AUTUMN 2015

The Wesley HOSPITAL
Caring for you for life

Medical Professionals direct link
to programs and services at the Wesley

Medilink

Wesley Firsts

Robotic revolution: Wesley leads nation with two Da Vinci robots

Articles in this issue:

Robotic surgeons cover four specialities

Left to right, back row: Urologist Dr Troy Gianduzzo, Urologist Dr John Yaxley, Hepato-pancreatico-biliary surgeon Dr David Cavallucci; Urologist Dr Geoff Coughlin; Gynae-oncologist Dr Jim Nicklin. Front row: Colorectal surgeon Dr Carina Chow, Gynae-oncologist Dr Piksi Singh and Urologist Dr Boon Kua.

Welcome

Dr Luis Prado

Director of Medical Services

Welcome to the autumn edition of Medilink. This edition has a particular focus on Wesley Firsts. The Wesley is the first hospital in Australia to operate two da Vinci surgical robot systems and the first to acquire the new "Xi" robotic surgical system. There are currently nine surgeons using the da Vinci system and a number more undertaking formal training, enhancing the Wesley's reputation as a centre of excellence in minimally invasive surgery including robotics. Our "firsts" in this field include Australia's first robotic-assisted partial liver resection and radical portal lymphadenectomy, the first cystectomy with intracorporeal neobladder and also the first pelvic exenteration.

In the diagnosis of prostate cancer the hospital now offers an Australian-first technology, following Wesley Medical Imaging's (WMI) installation of a Gallium68 generator to allow Prostate Specific Membrane Antigen (PSMA) PET-CT scanning. The new technology produces a tracer, PSMA, used in the staging of metastatic prostate cancer as well as identifying the source of recurrent disease. In addition, Senior Visiting Urologist Dr Les Thompson and WMI Radiologist Dr Rob Parkinson have conducted a world-first trial in MRI-guided diagnosis of prostate cancer.

In another first, Genesis CancerCare at the Wesley is now offering access to the only Varian TrueBeam™ Linear Accelerator in Brisbane. The advanced technology delivers targeted radiotherapy for people diagnosed with cancer.

As part of our paediatric and adolescent services, the Wesley is the first hospital in Queensland to provide diabetic patients with an advanced insulin pump that proactively monitors glucose levels, helping prevent potential hypoglycemic events.

With increased breast care services available in Brisbane, The Wesley Breast Clinic stands alone as the premier provider of comprehensive same-day breast screening and diagnostic services. It is the first private clinic of its kind in Queensland and emulated around the country. The Clinic has operated for 33 years and is unmatched in terms of clinical experience.

When it comes to patient satisfaction The Wesley Hospital is top of the nation for private hospitals with more than 300 beds as revealed in the most recent Press Ganey survey.

In March the Wesley was privileged to have two special guests, His Excellency The Honourable Paul de Jersey AC, Governor of Queensland, who officially opened the newly expanded Dr Russell Stitz Operating Theatre Complex, and Professor Stitz, one of Queensland's most pre-eminent colorectal surgeons, now retired.

Also in March the hospital recognised the outstanding contribution of its Visiting Medical Practitioners at the 2015 VMP Dinner. I would like to congratulate paediatrician Dr Bruce Lewis, this year's recipient of the Dr Jon Douglas award, and thank him for his leadership in the field of paediatrics and maternity services at the Wesley. The high calibre of our doctors once again confirms the Wesley as the hospital of choice for our top Queensland specialists.

Phone 07 3232 7926
Email dmsoffice.wesley@uchealth.com.au

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First Choice

Associate

Genesis Cancer Care Queensland
Genesis Sleep Care
Sullivan Nicolaides PATHOLOGY
Quality is in our DNA

New Website

Linking you to the right Wesley specialist to meet your patient's needs has never been more important. The Wesley website has been revamped to make it even easier to use. The specialist profiles and contact details are the most popular feature on our website – an invaluable resource for GPs and the general public. Please take a look at wesley.com.au

Guests at the Wesley's 2015 Visiting Medical Practitioner Dinner

The Official Opening of the Dr Russell Stitz Operating Theatre Complex: UnitingCare Queensland CEO Anne Cross, Dr Russell Stitz, His Excellency The Hon. Paul de Jersey and UCH Executive Director Richard Royle

GP Networking and Education

The Wesley Hospital CPD program is in full swing with our evening and Saturday events well attended. Our weeknight change to include Wednesday and Thursday evenings in addition to our traditional Tuesdays has provided GPs with more flexibility to attend. Our full day Active Learning Modules (ALMs) on Saturdays continue with four more events for 2015 with RACGP 40 Category 1 points awarded.

