WAKEFIELD HEALTH LIMITED

AWAKE

A Wakefield Health Magazine for GPs. Issue 1 Summer 2011

Tackling a challenging problem

Area: Atrial Fibrillation
Article by Dr Alexander Sasse, Wakefield Cardiologist, P: (04) 381 8115

On the surface, treating atrial fibrillation (AF) appears to be a straightforward concept: all that is needed is to set the rhythm right or make sure it isn't going too fast.

Yet there has always been a niggling dissatisfaction around the management of AF – and it has now been scientifically confirmed that AF is **unpopular** with both doctors and patients, which is why we have established an Atrial Fibrillation Service to tackle this challenging problem.

In a recently published survey[1] of 825 patients and 811 cardiologists in 11 countries, physicians rated AF as the third most demanding condition (after heart attack and heart failure) and the second most difficult condition (after heart attack) to manage in practice, out of a list of conditions that also included stroke, angina, diabetes, hypertension, high cholesterol, depression, asthma, and cessation of smoking. In the survey, only heart failure ranked consistently higher than AF in terms of management difficulty and demands on time – and quite a few patients have both heart failure and AF.

Fifty-five percent of the physicians surveyed were unsatisfied with the overall treatment of AF, and it would be interesting to find out how that compares to the experience of GPs in New Zealand. Needless to say, patients were also not content with AF (26%). Notably, the least liked AF topic was anticoagulation (72%) – we are frequently confronted with questions about the 'rat poison' Warfarin.

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Chief Executive's contribution

Chief Executive, Wakefield Health Limited
Andrew Blair, P: (04) 381 8100, E: andrew.blair@wakefield.co.nz

Welcome to the AWake Magazine – a Wakefield Health publication for GPs. Its purpose is to support the communication from our consultants and hospital staff to you. All of us at Wakefield Health value the partnership we have with the highly skilled and respected consultants who operate in our hospital facilities – Wakefield and Bowen Hospitals in Wellington and Royston Hospital in Hastings.

We recognise the importance of keeping GPs informed of developments at our hospitals, and of giving our consultants the opportunity to share news with you on changes and developments in their specialties.

Acknowledging the contribution of the private healthcare sector

The New Zealand health sector is in a state of continual change and development. The private hospital sector is inescapably involved in that change as the important contribution made by specialist consultants and hospitals in private practice becomes more widely acknowledged and appreciated. At last there is support for the view that New Zealand has and needs a balanced healthcare system – one that acknowledges the important co-operative contribution of both public and private sectors.

Approximately 160,000 procedures are performed in the private hospital sector throughout New Zealand each year, with an increasing number of specific procedures now only available from private providers. Wakefield Health has played a major role in delivering these services, with over 10% of operations (or around 16,000) performed each year in our hospital facilities. That figure does not include the large number of minor procedures and interventions undertaken in the private consulting rooms of practitioners working from the Wakefield, Bowen and Royston campuses.

Pressure increasing on the public hospital system

The ongoing pressures on the public hospital system will be exacerbated in future years as the population ages more rapidly with the number of people aged over 65 as a percentage of the population projected to double in the next 20 years.

Couple this with a public that is increasingly required to take greater personal responsibility for individual healthcare needs (and, consequently, has increasingly higher expectations, particularly around choice) and surgeons and hospitals in the private sector are likely to be called upon to provide increasing volumes of (particularly) elective surgery.

1.38 million

Currently, 1.38 million Kiwis have health insurance.

There are currently 1.38 million New Zealanders with health insurance. These individuals who have taken some personal responsibility for their healthcare needs deserve to be offered choice, and timely access to health services – just some of the many benefits offered by private hospitals such as Wakefield, Bowen and Royston.

Update of our world-class facilities

Wakefield Hospital has recently undergone a major refurbishment of all public and patient areas and a new Education Centre has just been opened on the Wakefield Hospital campus. This facility has a number of multi-use meeting and seminar rooms and features two-way audio visual connectivity. This will enable surgeons to hold real time lectures and demonstrations for GPs and other practitioners on the Wakefield Hospital site. Our consultants are eager to use these new facilities to provide a programme of informative lectures and informal gatherings with GPs to share knowledge and advancements in surgical options and techniques.

Royston Hospital in Hastings has similar educational facilities and continues to promote informative opportunities for registrars and GPs from throughout the Hawke's Bay region.

