

Health Matters

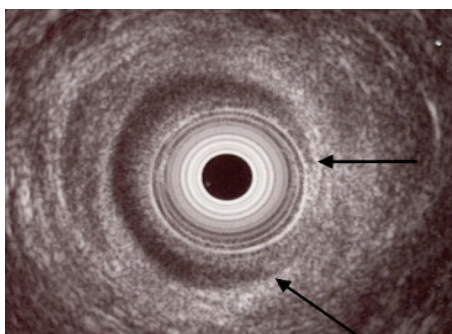
Faecal Incontinence

Dr Elizabeth Dennett



Wakefield Hospital

Area: Colorectal Surgery
Article written by: Dr Elizabeth Dennett,
General Surgeon, ph (04) 381 8120



Investigating the Causes of Faecal Incontinence, a Hidden Problem

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

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

It is recognised that for all women following a vaginal delivery approximately 30% will have occult damage to the anal sphincters^{2,3}. Of those who have had an assisted delivery (forceps/ventouse) studies report a prevalence of 49-73%. Hidden injuries can also involve the puborectalis muscle and the rectum. Many of the women are young and can compensate for any injury. For many, problems do not become apparent until the women are peri-menopausal.

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– Dr Lissa Judd
– Mr Leslie (Les) Snape
– Dr Muhammad Khalid



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The Royal New Zealand
College of General Practitioners
Endorsed CPD Activity

Programme

Acurity GP Conference
6 & 7 May 2016
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Message from Acurity Health Group

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

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

GP Conference

Registration is now open for the Acurity GP Conference: Connect 2016 a conference proving to be bigger, better and bolder than ever before. We have an exciting array of speakers, sponsors and exhibitors all looking forward to sharing their knowledge with you. Once again we have included the "quick fire" lightning talks that proved very

popular last year and a wide selection of concurrent sessions for you to choose from. Turn to the centre of this publication for a current programme (correct at print) and a list of sponsors and exhibitors. Hope to see you at Te Papa on Friday 6th and Saturday 7th May. Visit www.acurity.co.nz/connect/ to register for the Acurity GP Conference: Connect 2016, and for up to date information.

Wakefield Hospital – New General Manager



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

Feedback

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

Paul Quayle,
Chief Operating Officer,
Acurity Health Group Limited



Connect 2016

2016 IN-DEPTH TOPICS COVER:

NEUROLOGY	MEN'S HEALTH	OPHTHALMOLOGY
CARDIOLOGY	RENAL	MUSCULOSKELETAL

This GP Conference will also delve into other areas specifically relevant to GPs through concurrent sessions, interactive speaker presentations, panel discussions, case studies and lightning talks.

2016 More relevant and more informative

Faecal Incontinence

Continued from page 1

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

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

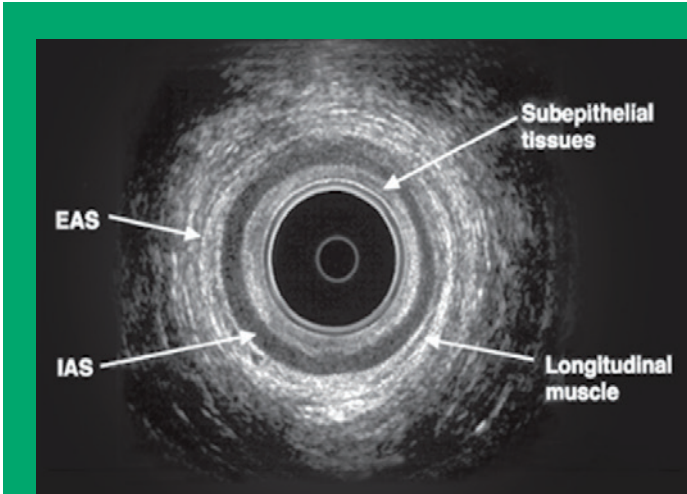
The ability to perform these studies has been available at Acurity's Wakefield Hospital since 2004 though the diagnostic ability of the equipment was limited. Recently the hospital upgraded its equipment to state of the art high resolution anal manometry including for the first time nerve stimulation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

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

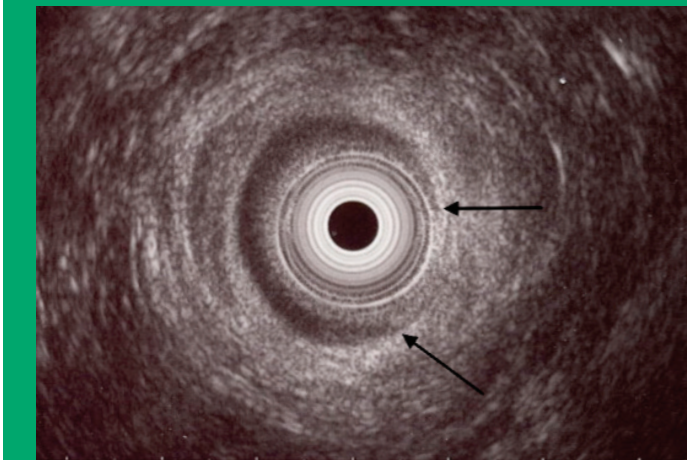
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Dr Elizabeth Dennett

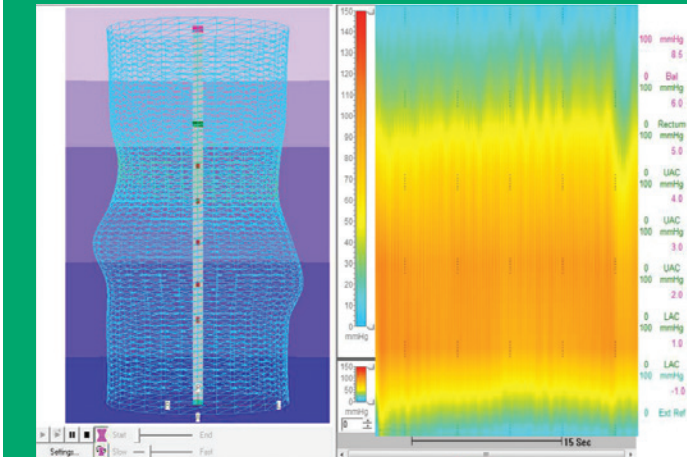


Ultrasound of a normal anal canal (EAS – external anal sphincter, IAS – internal anal sphincter)



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

One may have a normal ultrasound but still have problems with continence. This is where manometry is most useful. Manometry allows assessment of the function of the anus and rectum. Many measurements can be made and reflexes tested.



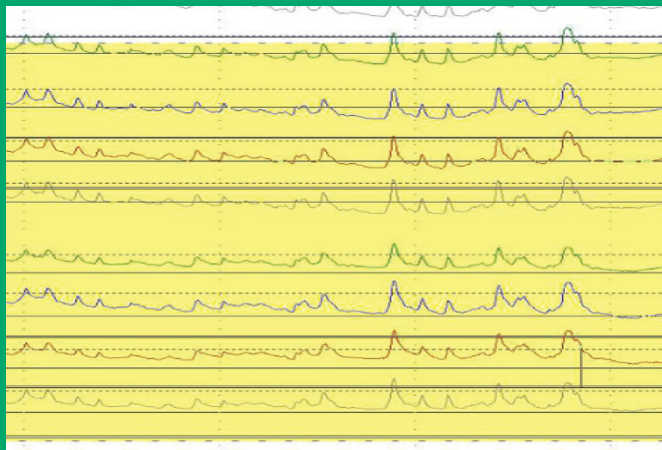
Three dimensional reconstruction of the anal canal based on pressure measured at rest. On the right is the recording of pressure at rest and on the left the reconstruction from this pressure measurement

Pressure measurements can be recorded in colour as shown here or as a wave (see over).

