

# Health Matters

## Iliofemoral Thrombolysis

Dr Lupe Taumoepeau



Wakefield Hospital

Area: Vascular Surgery. Article written by: Dr Lupe Taumoepeau, Vascular and Endovascular Surgeon, ph (04) 389 4999

### A New Standard of Care for Acute Proximal DVT?

The standard of care for acute deep vein thrombosis (DVT) is parenteral heparin administration followed by oral anticoagulants. This treatment aims to lessen both clot propagation and the risk of pulmonary embolism (PE).

However, this approach has been challenged because rapid symptom resolution does not often occur, with secondary complications being quite common. This is because anticoagulants alone do not lyse thrombus, and in fact, the fate of the clot depends on the vein's intrinsic fibrinolytic functions<sup>1</sup>.



Large clot burden, particularly in the iliofemoral system, often overwhelm these mechanisms, leaving residual thrombi that can lead to venous hypertension and post-thrombotic syndrome (PTS)<sup>2,3</sup>.

### Post-Thrombotic Syndrome

PTS develops in 40-60% of patients who suffer iliofemoral DVT<sup>1,3</sup>. The pathogenesis is complex. At a macroscopic level, it is currently thought that the inflammatory response to acute thrombosis directly damages the venous valves and alters the adjacent vein wall, leading to valvular reflux<sup>3,4</sup>. Residual thrombus also causes obstruction and increases risk of recurrent DVT. PTS most commonly causes chronic, daily limb pain/aching, fatigue, heaviness, and swelling. In severely affected patients, limiting venous claudication, stasis dermatitis, subcutaneous fibrosis, and skin ulceration may develop<sup>6</sup>. PTS clearly impairs quality of life, with sufferers scoring worse quality of life scores than patients with chronic lung disease and angina<sup>4-6</sup>.

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Acurity GP Conference  
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# Message from Acurity

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

 **A very warm welcome** to the Spring edition of Health Matters. In this issue Dr Lupe Taumoepeau, Vascular and Endovascular Surgeon, presents an article on Iliofemoral Thrombolysis: A New Standard of Care for Acute Proximal DVT? Along with articles from Ophthalmologists, Mr Kenneth Chan and Mr Neil Aburn; General Surgeon, Mr Wicks and Gynaecologist, Mr Simon McDowell.



**GP Conference**  
Planning for the CONNECT 2016: Acurity GP Conference is well and truly underway. If you haven't already done so please save the dates in your diaries for Friday 6<sup>th</sup> and Saturday 7<sup>th</sup> May 2016 for what promises to be bigger, bolder and a better conference than ever before. The programme is developing well with vibrant speakers, "quick fire" lightning talks and concurrent sessions, to provide you with the practical tools, knowledge and advice to offer your patients.

Please visit our website [www.acurity.co.nz](http://www.acurity.co.nz) for more information and keep an eye out in future editions of Health Matters.

Correction:  
Apologies for incorrect title of Anaesthetist, Dr Pia Raudkivi, in Edition 12, page 14.

Business Development. Article written by:  
Sarah Malone, Business Development Manager

**Patient Finance.** Acurity Health Group in partnership with Fisher & Paykel Finance, are providing an opportunity for specialists to consider offering finance to their patients for insurance co-payment shortfalls and treatment for the uninsured.

A steady increase in requests for payment plans from patients has led to our partnership with Fisher & Paykel Finance. For the past six years, Fisher & Paykel have financed millions of dollars in healthcare procedures for thousands of New Zealanders every year making them the ideal partner.

While finance is not appropriate for everyone, those who choose to self-fund can benefit from earlier access to treatment, leading to better recovery and long term outcomes.

As demand for medical treatment continues to grow, so too will wait times for many elective procedures. Q Health finance provides a solution for patients who want to explore self-pay options for their surgery.

Over a third of New Zealanders have private health insurance, however not all treatments and costs are covered by insurance policies. For patients with a co-payment clause, the Q Health payment solution provides an additional form of funding to cover the sometimes significant shortfall they need to cover themselves. The twelve months, no interest, no payment terms, may mean the difference between accessing treatment which would otherwise not be an option, or facing a lengthy wait for elective surgery in the public system.




**Patient Finance**  
Access to surgical services needs to be easier, and with lengthy public waitlists and less than optimal insurance cover we have been exploring our options around offering patient finance for certain procedures.

We have been working with Fisher and Paykel Finance, whose Q Card offering is already widely used in other areas of the healthcare industry, and hope to be able to launch this initiative prior to the end of 2015.

As well as providing patients another option for funding their surgery, the Q Card offering may be used for covering insurance co-payments as part of a larger procedure that is partially funded by an insurer. Please see the article on the right for further information.

I wish you happy reading.

  
Paul Quayle,  
Chief Operating Officer,  
Acurity Health Group Limited

# Iliofemoral Thrombolysis

Continued from page 1

Dr Lupe Taumoepeau



## Modern Endovascular Thrombolytic Techniques

Catheter-directed thrombolysis (CDT) has been shown to debulk thrombus faster and reduce recurrence and PTS<sup>7</sup>. CDT refers to the infusion of a thrombolytic drug directly into the venous thrombus via a multi-sidehole catheter, which is embedded in the thrombus using imaging guidance<sup>7,8</sup>. After the acute thrombus has been eliminated, the underlying veins are evaluated by venography and any venous obstructive lesion identified is treated with balloon angioplasty and/or stent placement. In 2012, Enden et al described the two year follow-up results from 209 patients randomised to either CDT and anticoagulation or anticoagulation alone in the Norwegian multicenter CaVenT Trial<sup>9</sup>. Venous patency was significantly superior in the CDT treated patients (65% vs 47%,  $p<0.05$ ) and there was a significant reduction (14.4%,  $p<0.05$ ) in PTS symptoms in the same group at two years<sup>9</sup>. Limitations of this technique include the long infusion times required to lyse extensive DVT (typically one to three days), healthcare resources used and risk of haemorrhage.