Our hospitals have always taken pride in leading the way in terms of quality and patient focused outcomes

Our confidence in the future growth in demand for private healthcare services underpins Wakefield's commitment to ongoing investment in our hospital facilities. Our hospitals have always taken pride in leading the way in terms of the quality of our staff, facilities, surgical equipment and the patient focused outcomes they provide. Despite the tough economic conditions currently being experienced, we never lose sight of these important components of our care.

Mr John Fleischl, General Surgeon, recently made a presentation on bariatric surgery in the Royston Centre. This gave great insight to nursing staff and GPs into what is becoming an increasingly popular treatment. A feature article in this edition discusses the valuable contribution from an overseas Gynaecologist and endorses the benefits of utilising the remote interconnectivity to the operating theatre to view these procedures.

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Less invasive process for keyhole surgery

Area: Women's Health Surgery
Specialist: Dr Dynes McConnell, P: (0800) 888 151

This medical breakthrough is a **first in Australasia**

Over the past 12 months, women's health surgeon Dr Dynes McConnell has been working with a team of dedicated nursing staff at Bowen Hospital to bring a ground-breaking, less-invasive technique to women undergoing a hysterectomy or other forms of gynaecological surgery at both Bowen and Wakefield Hospitals.

Background

Up until 2009, hysterectomy and endometriosis surgery traditionally involved either open wounds (laparotomies), vaginal surgery, or traditional multiple port laparoscopies. Being able to offer this wide range of care options required many subtle technical advances and a great deal of surgical skills training.

However, even in the relatively new area of laparoscopic surgery, a plateau in surgical wound approach had been reached. What was needed was a breakthrough in wound access; something that would reduce the number of incisions for women, but still allow the surgeon to safely complete the necessary intra-abdominal and pelvic procedures.

In 2008, early work emerging from the USA suggested that using a single umbilical port for inserting the multiple instruments needed for complex gynaecological surgery was not only feasible for existing laparoscopic procedures, but could increase the application of laparoscopic surgery to other women's health problems. Dr Lense from Atlanta Georgia, a leader in this field, has now successfully performed hundreds of such procedures for women.

How it works

Single Incision Laparoscopic Surgery (SILS) offers a less-invasive option for women undergoing a hysterectomy or other forms of gynaecological surgery. Using a single umbilical incision to insert specially developed instruments that 'bend' once through the umbilicus allows the surgeon to access the operative field without obstructing the field of vision. This engineering feat is described as 'reticulation' and means that where four ports were required to perform a hysterectomy, now only one is needed. The technique is technically demanding, and requires the surgeon to learn new skills but, once mastered, opens up significant benefits for women.
Continued over.

The benefits of SILS:

One port

Ports reduced from 4 to 1. More painful lateral ports are no longer needed.

Quicker recovery

An earlier return to normal functioning.

Shorter hospital visit

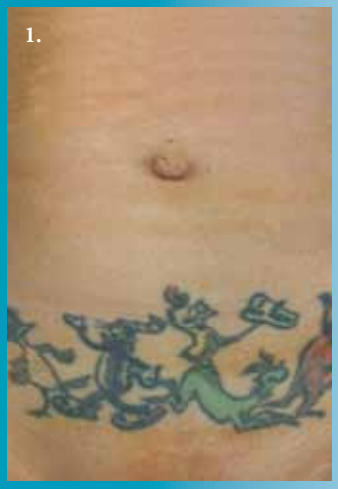
Usually one night.