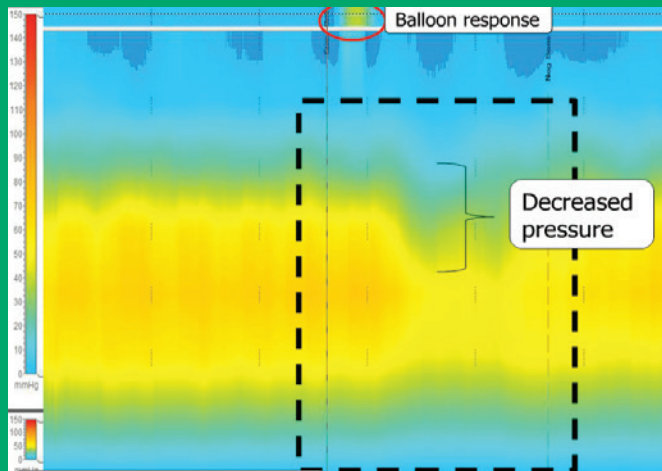
Faecal Incontinence

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Dr Elizabeth Dennett



Pressure measurements recorded as a wave



RAIR – recto-anal inhibitory response
This is anal reflex in which the upper anal canal relaxes in order to sample rectal content. A normal study is shown here, with the filling of a balloon placed in the rectum the upper anal canal responds by relaxing. This reflex enables a person to distinguish between liquid, solid and gaseous rectal content.

St Marks Electrode

The electrode once secured is inserted into the anal canal

Stimulating Electrode The ischial spine is located with the fingertip, the nerve is then stimulated with electrical pulses in various positions until the best response is achieved



Recording Electrode This electrode records the spincter muscles contraction in response to the stimulation

Manometry provides a lot of useful information about the function of the anorectum but investigation is not complete without knowing if the pudendal nerves work. The universally standard way to measure terminal motor latency in the pudendal nerves is to use a St Marks electrode while performing a PR examination.

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

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

References

- 1 Sharma A, Marshall RJ, Macmillan AK, Merrie AE, Reid P, Bissett IP. Determining levels of fecal incontinence in the community: a New Zealand sectional study. Diseases of the colon and Rectum 2011;54(11):1381-7
- 2 Johnson JK, Lindow SW, Duthie GS . The prevalence of occult obstetric anal sphincter injury following childbirth-literature review 2007;20(7):547-54
- 3 Mahony R, Behan M, O'Connell PR, O'Herlihy C Effect of second vaginal delivery on anal function in patients at risk of occult anal sphincter injury after first forceps deliver 2008;51(9):1361-6.

Manometry photos courtesy of Sandhill Scientific

Upcoming CME Sessions



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

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

Upcoming CME Sessions – 2016					
Date	Speaker	Title	Details	Venue	CME Endorsed
15 March Tuesday	Dr John Beaumont, Dr Alex Buller, Dr Muhammad Khalid, Ophthalmologists	Ophthalmology	Update on Ophthalmology 2016	Royston Centre Seminar Room	2 credits
17 March Thursday	Mr Fred Phillips, Orthopaedic Surgeon	Orthopaedics	Osteoarthritis of the Hip and Knee in Young Patients	Bowen Hospital Seminar Room	2 credits
22 March Tuesday	Mr Nick Bedford, Mr Simon McDowell, Gynaecologists	Gynaecology Update	Beyond That Time of the Month	Kapiti Lindale Conference Centre, Paraparaumu	2 credits
23 March Wednesday	Drs John Beaumont, Alex Buller, Muhammad Khalid, Ophthalmologists	Ophthalmology	Update on Ophthalmology 2016	East Pier Hotel 50 Nelson Quay Ahuriri, Napier	2 credits
31 March Thursday	Dr Jesse Gale Ophthalmologist	Ophthalmology	Abnormal Pupils and Diplopia	Bowen Hospital Seminar Room	2 credits
5 April Tuesday	Dr Elizabeth Dennett General Surgeon, Liz Childs Pelvic Health Physiotherapist	Pelvic Floor Dysfunction	Pelvic Floor Dysfunction: Related to Defecation and Incontinence	Wakefield Hospital Education Centre	2 credits
6 April Wednesday	Mr Jeremy Meates, Obstetrician and Gynaecologist, Leanne Wait Physiotherapist	Gynaecology	Endometriosis and Chronic Pelvic Pain (Dr Jeremy Meates), Musculoskeletal aspects of Pain (Leanne Wait)	Royston Centre Seminar Room	2 credits
13 April Wednesday	Mr Jeremy Meates, Obstetrician and Gynaecologist, Leanne Wait Physiotherapist	Gynaecology	Endometriosis and Chronic Pelvic Pain, Dr (Jeremy Meates), Musculoskeletal aspects of Pain, (Leanne Wait)	East Pier Hotel 50 Nelson Quay Ahuriri, Napier	2 credits
6 & 7 May Friday & Saturday	Multiple speakers	Connect 2016: Acurity GP Conference	For enquiries, email connect@acurity.co.nz	Te Papa, Wellington	11.5 credits
15 June Wednesday	Wakefield Heart Centre	Cardiology	Cardiology Update	Kapiti Lindale Conference Centre, Paraparaumu	2 credits
29 June Wednesday	Wakefield Heart Centre	Cardiology	Cardiology Update	Wakefield Hospital, Education Centre	2 credits
6 July Wednesday	Dr Alex Popadich General Surgeon	General Surgery	Breast Cancer and DCIS – What's New?	Wakefield Hospital Education Centre	2 credits
24 August Wednesday	Mr John Groom Gastrointestinal and Colorectal Surgeon Endoscopist	Gastroenterology	The Bottom Half of the Body	Bowen Hospital Seminar Room	2 credits
September Date TBC	Mr Ali Shekouh, Consultant General and Colorectal Surgeon	General Surgery	TBC	Bowen Hospital Seminar Room	2 credits
October Date TBC	Specialist Vein Health Dr Lupe Taumoepeau, Vascular and Endovascular Surgeon	Vascular Surgery	TBC	Kapiti Lindale Conference Centre, Paraparaumu Wakefield Hospital, Education Centre	2 credits



Glaucoma and its Treatment

Bowen Hospital

Area: Ophthalmology

Article written by: Dr Jesse Gale, Ophthalmologist, ph (04) 384 3937

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

I explain glaucoma to people as “accelerated wear and tear” of their optic nerves. I usually say, “We are born with one million nerve fibres in each optic nerve, and as we go through life they are gradually lost. Glaucoma is a process where the optic nerve fibres are lost more quickly and this can result in visual loss before the end of your life”. We can only claim to have helped a glaucoma patient if we modify their rate of deterioration to avoid visual symptoms (see figure 1).

The most important factor that affects the loss of fibres is the Intra-ocular Pressure (IOP), because it is the only factor we can modify. Even though half of glaucoma patients have normal IOP, the only treatment for glaucoma remains lowering the IOP. This can be achieved with medication, laser, or surgery.