Pharmacomechanical thrombolysis (PMT) has been developed in order to achieve a higher local intrathrombus drug concentration and minimise the systemic effects. The Trellis Peripheral Infusion System (Bacchus Vascular, Santa Clara, California) (Figure 1) is a hybrid catheter that isolates the segment of thrombosed vein between two occluding balloons and infuses a small dose of a lytic agent into the target segment. The intervening catheter assumes a spiral configuration which, when activated, oscillates to disperse the thrombus. Following aspiration of the liquefied and fragmented thrombus, the treated vein segment is re-evaluated and re-treated, if necessary. The time for one cycle of treatment is 15 minutes.

The benefits of this therapy (Table 1) and the importance of treatment designed to eliminate the thrombus in patients with acute iliofemoral DVT has been echoed by several evidence-based clinical practice guidelines. The Society for Vascular Surgery, American Venous Forum and American College of Chest Physicians, all recommend CDT or PMT as first line treatment to achieve more rapid relief of current symptoms and to prevent PTS in patients with acute iliofemoral DVT<sup>10,11</sup>.

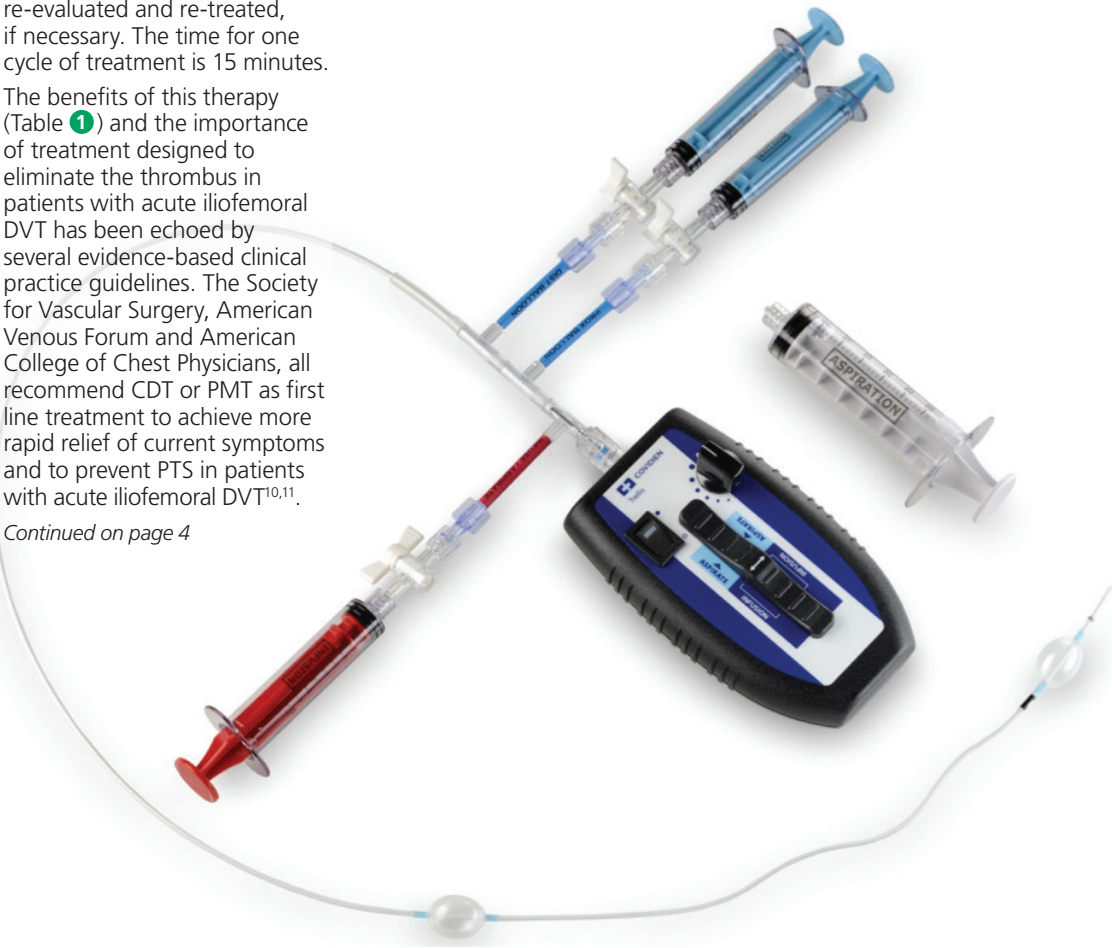
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Table 1 Benefits of pharmacomechanical thrombolysis for DVT
Local delivery of thrombolytic agent
Shorter duration of thrombolysis
Avoid risks of systemic effects of thrombolytic agents <ul style="list-style-type: none"><li>– Can be used in patients with relative contraindications to thrombolysis</li><li>– Decreases bleeding complications</li></ul>
Less costly.

## Summary

- DVT is a common problem that, when treated aggressively, will relieve a patient's acute symptoms and prevent potential lethal consequences, such as PE, and long-term sequelae such as post thrombotic syndrome.
- Pharmacomechanical thrombolysis with the Trellis device has been shown to be a safe and effective treatment that ensures rapid resolution of thrombus.
- Patients with acute (<21 days) iliofemoral DVT, with good level of function and minimal bleeding risk should be referred for consideration of PMT.