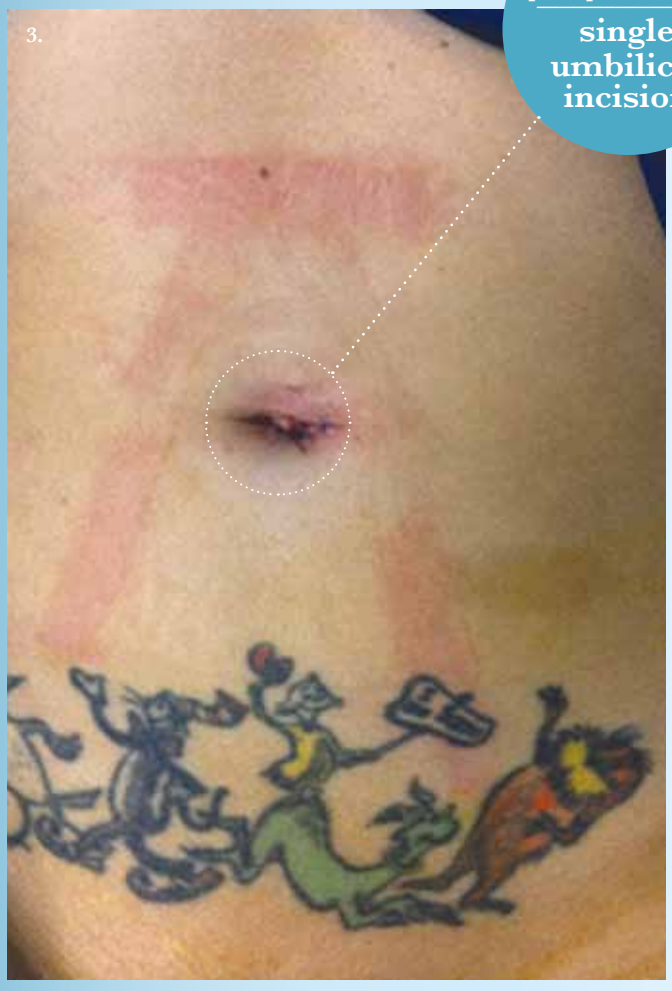
Minimal scarring

Once healed, the incision is virtually invisible.

Less invasive process for keyhole surgery

Continued from page 3.





Immediate postoperative view

single umbilical incision

1. Before

Preoperative abdominal view.

2. During

Intraoperative view – the flexible SILS port is in position, ready to accommodate the reticulating instruments and laparoscope.

3. After

Immediate postoperative view – single umbilical incision following hysterectomy for 14 week fibroid uterus in a woman with menstrual disturbance.

Continued from page 3.

Bringing SILS to Wellington

Dr McConnell performed the first SILS procedure in Australasia early in 2009, and is already seeing improved operative outcomes for his patients. He has been pleasantly surprised to see an additional benefit for women in the area of wound cosmesis. The umbilical incision, once healed, becomes virtually invisible. It is not just slim young women that desire positive cosmetic outcomes – many older women are also eager to realise the benefits of this new approach.

Over 90% of Dr McConnell's hysterectomy patients return to normal activities within three to four weeks, and with the advent of SILS surgery further improvements are anticipated. Most women require only one night's stay in hospital – occasionally women even willingly going home on the same day as their procedure.

Future developments

In future, Dr McConnell will be extending the range of applications for SILS, with the ultimate aim of reducing the overall laparotomy rate in his practice to less than 3%. This will mean using SILS techniques for large uterine masses (fibroids), large benign ovarian cysts, and complex endometriosis cases, bringing the benefits of SILS to an ever wider group of patients.

For more information, please feel free to contact Dr Dynes McConnell, who consults and operates at Bowen, P: (0800) 888 151, F: (04) 479 8563 or E: spec.centre@bowen.co.nz

Tips for ACC applications

Summary from New Zealand Private Surgical Hospitals Association Inc – 'Personal injuries and the ACC: A Guide to cover, entitlements, and the claims process.'

Tips for practitioners

When assisting with applications for cover, practitioners should:

Ensure you clearly:	Details
Identify the 'bodily injury'	Use diagnostic labels that describe the physical damage suffered wherever possible.
Identify the specific cause	Where the cause of the injury is an 'accident', identify the specific event that is the accident.
If applicable, specify the extent a gradual process or disease has contributed	Where appropriate, provide clinical justifications stating why the gradual process or disease is not the substantial cause of the injury.
Reference statutory language	Make reference to the specific statutory language. Incorporate terms such as 'physical injury', 'accident', 'application of external force' and 'substantially caused'.
Provide all supporting evidence	Always provide all relevant supporting evidence (such as investigation reports and radiology) with an opinion.
Provide clinical justifications	Always provide clinical justifications for the treatment that is being recommended, and include reasons why that treatment is necessary and appropriate for the patient.

If in your opinion ACC has made the wrong decision, immediately inform ACC of your differing opinion and the reasons for your opinion.

This brief overview of practical tips is taken from the New Zealand Private Surgical Hospitals Association Inc – 'Personal injuries and the ACC: A Guide to cover, entitlements, and the claims process' guide. For more guidance, please contact your Wakefield Health consultant.

CE's contribution

Continued from page 2.

Continued from page 2.

Bowen Hospital, which has been on its existing site for almost 40 years – and suffered from a lack of investment during much of that time due to the financial constraints of the former community trust owner – is now undergoing a much deserved major rebuild. The newly constructed five level Bowen Centre will be officially opened in March 2011 providing new consulting rooms for a number of key specialists who operate at Bowen Hospital, a new and expanded endoscopy suite, and a radiology facility using the very latest in technology.

The new Bowen Hospital will be the most modern private hospital facility in the lower North Island.

With the completion of the Bowen Centre, we are relocating other services to it so parts of the existing Bowen Hospital building can be replaced by five new operating theatres.

