

Health Matters

New Frontiers in Interventional Radiology

Dr Joe Feltham



Wakefield Hospital

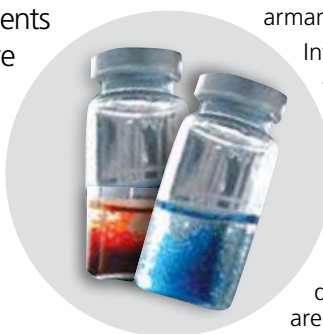
Area: Radiology. Article by: Dr Joe Feltham,
Consultant Radiologist and Director at
Pacific Radiology Ltd, ph (04) 978 5500

A number of new interventional radiology treatments can now provide minimally invasive therapies for cancer patients that can be as effective as traditional surgery or chemotherapy.

Accordingly these can then provide an alternative when co-morbidities or side effects prevent standard treatment, or can even be used in conjunction with standard care.

Interventional radiology and its place in the cancer treatment pathway has often fallen into the gap between 'curative surgery' and 'palliative chemotherapy'; with a lack of widespread knowledge of the technologies or their availability often compounding matters.

There is now however an increasing body of evidence to support their use alongside or even instead of their more established cousins in the cancer treatment armamentarium.



Interventional oncology is a rapidly growing sector of interventional radiology that is focused on providing curative or palliative cancer treatments using image guided techniques. This image guidance allows for percutaneous or catheter-delivered therapies that are better tolerated, with less morbidity, and often performed on a day-case basis. This is especially relevant with the increasing modern-day focus on treatments that are minimally invasive, and thus allow for reduced hospital stays, and better quality of life whilst being treated.

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Message from Acurity

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



Welcome to the latest edition of Health Matters, I hope you will find this issue's content interesting, educational and of relevance to your practice.

This issue contains a great article from Dr Joe Feltham of Pacific Radiology, on the topic of New Frontiers in Interventional Radiology, along with contributions from surgical consultants Mr Simon Bann and Mr Kenneth Chan.

GP Conference

My thanks to all of you who took the time to attend our GP Conference held at Te Papa in April. It was great to have an opportunity to speak with a number of you directly, and hear your thoughts on our business as well as the health market in general.

We received a lot of very useful feedback over the course of the conference, and will certainly be taking this into account as we structure next year's conference – scheduled for 8 and 9 May 2015 so please – 'Save the Date'.

I'd like to take the opportunity to formally thank all of those who were involved in the conference, our valued and respected speakers, our loyal sponsors, the organising committee and especially all of you who attended. I appreciate that it's difficult to take time out from your busy practices.

Specialist App

At the GP Conference we launched the first version of Acurity Health's Specialist Directory application for handheld devices. If you haven't already, please follow the instructions above right and download this application.

Continuing Professional Development (CPD) Sessions

In partnership with the Wakefield Heart Centre, we have recently hosted a series of CPD sessions focusing on 'Hot Topics in Cardiology for GPs'. Held in Wellington, the Hutt Valley and up on the Kapiti Coast these events have been very well attended and feedback thus far has been very positive.

It is our goal to deliver more of these sessions than we have done previously, all of which are RNZCGP approved and carry CPD / CME points. If there's something you'd particularly like to hear about, or a specific consultant you'd like to meet, please do let us know.

Later this year Royston Hospital will be presenting a half day Orthopaedic meeting, with renowned specialists providing expert perspectives and updates on a range of orthopaedic issues. Local GPs will have the opportunity to meet specialists over breakfast, tour Royston's state-of-the art facilities and witness live feed knee joint replacement surgery. This is an exciting event for the regions GP community to update their knowledge through shared research, exchange of experiences and practical demonstrations.

Download the new Acurity Specialist Directory App

Follow these easy instructions



Adding the App to your home screen on Android:

1. Using Google Chrome hit the menu button, and add the page **directory.acurity.co.nz** to your bookmarks.
2. Tap on the **star** and follow the prompt.
3. Open your **bookmarks** using the menu button, and find the new bookmark you've just added.
4. Press down and hold on the **bookmark** until you see an **action menu**. Select **"Add"** to homescreen.



Adding the App to your home screen on Apple:

1. Navigate to the website **directory.acurity.co.nz**
2. Tap on the **"Share"** icon at the bottom.
3. Select the **"Add to Home Screen"** icon.
4. Give your **Link Button** a name.
5. Tap on the word **"Add"** in the upper right hand corner.



Malaghan Institute of Medical Research

The Malaghan Institute are an independent organisation who are reliant on grants, donations and sponsorship for funding. Their scientists are committed to studying cancer, asthma, MS, arthritis and infectious diseases. Every day, they are a step closer to understanding and finding a cure for these tragic diseases that affect so many of us.

Inside this edition you will find a copy of the Malaghan Institute's newsletter, Acurity Health's way of supporting the incredible work of the Malaghan Institute.

I wish you happy reading.

Sincerest regards

Paul Quayle,
Chief Operating Officer,
Acurity Health Group Limited



New Frontiers in Interventional Radiology

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Dr Joe Feltham

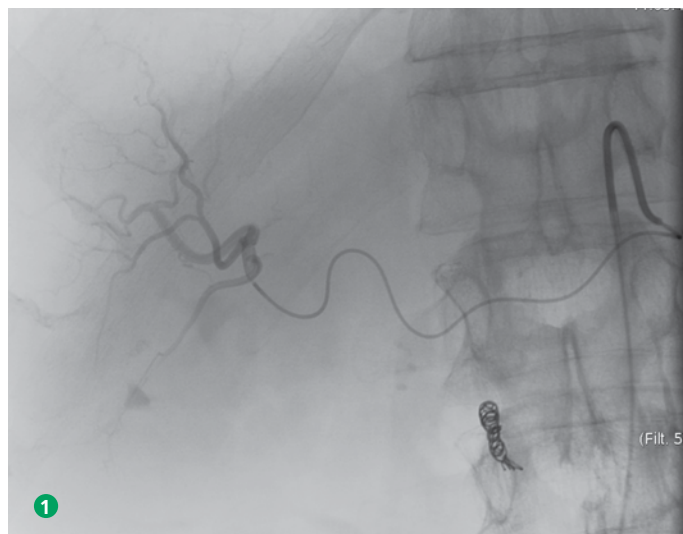


Catheter Delivered Liver Treatments

The liver is one of the commonest organs involved in both primary and secondary cancer; and is additionally one of the prime sites of disease ultimately resulting in death. When curative surgery is not an option due to size or number of lesions, then chemotherapy is often perceived as the only remaining treatment. In some tumours such as hepatocellular carcinoma (HCC), even this is not an option within the public system.