**Figure 1** The Trellis system (Bacchus Vascular, Santa Clara, CA) consists of proximal and distal balloons, with balloon inflation syringes, a thrombolysis infusion port, the thrombus aspiration syringe, and a drive unit for mechanical dispersion of the thrombolytic agent. Image provided by Covidien. Source: [www.medgadgets.com](http://www.medgadgets.com)





# Iliofemoral Thrombolysis

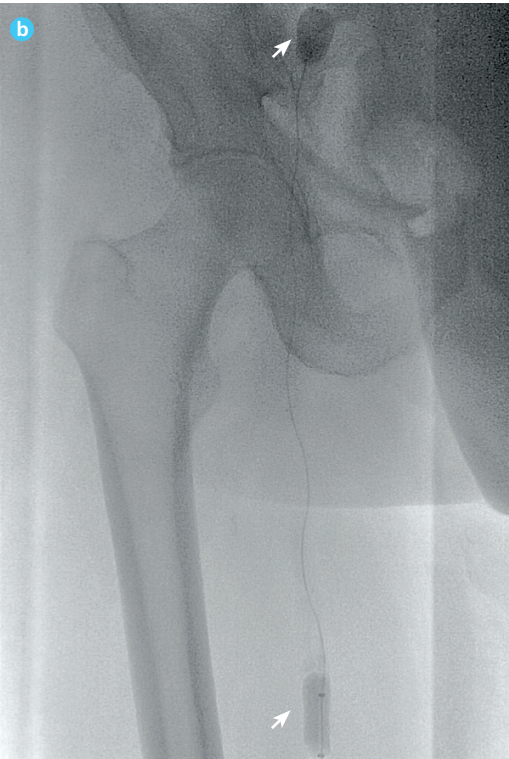
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Dr Lupe Taumoepeau



### Case Study

A 55-year-old man presented with a four-day history of right lower limb swelling and pain and was diagnosed with a right iliofemoral DVT. He was commenced on low-molecular-weight heparin and referred for endovenous therapy. The Trellis device was used successfully to debulk the thrombus and restore right common femoral and iliac vein patency, see figure 2 (a – c) below.



**Figure 2:**

- a** Venogram shows thrombosed right femoral and iliac veins.
- b** Trellis device with position of proximal and distal balloons in right femoral and iliac veins.
- c** Completion venogram showing resolution of thrombus.

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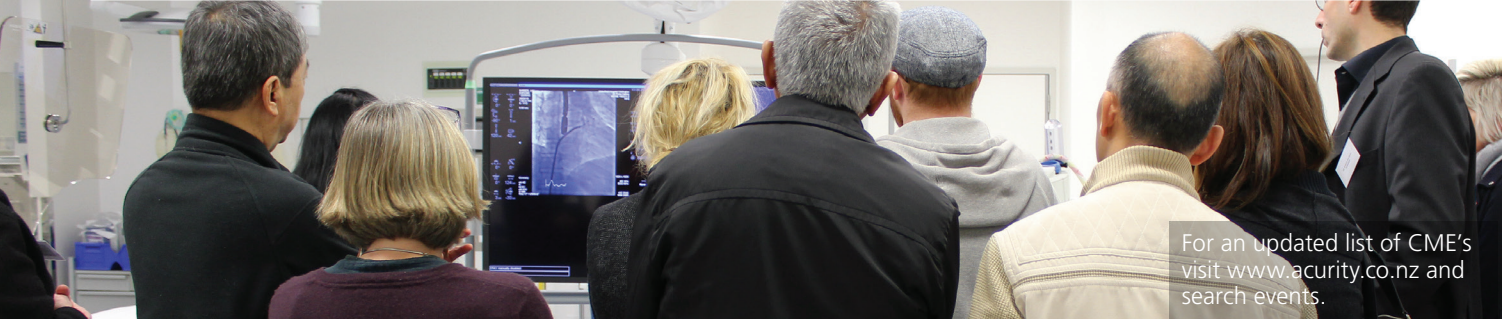
# Upcoming CME's (Educational Events)

Acurity Health Group host a variety of Continuing Medical Education (CME) sessions for GPs throughout the year. Each session is formatted to give you an opportunity to meet consultant physicians and surgeons, receive expert feedback and discuss topics in an interactive environment.

We aim to deliver practical sessions with a primary healthcare focus and leaning outcomes based on general practice diagnosis, management and investigation. Consultants are often able to provide updates on the latest research and cutting edge treatments and procedures.

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

Upcoming CME's 2015/16					
Date	Speaker	Title	Details	Venue	CME endorsed
<b>21 October 2015</b> Wednesday	Dr Lupe Taumoepeau and Mr J. Kes Wickremesekera, Vascular and Endovascular Surgeons	Vascular Update	TBA	Education Centre, Wakefield Hospital	2 credits
<b>4 November 2015</b> Wednesday	Wakefield Heart Centre Cardiologists	Cardiology Update	TBA	Education Centre, Wakefield Hospital	2 credits
<b>10 November 2015</b> Tuesday	Dr Latha Vasan, Gynaecologist	Gynaecology Update	An Overview of Abnormal Uterine Bleeding	Kapiti Lindale Conference Centre, Paraparaumu, Kapiti Coast	2 credits
<b>18 November 2015</b> Wednesday	Dr Ken Romeril, Haematologist	Haematology Update	TBA	Education Centre, Wakefield Hospital	2 credits
<b>February 2016</b> Date TBC	Mr Nick Bedford and Mr Simon McDowell, Gynaecologists	Gynaecology	TBA	TBA	2 credits
<b>March 2016</b> Date TBC	Mr Fred Phillips, Orthopaedic Surgeon	Orthopaedics	TBA	Seminar Room, Bowen Hospital	2 credits
<b>April 2016</b> Date TBC	Mr Jesse Gale, Ophthalmologist	Ophthalmology	TBA	Seminar Room, Bowen Hospital	2 credits
<b>6 &amp; 7 May 2016</b> Friday and Saturday	Multiple speakers	CONNECT 2016: Acurity GP Conference	For enquiries, email connect@acurity.co.nz	Te Papa, Wellington	TBA



For an updated list of CME's visit [www.acurity.co.nz](http://www.acurity.co.nz) and search events.