The Bowen site is a challenging one, but one which offers an excellent outlook and sunshine, setting Bowen apart from other facilities in terms of doctor, patient and staff comfort and convenience. The new building includes two floors of undercover car parking.

The redevelopment programme has been managed to ensure complete continuity of services throughout the build, with minimal inconvenience to consultants and patients.

As the new Bowen building has taken shape, it is attracting the attention of a number of surgeons interested in relocating their private practice to what will be, when completed, the most modern private hospital facility in the lower North Island.

A valuable resource

It has been our pleasure to produce this magazine for GPs. It provides a valuable range of articles and commentary that will be of interest to all health practitioners. We trust you find this a useful resource, and would appreciate it if you could take part in the online survey for this magazine at www.wakefieldhealth.co.nz/gp-area Your feedback would be valued as this magazine is designed especially for you – so we (Wakefield Health) can serve you and your patients better. Each survey we receive will go into the draw to win one of three (his or hers) Linden Leaves body care packs which retail at $250. You may also email general comments to us at WHLadmin@wakefield.co.nz

Finally, the Wakefield Health website has undergone a major rebuild and recently "went live". I would encourage you to spend some time visiting the new site. We thank you for the support that you, as important referrers of patients, give to Wakefield, Bowen and Royston Hospitals, and the surgeons who practise in these excellent facilities. Your support and contribution to the quality care that we provide to patients is truly appreciated.

Andrew Blair
Chief Executive

Please provide feedback on this magazine in our online survey at www.wakefieldhealth.co.nz/gp-area

To say thanks – each survey we receive will go into the draw to win one of three (his or hers) Linden Leaves body care packs which retail at $250.

Tackling the obesity problem

Area: Bariatric and Metabolic Surgery
Specialists: Mr S K Wickremesekera, P: (04) 381 8110
and Mr S D Bann, P: (04) 381 8110.

With 1.1 billion people worldwide considered to be overweight, adult morbid obesity has now been recognised as a worldwide pandemic. In New Zealand about 60% of the population is considered overweight, mainly due to our 'obesogenic environment': ready access to poor nutrition combined with reduced physical activity. In a proactive approach to resolving the many health problems associated with obesity, we have put together a multi-disciplinary team to ensure the best outcomes for our patients.

What causes obesity?

Society tends to attribute obesity to laziness and gluttony, rather than seeing it as a disease. It is important to realise and reassure that obesity is not a defect in the personality or character of the patient. Obesity's increasing prevalence is probably due to an obesity supportive environment, along with behavioural and biological influences. At the extreme end of the scale, the morbidly obese are thought to have a significant genetic component to their disorder.

The brain and gut work together to prevent conventional attempts to lose weight. This is why medical treatment programmes fail 95% to 97% of the time (National Institutes of Health Study 1992). It is important to recognise that obesity is associated with increased risk of morbidity and mortality; the higher the BMI, the higher the risk to the patient. Even moderate weight loss of 5% to 10% has been shown to produce measurable improved health outcomes.

Recognising the scale of the problem

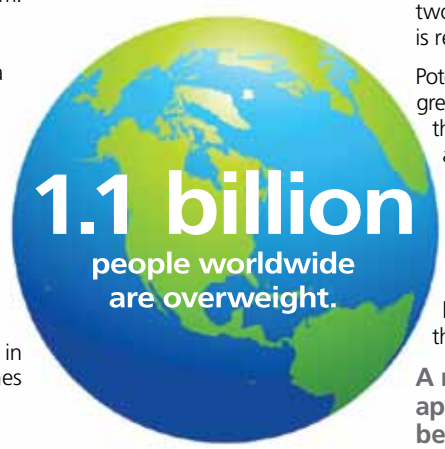
Doing something about the obesity epidemic in New Zealand has become a matter of urgency. Obesity is a severe medical problem. The direct health delivery costs of obesity to New Zealand have been estimated at $300 million a year. As a commonly associated co-morbidity, Type 2 diabetes continues to escalate in concert with obesity. Direct health costs attributed to Type 2 diabetes in 2008 were $600 million – forecast to increase to $1.3 billion by 2016.

Treatment options

The National Institutes of Health in the United States issued guidelines for the treatment of obesity in 2000. First line treatment consists of dietary, exercise and behavioural modification, with small resultant weight loss. Second line treatment is offered by drugs such as Reductil and Xenical. These should precede surgery; however, surgery offers the only method of sustained weight loss. Bariatric surgery is the technical term for the surgery used for weight reduction in people with severe obesity, while increasingly the term metabolic surgery is used to identify the resolution of co-morbidity.