Systemic chemotherapy can however have severe side effects, sometimes preventing completion of full therapy; and does eventually lose its effectiveness with repeat cycles.

Targeted treatments are delivered by an interventional radiologist, via angiographic catheters, and as such only treat the liver, with little if any systemic side effects. As such they offer an alternative treatment when disease is limited to the liver. They are usually delivered as a one night stay procedure, and are performed under mild-moderate sedation only. Transarterial Chemotherapy (TACE) has been used for some time as a targeted treatment for HCC; but is not effective for metastatic lesions, and does still result in side effects related to chemotherapy drugs rapidly passing through into systemic circulation.



1 Right hepatic angiogram prior to SIRT, with tortuous anatomy coils in gastroduodenal artery to prevent reflux into GI tract

Selective Internal Radiotherapy (SIRT)

provides a means of treating liver tumours with radiotherapy in high doses, whilst largely sparing normal tissue in and outside of the liver. Many phase two trials over the past decade have demonstrated improved response rates and overall survival for metastatic colorectal cancer and hepatocellular carcinoma, when compared with standard chemotherapy regimens.^{1,2} This is largely in the setting of chemo-resistant or recurrent disease, although there are several current multi centre trials such as SIRFLOX and FOXFIRE, which aim to take this one step further, by assessing SIRT's potential for being combined with chemotherapy as a first line agent. SIRT is usually a one-off treatment, has a low complication rate, and rarely requires more than a one night stay in hospital.

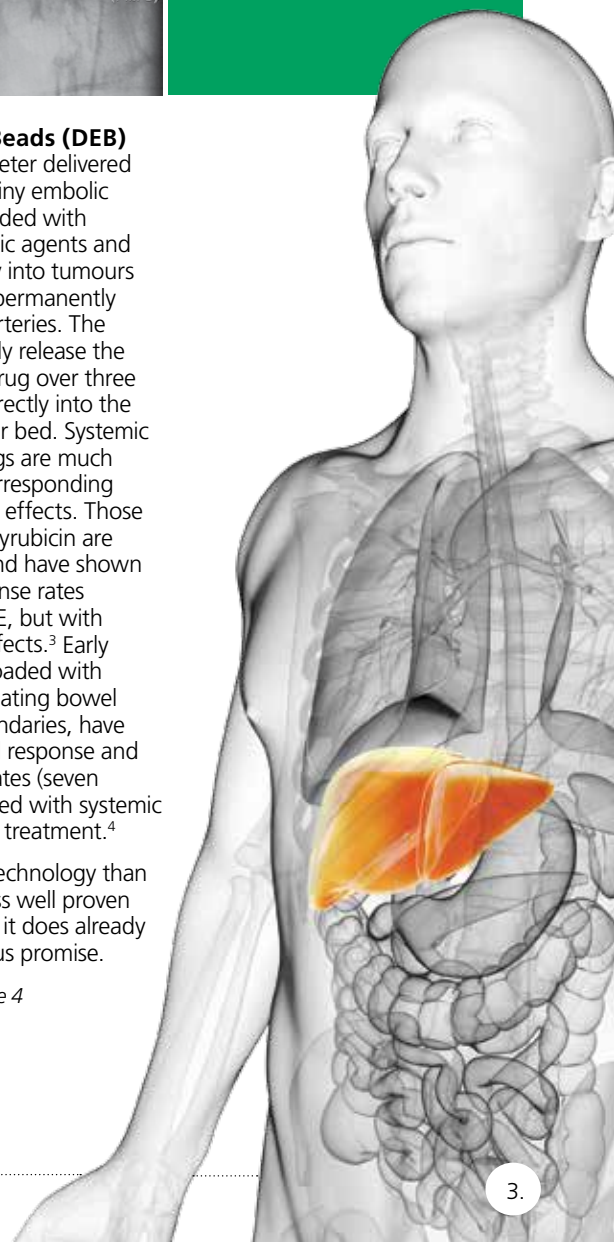
As it is only mildly embolic, it can also be delivered safely to patients who are unable to have standard chemoembolisation (TACE) owing to portal vein occlusion.

Drug Eluting Beads (DEB)

are another catheter delivered therapy, where tiny embolic beads are preloaded with chemotherapeutic agents and delivered directly into tumours within the liver, permanently lodging in end arteries. The beads then slowly release the chemotherapy drug over three to four weeks directly into the tumour's vascular bed. Systemic levels of the drugs are much reduced with corresponding reduction in side effects. Those loaded with Doxorubicin are used for HCC, and have shown equivalent response rates to standard TACE, but with far fewer side effects.³ Early trials of beads, loaded with Irinotecan for treating bowel cancer liver secondaries, have shown improved response and overall survival rates (seven months) compared with systemic Irinotecan based treatment.⁴

This is a newer technology than SIRT and thus less well proven or validated; but it does already show tremendous promise.