Friday 6<sup>th</sup>  
& Saturday 7<sup>th</sup>  
May 2016  
Te Papa, Wellington

# Connect 2016

Bigger,  
Bolder and  
Better than ever before

Explore sessions covering:  
Musculoskeletal – Ophthalmology – Neurology  
Renal – Cardiology – Men's Health

Quotes from CONNECT 2015 Acurity GP Conference:

"Very well run, lovely venue, feel good conference"

"Good value and a worthwhile two days"

"Well organised, enjoyed the quick fire presentations and many practical topics"

"Very relevant topics filled with gold nuggets, thank you so much!"



## Eyelid Tumours

Mr Kenneth Chan



Mr Neil Aburn



Bowen Hospital

Area: Ophthalmology, Article written by: Mr Kenneth Chan, Ophthalmologist, ph (04) 499 4940  
and Mr Neil Aburn, Ophthalmologist, ph (04) 475 9559

### Diagnosis and Management

The eyelids are complex structures, the main function of which is to protect the eyes and thus enable vision. Therefore tumours of the eyelids have importance not only in terms of the tumours themselves but also with regards to their secondary effects on the structure and function of the eyelids.

This article will discuss the diagnosis and treatment of eyelid tumours. Discussion of the treatment of eyelid tumours necessarily includes the topics of tumour clearance and eyelid reconstruction.

Table 1

#### Eyelid Tumours – Classification

Inflammatory
– Infected
– Non-infected
Benign
– Limited growth, no distant spread
Pre-malignant
– Potential to become malignant
Malignant
– Primary – Grow and invade local tissues and may metastasise
– Secondary – unusual

Table 2

#### Malignant Eyelid Tumours

Basal Cell Carcinoma
Squamous Cell Carcinoma
Sebaceous Cell Carcinoma
Melanoma
Rare primary tumours e.g. Merkel Cell Tumour, malignant oncocytoma
Secondary tumours – blood-borne, direct invasion

### Diagnosis of Eyelid tumours

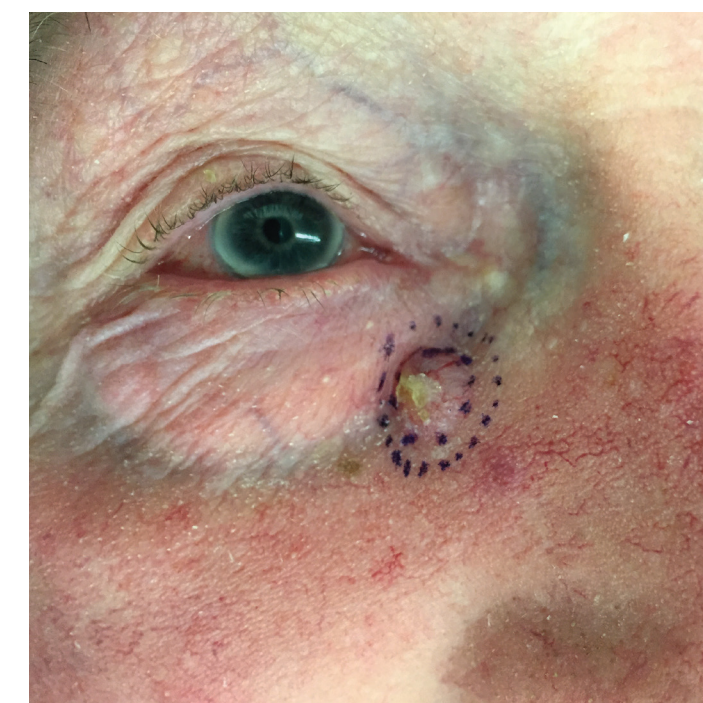
A brief classification of eyelid tumours is included in Table 1.

Inflammatory lesions include lesions such as chalazia and styes. The group of benign lesions includes benign cysts of sweat glands and sebaceous glands, as well as solid tumours including seborrheic keratoses, naevi and xanthelasmata.

Table 2 includes a brief classification of malignant eyelid tumours. Diagnosis of such tumours can be made on appearance, but typically tissue sampling is preferred. Such lesions can be sampled using shave or punch techniques.

Tumours where the diagnosis is obvious (typically nodular BCCs) can be treated primarily with excision biopsy with adequate margins – typically 3mm in the eyelids – and periocular reconstruction during the same surgical session.

