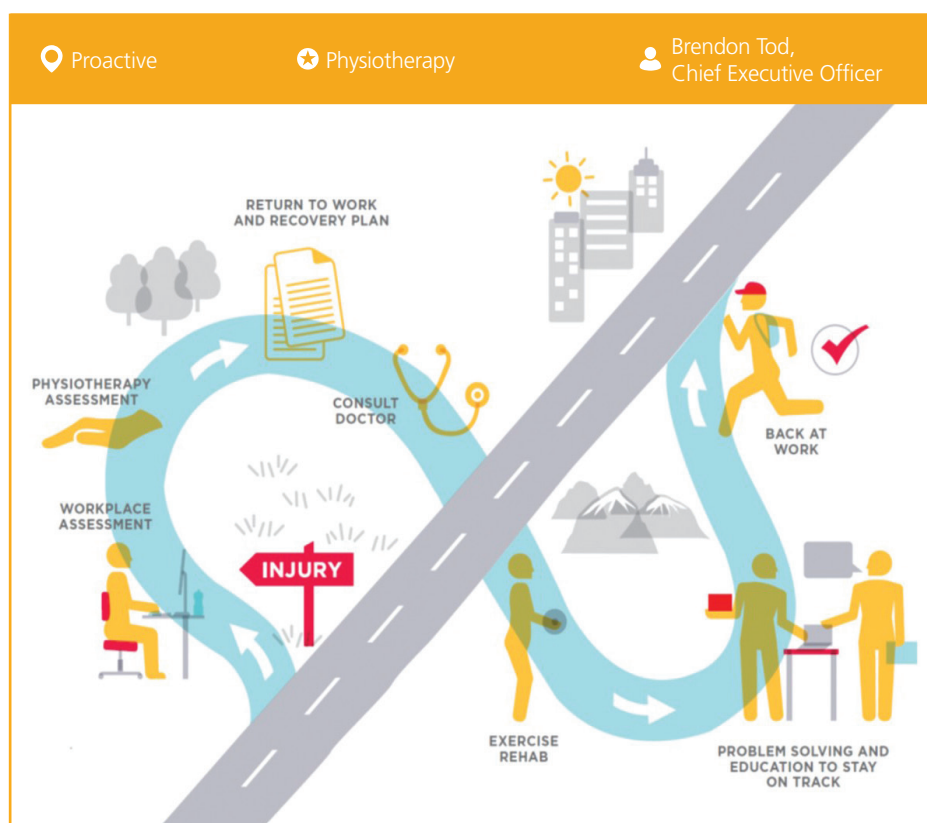


# Health Matters

## Why Patients Do Not Return to Work

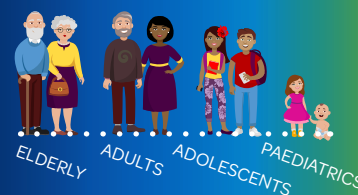
Brendon Tod



## Connect 2020

GP CONFERENCE

Health through the ages:



**15-16  
May 2020**

Save the date.  
Super Early Bird  
registration open  
in November

### Brain Tumours – Presentation, Diagnosis and Treatment

Dr David Okonji > 12



### Vascular Telehealth – First Steps

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### Diabetic Foot Ulcers

Mr JK Wicks > 8



## Welcome to Health Matters.

Keeping you up to date with services that are relevant to your patients.

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# Message from Acurity Health

 Acurity Health

 Dr Jonathan Coleman,  
Chief Executive Officer

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



**Mental Health is a topic that is at the forefront of everyone's mind in New Zealand. There's been a growing demand for services, and a major gap in the private healthcare landscape for a modern, private facility delivering the most up-to-date evidence-based treatments.**

So we are extremely excited that later this month we will be opening the doors on Re-centre, an outpatient mental health facility in central Auckland. This service will be a first for New Zealand, and already we are receiving high levels of interest.

We've been working alongside Sir John Kirwan on this project for several years, and his input has been invaluable in shaping our service. Acurity's parent company Evolution Healthcare has developed similar facilities in Australia, and that experience has stood us in good with the planning for Re-centre.

We have consulting space for 10 Psychiatrists and will be running a range of day group programmes aimed at those with mild to moderate anxiety and depression as well as post-traumatic stress disorder.

*Continued over*

 BOWEN  
HOSPITAL

 ROYSTON  
HOSPITAL

 WAKEFIELD  
HOSPITAL

 Re-centre

### About Acurity Health Group

One of New Zealand's leading private providers of healthcare services, Acurity owns and operates Wakefield and Bowen Hospitals in Wellington, and Royston Hospital in Hawke's Bay.

Through a partnership with Icon Group based in Brisbane, Australia, Acurity delivers private oncology services at Bowen Icon Cancer Centre in Wellington. They also have investments in Endoscopy Auckland, Laparoscopy Auckland, Grace Hospital Tauranga, Proactive, and Birthcare Auckland.

Acurity aims to be the preferred provider of private healthcare services, chosen by leading specialists, major health insurers, patients and their families. This is demonstrated through Acurity's commitment to developing and growing their hospitals and continuously investing in the latest technology, while being a leader in their sector.

“...We are continually looking for ways to improve the experience for your patients at our facilities.”

Of course, there's a lot else happening across the Acurity Health Group.

If you've had the chance to visit Wakefield Hospital's operating theatre tea room recently you will have been struck by the vastly different view looking out towards Rintoul Street; yes the building of our new hospital is well underway with the diggers going full-on as the earthworks continue apace.

All the careful planning is paying off with no disruption to our hospital services, and the contingency plans for staff parking coming in to play.

It's the same story at Royston as the new development progresses there as well.

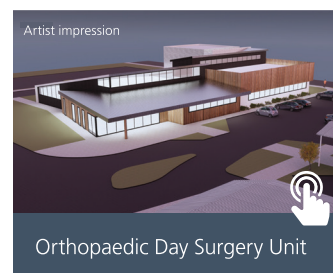
Overall, a period of intense development and growth as we expand our offerings for your patients across Acurity.



There is going to be major change on that site unfolding before our eyes over the next 15 months as the new hospital takes shape, culminating in the completion of Stage 1 in March 2021. After that, the builders will be moving on to the building of our brand new theatres and peri-operative facilities.

That's why at Acurity we're putting a real emphasis on digitalising systems and removing as much paper as possible. We've completed e-discharges and are now moving on to e-admissions; at the same time it's really important to be able to easily gather information about how our hospitals work, as well as being able to make our processes as efficient as possible.