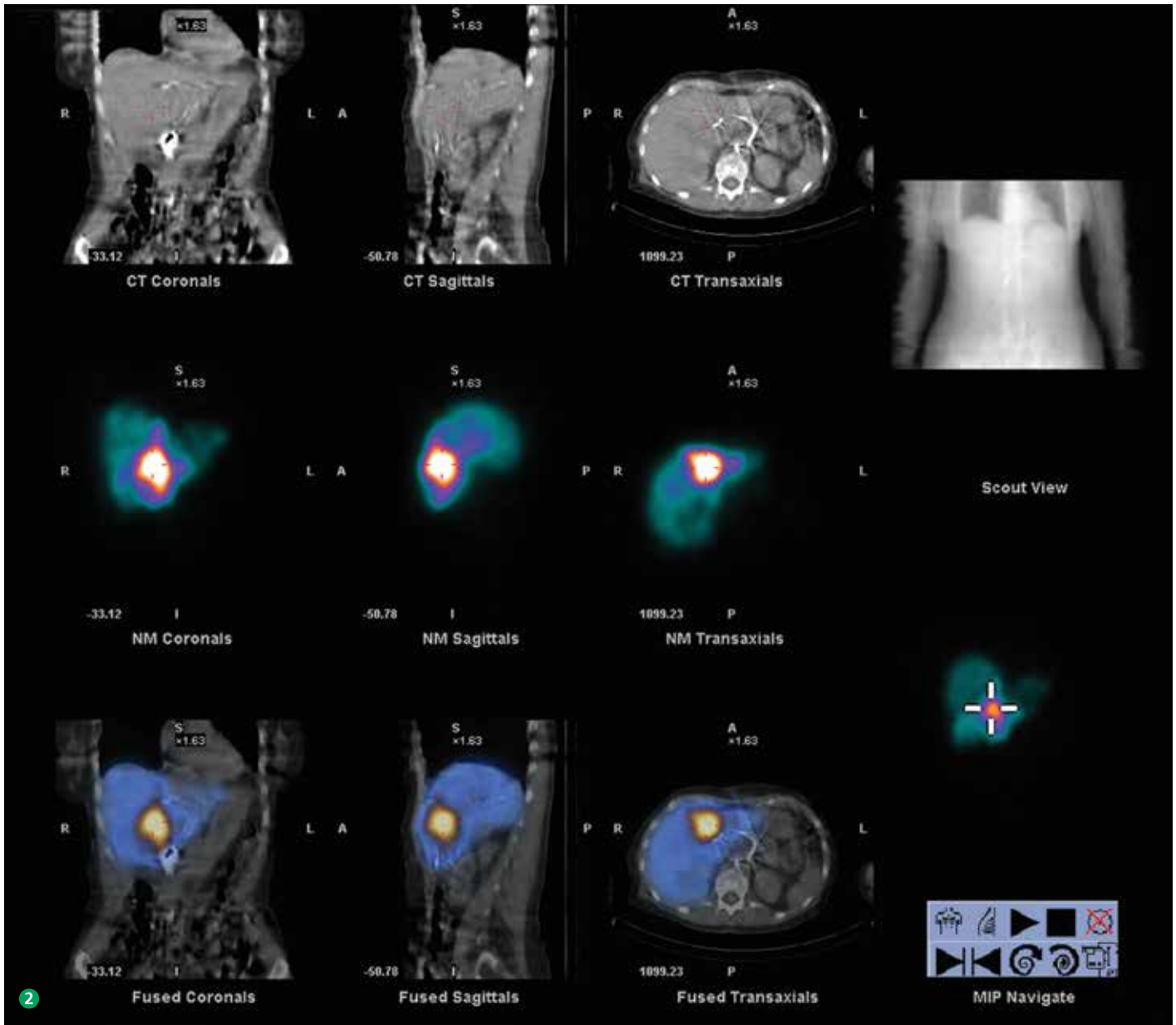
Continued on page 4





New Frontiers in Interventional Radiology

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- ② Nuclear medicine MAA study demonstrating SIRT take-up in tumour only
- ③ Drug eluting beads after chemotherapy loaded



Microwave Ablation

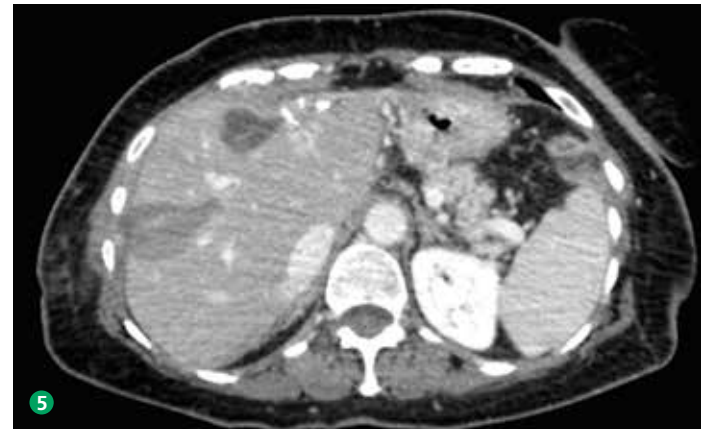
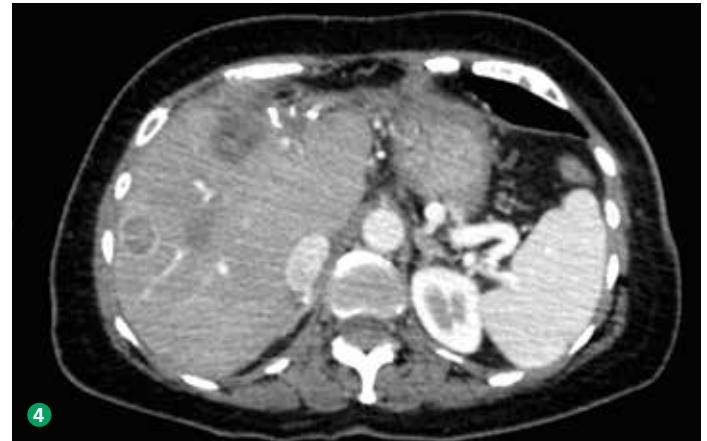
Microwave ablation (MWA) is a potentially curative therapy used to treat small primary or secondary cancers – predominantly within the liver. This is done by percutaneously placing a 17g needle probe into the tumour under ultrasound guidance, in a method not dissimilar to a routine liver biopsy. It is very similar in technique to radiofrequency ablation (RFA), in that it destroys tumour cells through heating effects (ie: thermal ablation). Many studies have already shown RFA to be as effective as surgical resection in treating small (less than three centimetres) liver tumours. In the right hands and with improved techniques, local recurrence rates are as low as three percent.⁵

Microwave ablation is a more recent improvement on RFA as a thermal ablative therapy, which enables ablation times up to ten times faster, and with reduced

need for re-ablations through much reduced vascular heat sink effect. As such it is now the preferred ablation method of choice at most international centres for liver lesions. As with RFA, microwave ablation can be performed percutaneously, under either general anaesthetic or moderate sedation; and generally only requires an overnight stay in hospital.

It is generally still used when surgery cannot be performed owing to patient morbidity, or where previously performed surgery precludes any further resection. Unlike surgery, ablative treatments also give the option of multiple repeat treatments, if further lesions subsequently develop.

The main drawbacks are that lesions of over three centimetres in size can be more difficult to treat, with higher recurrence rates; and lesions next to crucial structures such as the diaphragm can be impossible to ablate safely.



4 Recurrent metastasis in liver lateral to prior intra-operative ablation

5 Metastasis ablated over five minute period with two overlapping ablation zones



Pacific Radiology Group

Joe Feltham works at both Wakefield and Bowen Hospitals.

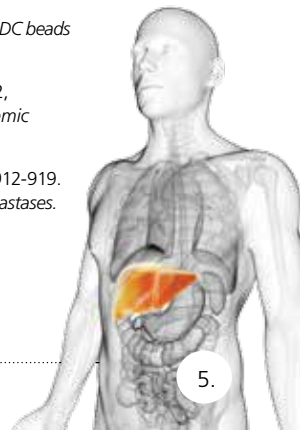
Pacific Radiology is part of the Pacific Radiology Group and has branches throughout New Zealand.