At your request we have an ALM on May 23 dedicated to emergency medicine which will give GPs practical advice on common emergency presentations. On June 13 we are delighted to be presenting our third annual Q&A hosted by ABC presenter Tony Jones. This must-attend panel discussion and gala dinner at the Brisbane Convention and Exhibition Centre will be preceded by our Saturday ALM. The Q&A evening topic for debate is 'Good Health... Can we afford it?' You can register at unitingcarehealth.com.au/qa

Our Wesley GP and specialist networking events continue to be a success with our second Wesley Women in Medicine function at The Golden Pig Food & Wine School attended by more than 43 GPs and 22 specialists. This was a great opportunity for GPs to catch up with old friends and to meet Wesley specialists in person. We are pleased to announce our first Wesley Men in Medicine event to be held on May 15 at the Reds v Rebels rugby game.

Finally, we have been visiting many practices around Brisbane bringing with us specialists new to The Wesley Hospital. If you would like a specialist to visit and present on a particular topic of interest, please contact the Wesley Business Unit on 07 3232 7222; Wendy Zernike at wendy.zernike@uchealth.com.au or 0428 227 372; or Vicki Goss at vicki.goss@uchealth.com.au or 0419 020 156.

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1. Dr Hannah Maher, Dr Sue-Ellen Silburn and Dr Genevieve Hopkins
2. Dr Maria Kowalczuk and Dr Anita Taylor (Wesley Breast Clinic)
3. Dr Jo Hallinan, Dr Caroline Clancy and Dr Emma Cowens
4. Dr Genevieve Hopkins, Dr Hannah Maher, Dr Carina Chow (Colorectal Surgeon), Dr Diana Conrad (Ophthalmologist), Dr Leila Davis, Lisa Erzetich (Director Wesley Breast Clinic), Dr Sue-Ellen Silburn and Dr Alexis Lake
5. Dr Griselda Calabrese, Dr Carol Adib (Dermatologist), Dr Genevieve Hopkins, Dr Sue-Ellen Silburn, Dr Diana Conrad, Dr Hannah Maher, Dr Su Laird, Dr Hong Shi, Dr Carina Chow and Dr Louise Wilson
6. Dr Maria Kowalczuk, Dr Helen Bajada and Dr Melissa Buttini (Gynaecologist)
7. Dr Jane Grice, Dr Anna Burrows (Gynaecologist), Dr Manh-Ha Le, Dr Maria Sharkey and Dr Michaela Lee (Obstetrician and Gynaecologist).

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Meet our new Visiting Medical Practitioners

Dr Kate Russell

General Paediatrician

Dr Kate Russell joined the Wesley this year, returning to work after the birth of her second child. She is a General Paediatrician with an interest in child development and infant health, and has worked in various hospitals both in Australia and the Pacific.

Dr Russell obtained her undergraduate Bachelor of Science and her Bachelor of Medicine degrees from the University of Queensland. Dr Russell also completed the majority of her Paediatric training in Queensland at the Royal Children's Hospital, with periods spent in Western Australia and New South Wales hospitals.

While in WA, Dr Russell spent six months in a Child Development Unit and six months with the neurology team at The Princess Margaret Hospital. She has also worked with foster children and their carers in her training, both with the Child Advocacy Service at the Royal Children's and at the Paediatric Outpatient Clinic at The Tweed Hospital.

An experienced clinician and member of The Royal Australasian College of Physicians, Dr Russell has run clinics independently throughout her career. Although she has an interest in infant health, her ability to communicate with and talk to children of all ages puts her in a superior position to treat difficult cases including ADHD and developmental delay.

Wesley Paediatric Sessional Rooms
Level 2, Main Hospital Building
451 Coronation Drive
Auchenflower Q 4066
T 07 3232 7759
E katerussellpaed@gmail.com

Dr Julian Hirst

Oral and Maxillofacial Surgeon

Dr Julian Hirst is an Oral and Maxillofacial Surgeon who uses the latest technology and minimally invasive techniques to perform orthognathic surgery, reconstruct facial trauma, place dental implants, and remove wisdom and other teeth.