“...Overall, a period of intense development and growth as we expand our offerings for your patients across Acurity.”



We are continually looking for ways to improve the experience for your patients at our facilities.

There's one thing for certain, keeping pace with technology is key to keeping right at the front of the private healthcare field, and that is where Acurity is determined to remain.

*Jonathan Coleman*

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



Digital  
Standardisation  
> page 7



# Why Patients Do Not Return to Work

Brendon Tod



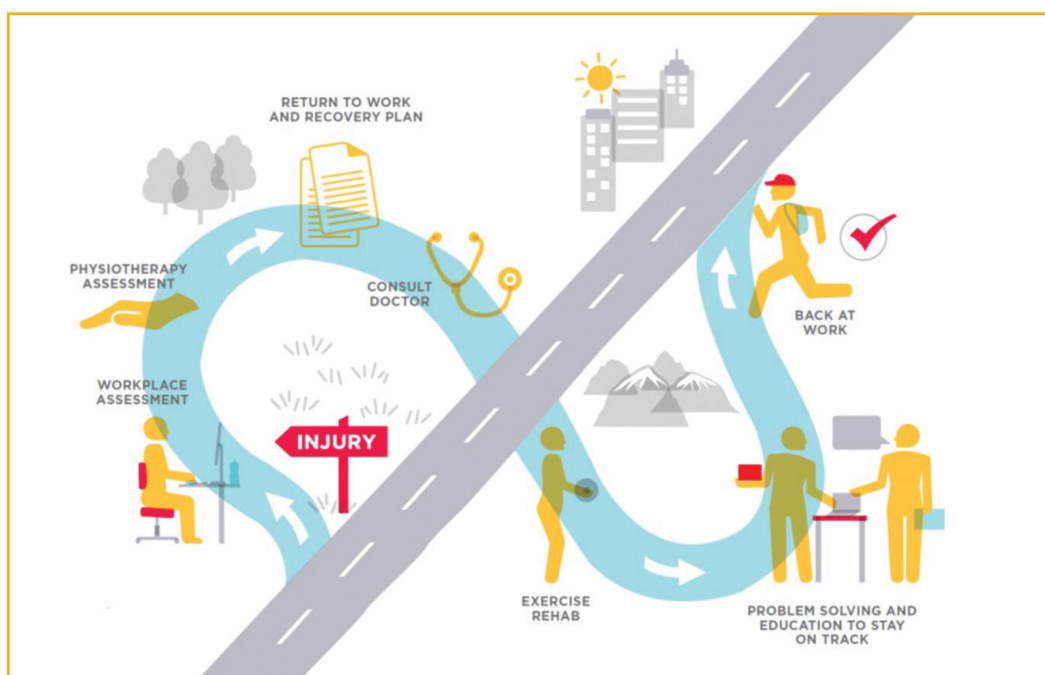
Proactive

Physiotherapy

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## Understanding the reasons that patients do not return to work following injury or illness – a practice-based evidence approach

There is compelling evidence that, for most individuals, engagement in employment is good for general health and wellbeing, and those in employment demonstrate reduced psychological stress. Even health issues that are frequently attributed to work (e.g. musculoskeletal and mental health conditions) have been shown to benefit from activity-based rehabilitation and an early return to suitable work. Additionally, research shows that long term absence from work has detrimental effects on physical health, mental health, wellbeing and socioeconomic status for the individual, as well as impacts on the wider family unit<sup>1</sup>. Knowing that sustaining employment is good for health, health professionals have the opportunity to substantially

improve health and wellbeing outcomes by promoting early re-engagement in suitable work following time off work due to an injury or illness<sup>1</sup>. Further to this, understanding the drivers for failed return to work may help us to recognise and address the barriers to returning to work faced by patients – further reducing the rate of long term absence from work.

### Evidence of barriers to returning to work

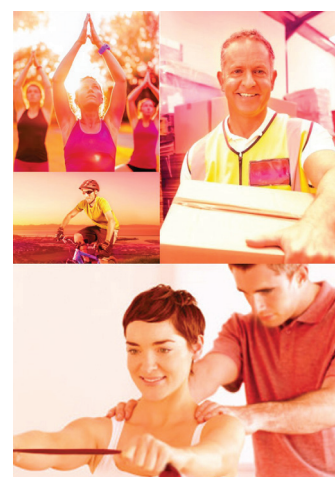
Research relating to the factors that influence an individual's ability to return to work (RTW) after injury or illness yields similar results across the literature. The consensus is that injury specific factors (severity or type of injury) are not in themselves barriers to returning to work following injury or illness.

### Research suggests that the main factors hindering a return to work are:

1. Low recovery or return to work expectations
2. Low job satisfaction
3. Depression.

### Factors that predicate a good likelihood of returning to work include:

1. Higher education or socioeconomic status
2. Optimistic expectations for recovery
3. Access to multidisciplinary vocational rehabilitation AND a supportive employer.



### Reasons that patients do not return to work – practice-based evidence

Proactive, a supplier of Vocational Rehabilitation Services (a service that aims to achieve early but safe and sustainable return to work outcomes for injured clients), has analysed the service delivery of more than 6000 Vocational Rehabilitation Programmes provided over the past 24 months, with a view to further understand the reasons that clients do not re-engage in pre-injury employment following the delivery of a multidisciplinary Vocational Rehabilitation Programme.

This review entailed the analysis of nearly 600 cases where patients receiving vocational rehabilitation services had not re-engaged at work by discharge from the service. The reasons for a failed return to work outcome were categorised and collated. A summary of the reasons that clients did not make a return to work and what health professionals may be able to do to help mitigate this is outlined in table 1 (over).