Medication: drops drops drops

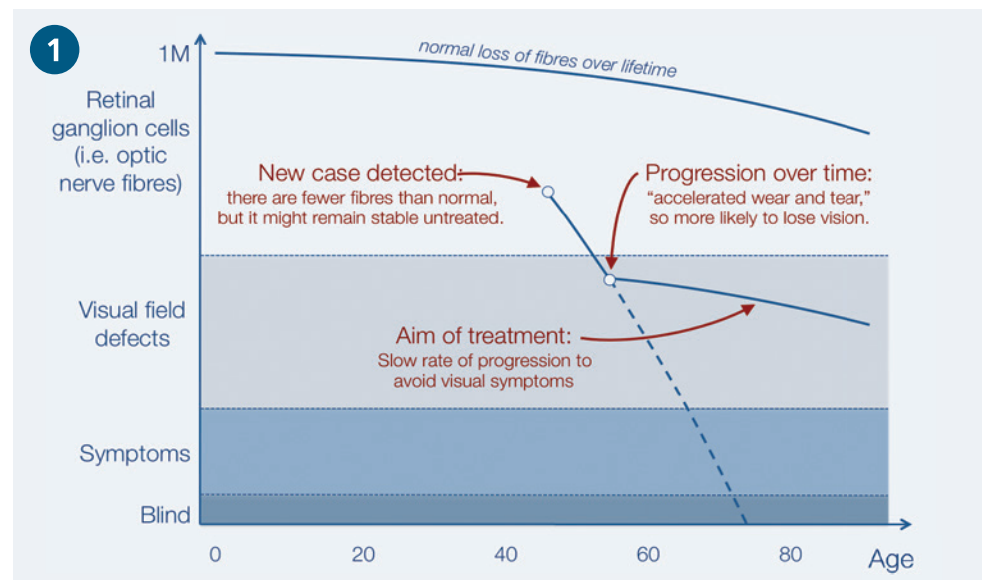
Drops are often the first and last treatment for glaucoma. Prostaglandin drops are popular because they are most effective, they are best tolerated, and they are applied

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

Timolol is our next most popular drop, and is fairly effective but can sometimes cause the systemic side effects of beta-blockers. I warn

patients about breathlessness, dizziness, lethargy, poor concentration, depression and loss of sex drive, and so many refuse to take it! We now use a low dose 0.25% gel-forming XE drops once daily, which seems to lower the pressure as much as 0.5% drops twice daily but with fewer side effects.

Brinzolamide and dorzolamide inhibit carbonic anhydrase (like acetazolamide tablets, Diamox), and brimonidine is an alpha-agonist, and these drops work to reduce the production of aqueous like timolol. All of these drops are second line as they have more ocular surface side effects and need to be taken at least twice daily. Many of the ocular surface side effects of drops relate to the preservative benzalkonium, and sometimes finding a non-benzalkonium alternative can help.



Fire the Lazar! Flag design by James Gray Auckland, www.govt.nz

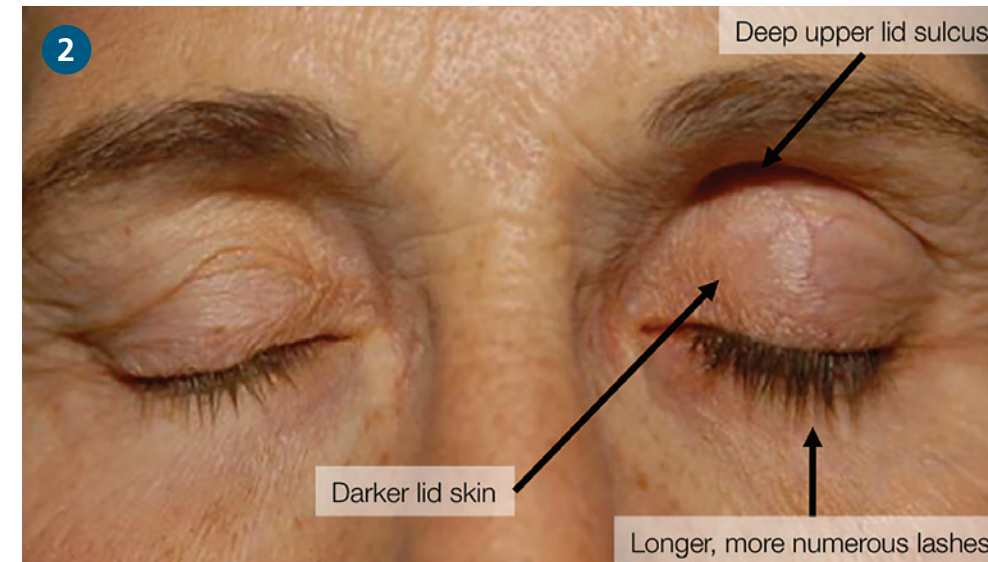
Fire the Lazar!

Several different lasers are used in ophthalmology and in treating glaucoma. Two types that can specifically lower the IOP are known as Argon Laser Trabeculoplasty (ALT) and Selective Laser Trabeculoplasty (SLT). In both types a green laser is applied directly to the drainage structure of the eye (the trabecular meshwork) using a thick mirrored contact lens to visualise the irido-corneal angle (figure 3). In ALT small high energy focal burns create discrete scars,

Connect

with Jesse at our 2016 Conference. Jesse is presenting on Friday afternoon (see p10)

Dr Jesse Gale



Tabbara, Weider & Awarad 2013 EyeRounds.org University of Iowa

resulting in improved function between the scars, while in SLT large low energy pulses are applied which stimulate or irritate the meshwork cells to function better. Both lasers have similar effect on IOP, and the effect is additional to drops (or can be an alternative), and there are also theoretical advantages because improving trabecular outflow may reduce diurnal variation. The main advantages of SLT is that it can be safely repeated indefinitely for as long as it remains effective, but the disadvantage is that SLT is not widely available in public hospitals at this point.

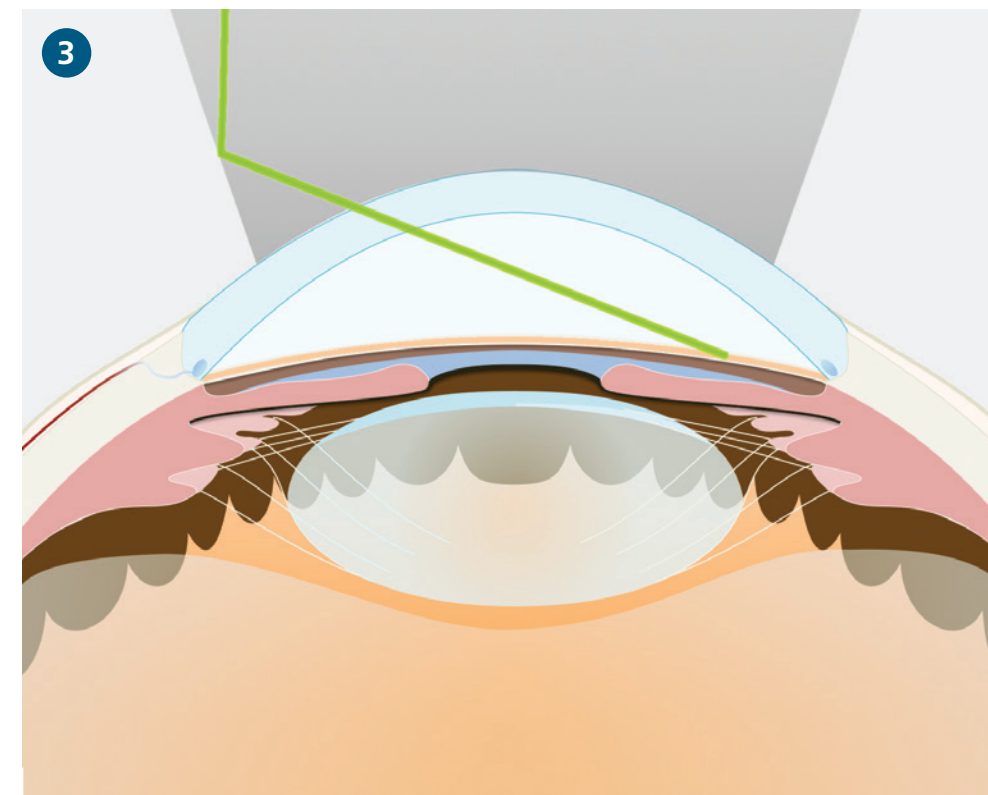
Surgery

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

Summary

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

Jesse Gale consults at Capital Eye Specialist, 148 Cuba Street, Wellington and operates at Bowen Hospital, 98 Churchill Drive, Crofton Downs, Wellington.