Key Points

- Interventional oncology therapies offer another option alongside standard treatment for cancer, or can be an alternative when standard therapies fail or are not tolerated.
- These are minimally invasive treatments; with reduced hospital stays, less side effects, and decreased costs.
- Whilst supportive research data is not yet as robust as that for gold standard therapies, that seen to date is overwhelmingly positive.
- SIRT and DEB can effectively control primary and secondary liver cancers.
- MWA can potentially cure small liver lesions, when surgery is not an option.

References

- 1 Sangro et al, Hepatology 2011, Vol.54(3):868-878. *Survival after yttrium-90 radio-embolization of HCC: a European evaluation*
- 2 Hendlicz et al, Journal of Clinical Oncology, Vol. 28(23):3687-94. *Phase III trial comparing IV fluorouracil infusion alone or with yttrium-90 radioembolization for CRC liver metastases refractory to standard chemotherapy*
- 3 Lammer et al, CVIR 2010, Vol 33:41-52. *Precision V trial for DC beads vs TACE in HCC*
- 4 Fiorentini et al, A. of Gastroenterology & Hepatology 2012, Vol. 3(1):39-48. *DC bead chemoembolization versus systemic therapy for hepatic metastases from colorectal cancer*
- 5 Tanis et al, European Journal of Cancer 2014, Vol. 50(5): 912-919. *Local recurrence rates after RFA or resection of CRC liver metastases.*



Management of Gastro-oesophageal Reflux Disease

Mr Simon Bann



Wakefield Hospital

Area: General Surgery

Article written by: Mr Simon Bann, Consultant UGI and Laparoscopic Surgeon, phone (04) 381 8120

Gastro-oesophageal reflux disease (GORD) is a prevalent condition with up to half the population suffering with symptoms in any given month.

Recent evidence based guidelines for the diagnosis and management of GORD have recently been published. These reviewed the medical; surgical and endoscopic therapies and the role of surgery quantified.

GORD develops when the reflux of stomach contents causes troublesome symptoms and or complications. These symptoms may be oesophageal or extraoesophageal. Presentation of these syndromes in the oesophagus, include the typical symptomatic heartburn and also those that cause oesophageal injury leading to oesophagitis, stricture, Barrett's oesophagus and potentially cancer. Extra-oesophageal symptoms rarely occur in the absence of typical GORD symptoms; these may affect the chest and upper airways. There needs to be awareness that oesophageal cancer is on the increase and that this is especially so in men who are overweight.

Reflux is caused by the failure of the lower oesophageal sphincter and the refluxed contents sit in the oesophagus. Initial management should include weight loss where needed; elevation of the head of the bed and avoiding late night eating.

Empirical treatment with a proton pump inhibitor (PPI) is recommended for eight weeks in the setting of typical symptoms of heartburn and regurgitation. Where there is chest pain this needs investigation prior to the

commencement of treatment. Upper GI endoscopy is not needed in the setting of typical symptoms; it is reserved for alarm symptoms and those at high risk of complications.

Medical treatment is incredibly effective and though there have been concerns regarding the use of PPI's there is little evidence of damage. However on cessation of PPI's there is a potential for relapse and for those at risk of relapse this will normally be within three months. There are also a variety of endoscopic techniques designed to help deal with reflux: they either narrow the gastro-oesophageal junction or aim to create a partial fundoplication. At present none can be recommended. A novel development for a group of patients with reflux disease is an implantable stimulator (EndoStim®) that strengthens the lower oesophageal sphincter; this holds promise but is still experimental.

Surgical interventions for reflux are based on the laparoscopic (keyhole) fundoplication. The oesophageal hiatus is dissected and hiatus hernia (where present) repaired followed by the wrapping of the fundus of the stomach around the gastro-oesophageal junction. Some patients have little to gain from surgery; however where there is intolerance of PPI's or persistent symptoms especially regurgitation there is much benefit to be gained.



A Nissen fundoplication with posterior crural repair and anterior fundoplication

It is recognised that surgery requires an experienced surgeon especially around the oesophagus. There are small risks as with any surgery but there is a very high level of patient satisfaction and excellent outcomes. Surgery will normally require a short stay in hospital. Where surgery is considered manometry must be undertaken to examine oesophageal function. Some patients have giant hiatus hernia and these require extra special care.

Reflux disease is a common problem. Most patients require simple management. Care must be taken to pick up on alarm symptoms such as weight loss and dysphagia. Surgery should be considered where there are treatment problems or volume reflux; this should be in the hands of an experienced surgeon.

Simon Bann consults at the Wakefield Specialist Medical Centre, Newtown, Wellington and operates at Wakefield Hospital, also in Newtown, Wellington.

References

Guidelines for the Diagnosis and Management of Gastroesophageal Reflux Disease. Philip O. Katz, Lauren B. Gerson and Marcelo F. Vela. American Journal of Gastroenterology 2013; 108:308 – 328

Antireflux surgery. Gatenby PA, Bann SD. Minerva Chirurgia. 2009 Apr;64(2):169-81.



Watery Eyes – A Practical Approach

Mr Kenneth Chan



Bowen Hospital

Area: Ophthalmology

Article written by: Mr Kenneth Chan, Ophthalmologist, phone (04) 499 4940

Excessively watery eyes (epiphora) can often be attributed to one or more of the following three factors:

1. Ocular surface disorder and tear film instability
2. Lower lid malposition and,
3. Obstruction within the lacrimal apparatus.

Each factor will have to be adequately addressed, with a combination of medical and surgical treatment, before patients notice improvement in their watering.



Figure. ① Patient with paralytic ectropion and symptomatic watering

Ocular Surface Disorders

The outermost layer of the tear film is made up of oils and lipids secreted by meibomian glands. Chronic inflammation of the meibomian glands (blepharitis) and obstruction of the meibomian gland orifices by debris lead to impaired lipid secretion and rapid breakdown of the tear film, which in turn cause excessive production of aqueous tears by the lacrimal gland and hence paradoxical tearing. Patients with significant blepharitis often complain of irritation and gritty sensation in the eyes, associated with excessive watering in windy conditions or when outdoors. There is no outright cure for blepharitis, but symptoms can be managed in most cases by a combination of hot compresses, viscous topical lubricants, low-dose oral tetracyclines and judicious use of topical steroid.