Obesity surgery

Just who should receive surgical treatment has been defined by many groups and government agencies worldwide, but essentially it is those with a BMI in excess of 40 kg/m² or 35 kg/m² and who have associated co-morbidity (e.g. diabetes or blood pressure). These patients should also be fit for anaesthesia and surgery and have attempted other methods of weight loss. The patient should be willing to undergo long-term follow-up after surgery.



There are two broad types of surgery: restrictive and malabsorptive – each performed both open and laparoscopically. The restrictive method restricts the volume of food that can be held in the stomach, while in the malabsorptive procedures, the food that is eaten cannot be properly absorbed because the gut is effectively shortened. Procedures such as gastric bypass feature elements of both types of surgery.

Comparing the results

Outcomes in terms of excess weight loss depend on the operation. In most studies weight loss is reported to be lower for the laparoscopic band compared to the sleeve gastrectomy and gastric bypass. Resolution of diabetes takes place soon after surgery for gastric bypass and sleeve gastrectomy, while it may take several months following gastric banding. Diabetes is completely resolved in up to 80% of cases, while hyperlipidaemia and hypertension are resolved in about two thirds of cases. Sleep apnoea is resolved in a similar manner.

Potential nutritional problems are greatest with the gastric bypass; they can be avoided by the use of a regular multivitamin. Mortality rates for bariatric surgery are low, depending on the procedure. For a laparoscopic gastric band they are in the region of 0.1%; for gastric bypass and sleeve gastrectomy they are less than 0.5%.

A multi-disciplinary approach to providing the best possible outcomes

The team at **Capital Obesity Group** consists of **surgeons, anaesthetists,** a **dietitian, counsellor/ therapist, nurses** and a **lifestyle coach**. The team is dedicated to helping the patient achieve their goal and maximise results.


60% of Kiwis are overweight

Our bariatric programme has been carefully developed and involves four distinct and vital steps (below) designed to help and support the patient on the journey to a better life using the sleeve gastrectomy as an operation of choice.

In a sleeve gastrectomy, the outer part of the stomach is removed to create a long narrow tube, reducing the volume of the stomach from


Mr Simon Bann (left) and Mr S Kusal Wickremesekera (right)

in the region of 2 litres to about 100 mls. This ensures that the patient feels full with these lower volumes of food and takes away the stimulus of hunger.

Healthy eating consists of three small meals per day of lean source protein, low starch carbohydrate, adequate fruits and vegetables and maintaining a calorific intake of less than 1500kcal per day in the long term. Ongoing counselling and support are provided to help deal with any ongoing issues.

It is vital to remember that surgery is only the tool, and in order to achieve good long-term results this reduction in intake must be accompanied by regular exercise and lifestyle change. The patient needs to realise and recognise these changes in the preoperative phase. Once these lifestyle changes are made and supported postoperatively a great outcome can be achieved.

For more information, you're welcome to contact Mr S Kusal Wickremesekera or Mr Simon Bann, who both consult and operate at Wakefield, P: (04) 381 8110, F: (04) 381 8111, or E: gastro@wakefield.co.nz

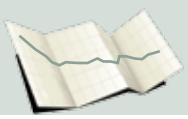
An overview of the steps:

Step 1.
Preoperative assessments by the various members of the team.

Step 2.
Sleeve gastrectomy operation.

Step 3.
Implement the dietary and exercise programmes.

Step 4.
Achieve exercise goals and long-term healthy diet.



Top laparoscopic surgeon brings new techniques

Area: Laparoscopic Surgical Procedures
Specialist: Dr Michael Wynn-Williams
Article: Dr Jeremy Meates, Royston Gynaecologist, P: (06) 835 4030


Dr Jeremy Meates

A recent visit to Royston Hospital by internationally recognised laparoscopic surgeon Dr Michael Wynn-Williams was an excellent opportunity for local specialists and theatre teams to explore new techniques that will benefit patients.

At the same time, the visit was an invaluable learning experience for our theatre nurses and support teams to ensure they continue to provide the very best of support to complement our specialists' work.

Dr Wynn-Williams – an international expert with a local background

A gynaecologist from Brisbane, Michael regularly travels throughout Australia, New Zealand and Europe demonstrating laparoscopic surgical techniques. Born in New Zealand, he was formerly a house surgeon at both Napier and Hastings Hospitals. He acknowledged the inspirational influence of his then consultants Drs John Wakeman, Peter Jennings and David Davidson in his decision to follow a career in obstetrics and gynaecology.