Table 1 Categorised Reasons for Failed RTW Programmes

Primary reason for not re-engaging in work by service discharge	Proportion of patients	Implications for healthcare providers
Lost / resigned from job	21%	<ul style="list-style-type: none"> <li>Ensure that patients understand the importance of work on their overall health and wellbeing.</li> <li>Encourage employers to engage in the Vocational Rehab process and be supportive.</li> </ul>
Required surgery	18%	<ul style="list-style-type: none"> <li>If unsure look to facilitate early and accurate diagnosis through physiotherapy assessment, appropriate imaging or referral to specialist.</li> </ul>
Unable to / refused to participate in programme	14%	<ul style="list-style-type: none"> <li>Ensure that patients understand the importance of work on their overall health and wellbeing.</li> <li>Provide key messages that promote patient trust in the Vocational Rehabilitation process.</li> </ul>
Does not have capacity to perform pre-injury job tasks	14%	<ul style="list-style-type: none"> <li>Recommend early treatment and rehabilitation with early decision making where a client is not expected to be able to make a return to their pre-injury work. This will enable activation of alternative Vocational Rehabilitation pathways.</li> </ul>
Unable to engage in work due to persistent pain	13%	<ul style="list-style-type: none"> <li>Identify risk of chronicity early.</li> <li>Refer to / recommend Pain Management Services early.</li> </ul>
Co-morbidity	10%	<ul style="list-style-type: none"> <li>Provide proactive management of co-morbidities, addressing these in a context that promotes engagement in suitable work types.</li> </ul>

### Predicting failure to return to work – practice-based evidence

With a view to help identify and address risk of a failed return to work programme early, Proactive has also worked to isolate the key predictive factors for failed return to work. Through this process, the factors that can be recognised early to predict a likelihood of a failed return to work outcome include:

- Contributing psychosocial factors as measured by the Orebro Short Form (OSF), a screening tool used to identify the risk of chronicity following musculoskeletal injury.
- Heavy or Very Heavy Work Type (especially in the presence of a high OSF Score).
- Diagnostic Status (incomplete or ambiguous diagnosis influence return to work outcomes).
- Poor relationship with employer or poor job satisfaction.
- Presence of co-morbidities.

### What can primary health do to help facilitate a successful return to work for sick or injured clients?

- Engage the patient in the health and wellbeing benefits of work, and help them to understand that returning to suitable work early will increase their likelihood of full recovery.
- Certify appropriately. Just because a patient states that they do not have light duties at their workplace, it does not mean that they are not fit for light duties. Appropriate certification can help to facilitate the rehabilitation process and give guidance on what activities-based rehabilitation the client is able to engage in.
- Indicate "Assistance Required" in the ACC18 if you feel like the client is at risk of not returning to work or will require support to achieve a good outcome.



### References

1. The Australasian Faculty of Occupational and Environmental Medicine. (2011). *Realising the Health Benefits of Return to Work. A Position Statement*. Sydney, New South Wales, Australia: Author
2. Shaw, WS., Nelson, CC., et al. (2018). Early Return to Work Has Benefits for Relief of Back Pain and Functional Recovery After Controlling for Multiple Confounds. *Journal of Occupational and Environmental Medicine*, 60(10), 901-910
3. Heymans, MW., de Vet HC., et al. (2006). Workers' beliefs and expectations affect return to work over 12 months. *Journal of Occupational Rehabilitation*, 16(4), 685-695
4. Young, AE., Besen, E., & Willetts, J. (2017). The Relationship Between Work-Disability Duration and Claimant's Expected Time to Return to Work as Recorded by Workers' Compensation Claims Managers. *J Occup Rehabil*, 27(2), 284-295
5. Hogg-Johnson, S., & Cole, D. (2003). Early prognostic factors for duration on temporary total benefits in the first year among workers with compensated occupational soft tissue injuries. *Occup Environ Med*, 60(4), 244-253.



For further information, please feel free to contact Brin Williams, Proactive's National Manager for Vocational Rehabilitation at [brin.williams@proactive4health.co.nz](mailto:brin.williams@proactive4health.co.nz)

# Vascular Telehealth – First Steps

Mr Richard Evans



📍 Bowen Hospital: Practices & Consults  
Wakefield Hospital: Consults

★ Vascular and  
Endovascular

👤 Mr Richard Evans,  
Vascular Surgeon

☎ 0800 45 45 88  
EDI: acurityh

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

**Telehealth initiatives are now commonplace in all aspects of medicine. Remote communication with patients and other health professionals using cloud-based technology platforms, such as Zoom and Skype, are rapidly picking up pace.**

**Productivity gains through reduced waiting times and larger numbers of patients being assessed and treated are all readily achievable. Carbon footprint reduction is also a major benefit.**

Vascular surgery is ideally suited to telehealth. Vascular patients come from all over the Wellington region and are often elderly and frail patients who are less able to travel to their appointments in Wellington. In addition, a substantial amount of vascular decision-making is based on high-quality imaging, such as vascular ultrasound and CT angiography.

Within the Wellington context, vascular telehealth is thriving. At CCDHB the department has recently funded a state-of-the-art Zoom Room, with three high-definition, widescreen monitors and associated Zoom videoconferencing facilities.

## Services

This has enabled us to have:

- telephone and videoconference clinics
- regional multidisciplinary meetings with Hawke's Bay, Whanganui, Manawatu and Nelson-Marlborough
- virtual ulcer clinics with community nurses and wound nurse specialists
- renal transplant assessment clinics.

Diabetic foot clinics via telephone and videoconference are also on the agenda.

Within the private medicine context, vascular telehealth has similar imperatives, particularly in terms of patient convenience, time-saving and accessibility. Younger private patients have been early-adopters and the expectation is that this will increase rapidly over time, particularly in this tech-savvy cohort.