Once the diagnosis has been established and if residual tumour is present, a decision must be made to monitor or re-excite the lesion. Complete surgical clearance should be the goal for the majority of patients if clinically feasible. Standard surgical and pathological processing techniques are usually adequate for well-circumscribed lesions (Picture 1);



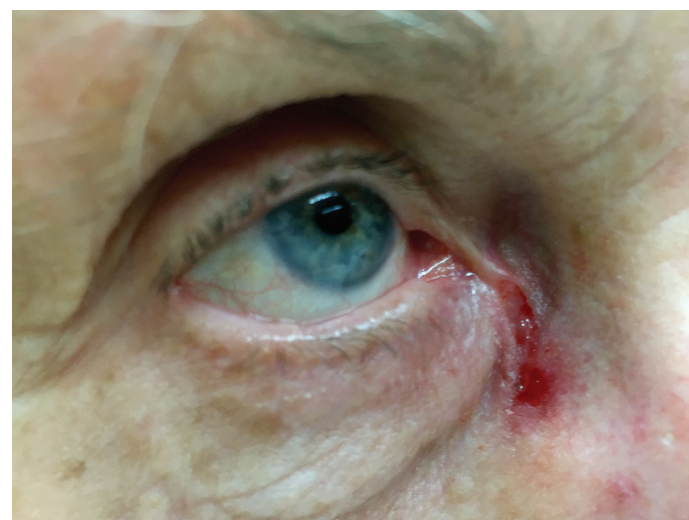
1 Typical appearance of a nodular BCC in the right lower lid, marked with a 3mm surgical margin prior to excision



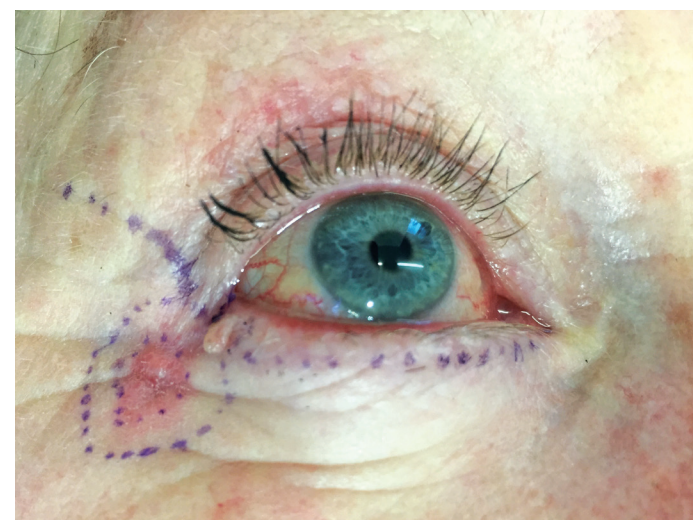


# Eyelid Tumours

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**2** Biopsy-proven morphoeic BCC of the right medial canthus, with ulcerative centre and indistinct margin. The lacrimal drainage apparatus may be affected by the tumour. This lesion will benefit from margin control at the time of surgery



**3** Pre-operative design of a local myocutaneous sliding flap for a recurrent lower lid BCC, in conjunction with shortening of the lateral lower lid

while diffuse, infiltrative lesions with irregular margins will benefit from some form of margin control at the time of surgery (Picture 2). The Mohs technique is a good example of an efficient excisional technique that allows the operating dermatological surgeon to inspect the entire margin of the specimen at the time of excision, who is then able to resect further tissue if there is microscopic evidence of residual tumour.

## Eyelid Reconstruction

Defects confined to the skin and muscle layers of the eyelid can be reconstructed with local flaps, skin grafts or a combination of both, depending on the amount of tissue loss as well as redundancy in local tissue. In order to prevent eyelid

malposition, judicious resection or lengthening of the eyelid may be required (Picture 3). Small full-thickness defects of the eyelids can often be closed directly, whereas large full-thickness defects of the eyelids will need to be reconstructed in their respective layers. A defect in lower lid tarsus is most commonly reconstructed with a tarsconjunctival flap from the ipsilateral upper lid (Picture 4); alternatively a tarsal, hard palate or nasal septal cartilage graft can be inserted. By restoring normal anatomical relationship within the eyelids, normal function of the periorbital can be maintained while a satisfactory cosmetic appearance can usually be achieved (Picture 5).

In summary, there are multiple lesions that can affect the eyelids, the most notable of these are the malignant lesions. It is important to have a high index of suspicion regarding these lesions – early diagnosis is critical to maximise the chances of tumour clearance with limited loss of eyelid tissue and satisfactory results from eyelid reconstruction.

### Mr Kenneth Chan

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

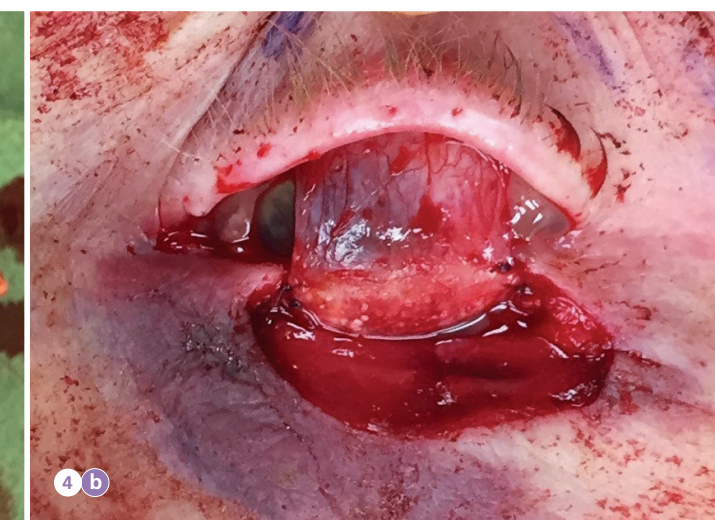
### Mr Neil Aburn

consults at the Kelburn Eye Centre, 8 Upland Road, Kelburn, Wellington and also operates at Bowen Hospital.