After completing his specialist training in New Zealand, he moved to Sydney to take up a post as a Laparoscopic Surgery Fellow with Dr Alan Lam. He then completed his subspecialty training in Oxford, England before returning to Australia to his current post as a Consultant Gynaecologist in Brisbane.

Michael has a passion for teaching and has mastered the art of talking to an audience while performing operations. He had a vast array of pre-prepared presentations and surgical videos that he was able to share with attendees on request, and he adds further value through his strong focus on surgical technique and safety.

Royston's facilities provide excellent platform for demonstration

The two surgical cases demonstrated in the Royston operating suite – one a prolapse repair with a mesh Sacrocolpopexy and the other an endometriosis resection – were projected onto a big screen upstairs in the seminar room where the specialists were gathered.

Mainly images from the laparoscopic camera were shown, but there were also views from cameras mounted on the theatre wall and the overhead operating light to give a range of angles and maximise learning opportunities.

Michael's microphone allowed him to converse freely with the audience upstairs, while a roving microphone was available for questions and comments from the audience. The wall mounted camera in the conference seminar room provided Michael with a view of the audience and there was plenty of interaction between the seminar room and the theatre.

It was also an opportunity for Michael to demonstrate some of the latest advances in instrumentation. 'Pelvitrainer' equipment was available for the audience to practise some of the surgical techniques displayed, particularly laparoscopic suturing.

The Royston Hospital Trust Board recognises the benefit of these meetings to the community both as a significant education opportunity for local doctors and nurses and in bringing improved surgical skills and an extended range of treatment options to our patients.

It was also a great opportunity for specialists from around the country to visit Royston Hospital and experience the world-class facilities available.

Excellent example of public/private sector collaboration

The meeting was supported by the DHB and was a good example of collaboration between the private and public sectors. The patients involved in the demonstrations were taken off the public hospital waiting list. They were delighted to be having their surgery at Royston Hospital – and of course this helped to take pressure off the public waiting list.

Further opportunities

The meeting was a great success with all participants indicating their desire to return again next year. It is the second time the meeting has been held and it is hoped to make this an annual event.

The details are yet to be finalised but Dr Wynn-Williams has tentatively made himself available for August 26 2011.

"Events such as this – combining international expertise with the latest in techniques and equipment in world-class facilities – are an excellent way to bring benefits to our patients."

The benefits

This interactive demonstration brings a wide range of benefits to specialists and theatre teams – benefits that will be passed on to our patients.

Development
Local specialists can learn new techniques.

Inclusiveness
Entire theatre nurse and support teams benefit from an on-site demonstration. (It's difficult for entire teams to attend events off site.)

Cutting-edge
Specialists get to see some of the latest instruments available in application – further enhanced by the presence of drug company representatives who had samples available.

Hands-on
'Pelvitrainer' boxes allowed attendees to practise some techniques.

Mentors
Mentors in the seminar room assisted less experienced attendees.

Keeping our patients walking tall

Area: Reducing Post Surgery Risks
Article written by Denise Primrose, Royston Hospital Manager

Patient safety is always an absolute priority in our hospitals – and when an issue is identified we take immediate steps to understand what has happened and do all we can to prevent it from happening again.

An example of this is a Quality Initiative undertaken at Royston Hospital during the past year to address a spate of incident reports identifying inpatient falls during 2008/09, including a Serious Harm notification to the Department of Labour. These events prompted staff to develop an earlier warning system for patients at risk of falling post surgery.

For this project, which adopted a hospital-wide approach, Royston Hospital was one of three nationwide finalists in the NZ Private Surgical Hospitals Association Quality Awards in September 2010.

The elderly – an at-risk group

ACC reports that if you are over 65 years of age, you are three times more likely to have a fall this year. If you are over 80, this risk increases to 1 in 2. Add to the mix an unfamiliar hospital environment, a painful wound, the effects of general or regional anaesthesia, postoperative analgesia, and surgical and anaesthetic 'appendages', and it can be argued that our surgical hospitals are a minefield for the elderly.

It is widely recognised that our general population is aging and our surgical patient demographic is in turn following this trend: one third of patients admitted to Royston in 2009 were over the age of 65.

Taking steps to minimise the risk of falls

Steps undertaken as part of the quality initiative included:

- developing a Falls Prevention leaflet to give to our patients before their admission about fall prevention strategies during their stay, along with tips for preventing falls after they are discharged
- developing a Fall Risk Assessment/Prevention and Management Policy
- identifying the level of fall risk for all inpatients at the time of their admission using the Morse Fall Risk assessment score
- initiating environmental and equipment audits to identify anticipated extrinsic fall risks
- discarding the 'Royston slippers' that had been provided to patients for their walk from DSU into theatre, and replacing them with non slip/grip sole socks – these have been very well received
- educating staff about patients at risk of falling.