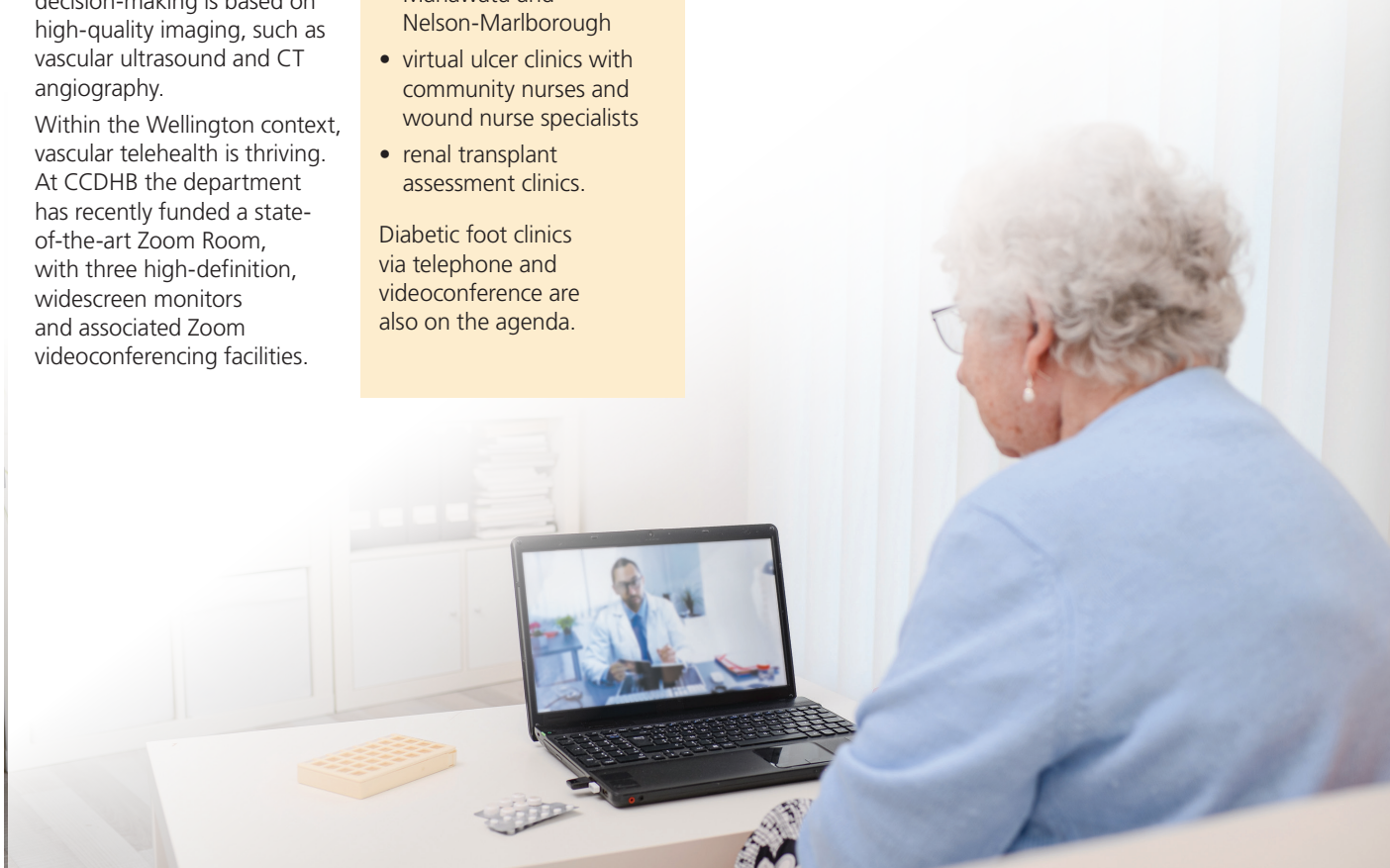
One-on-one consultations obviously still have an important role, but as technology improves and remote health interactions become more widespread, the area will continue to expand with more services bringing easier access for patients.



**Richard Evans is a Wellington-based Vascular Specialist and Surgeon**

Richard Evans Vascular has clinics available in South Auckland, Wellington, Hutt Valley, Kapiti Coast, Wairarapa and Palmerston North. Patients do not require a doctor's referral.

REV | Richard Evans Vascular  
Vein specialists





# Transforming Our Service

## Digital Standardisation

Steven J. Russon



Acuity Health Group

Digital  
standardisation

Steven J. Russon,  
Change Manager

(04) 920 0131

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**"Acuity is continuously embracing new technology to ensure we deliver you and your patients world-class healthcare. Over the next few months, I'll share with you some of the initiatives that we are embarking upon – below is a great example."**

Steven J. Russon

### Endoscopy goes digital with ProVation Medical

Following a period of consultation with our endoscopists and staff, Acuity are pleased to announce that we have entered into a partnership with ProVation Medical to bring their ProVation endoscopy reporting software to Bowen, Royston and Wakefield Hospitals.

ProVation has long since established itself in the New Zealand health sector with all DHBs currently relying on ProVation for its easy to use interface and reporting.

Dorothy Shaw, General Manager at Bowen Hospital and Project Sponsor, is delighted by the move.

**"Not only is the ProVation software preferred by our practitioners, GPs are familiar with the reporting format. This is good news for consistency and patient care."**

While ProVation offers scope for individual template customisation, standardised reporting will ensure that all mandatory fields required from a KPI and credentialling perspective have been captured. In the event this data is requested by the Ministry of Health, ProVation's partnership with the Deloitte's National Bowel Screening Solution will further streamline the reporting process.

Whilst our staff at Bowen Hospital are no strangers to computerised endoscopy capture and reporting, Karen Tickelpenny, the Endoscopy Team Leader at Bowen, welcomes the move.

"The interface capabilities of ProVation will prevent double-documenting as we can pull the patients' information directly out of our administration system. We've enjoyed electronic reporting for some time at Bowen Hospital now, but this will make things even more efficient."

Marie Verschoor, the Clinical Coordinator at Wakefield Hospital, and long-time sufferer of pen and paper-based

reporting, is delighted to be throwing her stapler in the bin.

"It's been a long road getting to this point but the team are super-eager to get started."

Acuity recognises that our consultants wish to use a system they are familiar with and ProVation's popularity and exposure in the DHBs ensures that our doctors already possess the software skills to complement their clinical practice. There is no need to train in an additional software application.

Our endoscopy nurses will undertake super-user training to assist our specialists where required and Acuity will continue to work closely with ProVation Medical to ensure a smooth implementation. This ensures our clinicians can focus on their patients' safety, hospital experience and clinical outcomes.

The rollout will commence at the end of October across our Wakefield and Bowen Hospitals, with Royston set to follow soon after.

ProVation arrives just in time to complement Acuity's broader standardisation and process improvements. While our existing electronic



Marie Verschoor and Karen Tickelpenny looking over the ProVation reporting templates.

files from Bowen Hospital will remain accessible, ProVation will run alongside our TrackCare Patient Administration System and is also compatible with the WebPAS Patient Administration System, which is set to launch in the second half of 2020. In addition, endoscopy reports can be saved as PDFs to the patient's Electronic Medical Record, as well as Profile and Medtech.