Other disorders such as allergic conjunctivitis, retained foreign body, floppy eyelid syndrome and corneal diseases can also cause watering. Patients with

persistent watering and ocular irritation not responding to simple treatment (such as an empiric trial of topical antihistamine or lid hygiene measures), should be referred to an optometrist or an ophthalmologist for review.

Lower Lid Malposition

Patients with significant lower lid laxity and punctal eversion (ectropion) tend to be older and typically complain of gradual onset watering that runs down their cheek over the lateral aspect of the lower lids. This may be clinically obvious, Figure ①, but subtle cases of lower lid laxity can also cause significant symptoms, Figure ②. Treatment is usually surgical and involves inversion of the inferior punctum against the globe (medial spindle or medial canthal tendon plication) and/or tightening of the lower lid (lateral tarsal strip, lateral wedge resection or lateral canthal tendon plication). Surgical treatment has a high success rate, especially if there are no other causes identified for the patient's watering.

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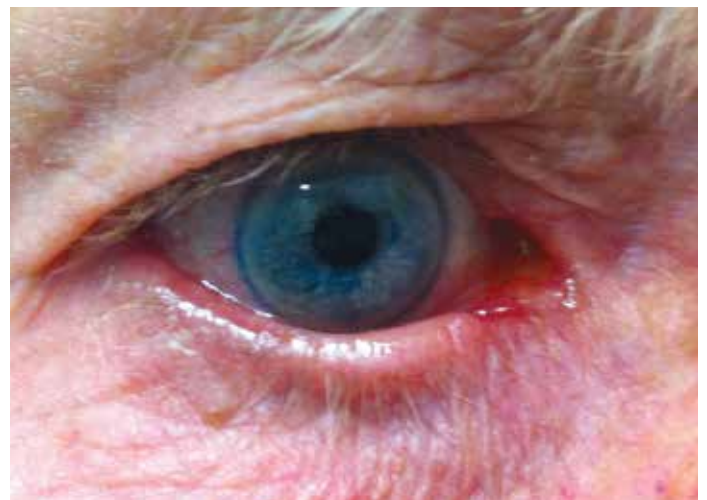


Figure. ② Patient with lower lid laxity, punctal eversion and punctal stenosis



Watery Eyes – A Practical Approach

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Obstruction within the Lacrimal Apparatus

With every blink, tears circulate across the ocular surface and collect medially, where they drain through small openings in both upper and lower lids (superior and inferior puncta) into the nasolacrimal duct, delivering tears into the nose. Any obstruction along this pathway can lead to constant, relentless watering that overflows at the inner corners of the eyes. Patients often remark that they need to wipe their eyes more than once per hour in both indoor and outdoor settings.

Stenosis of the inferior punctum is often secondary to ectropion and lower lid laxity, which can be easily treated by enlarging the punctal opening with a pair of fine scissors (1- or 2-snip punctoplasty) under local anaesthetic. 3-snip punctoplasty, where the entire length of the inferior canaliculus is exposed, should be avoided if possible, as it irreversibly damages the pump mechanism of the lacrimal apparatus.

Partial nasolacrimal duct obstruction and functional obstruction (where the tear duct appears patent on direct syringing but there is significant delay in tear passage in real life) are often associated with allergic rhinitis and chronic sinus diseases. For these patients a trial of intranasal steroid for three months, together with oral antihistamine and regular sinus rinse, may provide sufficient improvement in symptoms so that surgical treatment can be avoided / delayed.

Nonetheless, when there is complete obstruction of the nasolacrimal duct, lacrimal sac mucocoele or previous dacryocystitis, conservative treatment is usually insufficient and surgery is often indicated to relieve watering and / or to prevent future recurrences of dacryocystitis, which is potentially blinding if infection spreads into the orbit. Tear duct bypass (dacryocystorhinostomy) can be performed through an external approach or an endonasal approach. External approach allows good surgical exposure and direct suturing of flaps created (Figures 3 – 6), while endonasal approach negates the need for a skin incision. In experienced hands, endonasal endoscopic dacryocystorhinostomy has a similar success rate to external surgery, which is in the range of 80 – 90% in terms of complete resolution of watering. Revision surgery and repeat intubation may be required to overcome any recurrent scar tissue across the internal bony opening, while intractable cases can be managed with Lester-Jones tube insertion or Botox treatment to the lacrimal gland.

Rarely, primary malignancy of the nasolacrimal duct mucosa or the periorbital region can present with watery eyes and any suspicious areas encountered during surgery will be biopsied by the operating surgeon.



Figure. 3 Following skin incision, the lacrimal bone is exposed and the sac of the nasolacrimal duct is dissected off the lacrimal bone

Epiphora is a multi-factoral problem that requires a variety of clinical intervention to bring it under control. Patients may benefit from the knowledge that there is often not a quick fix for watery eyes, but with patience and perseverance their symptoms should eventually become manageable following appropriate interventions.

Success rate for external and endonasal dacryocystorhinostomy is similar (80 – 90%) in experienced hands.

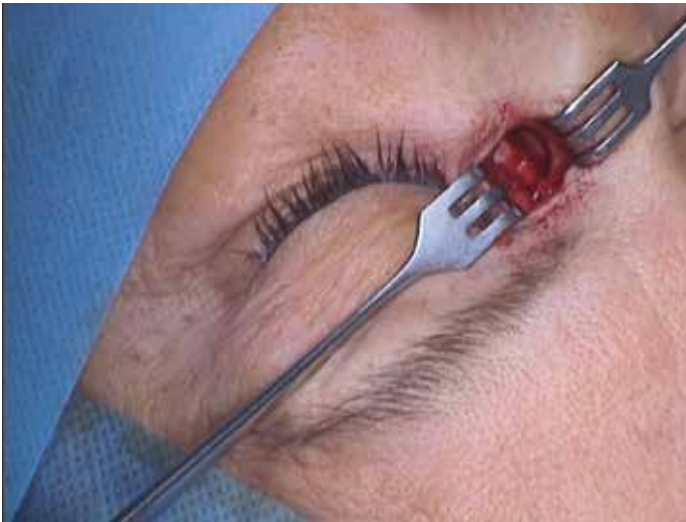


Figure. 4 An opening is created in the lacrimal bone and nasal mucosa is exposed, while care is taken to avoid entering the nasal cavity prematurely



Figure. 5 Both the nasolacrimal duct and the nasal mucosa has been incised to create anterior and posterior flaps (the posterior flaps can be visualised in this picture)



Figure. 6 A silicone stent has been passed through the tear duct into the nose across the anastomosis of the posterior flaps, secured with a plastic sleeve (visible within the surgical site). The anterior flaps are closed on top of the stent while the orbicularis and skin are closed in their respective layers



Figure. 7 Appearance at the end of the procedure before trimming of the silicone stent. Non-dissolving sutures are removed one week after surgery and the silicone stent is removed from the nose three months post-operatively.