We will continue to monitor the results of our falls prevention programme over the months ahead. To find out more, or to get a copy of our Falls Prevention leaflet, please call (06) 873 1111.

Key statistics

Over 65's
Are 3 times more likely to have a fall this year

Over 80's
50% will have a fall this year.

Atrial Fibrillation

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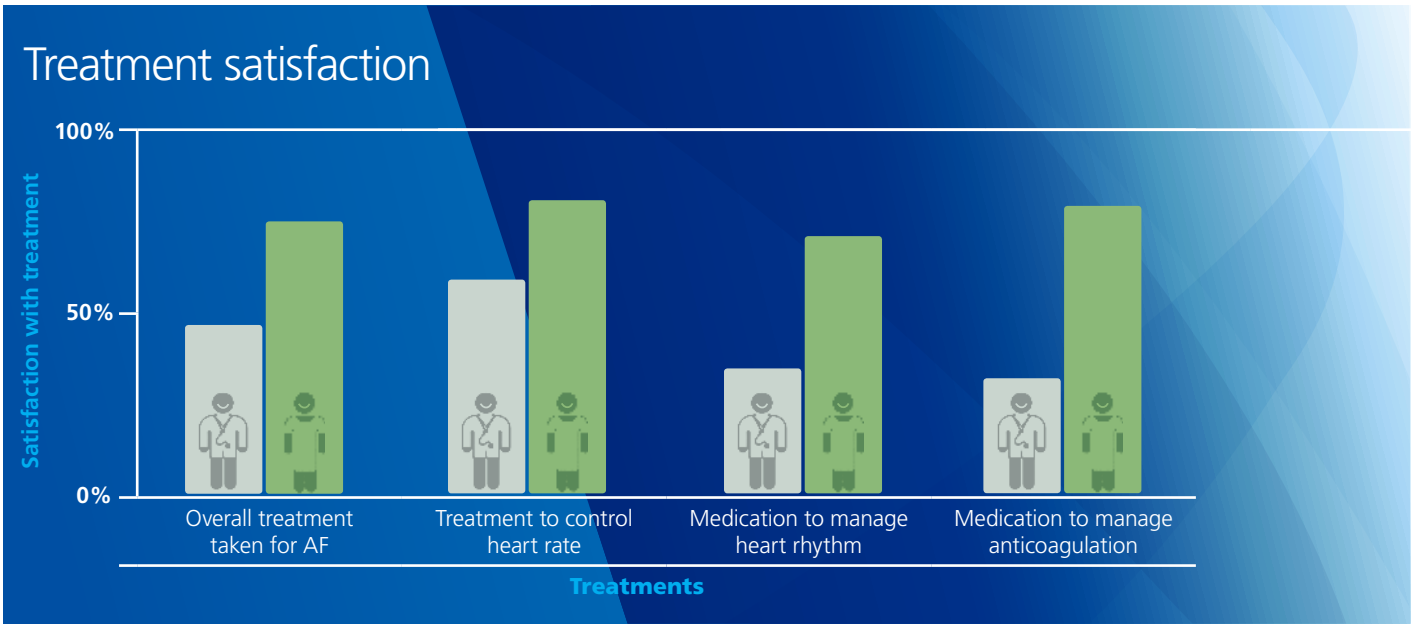
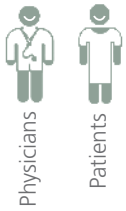


The above graph outlines the satisfaction with treatments. While patient satisfaction is relatively steady, the interesting results are those of physicians.



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Latest developments

While ACC/AHA and **ESC** had collectively released AF guidelines in 2006, ESC has just gone solo with its **new 2010 guidelines**.[2] It confirms that AF is on the rise, with an increase of 13% over the last two decades and a prevalence of up to 15% in the 80+ age bracket. The lifetime risk of developing AF is up 25% in those who have reached the age of 40.

As per the New Zealand guidelines, an **initial investigation** with ECG and echocardiogram is a Class I recommendation for a speedy diagnosis, especially with new onset AF – the old proverb 'Atrial Fibrillation begets Atrial Fibrillation' still holds true.