Dr Hirst attained a Bachelor of Medicine and Surgery at the University of Queensland in 2000. After completing two years of basic surgical training through the Royal Australian College of Surgeons, including a year of General and Plastic Surgery, Dr Hirst completed a Bachelor of Dental Science degree and carried out another four years of advanced training in Oral and Maxillofacial Surgery. Before setting up his own practice Dr Hirst worked as a Staff Consultant at RBWH and in joint private practice for four years.

In addition to consulting privately in Newstead, Graceville, Chermside and Toowoomba, Dr Hirst is also a member of the Brisbane Maxillofacial Trauma on-call roster. He volunteers as convenor of the Queensland Oral and Maxillofacial Surgery Training Program and of the University of Queensland Orthognathic/Orthodontic Training Program. Dr Hirst also served as Secretary/Treasurer and then President of the Queensland branch of the Australian and New Zealand Association of Oral and Maxillofacial Surgeons (ANZAOMS), and is a member of the Queensland Regional Surgical Committee.

103/33 Longland Street
Newstead Q 4006
T 1300 697 874
F 07 3319 6399
E info@drjulianhirst.com.au

Dr Romi Das Gupta

Paediatric Surgeon

Dr Romi Das Gupta has a particular interest in minimal access surgery (laparoscopic and thoracoscopic), surgical oncology, neonatal surgery, vascular anomalies and burns. She is one of the surgeons involved in the multidisciplinary vascular anomalies clinics at the Lady Cilento Children's Hospital to advise and treat children with a diverse range of congenital vascular malformations and tumours.

She completed her medical degree (MBChB) at the University of Otago, New Zealand. After attaining her surgical training and qualifications (FRACS), she worked at various Sydney and Brisbane adult and children's hospitals including Sydney Children's Hospital, Children's Hospital at Westmead, and Royal Children's and Mater Children's hospitals in Brisbane.

On completing her Fellowship, she accepted a consultant position as a Paediatric and Neonatal Surgeon at the Royal Children's and Mater Children's hospitals in Brisbane in February 2011. This position has now transferred across to the Lady Cilento Children's Hospital.

She has undertaken substantial research, completing her PhD at the Oncology Research Centre at The Prince of Wales Hospital in Sydney, and Clive and Vera Ramaciotti Centre for Gene Function Analysis at the University of NSW. Her research has included mastering laboratory-based protocols such as microarrays and real time RTPCR. The focus of her PhD was on gene and tissue expression profiling of soft tissue sarcomas to establish predictors of tumour progression. More recently, as part of a multi disciplinary burns unit, she has had some involvement in a review of procedural pain management, with a view to developing pain management protocols for acute burns debridement and dressings.

Wesley Paediatric Sessional Rooms
Level 2, Main Hospital Building
451 Coronation Drive
Auchenflower Q 4066
T 07 3232 7759
E romidasgupta@gmail.com

Dr Simone Geere

Breast and Endocrine Surgeon

Dr Geere is a General Surgeon with a special interest in breast and endocrine surgery, and acute general surgery/ Trauma. Her private practice, based at The Wesley Hospital, offers specialist treatment for breast cancer and benign breast disease, as well as surgical management of endocrine disorders including thyroidectomy, parathyroidectomy and adrenalectomy. She also offers surgical management of general surgical conditions.

Dr Geere completed her fellowship of the Royal Australasian College of Surgeons in 2012. The majority of her training was performed at the Princess Alexandra Hospital, in addition to working in a number of other Queensland hospitals including Nambour Hospital, Gold Coast Hospital and QEII Hospital. She undertook a period of fellowship training in breast and oncoplastic surgery in Western Australia before returning to Queensland to complete a 12 month fellowship in breast and endocrine surgery at the Princess Alexandra Hospital.

Dr Geere holds positions in the Breast and Endocrine Surgical Unit and the Acute Surgical Unit at the Princess Alexandra Hospital. She has recently commenced private work at The Wesley Hospital and is taking new referrals.

Suite 75, Level 3
Sandford Jackson Building
30 Chasely Street
Auchenflower Q 4066
T 07 3371 5377
F 07 3371 5399
E drsimonegeere@gmail.com

Dr Amanda Scott

Paediatric Endocrinologist

Paediatric Endocrinologist Dr Amanda Scott is a University of Queensland medical graduate who has trained in all aspects of endocrinology. Her special interests lie with diabetes type 1, and growth and puberty issues.

Born and bred in regional Queensland, Dr Scott understands the challenges rural families face in needing to travel to the city for specialist appointments and runs outreach clinics for Queensland Paediatric Endocrinology.