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Watery Eyes – A Practical Approach

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Mr Kenneth Chan



A Practical Approach to the Assessment and Management of Epiphora

Epiphora

Major causes

Blepharitis / Ocular surface irritation

Lower lid laxity / malposition

Obstruction within lacrimal apparatus

Typical features

Ocular irritation / worse outdoors and in wind

Senile patients / chronic history / lateral overflow

Constant / frequent wiping / medial overflow

Treatment options

Hot compress / lubricants / oral antibiotics / topical steroid

Surgical correction

Nasal steroid & sinus rinse / oral anti-histamine / surgical correction



Kenneth Chan consults at the Thorndon Eye Clinic, 230 Thorndon Quay, Wellington and operates at Bowen Hospital, 98 Churchill Drive, Crofton Downs, Wellington.

Please note:
Kenneth can conduct his consultation in Cantonese and Mandarin if required.

Acurity Health GP Conference 2014

On 4th and 5th of April GPs from as far afield as Invercargill in the South and Auckland in the North came together at Te Papa, Wellington for the 16th Annual Acurity Health GP Conference (formerly the Wakefield Health GP Conference).

Embracing the theme New Challenges New Directions, Promoting Quality in Your Practice, an expert body of speakers covered the latest in research, new procedures and diagnosis. Twenty six diverse presentations and workshop topics, highlighted the challenges GPs face in having to be expert generalists in the constantly evolving healthcare environment. Presentations struck a chord with many GPs, one remarked "I will now start to think outside the square following Glenn Singleman's presentation on Risk Management."

With the motivation and new knowledge from successful presentations, and a chance to interact with colleagues, sponsors and key industry leaders, it was a captivating two days summed up by one GP as "a valuable conference, with excellent content. The speakers were awesome and I will be encouraging my colleagues to come next year."

Thank you to everyone who took part in this year's conference, we appreciate the positive feedback received and look forward to welcoming you back in 2015.

Save the date

8 & 9 May 2015 / Acurity Health
GP Conference, Te Papa, Wellington

Please check our website
www.acurity.co.nz for updates.



Special thanks to the following speakers

Dr David Abernethy, Neurologist
Dr Malcolm Abernethy, Interventional Cardiologist
Mr Simon Bann, Consultant Upper GI and Laparoscopic Surgeon
Mr Nick Bedford, Gynaecologist and Obstetrician
Dr Tim Blackmore, Infectious Diseases Physician and Microbiologist
Mr Peter Blake, Otolaryngologist/Head and Neck Surgeon
Dr Rees Cameron, Clinical Leader of the Department of Gastroenterology, CCDHB
Dr Angela Campbell, Manager of WellSleep, the University of Otago Wellington Sleep Investigation Centre
Dr Justine Cornwall, Deputy Children's Commissioner
Dr John Denton, Interventional Neuroradiologist and General Radiologist, Pacific Radiology
Dr Cathy Fergusson, Otolaryngologist/Head and Neck Surgeon
Dr Ben Gray, Otolaryngologist/Head and Neck Surgeon
Mr John Groom, General Surgeon, Laparoscopic GI and Colorectal Surgeon
Dr Alejandro Jimenez Restrepo, Cardiologist and Electrophysiologist
Mr John Keating, Colorectal and General Surgeon
Mr Burton King, Breast and General Surgeon
Dr Phil Matsis, Interventional Cardiologist
Mr Fred Phillips, Orthopaedic Surgeon, Hip and Knee Surgeon
Associate Professor Sue Pullon, Head of Department, Primary Health Care and General Practice, University of Otago, Wellington
Mr Simon Robinson, Otolaryngologist/Head and Neck Surgeon
Adj. Professor Alexander Sasse, Cardiologist
Dr Glenn Singleman, Emergency and Critical Care Doctor and Adventure Filmmaker, Sydney
Dr Maria Stubbe, Senior Lecturer and Research Director in the Department of Primary Health Care and General Practice, University of Otago, Wellington
Dr Robert Weinkove, Consultant Haematologist, CCDHB and Clinical Research Fellow, Malaghan Institute of Medical Research
Mr Peter Welsh, Orthopaedic Surgeon, The Back Institute/TBI Health
Mr S Kusal Wickremesekera, Upper GI, Hepatopancreaticobiliary and Laparoscopic Surgeon

Continued on page 12

Acurity Health GP Conference 2014

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"Excellent relevant conference, congratulations to Acurity"



"Topics were relevant to GPs"



Dr Glenn Singleman – Guest Speaker



Gold Sponsor, Pacific Radiology's Dr John Denton and Dr Trevor FitzJohn with Gynaecologist, Mr Nick Bedford (centre)



Sanofi – Silver Sponsor. Nikola Terry and Michael Lewis



Wakefield Specialist Medical Centre Practice Manager, Marg Jenner, with Mr Richard Stubbs, P3 Research, Lunchtime Sponsor, and Dr Ken Romeril, Haematologist



Boehringer Ingelheim – Silver Sponsor. Donovan Daniels and Andrew Wilson



Wakefield Heart Centre – Mr Barry Mahon, Cardiothoracic Surgeon, Carol Allen, Sue Pankhurst, Echocardiographers, with Cardiologists Dr Phil Matsis and Dr Tim O'Meehan



Bowen Hospital Manager, Dorothy Shaw, GP Peter Rich, Paul Quayle, Chief Operating Officer, Acurity Health Group Ltd

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Acurity Health GP Conference 2014

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"I'll be
back next
year"



TBI Health – Silver Sponsor. Doug Bryant, Physiotherapist from Hand Rehabilitation Ltd, with TBI Health's Rachel Lilley, Team Leader for Vocational Health and Renee Cunningham, Team Leader for Community Health



Southern Cross Health Care Society Natalie Huggard, Sean Izzard and far right Emma Trotman with Paul Quayle, COO, Acurity Health Group Ltd, Sue Pullon, University of Otago, and Acurity Health Group Ltd Chief Executive Ian England.

Attention Hawke's Bay GPs

Royston Hospital Orthopaedic Symposium

Join us for this half day event packed with valuable instructional content and recent information in Orthopaedic issues and treatments.