Acuity Health





# Diabetic Foot Ulcers

## The Growing Burden

Mr JK Wicks



Wakefield Hospital

Vascular

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## The growing burden of diabetic foot ulcers and the multidisciplinary diabetic foot clinic

Diabetic foot disease poses a huge burden on the healthcare system worldwide. The burden in the United States was estimated at \$174 billion US dollars (USD) in 2007. The American Diabetes Association study estimated that 33% of that cost was related to diabetic foot disease<sup>1</sup>. A decade later the costs had risen to over \$300 billion USD<sup>2</sup>.

In New Zealand the costs of diabetic foot disease are similarly rising, and in 2021 the expected costs are estimated at \$1.8 billion New Zealand dollars (NZD). A study from Auckland hospital showed the median cost of treatment related to diabetic foot wounds was approximately \$30,000.00 NZD per patient.

This same study showed that one in three diabetic foot wound patients unfortunately had major amputation despite this care<sup>4</sup>. In other words, despite expensive care these patients still do poorly. The question has always been: **how can we do things better?**

### Clinical assessment and differentiating ulcers

An ulcer is a defect with loss of epidermis and at least part of the dermis. Causes of ulcers can be varied but diabetic patients are particularly susceptible to ulceration. However, the most common cause of ulceration is venous disease, seen in up to 60% of patients (see table 1).

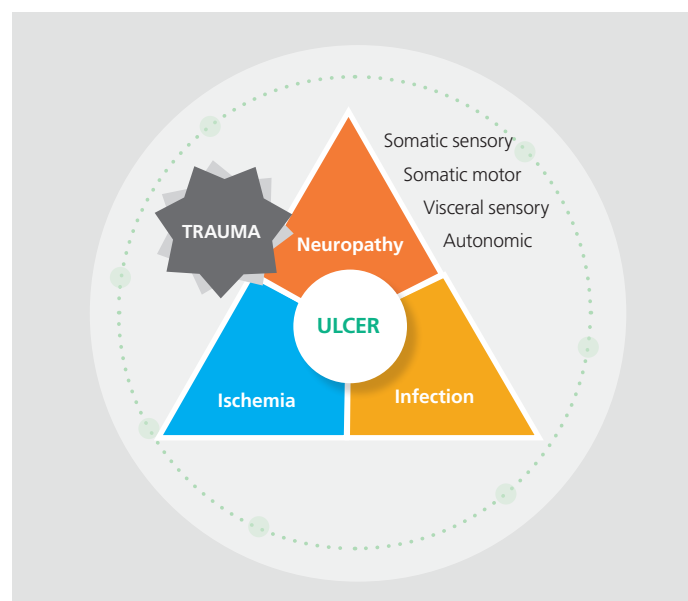
Differentiating these ulcers depends on several things including site, symptoms such as pain, and characteristics of the ulcer. Diabetic foot ulcers are often on areas of weight bearing or pressure. Because of changes in the shape of feet of diabetic patients due to motor neuropathy, these pressure areas need to be objectively evaluated for each patient as weight bearing areas can change. Also, diabetic foot ulcers are often painless and have regular punched out margins. There is often healthy granulation tissue at the base if there is minimal vascular disease, and often callous formation showing lack of sensation and the effects of pressure (see table 2 (over)).



Once a diabetic foot ulcer is suspected or diagnosed clinically, a full assessment of sensation, vascular insufficiency and presence of infection should be undertaken. This reflects the pathophysiology of diabetic foot ulcers which include the above triumvirate. Initial treatment and care can be undertaken in the primary health space and can be helped with primary podiatry referral and district nursing. If the ulcer is present for more than six weeks and is resistant

Table 1 CAUSES OF LOWER LIMB ULCERATION

- ★ **Venous insufficiency** (45-60%)
- ★ **Arterial insufficiency** (10-20%)
- ★ **Diabetes – neuropathic** (15-20%)
  - Lymphoedema
  - Vasculitis
  - Skin conditions – Pyoderma Gangrenosum
  - Malignancy
  - Trauma
  - Drugs



to healing a referral to the multidisciplinary diabetic foot clinic can be made. If concern of uncontrolled infection or acute ischemia is present, acute referral is indicated.

### The multidisciplinary diabetic foot clinic

The multidisciplinary diabetic foot clinic treatment to patient-centred treatment has shown promise in diabetic foot disease patients as their care does span across multiple medical, surgical and ancillary specialties. In

diabetic foot disease, research shows that multidisciplinary diabetic foot clinics (MDDFCs) result in a reduction of major amputation rates<sup>5,6</sup> and mortality<sup>7,8</sup>. The validity of this growing body of evidence was reflected by the adoption of the MDDFC as the recommended model of care for diabetic foot disease by both the International Working Group on the Diabetic Foot and the Society for Vascular Surgery<sup>9,10</sup>.

Table 2 DIFFERENTIATING ULCERS

### ★ VENOUS

Site	Gaiter area, commonly medial Circumferential
Pain	Painless or mild, relieved by elevation
Characteristics	Large, irregular margin Shallow, sloping edge Slough with granulation tissue in base Moderate to heavy exudate
Associated findings	Haemosiderin staining Dry skin, eczema Varicose veins, oedema Pedal pulses present



### ★ ARTERIAL

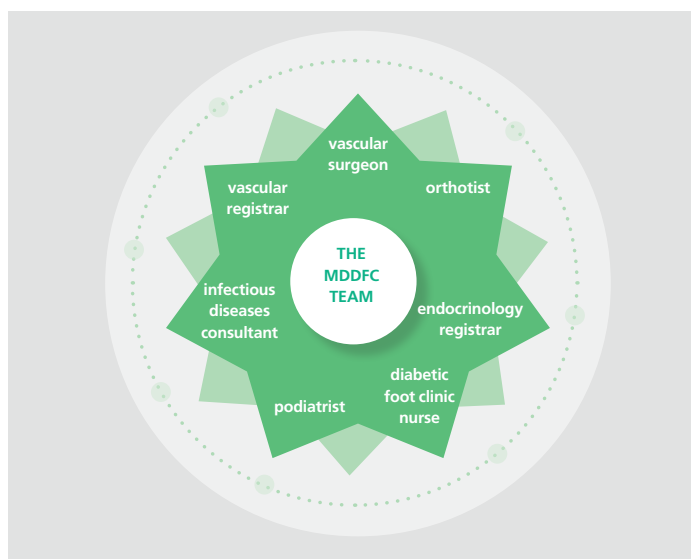
Site	Pre-tibial, lateral malleolus Toes, heel
Pain	Severe, relieved by dependency
Characteristics	Small, irregular shape Punched-out, deep Shallow base with necrotic tissue Low exudate unless infected
Associated findings	Thin, shiny, dry skin Reduced or no hair on lower leg Pallor on leg elevation Absent or weak pedal pulses Delayed capillary refill



### ★ NEUROPATHIC

Site	Pressure areas
Pain	Painless
Characteristics	Regular margins Deep, can probe to bone/sinus Sloughy base
Associated findings	Callous formation Loss of sensation, vibration Warm foot





**All clinicians within the hospital or from the community, including podiatrists, can refer to the MDDFC.**



**Any referral sent in for a diabetic patient with an ulceration is prioritised and should be seen by the clinic within six weeks.**

Recent studies from Auckland hospital have shown that not only does MDDFC reduce the cost of treatment of diabetic foot ulcer patients but also there are improved patient outcomes by significantly reducing patient mortality and major amputations<sup>11</sup>.