Industry Insights



Evolution of the Practice Management System

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

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

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

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

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

Analytics Medtech's Clinical Business Intelligence Tool (CBIT), is a fully integrated clinical and financial analysis tool designed to report business growth and provide improved income analysis.

CBIT provides practices a framework that not only covers clinical factors (Chronic, Preventative, Screening) it also provides the ability to

measure and improve practice performance – maximising revenue.

- One-click pre defined reports aligned against national standards, best practice and health targets.
- Filter lists with graphical charts and customisable information on each report
- Dashboards that present comprehensive information regarding registration/enrolment, screening and preventative health measures
- The ability to refresh data at will ensures it's constantly relevant and up to date
- Built in, fully integrated and not a third party tool. No need to pre-emptively request reports in advance.

Integration Medtech Evolution features a suite of fully integrated solutions, including third party and government integration with current providers such as HealthLink, Healthstat, BPAC, MoH and ACC. Integration requirements are constantly being re-evaluated and thus evolving.

Customisation / Automation Evolution is customised to meet the needs of different types of practices. It can remove many tiresome manual processes commonly encountered in Specialist Practices such as; theatre bookings, quotes, direct voice dictation and accounting processes. Or, for GP Practices it can streamline processes such as repeat prescriptions, reduce the number of patients who don't arrive to appointments (DNA's) while ensuring patients are triaged more efficiently with intuitive management tools.

New functionality such as the ability to email invoices and statements directly from your PMS system ensures no matter what type of practice Medtech Evolution can reduce your administrative workloads without encroaching on valuable clinical time.

If you want to know more about how Medtech Evolution can streamline your patient management and be a more productive business growth and income analysis tool then come and talk to the Medtech team at the 'Connect 2016' Acurity GP Conference. Alternatively contact us – via phone (09) 358 1123 or email salesnz@medtechglobal.com

Connect
with Medtech and
TBI Health at their
exhibits at our 2016
Conference



Recognising Adverse Pain Behaviour in Low Back Pain Patients

Steve Jacobs (not his real name) is a successful CEO for a manufacturing company in Wellington. He is 45, married, healthy and loving life. Within five years he will have lost everything.

What happened you ask? Was it cancer, a car accident or a heart attack? It wasn't any of these things – Steve simply hurt his back one day when he lifted a suitcase into the car.

Let me explain... At first Steve went to see a chiropractor to sort out the problem – but it didn't help and his pain continued. Over the next month, Steve visited a physio, an osteopath, a massage therapist, and an acupuncturist and no one seems to know what was wrong – and nothing seemed to help. The pain got worse – and then it started to spread. Steve's GP prescribes pain relief (including Oxycodone) and he was referred to a specialist. The specialist investigated. There are multiple irregularities on the MRI scan – Steve hears the words 'degenerative disc disease', 'prolapse' and 'annular tear' – and he starts to think that something is terribly wrong.

Fast forward five years and Steve has constant back, neck and leg pain, won't leave the house, can't sleep, is dependent on prescription medication, has lost his job, is 30kg overweight, can't move and struggles to get dressed. He stays in bed most days, is angry, frustrated and clinically depressed. His wife has moved out with the kids. Steve couldn't pay the mortgage and the bank took the house. All treatment has failed. Steve has hit rock bottom. Worst of all – he has just booked an appointment to see you!

Although a true story, Steve's case is clearly an extreme example but it does highlight how dangerous a back problem can be if you start to develop a negative behavioural response to your pain. It can happen to anybody and unfortunately, once it starts, it can quickly lead to a downward spiral.

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

Within our network of clinics, we have developed a specific multi-disciplinary programme to help patients that are not coping with their back pain. The programme is run by a team of physiotherapists, occupational therapists and psychologists and is designed to help people to better understand their situation and provide a staged and supported return to activity, work and independence. In my experience, the best results are achieved when there is a consistent and committed effort from everyone involved – including the patient, the GP, their whanau and friends, and the rest of the rehab team.

References:

1. Gregg C.D. et al. Prognostic factors associated with low back pain outcomes. Journal of Primary Health Care. 2014, volume 6 (1): pg 23-30
2. McIntosh G, Frank JW, Hogg-Johnson S, Bombardier C, Hall HH. Prognostic factors for time receiving workers' compensation benefits in a cohort of patients with low back pain. Spine. 2000;25:147-157
3. Hill JC, Dunn KM, Lewis M, Mullis R, Main CJ, Foster NE, et al. A primary care back pain screening tool: identifying patient subgroups for initial treatment. Arthritis Rheum. 2008;59 (5):632-41.



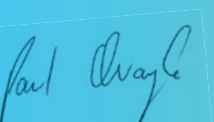
Connect 2016

 NEUROLOGY	 MEN'S HEALTH	 OPHTHALMOLOGY	 CARDIOLOGY	 RENAL	 MUSCULOSKELETAL	 OVER 30 SPEAKERS
 LARGE RANGE OF EXHIBITORS	 NETWORKING DRINKS	 11.5 CME CREDITS	 MEET OTHER GPs & SPECIALISTS	 PRACTICAL DEMONSTRATIONS	 LIGHTNING TALKS	 Conference programme enclosed.

Presented by Wakefield, Bowen and Royston Hospitals and our partner The University of Otago, Department of Primary Healthcare and General Practice, we are delighted to bring you Connect 2016: Acurity GP Conference.

Building on the success of the 2015 conference, 'Connect 2016' promises to be bigger, bolder and better than ever before. Your feedback has been used in developing this year's programme which will bring together world leading researchers, highly skilled specialists and other notable healthcare practitioners who are engaged in the health and well-being of your practice communities. This conference has developed a reputation for providing a strong relevant programme and this year is no exception. Six in-depth topics will be explored including: musculoskeletal conditions; ophthalmology; neurology; men's health; renal disease and cardiology. The Acurity Health GP Conference: Connect 2016 has been endorsed by The Royal New Zealand College of General Practitioners (RNZCGP) and has been approved for up to 11.5 credits.














Invitations are open to all general practitioners, registrars, registered nurses, practice managers and optometrists. (Optometrists: Ophthalmology session admission only). The New Zealand Optometrists and Dispensing Opticians Board have given their approval for 2.0 CD credits for the Friday Ophthalmology session. We look forward to welcoming you to the 2016 conference. To register, contact Sarah Malone (04) 920 0158, or go to www.acurity.co.nz/connect/











Paul Quayle,
Chief Operating Officer
Acurity Health Group


Sarah Malone,
Business Development Manager
Acurity Health Group










Programme preview

Friday 6 May 2016 – Day One

0800		Registration Desk Open	
0845		Official Conference Opening Remarks	<div><div>Dr Ian England Chief Executive Acurity Health Group</div></div> <div><div>Dr Sue Pullon, Associate Professor and Head of Department, Primary Health Care and General Practice, University of Otago, Wellington</div></div>
<div>MUSCULOSKELETAL</div>			
0900		Sports Related Concussion	<div><div>Dr Ian Murphy Sports Physician</div></div>
0925		Major Tendon Ruptures: Water-skiing Anyone...?	<div><div>Dr Jake Pearson Sports Physician</div></div>
0940		On Field Assessment and Management of Acute Knee Injuries: A Physiotherapist's Perspective	<div><div>Jessica Condliffe Physiotherapist</div></div>
0955		Hip Replacement	<div><div>Mr Fred Phillips Orthopaedic Surgeon</div></div>
1010		Musculoskeletal Imaging: What to Order and When?	<div><div>Dr Mulvey Kelly Radiologist</div></div>
1025		Questions and Discussion	
1040		Morning Tea / Exhibition	
1110		Concurrent Sessions A:	
		Management of Acute and Chronic ACL Injuries: From Weekend Warrior to All Black	<div><div>Mr Grant Kiddle Orthopaedic Surgeon</div></div>
		Common Surgical Shoulder Injury Repairs	<div><div>Mr Ilia Elkinson Orthopaedic Surgeon</div></div>
		Plantar Plate Injuries	<div><div>Kim Tottenham Podiatrist</div></div>
1145		Concurrent Sessions B (repeat of A)	
1225		Practical Physio Demo Session – Neck Pain	<div><div>Rodney Ford Physiotherapist TBI Health</div></div>
1235		First Presentation of Joint Pain	<div><div>Assoc. Prof. Andrew Harrison Rheumatologist</div></div>