Mr Kenneth Chan



Mr Neil Aburn



## 4 Reconstructing:

- a** a large defect of the left lower lid
- b** with a tarsconjunctival flap
- c** orbicularis advancement flap
- d** and full-thickness skin graft from the upper lid



**5** Appearance one year after lower lid reconstruction using a tarsconjunctival flap, with a small sebaceous cyst at the flap-host junction of the lid margin



# Why Does Endometriosis Occur?

Mr Simon McDowell



Wakefield Hospital | Area: Gynaecology  
Article written by: Mr Simon McDowell, Gynaecologist, ph (04) 381 8120



Throughout my early specialist gynaecology training I compared the pathogenesis of endometriosis to one of my Otago University Dunedin flats. My bedroom in this flat had a serious case of 'mouldy roof'. If I neglected to 'mop the roof' every few months, things got way out of control.

At the time this seemed a fitting analogy to the pathogenesis of endometriosis. The development of endometriosis reflected 'parasitic endometrial glands and tissue' that had refluxed through the fallopian tubes and then found a suitable place to grow'. If this tissue (or 'mould') was not 'mopped up' every few years, things were liable to become seriously problematic.

With experience, further training, and a more complex understanding of endometriosis, I began to appreciate that the theory of 'retrograde menstruation' could not be the only pathogenic mechanism. If this were the case simply clipping or removing the fallopian tubes would be curative. While still not completely understood, we now understand that the development of endometriosis is related to multiple and complex overlapping mechanisms.

Retrograde menstruation appears to somehow trigger a change in the underlying peritoneal mesothelial cells. Given that 90% of women will have retrograde menstruation, the peritoneal mesothelial cells must be susceptible to 'change'<sup>2</sup>. Deficient immune and inflammatory systems may contribute to endometriosis development as menstrual debris evade clearance<sup>3</sup>. Genetic or hereditary factors may play a role in each of these mechanisms. If a first-degree relative has endometriosis the individual has a seven percent chance of developing endometriosis. This is compared to one percent background risk<sup>4</sup>.

Emerging evidence shows that genetic and environmental factors may enhance the ability of refluxed endometrial tissue to development in ectopic sites. Micro RNAs (miRNA) are epigenetic modifiers of gene

expression, and differential regulated miRNAs have been found in eutopic and ectopic endometrium<sup>5</sup>. This area of research is interesting as it may lead to miRNA-based therapies of endometrial disorders such as endometriosis.

A better understanding of the pathogenesis also challenges us to review our understanding of endometriosis 'recurrence'. Does endometriosis truly recur? Or, is it reemergence of abnormal peritoneal mesothelial cells that have not been surgically removed?

'Parasitic' endometriosis would continue to develop until the source (uterus) is removed or fallopian tubes blocked. Women would require laparoscopy every few years to keep things 'under control'. Then hysterectomy once childbearing is complete. Certainly this has been the approach in the past.

In many patients 'recurrence' of endometriosis reflects endometriotic tissue that was incompletely removed at initial surgery<sup>6</sup>. We know that ablation or cauterisation of endometriosis has higher rates of recurrence<sup>7</sup>. This likely occurs because the tissue was never completely removed. Full excision of disease with wide and clear margins should lead to more women having a solitary laparoscopy or a very limited number of procedures. Unfortunately endometriosis can be challenging to remove in entirety; the more severe disease the higher the risk of residual endometriosis. Progressive development of residual disease will continue to be a problem. Repeat endometriosis surgery is also

challenging due to adhesions. Endometriosis and adhesions can be difficult to differentiate.

The idea that endometriosis develops like a parasite is incorrect. Retrograde menstruation plays a role in the development of endometriosis but is not the only mechanism. Endometriosis surgeons should focus on performing 'one excellent operation' and avoid ablation or partial resection. This may mean women with unexpected severe disease have a short 'planning laparoscopy' with no attempt to 'make a start'. Clinicians should endeavour to avoid performing multiple laparoscopies on the same woman.

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# Welcoming Mr Simon McDowell



October 2015

Dear General Practitioners

Mr Simon McDowell  
FRANZCOG, MBCHB, PGDipOMG

**Gynaecologist, Mr Simon McDowell, now consulting at the Wakefield Specialist Medical Centre.**

I am pleased to welcome Mr Simon McDowell to our specialist team at Wakefield.

His area of expertise includes:

- Endometriosis
- Menstrual disorders
- Ovarian cysts
- Fibroids
- Infertility
- Tubal disorders.

Simon takes a personal approach to his patients, has high attention to detail and prides himself on communicating to patients in an honest and straightforward manner.

He is uniquely qualified to manage woman's health issues. With Obstetrics and Gynaecology specialty qualifications Simon is one of around ten New Zealanders to have completed subspecialty qualifications in Reproductive Endocrinology and Infertility.

One of the first New Zealanders to complete an advanced laparoscopic fellowship in minimally invasive surgery, Simon's main area of interest is endometriosis and the management of menstrual disorders via a minimally invasive approach.

Simon runs his general gynaecology practice at Wakefield Specialist Medical Centre and will see all patients with gynaecological problems. He is also happy to undertake remote consultations via skype or phone when patients live afar. Simon manages his fertility practice through Fertility Associates Wellington.

Referrals can be sent to:  
Wakefield Specialist Medical Centre  
99 Rintoul Street, Newtown  
Health Link Address: acurityh  
Telephone: 04 381 8120  
Fax: 04 381 8121  
Address: PO Box 16-116, Wellington 6242.