Our MDDFC at Wellington Hospital has been running for almost two years. Prior to the MDDFC, patients with diabetic foot wounds were referred to the Department of Vascular Surgery and either admitted as an inpatient or reviewed in a general vascular surgery outpatient clinic. Any input from other teams had to be sought with separate consultation at specific clinics via referral.

The MDDFC team consists of a vascular surgeon, a vascular registrar, an infectious diseases consultant, an endocrinology registrar, a podiatrist, a diabetic foot clinic nurse, and an orthotist. This allows the integration of all the multidisciplinary clinic team members' expertise and results in a coordinated, patient-specific management plan that consists of the recommendation for acute or elective inpatient treatment, further outpatient care, or discharge of the patient from the clinic to community podiatrists, district nurses and primary physicians.

The clinic, which is held fortnightly, exclusively deals with patients suffering from an active diabetic foot wounds.

Each clinic begins with a multidisciplinary team discussion in which the cases of all patients present are reviewed.

Patients seen at the clinic are assigned a room and are seen by the multidisciplinary clinic team members who are present as required in the examination room.

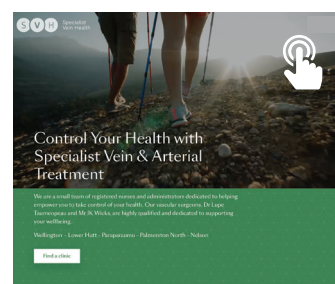
The vascular surgeon assesses the wound for surgical management (need for revascularisation, surgical debridement, and amputation). The endocrinologist assesses the patient's diabetic control and optimises diabetic treatment in addition to optimising any other medical parameters. The diabetic foot nurse specialist focuses on patient education (diet, exercise, medication, wound care).

The podiatrist and orthotist work in close collaboration to optimise footwear, offloading, and foot care. Each clinic begins with a multidisciplinary discussion in which the cases of all patients are reviewed.

Clinic-based treatments, such as superficial wound debridement, dressing changes, and provision of orthotic footwear, are also performed at the clinic.

## References

- American Diabetes Association. (2008). Economic Costs of Diabetes in the U.S. in 2007. *Diabetes Care*, 31(3), 596-615
- American Diabetes Association. (2018). Economic Costs of Diabetes in the U.S. in 2017. *Diabetes Care*, 41(5), 917-928
- Ministry of Health. (2009). *Report on New Zealand cost-of-illness studies on long-term conditions*. Wellington, New Zealand: Ministry of Health
- Joret, MO., Dean, A., Cao C., Stewart, J., & Bhamidipaty, V. (2016). The financial burden of surgical and endovascular treatment of diabetic foot wounds. *J Vasc Surg*, 64(3), 648-655
- Wang, C., Mai, L., Yang, C., Liu, D., Sun, K., et al. (2016). Reducing major lower extremity amputations after the introduction of a multidisciplinary team in patient with diabetes foot ulcer. *BMC Endocr Disord* 16(38)
- Rubio, JA., Aragon-Sanchez, J., Jimenez, S., Guadalix, G., Albarracin, A., et al. (2014). Reducing major lower extremity amputations after the introduction of a multidisciplinary team for the diabetic foot. *Int J Low Extrem Wounds*, 13(1), 22-26
- Martinez-Gomez, DA., Moreno-Carrillo, MA., Campillo-Soto, A., Carrillo-Garcia, A., & Aguayo-Albasini JL. (2014). Reduction in diabetic amputations over 15 years in a defined Spain population. Benefits of a critical pathway approach and multidisciplinary team work. *Rev Esp Quimioter*, 27(3), 170-179
- Cahn, A., Elishuv, O., & Olshatkin-Pops K. (2014). Establishing a multidisciplinary diabetic foot team in a large tertiary hospital: a workshop. *Diabetes Metab Res Rev*, 30, 350-3
- Bakker, K., Apelqvist, J., Lipsky, BA., & Van Netten, JJ. (2016). The 2015 IWGDF guidance documents on prevention and management of foot problems in diabetes: development of an evidence-based global consensus. *Diabetes Metab Res Rev*, 32(1), 2-6
- Sumpio, BE., Armstrong, DG., Lavery, LA., & Andros, G. (2010). The role of interdisciplinary team approach in the management of the diabetic foot: a joint statement from the Society for Vascular Surgery and the American Podiatric Medical Association. *J Vasc Surg*, 51(6), 1504-1506
- Maximilian, JO, Osman, K., Dean, A., Cao, C., van der Werf, B., et al. (2019). Multidisciplinary clinics reduce treatment costs and improve patient outcomes in diabetic foot disease. *J Vasc Surg*, 70(3), 806-814
- Lam, K., van Asten, SA., Nguyen, T., La Fontaine, J., & Lavery, LA. (2016). Diagnostic accuracy of probe to bone to detect osteomyelitis in the diabetic foot: a systematic review. *Clin Infect Dis*, 63(7), 944-948
- Siribumrungwong, B., Noorit, P., Wilasrusmee, C., Attia, J., & Thakkestian, A. (2012). A systematic review and meta-analysis of randomised controlled trials comparing endovenous ablation and surgical intervention in patients with varicose vein. *Eur J Vasc Endovasc Surg*, 44(2), 214-223
- O'Donnell, T., Passman, M., Marston, W., Ennis WJ., Dalsing, M., et al. (2014). Management of venous leg ulcers: Clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. *J Vasc Surg*, 60(2 Suppl), 35-59S
- Pavlovic, MD., Schuller-Petrovic, S., Picot, O., et al. (2014). Guidelines of the First International Consensus Conference on Endovenous Thermal Ablation for Varicose Vein Disease – ETAV Consensus Meeting 2012. *Phlebology*, 30(4), 257-273
- NICE. (2013). *Varicose veins: diagnosis and management*. NICE guidelines. Retrieved from <https://www.nice.org.uk/guidance/cg168>
- Neville, R.F., Attinger, C.E., Bulan, E.J., Ducic, I., Thomassen, M. et al. Revascularization of a specific angiosome for limb salvage: does the target artery matter? *Ann Vasc Surg*. 2009; 23:367–373
- Iida, O., Nanto, S., Uematsu, M., Ikeoka, K., Okamoto, S., Dohi, T., et al. (2010). Importance of the angiosome concept for endovascular therapy in patients with critical limb ischemia. *Catheter Cardiovasc Interv*, 75(6), 830-836
- Katib, N., Thomas, SD., Lennox, AF., Yang, JL., & Varcoe, RL. (2015). An Endovascular-First Approach to the Treatment of Critical Limb Ischaemia Results in Superior Limb Salvage Rates. *J Endovasc Ther*, 22(4), 473-481.