1255		Lunch / Exhibition	
<div>OPHTHALMOLOGY / NEUROLOGY</div>			
1355		Acute Vertigo	<div><div>Dr Jeremy Lanford Neurologist</div></div>
1425		Concurrent Sessions C:	
		Prompt and Practical Tips for Red Eye Diagnosis and Management/ Cataract Surgery: Technological Innovations in Lens Implant Calculation and Design Surgical Productivity Analysis and Design	<div><div>Mr Steve Mackey Ophthalmologist</div></div>
		Glaucoma in the Community	<div><div>Dr Jesse Gale Ophthalmologist</div></div>
		Optic Neuropathies	<div><div>Mr Neil Aburn Ophthalmologist</div></div>
1500		Concurrent Session D (repeat of C)	
1530		Morning Tea / Exhibition	
1600		Mitochondrial Research: New Approaches For Understanding Debilitating Brain Diseases	<div><div>Prof Mike Berridge Cancer Cell Biology Group Leader, Malaghan Institute of Medical Research</div></div>
1625		Ocular Trauma in Primary Care	<div><div>Mr Kenneth Chan Ophthalmologist</div></div>
1640		Macular Degeneration Update	<div><div>Dr Helen Long Ophthalmologist</div></div>
1655		Ophthalmic Problems in Diabetic Patients	<div><div>Dr Muhammad Khalid Ophthalmologist</div></div>
1710		Questions and Discussion	
1725		Closing Remarks for Day One	
1730		Networking function hosted by Acurity Health Group	

Saturday 7 May 2016 – Day Two

0800		Registration Desk Open	
<div>RENAL DISEASE / CARDIOLOGY</div>			
0900		Available online soon	<div><div>Wakefield Heart Centre Cardiologist</div></div>
1000		Treatment Options for End-stage Renal Failure	<div><div>Dr Nicola Hay Renal Physician</div></div>
1025		Morning Tea / Exhibition	
1055		Concurrent Sessions E:	
		Managing Chronic Kidney Disease In Primary Care. The Role of Nurse-Led Clinics in the Management of Patients with Progressive CKD in Primary. Case-Based Discussions	<div><div>Dr Nicola Hay Renal Physician</div></div> <div><div>Lorna Bingham Nurse Practitioner in Diabetes and Related Conditions</div></div> <div><div>Kay McLaughlin Renal Nurse</div></div>
		Update in the Management of Diabetes in Advanced Chronic Kidney Disease (CKD) and Dialysis Patients	<div><div>Dr Richard Carroll Endocrinologist</div></div>
		Practical Advances in Paediatric Surgery and Paediatric Urology	<div><div>Mr Brendan Bowkett Paediatric Surgeon</div></div>
1130		Concurrent Sessions F (repeat of E)	
1205		Renal Cancers and Renal Surgery: Early Diagnosis / Red Flags – What to Test For?	<div><div>Mr Andrew Kennedy- Smith, Urologist</div></div>
1230		Lunch / Exhibition	

<div>MEN'S HEALTH</div>			
1330		Concurrent Sessions G:	
		Erectile Dysfunction ... Smart Management For a Complex Problem	<div><div>Prof John Nacey Urologist</div></div>
		Update on Prostate Cancer	<div><div>Mr Kim Broome Urologist</div></div>
		She'll Be Right: Kiwi Blokes and Lifestyle	<div><div>Assoc. Prof. Marc Wilson Associate Professor of Psychology, VUW</div></div>
1405		Concurrent Session H (repeat of G)	
1440		Prize Draw	
1445		Old Favourites and Emerging STIs for MSM	<div><div>Dr Jane Kennedy Sexual Health Specialist</div></div>
1500		Prostate MRI	<div><div>Dr Nick Kenning Radiologist</div></div>
1515		Renal Calculus	<div><div>Dr Rodney Wu Radiologist</div></div>
1530		Travel Medicine	<div><div>Dr Jenny Visser Senior Medical Advisor</div></div>
1545		Questions and Discussion	
1555		Hernia	<div><div>Mr John Groom Gastrointestinal and Colorectal Surgeon/ Endoscopist</div></div>
1620		Close of Conference – final remarks	

Legend

-  Plenary sessions (Soundings Theatre)
-  Lightning talks (short, sharp sessions)
-  Questions for lightning speakers
-  Concurrent sessions (you pick two for each session)

For the most current programme, please visit www.acurity.co.nz/connect/

Registration details

Registration fees		Early bird	Standard
Doctor	Full	\$480	\$540
	Day	\$300	\$340
Nurse	Full	\$200	\$250
	Day	\$180	\$200
Other Health Professional	Full	\$200	\$250
	Day	\$180	\$200
Optometrist	Ophthalmology	\$60	\$70
	Session Admission Only		

For more details, go to www.acurity.co.nz/connect/

Ways to register

Online	www.acurity.co.nz/connect/
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New Initiatives for Vascular Ultrasound



SPECIALIST VEIN HEALTH

Wakefield Hospital

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



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

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

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

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

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

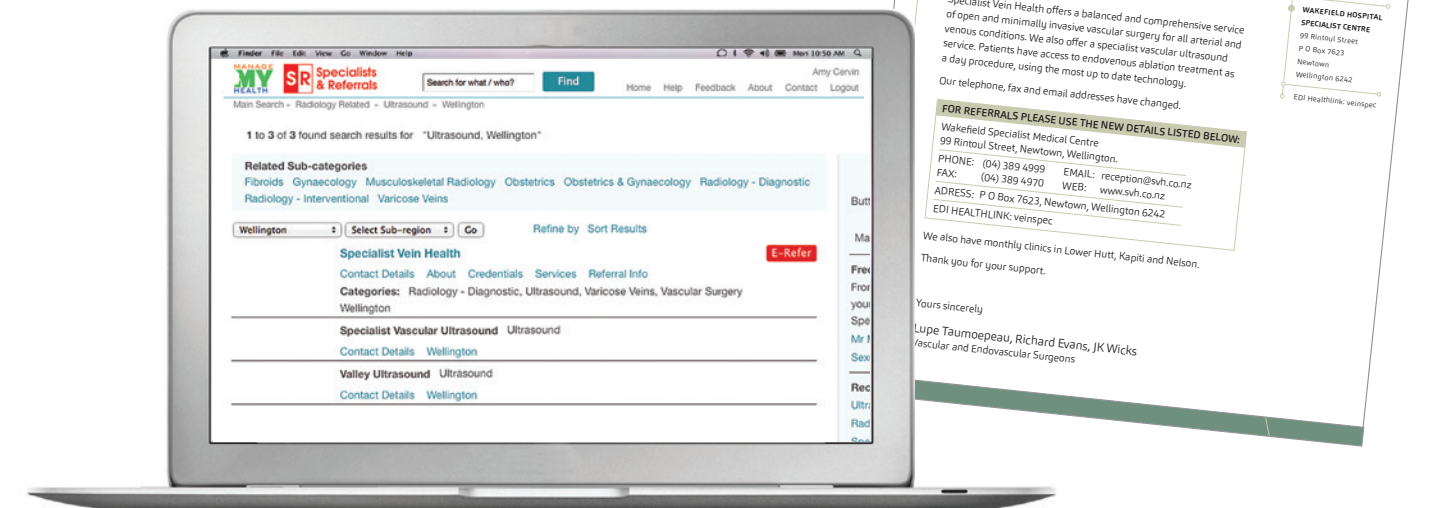
The next new initiative is a prompt specialist vascular opinion on management of the patient's problem. This takes the form of same day reports sent to the referrer via Medtech, or a phone call from a vascular surgeon if the problem is urgent – such as a DVT which may be suitable for thrombolysis, or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