Yours sincerely

*Marg Jenner*

Marg Jenner  
Practice Manager



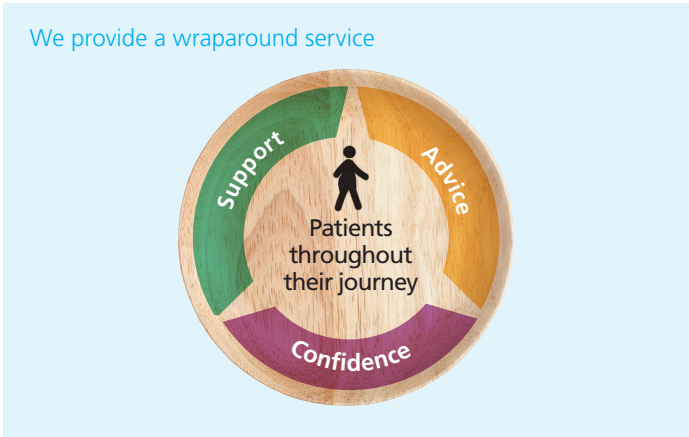
# Laparoscopic Sleeve Gastrectomy: Is it the ideal bariatric procedure?

Wakefield Hospital | Area: General Surgery  
Article written by: Mr Wicks, General Surgeon, ph (04) 381 8120

Is there such an entity, as an ideal bariatric procedure, and are we there yet? It has now been nearly 25 years since the National Institute of Health in the United States established its original guidelines recommending bariatric surgery to control severe obesity<sup>1</sup>. Currently, in order to minimise risk, selection criteria for bariatric surgery are standardised around the world. Over the years, a number of bariatric procedures have been devised and tried, and these include vertical banded gastroplasty, laparoscopic gastric banding, gastric bypass, duodenal switch, biliopancreatic diversion, and laparoscopic sleeve gastrectomy<sup>2</sup>. The laparoscopic sleeve gastrectomy was born as the first stage of the duodenal switch, but due to the weight loss being dramatic and effective with the sleeve gastrectomy, it was established as its own definitive procedure<sup>3</sup>.

Over the course of the last few years, laparoscopic sleeve gastrectomy has gained great popularity amongst bariatric surgeons and patients alike due to its effectivity and simplicity<sup>4</sup>. It is now a well established bariatric procedure and can boast a number of virtues that has contributed to its popularity<sup>5</sup>. Primarily it is a relatively straight forward procedure which is performed laparoscopically and involves removal of approximately 75% of the stomach via application of multiple reinforced staple firings over a bougie placed into the stomach which acts as a guide<sup>6</sup>. The new stomach has a capacity of about 100mls. Post-operatively, patients are commenced on a pureed diet by day two and discharged home.

There is very little post-operative pain and patients usually return to normal activity rapidly. The surgical risk profile is low with a risk of major morbidity such as leak, bleed and stricture in the order of approximately 3-4%, and a mortality rate of only 0.3-0.5%<sup>7,8</sup>. Conventionally, the primary goal of bariatric surgery has been weight loss, and the sleeve gastrectomy affords an excess weight loss (EWL) in the order of 55-75% in the first three years with some studies now publishing five year EWL rates of 65-75%<sup>4</sup>. Laparoscopic sleeve gastrectomy is a metabolic procedure which results in resolution of diabetes in 80-90%, resolution in hypertension and dyslipidemia in 66%, and 90% chance of improvement in sleep apnea



in patients<sup>9</sup>. Finally and most importantly, by about three months post-operatively, the eating pattern that is usually achieved by patients is essentially normal, with an ability to tolerate a variety of meats, grains, vegetables and fruits, ie. a normal diet but on an entrée sized plate<sup>10</sup>.

Post-operative weight regain is evident with all bariatric procedures and necessitates clear commitment by the patient to the requirements of their new lifestyle. In order to optimise outcome, we believe that laparoscopic sleeve gastrectomy should be performed in the context of a multidisciplinary evaluation.

Our multidisciplinary team (MDT) comprises surgeon, counselor, dietitian and lifestyle coach. We undertake a preoperative evaluation process whereby patients are carefully assessed and educated by team members (surgeon, counselor, dietitian), followed by an MDT discussion prior to selection for surgery. The lifestyle coach is involved post-operatively to help adjust to a new life. This wraparound service provides support, advice and confidence to patients throughout their journey.

Mr Wicks



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The laparoscopic sleeve gastrectomy is an effective procedure with good outcomes on a number of levels.

**Is it the ideal bariatric procedure?**  
Well, we are nearly there.





# Education in the Bay



## Royston Hospital Committed to Delivering Medical Education in the Bay

Royston Hospital has a proud history of providing quality clinical education across the healthcare sector.

Over the past seven years, Royston has been able to open one of its four operating theatres to clinical observers by providing 'live feed' surgery via images from several cameras in theatre to a large projected screen in the Royston Centre seminar room. A head mounted microphone allows the surgeon to commentate to the delegates during cases with a mobile 'roaming' microphone to enable questions and comments to be directed back to theatre. This two way communication is integral to allowing the meeting to be interactive between the audience and the surgeon.

Last September eight Hawke's Bay orthopaedic surgeons hosted 22 local GP's at a symposium on orthopaedic related topics including live streaming of a total knee joint replacement from within Royston's operating theatre. The day included presentations on shoulder, elbow and foot conditions as well as joint replacement longevity. GP's found this to be extremely valuable and informative.

The second Oral and Maxillofacial Surgical Day was held recently with Mr Derek Goodisson, Maxillofacial



Surgeon, performing two procedures in theatre while an audience of over 30 Hawke's Bay dentists observed technique and gained considerable insight from viewing the surgery.