**SVH Specialist Vein Health**



# New Orthopaedic Day Surgery Unit

📍 Acurity Health 📞 (04) 920 0131 🌐 [www.acurity.co.nz](http://www.acurity.co.nz)



## Hawke's Bay will be getting a new, state of the art Orthopaedic Day Surgery Unit (ODSU) in Hastings.

The new purpose-built unit will be a joint venture between Hawke's Bay's leading orthopaedic surgeons and Royston Hospital; which is owned and operated by Acurity Health Group Ltd (AHGL).

Acurity CEO, Dr Jonathan Coleman says the development is in response to increasing demand for orthopaedic surgical services in the region.

"The new facility will have the latest technology and be patient-focused, providing a seamless end to end service in the Bay area.

"This not only increases access to orthopaedic surgery in the region, but emphasises our commitment to quality healthcare investment, which is really important to us," says Dr Coleman.

The ODSU will consist of one fully commissioned operating theatre with provision for a future theatre as demand increases. The facility will include reception, recovery,



central sterilising department and support services.

The unit will be located on Southland Road adjacent to Royston Hospital and provide car parking and a drop off area.

Royston Hospital also commissioned an additional 44 car parking spaces adjacent to the racecourse, ensuring overall car parking is not compromised for patients, surgeons, and staff.

The ODSU will be operational in April 2021.

"This comes at a time of major investment for Acurity at Royston as well as at Wakefield Hospital in Wellington, and is a major show of confidence by the Acurity Board in the prospects for private healthcare in Hawke's Bay," says Dr Coleman.



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

Royston Hospital is the number one provider of private surgical services in the Hawke's Bay region. With highly qualified and experienced specialists and nursing professionals, welcoming facilities and the latest in equipment and surgical techniques, at Royston you are in great hands.



Part of the Acurity Health Group



# Brain Tumours – Presentation, Diagnosis and Treatment

Dr David Okonji



📍 Bowen Hospital

🏥 Medical Oncology

👤 Dr David Okonji,  
Bowen Icon Cancer Centre

☎ (04) 896 0200

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

**Brain tumours can be divided into primary and secondary tumours.**

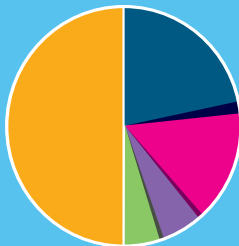
**Primary tumours** can be further divided into benign or malignant subtypes. Malignant primary brain tumours, the most common being gliomas, are the most difficult to treat and have an average five year overall survival of not more than 35%.

**35%**

maximum average  
five year overall  
survival rate

**Secondary brain** tumours, on the other hand, are more common with the likely source of metastases originating from:

- lung (50%)
- breast (15-20%)
- melanoma (5-10%)
- renal (7%)
- colon (4-6%)



where appropriate, followed by chemoradiotherapy. Prognosis is dependent on tumour subtype, age, performance status, and tumour grade. On the other hand, the management of metastatic disease to the brain is aimed at alleviating symptoms, improving functional independence and thus ultimately improving survival in patients with low burden/well-controlled extra-cranial metastatic disease. In those with excellent performance status, surgical

resection followed by whole brain radiotherapy (WBRT) or WBRT alone may be considered. However, in the last decade, there has been a significant paradigm shift to deploying targeted single fraction radiation in the form of stereotactic radiosurgery (aka "gamma knife") or stereotactic radiation treatment (which involves multiple fractions). When compared to WBRT, these options are likely to avoid the treatment of unaffected brain parenchyma, hence preserving long-term neurocognitive function.

Clinical presentation is dependent on the location of the tumour and may overlap with common diagnoses such as cardiovascular stroke and delirium: these symptoms include, but are not limited to, headache (mild, severe, persistent, intermittent), slurred speech, word finding difficulties, dysphasia, visual disturbances, altered taste or smell, seizures (focal or generalised), limb weakness, loss of balance, nausea and vomiting, and change in personality. The distinguishing feature from stroke syndromes is that brain tumour symptoms tend to be insidious and chronic (over months to years for primary tumours). However, in complicated cases where

there is rapid tumour growth with associated peritumoural oedema and haemorrhage, the presentation may be more acute (over days to weeks). After clinical examination, the investigation of choice in the first instance is a CT Head; however, MRI with gadolinium contrast is more sensitive and provides the most information. Completion CT Body is recommended as it is more likely that the identified malignant brain tumour is a metastases. Subsequently, a tissue biopsy should be pursued in order to determine the diagnosis. In fit patients with malignant primary brain tumours, curative intent may potentially be achieved by maximal resection





Finally, there are now several novel systemic therapies that are active in intracranial disease. In metastatic breast cancer, Pertuzumab, Trastuzumab, Docetaxel and the recently PHARMAC approved Trastuzumab Emtansine provide a three and two year overall survival benefit in first and second line setting respectively for HER2 positive patients with intracranial metastases. Likewise, in a specific lung cancer subtype, the tyrosine kinase inhibitor, Alectinib, which

will soon be publicly funded, confers an 81% response rate (RR) with a corresponding 17 month durable response in brain metastases. In melanoma, Pembrolizumab immunotherapy has a 22% intracranial disease RR.