View live feed knee joint replacement surgery along with orthopaedic treatment updates. Meet key specialists over breakfast, tour our state-of-the-art facilities and see how we are providing exceptional and compassionate care to your patients.

Saturday 27 September 2014
Seminar Room,
Royston Centre
500 Southland Road,
Hastings

Full programme details
will be available shortly.

To reserve one of 40 limited places,
please contact Carolyn Young,
PA to Hospital Manager
Royston Hospital
P: (06) 873 1111 Extn 6099
F: (06) 873 1112
E: carolyn@royston.co.nz

**Reserve
a place
TODAY**

Congratulations To...

Mr Peter Devane

Summit of Egmont
23/04/2014

"A rare (but good!) day out
of the Operating Theatre!"

Peter is an Orthopaedic Surgeon
practicing at the Wakefield
Specialist Medical Centre. His
special interest is in primary
and revision surgery for Total
Hip and Knee Joint Replacement
Trauma Reconstruction.



Dr Ian Wilson

Ian (far left) and Vicki Robinson were part of Oxfam New Zealand's largest fundraising event, Oxfam Trailwalker, held on 5-6 April 2014. They walked 100km in 36 hours around Lake Taupo to raise funds which are used to help save and improve the lives of people throughout the Pacific.

Ian is a Gastroenterologist who consults at the Wakefield Gastroenterology Centre and operates at Wakefield Hospital. Ian sees many patients with Crohn's disease, IBD and hepatic problems, and Hepatitis. He also does regular Oesophageal Manometry +/- 24 hour Ph Study testing for doctors as far away as Wanganui. This tests the muscular function of the oesophagus.



Dr Dick Dinsdale

Dick completed the Speight's Coast to Coast on Friday 14 February 2014. Dick ran a total of 36km, cycled 140km and kayaked 67km to complete the course in just over 19 hours!

Dick has been practicing as an Anaesthetist and Intensive Care Specialist at Wellington Hospital and at Wakefield and Bowen Hospitals since 1988. He is part of the Intensive Care Specialist team who provide 24 hour care for patients in the Wakefield Hospital Intensive Care Unit.



In-depth Look at Healthcare by Visiting American Students

Royston Hospital

| Event: Visiting Students



“Information technology was much better in New Zealand compared to America...”

Five years ago Dr Marilyn Skirocki, a Professor in health sciences at the University of Michigan, United States of America visited Royston Hospital and Hawke's Bay District Health Board (HBDHB) and vowed to return with some of her students.

She recently returned with fifteen medical, nursing and health administration students to check out Hawke's Bay's public and private health system to take learnings back to America.

Dr Skirocki said the biggest difference between the two health systems was obviously the open public access to health in New Zealand, which was unavailable in America unless you had health insurance.

“Information technology was much better in New Zealand compared to America where there were hundreds of different information technology systems being used and therefore only a remote possibility of clinicians ever being able to share information”.

The fifteen students spent two days in Hawke's Bay meeting with various clinical and administration teams including quality and risk, pharmacy and finance as well as being shown through Royston and HBDHB.

The group also spent time visiting Eastern Institute of Technology, ACC, Southern Cross Insurers and Ministry of Health as part of their in-depth research of New Zealand's health care system.

New Consultants



Mr Albert Lo

MB ChB, FRACS (GS), FRACS (Vascular Surgery)

Vascular Surgeon

P: (06) 873 1164

F: (06) 873 1165

E: hawkesbayvascular@yahoo.co.nz

Mr Albert Lo is a Vascular Surgeon who consults and operates at Royston Hospital.

Specialty

Vascular Surgery

Training

Albert is a graduate of Auckland University. He started his surgical career in General Surgery, obtained his FRACS in 2009. He then completed the fellowship in Vascular Surgery, and was awarded FRACS in 2012. During his training in New Zealand and Australia, he gained significant experience in all aspects of open and endovascular surgery.

Special Interests

Albert will be offering the full range of vascular services, including open arterial and endovascular interventions for carotid disease, abdominal aortic aneurysm, peripheral arterial disease. In addition, he also provides dialysis access, endovenous treatment for varicose veins, thorascopic sympathectomy for primary hyperhidrosis.

Background

Albert practiced as Consultant Vascular and Endovascular Surgeon in Wellington Hospital from 2012 to 2014.



Dr Marion Leighton

MBBS, MRCP, FRACP, PGDipClinED

Specialist General Physician

P: (04) 380 0125

F: (04) 380 0127

E: drleighton@greenstoneconsultants.co.nz

Healthlink: nzdermas

W: www.greenstoneconsultants.co.nz

Dr Marion Leighton is a General Physician who consults at The New Zealand Dermatology and Skin Cancer Centre in the Lychgate Centre, 100 Riddiford Street, Newtown, Wellington. Marion also does peri-operative consultations, on request, at Bowen and Wakefield Hospitals.

Specialty

General Internal Medicine

Background and Training

Marion trained at the University of Newcastle-on-Tyne and worked in local hospitals while gaining her MRCP (Edinburgh). She then moved to New Zealand and completed her advanced training in General and Acute Medicine with the RACP. She has also undertaken a postgraduate diploma in clinical education through the University of Auckland. She works in private practice in Wellington and also as a consultant at Wellington Hospital and the Mary Potter Hospice. She has worked in many hospitals in New Zealand and Australia giving her a breadth of experience.

Special Interests

As a General Physician, Marion specialises in complex diagnoses, multiple medical conditions and applied pharmacology. She sees many people who need more information about managing their medical problems, or helping them sort out their symptoms. She works closely with other practitioners including other specialists, psychologists and allied health care when needed.

Mr Nick Tramoundanas

BSc, BDS

Dental Surgeon

P: (04) 388 9999

F: (04) 388 9348

E: smiledoctor@smiledoctor.co.nz

Mr Nick Tramoundanas is a dental surgeon who consults at Unit 5, 37 Miramar Avenue, Miramar Wellington and operates at Bowen Hospital, 98 Churchill Drive, Crofton Downs, Wellington.

Specialty

Dental Surgeon

Training

Nick graduated from Otago University.

Special Interests

- Restorative dentistry
- Implant dentistry using CAD/CAM guided surgery
- Oral factors causing speech and feeding problems in children.

Background

Nick attended Wellington College and then went on to attend Otago University graduating in 1975 BSc Biochemistry. He entered Dental Faculty and graduated in BDS in 1979. Nick moved into private practice and has been practicing since in Wellington.

He is certified in CAD/CAM restorative techniques 2004, founder of the NZ Cerec Users Group (2004), visiting Lecturer Faculty of Dentistry since 2007 and a past member of the Clinical Advisory Board Lumino Dental Group.