Above: (left to right) JK Wicks, Lupe Taumoepeau and Richard Evans

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

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

Connect
with the SVH team,
stand 6 at our 2016
Conference



Cancer Immunotherapy



Dr Robert Weinkove



Acurity Health Group

Article written by: Dr Robert Weinkove – Consultant Haematologist, CCDHB and Wade Thompson Clinical Research Fellow and Clinical Director of Clinical Human Immunology Laboratory, Malaghan Institute

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

The notion of using the body’s immune system to fight malignancy is not new. Spectacular but rare cases of spontaneous tumour regression have long been documented and attributed to the immune system. In the 1890s, Dr William Coley injected patient’s tumours with live bacteria, and observed dramatic regressions among some of those who survived his ministrations. Bone marrow transplantation, effectively an immune system transplant, prevents lymphoma and leukaemia recurrence, and we now know that this protection is due to lymphocytes (specifically, T cells) from the healthy donor recognising and attacking the recipient’s cancer.

Current immune therapies for cancer can be divided into two types: passive and adaptive immunotherapies. Passive immune therapies, such as the monoclonal antibodies trastuzumab (Herceptin) and rituximab, avidly bind to the surface of cancer cells and label them for destruction by the innate immune system. Although effective and in widespread clinical use, these treatments do not lead to long-lasting immunological memory – they only work for as long as they are given.

In contrast, the adaptive immune system has the

capacity for ‘immunological memory’ – it can learn to recognise abnormal cells and keep attacking them whenever they appear. Training T cells to identify tumour cells as foreign, and to destroy them is the goal of many experimental immune therapies.

Our immune system has inhibitory pathways, called ‘immune checkpoints’, which prevent undesirable autoimmunity. Inhibitory pathways in our T cells are often triggered in the vicinity of cancers. Molecules that block these inhibitory pathways can ‘unleash’ T cell function against cancer cells. Nonetheless, it was a surprise to many when the first of these ‘checkpoint inhibitors’ (ipilimumab, or anti-CTLA4) led to dramatic regression of metastatic melanoma in a large fraction of patients. Since then, other checkpoint inhibitors, such as pembrolizumab (anti-PDL1) and nivolumab (anti-PD1) have been licensed in the US and elsewhere, having shown impressive activities against a range of cancers such as melanoma, non-small cell lung cancer, renal cell carcinoma and Hodgkin lymphoma. These inhibitors are generally given by intravenous infusion every few weeks in cancer centres.

Unsurprisingly, the principal toxicity of ‘checkpoint inhibitors’ is autoimmunity – damage to

normal tissues caused by undesirable activity of the ‘unleashed’ T cells. This can manifest in many ways, including pneumonitis, hepatitis, colitis, conjunctivitis, rash or endocrine dysfunction. Although these adverse events can sometimes be managed symptomatically if mild, close monitoring, drug cessation and steroids are often necessary. The patient’s oncologist should be contacted promptly if you suspect autoimmunity in a patient receiving checkpoint blockade, as there are specific algorithms for managing such events.

Typically costing more than NZ\$200,000 per patient, it is unlikely that checkpoint inhibitors will be widely funded in New Zealand in the near future. However, some patients have accessed them through clinical trials, compassionate access schemes or by self-funding. Treatment options will vary according to disease, stage, site, prior therapies and patient co-morbidities; GPs may wish to refer questions about suitability for these drugs to the patient’s oncologist.

The Malaghan Institute of Medical Research in Wellington, New Zealand is working on cancer vaccination approaches, designed to stimulate T cell activity against cancer. Developed through a joint research venture between the Ferrier Institute and the Malaghan Institute, one of our approaches has been patented and a company called Avalia Immunotherapies formed to progress this research. Our approach might prove useful alone or in combination with checkpoint inhibitors, although

at this stage our vaccines are experimental, and can only be given within clinical trials.

In summary, a new class of immune therapies for cancer, called ‘checkpoint inhibitors’ have entered clinical use. They are effective for some malignancies, although their optimal place in cancer treatment is yet to be defined, and cost will limit their use in the short term. It seems certain that immune therapy will become established as a core modality in cancer treatment, alongside surgery, radiotherapy, chemotherapy, hormonal therapy and kinase inhibitors, and that immune therapies will contribute to the eventual achievement of Obama’s “moon-shot”.

This article is an update on the research talk on ‘Immune Therapies for Cancer Treatment’ Robert presented at the 2014 Acurity GP Conference.

At this year’s Conference, Professor Mike Berridge – also from the Malaghan Institute and named as one of the ten semi-finalists for New Zealander of the Year 2016 – will deliver yet another informative presentation.

Connect

with Professor Berridge at our Conference. Professor Berridge is presenting on Friday afternoon (see p10)

Hawke’s Bay Awards



2015 HB Health Awards - The Winners



Partnership Advisory Group (PAG)

Co-design of HBDHB Mental Health Services

WINNER OF SOUTHERN COMMUNITY LABORATORIES EXCELLENCE IN SERVICE IMPROVEMENT AWARD AND ROYSTON HOSPITAL SUPREME AWARD WINNER

The Supreme Award winner of the 2015 HB Health Awards, the Partnership Advisory Group (PAG), is in a league of its own when it comes to co-designing health services in our region.

PAG, which works with HBDHB Mental Health Services, consists of like-minded people/tāngata whāiora who use or have used the services from many perspectives, their family/whānau members and consumer advisors/advocates.

Their aim is to ensure mental health services are designed not just by health staff, but in partnership with the community who use them.

Initially, this group, set up last year, was going to function for the period of the construction of Ngā Rau Rākau, the new Mental Health Inpatient Unit. But the value of the collaboration and contribution from this group has been such that there is now a long term commitment from both sides to continue to work together to improve patient care, treatment and service delivery.

PAG work in partnership with 200 DHB stakeholders, providing timely advice to ensure that the needs, wants and aspirations of people/tāngata whāiora are considered in the development, implementation and evaluation of the new reconfigured services underpinning the Mental Health acute model of care and the associated facilities.

This is a first for Hawke’s

Bay, and the success of PAG has already attracted interest from other organisations within the province’s healthcare community who are initiating capital projects and service developments.

The client/whāiora and family/whānau voice and experience is now accepted as more rounded, giving a different perspective to that of health staff.

Their voice is not only heard but listened to. The positive influence of PAG has resulted in changes within the project, design of the facilities and service delivery.

A good example of this is when concerns were raised regarding the planned closures of the recovery centres prior to Christmas last year. PAG voiced their concern that this was a vulnerable time for clients/whāiora, it was heard and, after consultation, the HBDHB decided to keep the centres open over the Christmas/New Year period.

PAG also influenced changes around colour and design in the new inpatient unit, and managed a significant part of the process around the commissioning of external artwork, such as the sculpture positioned in front of the new unit. This has required significant time and energy, including fundraising.

Another significant achievement has been the input of PAG into the successful transition of unplanned respite care to NGO partner Te

“The people/tāngata whāiora and families/whānau involved in the care we provide will solve a lot of your problems if you allow them some insight to the issue. When you think you have done enough consultation with patients and their family/whānau ... you probably haven’t done enough.”