#### References

1. Lapointe, S., Perry, A., & Butowski, N.Z. (2018). Primary brain tumours in adults. *Lancet*, 4(392), 432-446
2. Fecci, PE., Champion, CD., Hoj, J., McKernan, CM., Goodwin, CR., et al. (2019). The Evolving Modern Management of Brain Metastasis. *Clin Cancer Res*, 25, 1-11. DOI: 10.1158/1078-0432.CCR-18-1624.

**In summary,** the diagnosis of brain tumours can be difficult and treatment often involves a multi-modal approach. With rapidly evolving and improved techniques in local therapies for primary brain tumours and novel systemic targeted treatments that are active in brain metastases, patients are now living longer with better quality of life. As such, the management of these conditions should be customised to the individual patient. To this end, clinical decision-making and treatment plans are best determined collectively in a multidisciplinary setting by neuroradiologists, neurosurgeons, radiation oncologists, and medical oncologists. Finally, the input of social workers, physio- and occupational therapists, speech and language therapists, family, carers and GPs in the long-term management of such patients cannot be under-estimated.

**Bowen Icon Cancer Centre offers SRS services** using the latest Varian TrueBeam Linear Accelerator Technology equipped with HyperArc delivery streamlined workflows, improved accuracy, and enhanced patient safety. For further information or referrals contact [referrals.bowen@oncnz](mailto:referrals.bowen@oncnz) team or ph (04) 896 0200

**Bowen**  
icon cancer centre

#### About Bowen Icon Cancer Centre

We are proud to provide world-class private cancer treatment in a friendly and supportive environment for our patients and loved ones. Our experienced team work as one from diagnosis to treatment to ensure patients receive personalised, exceptional care every step of the way.



**BOWEN**  
HOSPITAL

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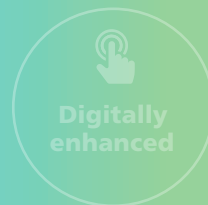
Bowen's modern, conveniently located private surgical hospital offers the best in private healthcare services Wellington has to offer. With our team of highly trained and dedicated medical specialists, and the very latest in equipment and techniques, we have a proud reputation for the quality of our care.



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# Connect 2020<sup>GP CONFERENCE</sup>



## Connect 2020: Health through the Ages

We're delighted to announce Connect: Health through the Ages is to be held at Te Papa Museum, Wellington on Friday 15 and Saturday 16 May 2020. Now in its 22<sup>nd</sup> year, our conference continues to grow in popularity, with our Connect 2019 conference bringing together over 250 GPs and primary healthcare practitioners from across New Zealand for what is known as one of the best educational events for GPs in the country.

In association with the Department of Primary Healthcare and General Practice, University of Otago, Wellington, Connect 2020 delivers a programme which includes a stunning line-up of leading specialists, researchers and expert healthcare professionals from New Zealand. Our speakers will provoke thought, discuss, debate, and provide updates on the common – and not so common – issues seen in primary healthcare practice.

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

Over two days of networking, education, skills development, debate and discussion there will be numerous opportunities to enhance your knowledge, widen your network, and help shape the future of primary healthcare.

We look forward to welcoming you to Connect 2020.

Connect Organising Committee  
Acurity Health Group

**15-16  
May 2020**

**Save the date.**

Super Early Bird  
registration open  
in November.

Event Partners





ELDERLY

ADULTS

ADOLESCENTS

PAEDIATRICS

**FRIDAY  
MORNING  
15 MAY**

**WE'LL EXPLORE:**

- dementia
- menopause
- rheumatoid arthritis
- community therapies

**FRIDAY  
AFTERNOON  
15 MAY**

**WE'LL EXPLORE:**

- cardiology and rehabilitation
- fertility
- presentations from our keynote speakers (below)

**SATURDAY  
MORNING  
16 MAY**

**WE'LL EXPLORE:**

- mental health
- sleep disorders and digital disruption
- headaches
- sexual health

**SATURDAY  
AFTERNOON  
16 MAY**

**WE'LL EXPLORE:**

- orthopaedics
- failure to thrive
- paediatric surgeries and when to refer
- ophthalmology
- gastroenterology and infants

#### OUR KEY NOTE SPEAKERS:



**Holly Carrington,**  
DVFREE & Policy Adviser for SHINE  
Presenting: GPs' vital role in addressing  
NZ's epidemic of domestic violence



**Dr Fiona Moir,** MBChB, MRCP, PhD,  
Director Connect Communications  
Presenting: Mindfulness  
for Health Professionals

**A number  
of relevant  
topics will be  
covered**

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

### Connect 2020: Health through the Ages

Registration fees		Super Early Bird (closes 31.12.19)	Early Bird (closes 15.2.20)	Standard
Doctor	Full	\$450	\$500	\$600
	Day	\$300	\$350	\$450
Nurse	Full	\$200	\$250	\$300
	Day	\$150	\$200	\$250
Other Health Professional	Full	\$200	\$250	\$300
	Day	\$150	\$200	\$250
GP Registrar and student	Full	\$200	\$250	\$300
	Day	\$150	\$200	\$250



# New Consultant

📍 Acurity Health ★ New Consultants

Acurity Health welcomes Dr Basu to Wakefield Hospital. Please feel free to contact her directly.



## Dr Anju Basu

MBBS, FRANZCOG

### Gynaecologist

P: (04) 910 2178

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### Specialty

Gynaecology

### About Anju Basu

Anju is a New Zealand trained gynaecologist. Anju has a special interest in minimally invasive surgery and pelvic floor disorders; she is trained in complex laparoscopic procedures and the latest treatment options for vaginal prolapse and urinary incontinence. Her focus is on a well-informed patient. Doctor-patient communication is the first step to good health. Anju spends time with patients to individualise their care plan. She combines excellent surgical training and cutting edge technology to optimise patient outcomes.

Anju keeps herself up to date with advances in her field and participates in an international surgical audit to provide the best care and monitor outcomes.

Anju works in close collaboration with a urologist, colorectal surgeon and pelvic floor physiotherapist to provide a comprehensive and complete care for women with complex pelvic floor problems.

### Special Interests

- Endometriosis
- Urinary incontinence
- Bladder sling procedures
- Uterine / bladder prolapse
- Hysterectomy
- Fibroids
- Ovarian cysts
- Reconstructive pelvic surgery
- Minimally invasive surgery.

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