Neurosurgery – Update of Services



WAKEFIELD

SPECIALIST MEDICAL CENTRE

Dear General Practitioners

We are taking this opportunity to update you on the services provided to your patients at Wakefield Neurosurgery.

Our practice has developed over the last 12 years. Patients can be referred to the group to be seen at the first available clinic, or they can be referred to a specific consultant.

The recent introduction of an intensivist service at Wakefield Hospital and the purchase of a Sonapet (Ultrasonic Aspirator) has enabled us to operate on and treat a wider range of intra-cranial and intra-spinal tumours. We continue to treat trigeminal neuralgia, along with the standard neurological conditions we have always seen.

Wakefield Hospital nursing staff are trained and experienced in caring for patients after complex neurosurgical procedures including endoscopic skull base operations.

Referrals can be sent to:

Wakefield Neurosurgery
Wakefield Specialist Medical Centre

Health Link Address wakespec
Telephone (04) 381 8120; 0800 277 646
Fax (04) 381 8121
Address 99 Rintoul Street
Newtown, Wellington 6021
PO Box 16 116, Wellington 6242

Thank you for your ongoing support.

Regards



Martin Hunn



Agadha Wickremesekera



Andrew Parker

Geoffrey Horne – Retirement Notification



THE WAKEFIELD JOINT
REPLACEMENT INSTITUTE

30 June 2014

Dear General Practitioners

After 33 years practicing as an Orthopaedic Surgeon in Wellington, I am now retiring from my private practice at the Wakefield Joint Replacement Institute.

I have thoroughly enjoyed my time in practice and I want to thank you very sincerely for your support over many years. The Wakefield Joint Replacement Institute has provided the very best of care for patients requiring joint replacement and reconstruction, and I am confident that will continue in the future.

My successor Gareth Coulter, is an excellent young orthopaedic surgeon and I'm sure that he will give you a very good opinion and offer excellent management for any patients you refer to him. Gareth works alongside Peter Devane in the Wakefield Joint Replacement Institute and also consults in Waikanae.

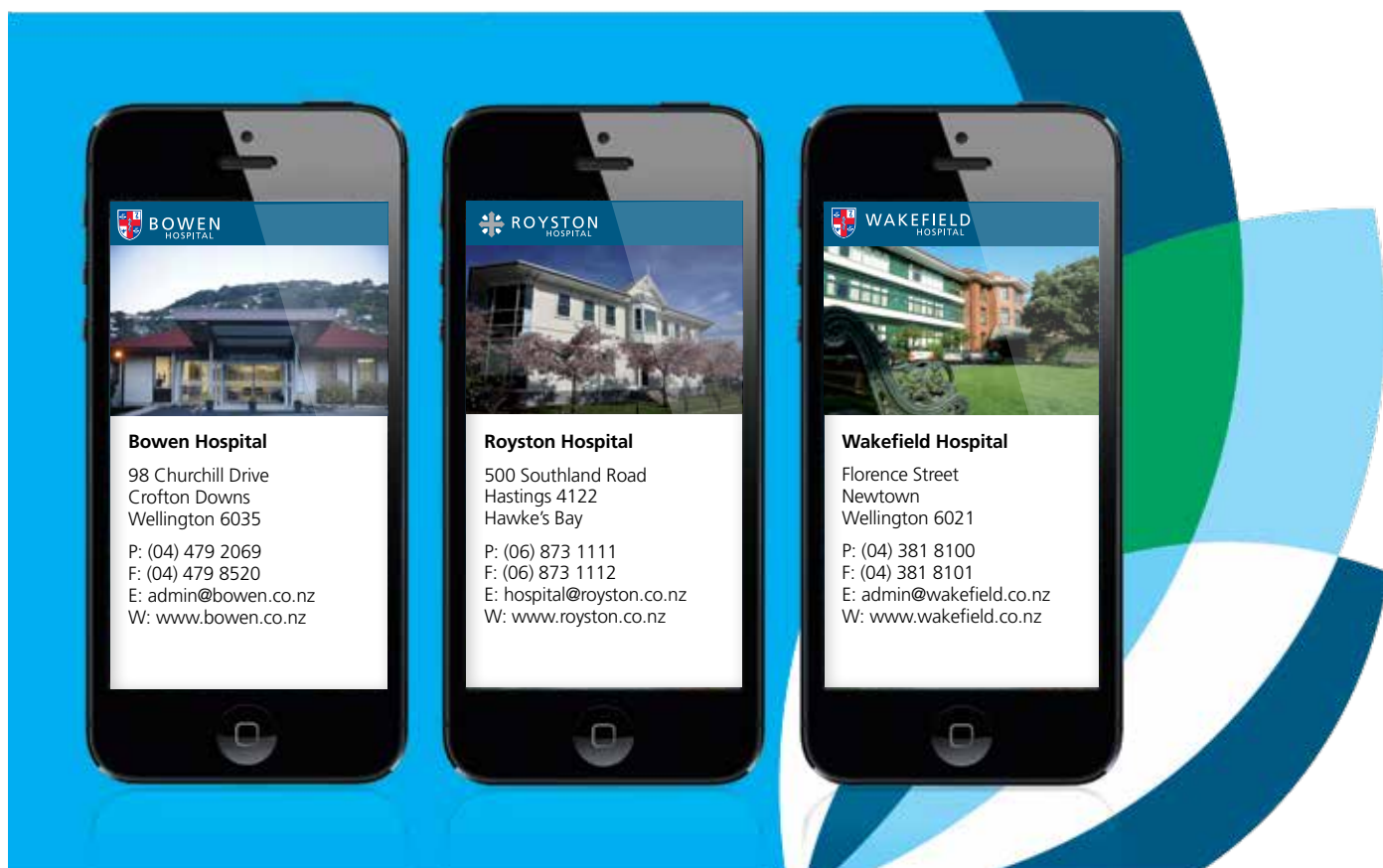
Kind regards

A handwritten signature in blue ink that reads "Geoffrey Horne".

Geoffrey Horne
Orthopaedic Surgeon
Wakefield Joint Replacement Institute

99 Rintoul Street, Newtown, PO Box 16-116, Wellington 6242 Tel: 04-381 8120 Fax: 04-3818121

Contact Us



Missed an Edition?

Go to our 'For our GPs' section on our website – www.acurity.co.nz

GP Survey

We value your feedback and will use your comments to improve this magazine. Go to our 'For our GPs' website and complete the brief survey – www.acurity.co.nz