- Allison Stevenson

Taiwhenua o Heretaunga’s Wai-o-Rua facility. PAG are actively involved in the ongoing development of this service to ensure it is meeting the needs of those who require it.

PAG’s impact has grown far beyond what was originally envisaged – feedback on new services, identifying gaps in services from a community perspective, advice on how to communicate with consumers, and advice on transitioning clients/whāiora from one service to another are just some of the areas in which this voluntary group has benefited the DHB.

Mental Health Services Director Allison Stevenson says the relationship has evolved to a point where both PAG and the DHB are working in true partnership in the co-design of services with both involved from the outset of any development. “The lessons learnt have been huge and the gains made even bigger.”



The Partnership Advisory Group (PAG), HBDHB Mental Health Services chaired by Deborah Grace (at far left), took out the Supreme Award.

Plantar Calcaneal Spurs: What is the Research Telling Us?

Wakefield Hospital | Area: Podiatry
Article written by: Kim Tottenham, Podiatrist, ph (04) 381 8125

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

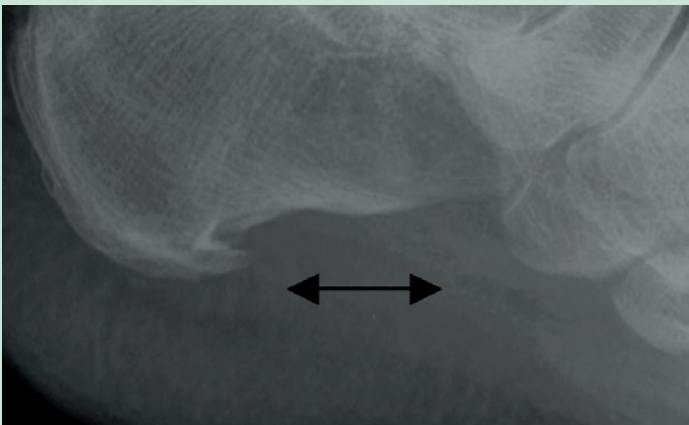
Based on the reportedly high prevalence of spurs in the asymptomatic population, the role of sub-calcaneal spurs in heel pain has been questioned in musculoskeletal medicine, leading to an emerging view that the finding has limited diagnostic value¹. The association between a spur formation and heel pain have not been adequately investigated.

Plantar calcaneal spurs are common. It is estimated that 11% to 16% of the general population have radiographic evidence of spurs². Evidence of spurs are over represented in particular sub groups such as older people, females, people with osteoarthritis, and those with previous or current heel pain. The pathophysiology of spurs is poorly understood. There are risk factors for a symptomatic heel spur. These include increased age (usually over the age of forty years), athletes (usually runners), obesity and increased hours of standing usually on hard unyielding surfaces³. Up to 65% of patients complaining about heel pain have signs of a plantar spur, it is a common finding in plantar heel pain. There appears to be a correlation between heel spurs and plantar heel pain⁴. However it is unclear whether the spur is the cause of the heel pain or just a correlation. Many people have a spur but no pain⁵.

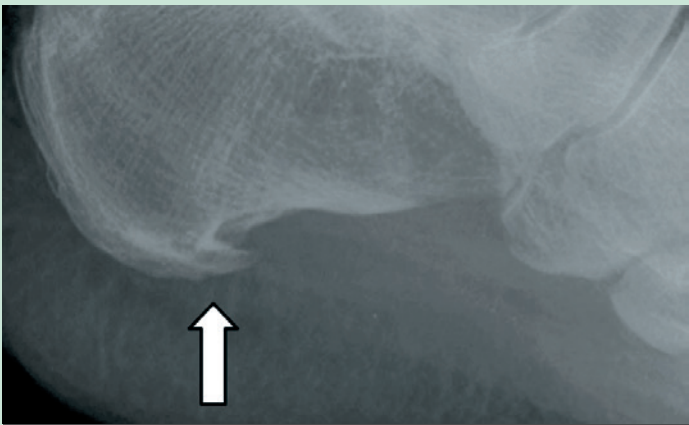
Functional problems have long been suggested as a cause. There is some evidence for this but it is very weak. These factors include decreased ankle joint and 1st MTPJ dorsiflexion, and increased pronatory forces⁶. Heel spurs were unrelated to radiographic measures of foot posture. However we must remember that those radiographs were static and do not represent dynamic movement.

What causes heel spurs?

One theory for spur formation is the *mechanical overload theory* where a series of stresses combine to push the fascia or plantar heel past a "critical limit". The repetitive traction of the insertion of the plantar fascia into the calcaneus leads to inflammation and reactive ossification of the enthesis. There is also the *longitudinal traction hypothesis* (Figure A) where the plantar fascia lengthens with lowering of the medial longitudinal arch and that people with heel pain are more likely to be flat footed. However, studies have shown that most spurs are located deep to the plantar fascia (in deep intrinsic muscles) and also within fibrocartilage and loose connective tissue. Histological evidence shows no sign of inflammation and the bony trabeculae of spurs are not aligned in the direction of the soft tissue traction⁷. It also showed that excised spurs can reform after the release of



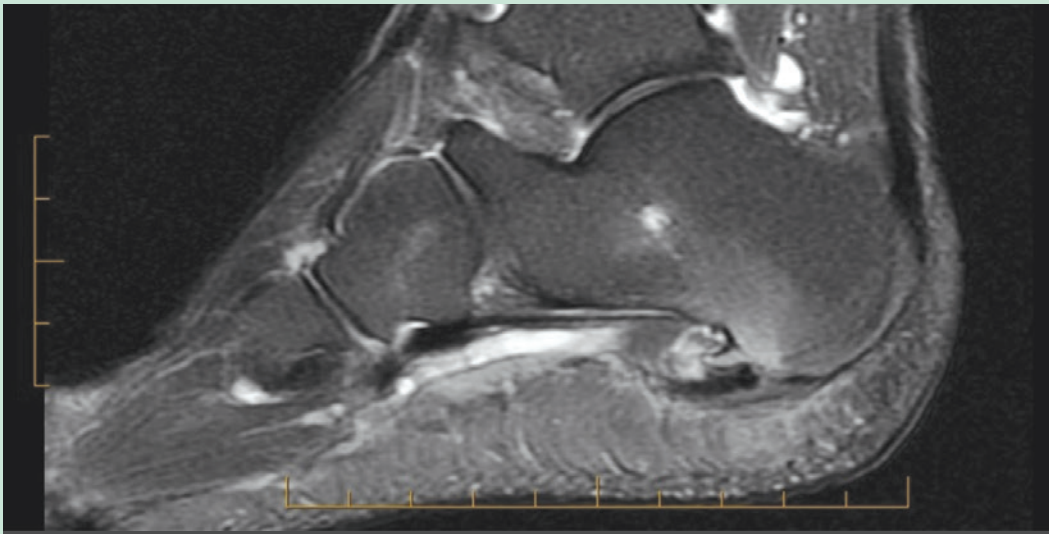
A Longitudinal traction hypothesis



B Vertical compression theory – bone adaption, increasing the heel surface area to adapt to load

the plantar fascia⁸. The *vertical compression theory* (Figure B) suggests that plantar calcaneal spurs are an adaptive response to vertical compression of the heel rather than longitudinal traction of the plantar fascia (they are not traction spurs). Fibrocartilagenous outgrowths which form in response to calcaneal stress fractures in an attempt to protect the calcaneus against micro cracks.

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



C T2 fat suppressed sagittal image demonstrates abnormal signal in proximal plantar fascia as well as oedema (bone marrow oedema), 9mm heel spur

Why are some spurs symptomatic?