As we go to print Royston is preparing to host the seventh annual Gynaecology Laparoscopic Surgical Educational Day, facilitated by Dr Jeremy Meates. This seminar provides an invaluable learning experience through 'live feed' surgery focusing on advanced laparoscopic technique by Australian gynaecologist Mr Michael Wynn-Williams to an audience of gynaecologists from throughout New Zealand.


Acurity Health recently held two very successful CME meetings for general practitioners and

practice nurses in Napier and in Hastings. Both meetings were presented by General Surgeons Mr Bernard McEntee and Dr Bertrand Jauffret. The presenters delivered a well-received update on Colon Cancer Screening and Common Bile Duct Exploration for Cholelithiasis.

Acurity are committed to providing more CME sessions like these to complement the already established educational programme on offer in the Bay.

We are always open to suggestions of topics you would like to have presented. Please email Sarah Malone, Business Development Manager, [sarah.malone@acurity.co.nz](mailto:sarah.malone@acurity.co.nz) with any suggestions.

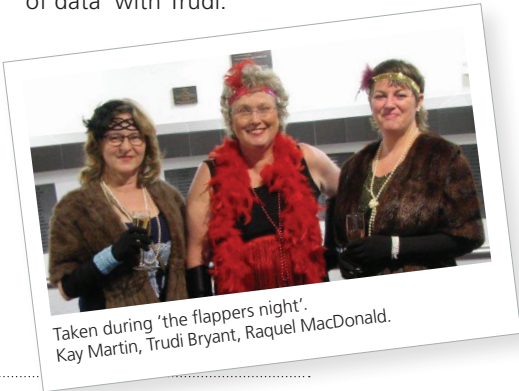
## IPCNC Conference

 Congratulations, to Trudi Bryant, Nurse Manager and Infection Preventionist, Bowen Hospital, as she has won the BD Best Presenter at the NZNO Infection Prevention and Control Nurses College Conference in Napier held between 2<sup>nd</sup> and 4<sup>th</sup> September.

Trudi's presentation looked at wound management as a strategy to reduce surgical site infections. It followed a project carried out at Bowen Hospital to reduce and contain bleeding following knee and hip arthroplasty and to reduce blister rates.

Trudi's prize is \$3000 towards an Infection Prevention and Control Conference anywhere in the world.

Acurity Health was a proud sponsor of this event. Along with Trudi, who won the BD 'Best Presenter' prize, Raquel MacDonald, Infection Control Coordinator, from Royston Hospital was instrumental to the success of this event with her key role on the organising committee and Kay Martin, Infection Preventionist, from Wakefield Hospital, who delivered a poster presentation on 'surveillance and collection of data' with Trudi.



Taken during 'the flappers night'. Kay Martin, Trudi Bryant, Raquel MacDonald.

# New Consultants

Acurity Health welcomes the following consultants to Bowen Hospital. Please contact them directly if you would like more information about their specialties. All of our consultants can be easily viewed on our website [www.acurity.co.nz](http://www.acurity.co.nz)



**Dr Jesse Gale**  
MB ChB FRANZCO  
**Ophthalmologist**  
P: (04) 384 3937  
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E: [jg@ces.net.nz](mailto:jg@ces.net.nz)  
Jesse consults at Capital Eye Specialists, 148 Cuba Street, Wellington and operates at Bowen Hospital, 98 Churchill Drive, Crofton Downs, Wellington.  
**Specialty**  
Ophthalmology  
**Training**  
Jesse studied at University of Otago, graduating from medical school in 2005. He was awarded the Prince of Wales prize as the top graduate of any undergraduate degree in 2005. After house officer work in Wellington and Nelson, and registrar rotations in Dunedin, Wellington, Hamilton and Auckland, Jesse had two years of overseas fellowship training. In 2013 he was Fred Hollows Foundation Fellow in Nepal, Alice Springs, Fiji, Samoa and Tonga, and then had neuro-ophthalmology training at the Doheny Eye Institute in Los Angeles, USA. In 2014 he

completed a clinical glaucoma fellowship in Cambridge, England.  
**Special interests**  
Jesse is well grounded in general ophthalmology and cataract, with subspecialty training in glaucoma and neuro-ophthalmology. Neuro-ophthalmology refers to problems with the optic nerve, pupils or eye movements (double vision). Jesse is developing collaborative new research projects in Wellington into how glaucoma and other optic nerve problems are linked and differentiated.

Jesse also has training and experience in global ophthalmology, and makes annual trips to Pacific countries. At home, this experience has resulted in an interest in managing eye diseases across populations and regions. He is exploring a new online system for enhancing collaborative care between optometrists and ophthalmologists, to improve patient pathways and to reduce unnecessary testing and travel.

**Background**  
Jesse was born in Wellington, he is excited to be home again as a consultant with a new family and stimulating opportunities ahead.



**Mr Andrew Matthews**  
MB ChB (Otago) FRACS (Orthopaedics)  
**Orthopaedic Surgery**  
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**Specialty**  
Orthopaedics

**Training**  
Andrew completed his orthopaedic training in Wellington, Christchurch and Palmerston North. He then went on to complete two years of post-fellowship training at large teaching hospitals in the United Kingdom.

**Special interests**  
He has special interests in foot and ankle surgery with all aspects of arthroscopic and open surgery, also interests in knee surgery, particularly in ligament reconstruction, osteotomy and joint replacement surgery.

**Background**  
Andrew returned to New Zealand following subspecialty training in the UK in January 2015. He also works at the Wellington Regional Hospital. His time away from work is taken up by two young children.



# Contact Us



# Connect 2016

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