There are some suggested changes to **anti-thrombotic management** as well. While the CHADS2 score is well established, it has now been amended to become the **CHA2DS2-VASc** score:

Original CHADS2 score

Congestive heart failure	1 point
Hypertension: blood pressure consistently above 140/90 mmHg (or treated hypertension on medication)	1 point
Age 75 years or over	1 point
Diabetes Mellitus	1 point
Stroke: prior Stroke or TIA	2 points

CHA2DS2-VASc score

Congestive heart failure/EF < 40%	1 point
Hypertension: blood pressure consistently above 140/90 mmHg (or treated hypertension on medication)	1 point
Age 75 years or over	2 points
Diabetes Mellitus	1 point
Stroke: prior Stroke or TIA	2 points
Vascular disease	1 point
Age 64–74 years	1 point
Sex category (ie female)	1 point

Wakefield Health GP Conference

Drug therapy options

Warfarin, with a target INR of 2.5, remains the drug of choice in moderate and high-risk patients (≥ 2 points). Unfortunately, Clopidogrel plus Aspirin has not been shown to be advantageous over Warfarin.

Dabigatran, a new direct thrombin inhibitor, has been shown to be as effective as Warfarin at 110 mg bid with less bleeding, and superior to Warfarin with similar rates of serious haemorrhage at the dose of 150 mg bid in the long-term management of atrial fibrillation (RE-LY study). The ESC lists Dabigatran as an 'investigational drug' and promotes its use, especially in patients with higher bleeding risk. It is available in New Zealand for prophylaxis of deep venous thrombosis. Since it anticoagulates the patient within two to four hours and doesn't require anticoagulation tests, it might be an option that can be discussed with patients as an alternative to Warfarin – it actually has the potential to supersede Warfarin in the future.

Dronedarone is the eagerly awaited 'new Amiodarone'. It has been shown to have significantly less side effects than Amiodarone, but it's also not quite as effective. It has been released on the European and – very recently – Australian markets, much boosted by receiving a Class I A indication for rhythm control in AF from the ESC. However, so have Flecainide, Propafenone, Sotalol and Amiodarone. It can also be used for rate control, but is clearly contra-indicated in heart failure. When it may become available in New Zealand remains uncertain.

Vernakalant, a new cardioversion drug, is further on the horizon. What is innovative about this atrial repolarising delaying agent (ARDA) is that it selectively affects atrial ion channels. It has been given acutely as an i.v. infusion and was able to cardiovert 50% of patients within 90 minutes – median time to cardioversion was 14 minutes. However, it is not seen as useful for long-term or oral medication. In September 2010, Vernakalant was approved for infusion in the European Union for rapid conversion of recent onset AF.

Ablation

Sometimes AF – despite all our efforts – remains symptomatic. While the recent ESC guidelines clearly see a benefit of **ablation** compared to anti arrhythmic drug therapy, they also highlight that it can have significant complications. The overall success rate is quoted as being from 56% to 89% – in highly specialised and large centres. For a patient with symptomatic AF, there needs to be sufficient potential benefit to justify a complex ablation procedure associated with possibly severe complications. Nevertheless, great progress has been made in this area and will continue to do so.

Wakefield's Heart Centre now has a dedicated Atrial Fibrillation Service for the rapid assessment and treatment of AF

The way forward

The emergence of 60+ pages of new guidelines, as well as a range of new drugs, suggests some progress has been made in the treatment of AF, but it also signals that AF remains a moving target. At least we now officially know that atrial fibrillation is unpopular, which is why the **Wakefield Heart Centre** has initiated our dedicated **Atrial Fibrillation Service** for the rapid assessment and treatment of AF.

References

1 Europace (2010) 12, 626–633.
2 European Heart Journal (2010): www.escardio.org/guidelines.

For more information, contact Dr Alexander Sasse, Wakefield Cardiologist, P: (04) 381 8115.

Date for the next conference

Thank you to all GPs who provided feedback on a potential change in timing for the Conference due to the impact of the 2011 Rugby World Cup. The next Wakefield Health GP Conference will now be held 13-14 April 2012.

Please visit our website www.wakefieldhealth.co.nz for further updates as they occur.

Dr Alexander Sasse

Contact details

Thank-you...

To say thanks for your feedback, each survey we receive will go into the draw to win one of three (his or hers) Linden Leaves body care packs which retail at $250.

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Share your thoughts on this magazine

This magazine is designed especially for you – so we (Wakefield Health) can serve you and your patients better. We believe it provides a valuable range of articles and commentary that will be of interest to all health practitioners. To make it as useful as possible, we would appreciate it if you could provide feedback about this magazine in an online survey.

To complete the survey, go to www.wakefieldhealth.co.nz/gp-area
General comments can also be emailed to WHLadmin@wakefield.co.nz

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