The presence of a plantar calcaneal spur does not always lead to heel pain. The size of the spur could be an important factor. The larger the spur the more likely to be symptomatic and if there were also fat pad abnormalities this could lead to increased shock transmission to the spur⁹.

It is thought that the following factors may contribute to painful spurs: the size of the spur, presence of concurrent fat pad abnormalities leading to increased shock transmission to spur, entrapment of the nerve to abductor digiti minimi caused by the spur and fracture of the spur. Extrinsic factors such as footwear, work environment and level of physical activity can contribute to a symptomatic spur. In very painful heel spurs a fracture could be the cause. Histological examination of excised spurs showed that the cortical shell was lacking and endochondral

ossification a feature (fracture healing going on). Fracture of the spur itself is a common feature as shown by MRI in a patient I saw recently (Figure C).

Conclusions

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

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

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

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

Podiatry to Kim is about keeping people active.

E: sportsmed@wakefield.co.nz

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Connect

Kim is presenting a concurrent session in the Musculoskeletal session on Friday morning (p10)



Kim Tottenham

New Consultants



Mr Ali R. Shekouh

MB CHB, MRCS, MD, FRCSEd
(General Surgery), FRACS

Consultant General and
Colorectal Surgeon
P: (04) 479 2019
F: (04) 479 8563

I am consulting at the Bowen
Specialist Medical Centre and
practicing at Bowen Hospital.

Specialty
Colorectal and General Surgeon

Training
I graduated at the University
of Liverpool, UK in 1995 and
trained extensively in all aspects
of colorectal and general
surgery in Merseyside, UK.
I completed two colorectal
specialist fellowships in the
USA and Singapore.

During my training, I undertook
a two year laboratory-based
research at the University
of Liverpool and researched
in the molecular biology
of cancer. I developed the
proteomic techniques for this
research. This resulted in a MD
higher degree in 2007. I have
published several articles in high
profile medical and scientific
journals. I still retain an active
interest in surgical research
and I am a strong advocate
of undergraduate and allied
medical teaching.

My areas of expertise include
all surgical aspects of lower
gastrointestinal disease, but in
particular, colorectal disease
(including inflammatory bowel
disease, colorectal cancer,
diverticular disease, rectal
prolapse, anal incontinence,

and anal pathology). My
general surgical expertise
includes gallstone disease,
hernias (including laparoscopic
incisional hernia repair)
and endoscopy (gastroscopy
and colonoscopy).

Special interests

- Laparoscopic colon and
rectal cancer surgery
- Colon and small bowel
surgery (open and
laparoscopic)
- Inflammatory bowel disease
management and surgery
- Pelvic floor disorders (including
prolapse) and surgery
- Anorectal diseases (including
haemorrhoids, fissures
and fistulae)
- Laparoscopic gallbladder
surgery
- Laparoscopic and open
hernia repair (including
ventral and abdominal
wall repair)
- Colonoscopy, colonic
surveillance and gastroscopy
- Clinical research and
medical education.

Background

Ali is currently a member of
the following professional/
other bodies:

- Fellow of the Royal College
of Surgeons Edinburgh, UK
- Member of the Association
of Coloproctology of Great
Britain and Ireland, UK
- Member (provisional) of the
Colorectal Surgical Society
of Australasia
- NZ Conjoint Committee for
Recognition of Training in
Gastrointestinal Endoscopy.



Dr Lissa Judd

BMedSci, MBChB, DipOHP, DIH,
FAFOM (RACP)

Dermatologist
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F: (04) 233 1497
E: drjudd@anwyl.com

Lissa consults in Dermatology
at Bowen Hospital, 98 Churchill
Drive, Crofton Downs, Wellington.

Specialty
Dermatology

Training
Lissa completed her dermatology
training in Wellington, Auckland
and Australia, and then went
on to do her occupational
medicine training in
Wellington and Dunedin.

Special interests

Special interests in occupational
dermatology (in 2010 was
awarded the Dr John Stoke
Medical for excellence in
occupational medicine),
contact dermatitis, patch
testing, eczema, phototherapy,
acne and psoriasis.

In addition to working full time
as a dermatologist Lissa also
lectures in dermatology for
the University of Otago.



Mr Leslie (Les) Snape

MBChB, FRCS (Edin), FRCS (Eng), FFDRCSI

Oral and Maxillofacial Surgeon
P: (06) 974 8150
F: (06) 974 8151
E: maxfacenz@gmail.com

Leslie consults at the Scott
Clinic, 509 Southland Road,
Hastings and operates at
Royston Hospital.

Specialty
Oral and Maxillofacial Surgery

Training
He completed his Core Surgical
Training at Christchurch
Hospital between 1978 and
1981. During 1983 and 1987
he was accredited in Advanced
Specialty Training at Mercyside
Regional Rotation.

Special interests
Leslie has a special interest in
facial trauma, orthognathic
surgery, maxillofacial pathology
and general oral surgery.

Background

He began in specialist practice
in 1987, was a consultant
surgeon at Christchurch Hospital
between 1987 and 2015 and
a Clinical Senior Lecturer,
Department of Surgery, at the
Christchurch School of Medicine.
He is a AOCMF Faculty Member
– Courses and Workshops
(Internationally) and the
previous president at ANZAOMS.



Dr Muhammad Khalid

MBBS, DO, FRCS, PgDeg In Med
Diplomate European Board of Ophthalmology

Ophthalmologist
P: (06) 873 1152, F: (06) 873 1153

I am consulting at the Eye Surgeons Hawke's Bay,
Royston Centre and operates at Royston Hospital.

Specialty
Ophthalmology

Training
Dr Muhammad Khalid was trained in
Ophthalmology in Ireland and obtained his
fellowship in Ophthalmology from The Royal
College of Surgeons of Edinburgh (FRCS ED).
He is also Diplomate European Board
of Ophthalmology and has a post graduate
degree in medicine from the National
University of Ireland Galway.

Special interests
Dr Khalid is well grounded in general Ophthalmology
and has extensive experience in cataract surgery.
With subspecialty training in medical and
surgical retina Dr Khalid provides surgical care
for retinal detachments, macular degeneration
and retinal vascular problem related to diabetes
and hypertension.

Background
Before moving to the Hawke's Bay and taking
up a consultant ophthalmologist position,
Dr Khalid served as locum ophthalmologist
at Mid-West Regional Hospital Limerick and
the University Hospital Waterford, Ireland after
completing his training in ophthalmology
under the Irish College of Ophthalmologists.

He developed an interest in retinal disease
and completed a year each fellowship in
medical retina and retinal surgeries from the
Royal Victoria Eye and Ear Hospital, Dublin.

Dr Khalid is also a voluntary eye surgeon
with a number of charity organisations including
Rose Charities, New Zealand. He served in
several African countries and Cambodia.

His wife and three children are enjoying life
in Hawke's Bay.



March 2016

Dear Colleagues

Alex Buller and John Beaumont are pleased to welcome
Dr Muhammad Khalid to Eye Surgeons of Hawke's Bay.
Muhammad has sub-speciality training in medical and surgical
retina and extensive experience in general ophthalmology.

He will continue as a consultant at Hawke's Bay DHB and
initially will consult and provide treatments at Eye Surgeons of
Hawke's Bay rooms in Royston Centre one to two sessions per
week. At Royston Hospital he will perform cataract and general
ophthalmology procedures and it is hoped also retinal surgery in
the very near future.

We hope this service will be able to provide your practice with
further local support.

Yours sincerely

John Beaumont
Ophthalmologist

Alex Buller
Ophthalmologist

Contact details:
Telephone: (06) 873 1152
Email: info@eyesurgeonshawkesbay.co.nz
Address: Royston Centre
325 Prospect Road
Hastings

Connect
with Dr Khalid
presenting in the
Ophthalmology
section at our 2016
Conference

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