Surgeons Edinburgh, UK  
- Member of the Association of Coloproctology of Great Britain and Ireland, UK  
- Member (provisional) of the Colorectal Surgical Society of Australasia  
- NZ Corjoint Committee for Recognition of Training in Gastrointestinal Endoscopy.

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**Mr Leslie (Les) Snape**  
MB ChB, FRCS (Ed), FRCS (Eng), FFDRCS  
Oral and Maxillofacial Surgeon  
P: (04) 974 8150  
F: (04) 974 8151  
E: maxfacorz@gmail.com

Leslie consults at the Scott Clinic, 509 Southland Road, Hastings and operates at Royston Hospital.  
**Specialty**  
Dermatology  
**Training**  
Lissa completed her dermatology training in Wellington, Auckland and Australia, and then went on to do her occupational medicine training in Wellington and Dunedin.  
**Special interests**  
Special interests in occupational dermatology (in 2010 was awarded the Dr John Stoke Medical for excellence in occupational medicine), contact dermatitis, patch testing, eczema, phototherapy, acne and psoriasis.  
In addition to working full time as a dermatologist Lissa also lectures in dermatology for Wellington and Dunedin.  
**Specialty training**  
University of Otago.  
**Recognition of Training in Ophthalmology**  
Dr Khalid served as locum ophthalmologist at Mid-West Regional Hospital Limerick and the University Hospital Waterford, Ireland after completing his training in ophthalmology under the Irish College of Ophthalmologists.  
He developed an interest in retinal disease and completed a year each fellowship in medical retina and retinal surgeries from the Royal Victoria Eye and Ear Hospital, Dublin. Dr Khalid is also a voluntary eye surgeon with a number of charity organisations including Rose Charities, New Zealand. He served in several African countries and Cambodia.  
His wife and three children are enjoying life in Hawke’s Bay.