Away from work, Dr Scott enjoys spending time with her family, playing in the park with her nephew, attending live theatre and dreaming of the next overseas trip when she can learn about another culture.

Dr Scott looks forward to working in close collaboration with you to provide multidisciplinary care and ensure the best outcome for all patients .

Suite 10A
Taylor Medical Centre
40 Annerley Road
Woolloongabba Q 4102
T 07 3393 1916
F 07 3891 7445

12 reasons for GPs to refer to the Wesley Breast Clinic

This is what sets Wesley apart from other services:

1. 32 years of operation: Wesley is the benchmark for other practices with numerous site visits from within Australia and overseas
2. Over 50 highly experienced professionals specialising in breast imaging and clinical assessment
3. Close collaboration with GPs and Breast Surgeons for best patient outcomes
4. Continuity of care – all patients results communicated to referring doctors
5. Dedicated GP Hotline for urgent appointments
6. All investigations are completed in one visit where possible
7. Same day results (biopsy results next day)
8. All diagnostic procedures and biopsies (fine needle biopsy, core biopsy, Vacuum Assisted Biopsy – VAB) performed at the clinic
9. Digital mammography including 3D mammography (Tomosynthesis), high quality ultrasound, a dedicated breast MRI unit. Biopsy capability using all imaging modalities
10. Tertiary referral centre for complex patient problems
11. Core biopsy and patients requiring surgical management followed up by Breast Care Nurse
12. Easily accessible by train, bus, or car (multi-storey car park)

The Wesley Breast Clinic Years of Experience

Clinic Medical Officers	162 years
Radiologist	105 years
Radiographers	103 years
Sonographers	165 years
Breast Care Nurses	66 years
TOTAL	**601 YEARS**

Wesley Breast Clinic
Urgent Referral Service
Doctor Hotline: 07 3232 7085
or fax 07 3217 8840
E: wesleybreastclinic@uchealth.com.au
W: wesley.com.au/breastclinic

Genesis CancerCare at Wesley first with TrueBeam™ technology in Brisbane

Over the past six months a major transformation in radiation oncology services has been underway at The Wesley Hospital. This change, led by Genesis CancerCare Queensland, is helping reshape how complex cancer conditions are managed for patients living in the Brisbane metropolitan area.

As part of its program of redevelopment Genesis CancerCare Queensland has recently finalised the commissioning of a new Varian TrueBeam™ Linear Accelerator (Linac) at its Wesley radiation oncology centre.

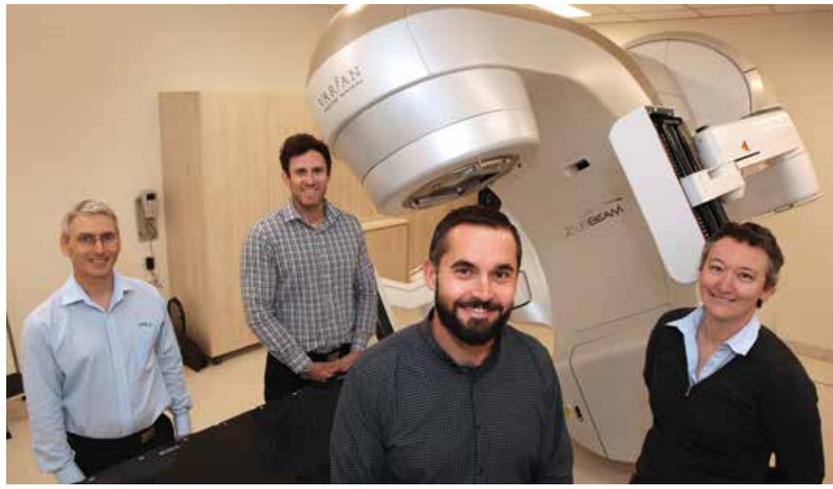
Radiation therapy staff started using the new technology to treat cancer patients in February this year.

For those unfamiliar with linear accelerators, they are essentially large machines that convert electricity into a controlled beam of high energy radiation. When used for cancer treatment additional components built into the machine enable the radiation beam to be modified and monitored so it can be administered to a patient in a targeted way.

Unlike other linear accelerators, the TrueBeam™ system uniquely integrates advanced imaging and motion management technologies within a sophisticated modern architecture.

Mark West, lead physicist at the Wesley, said the commissioning phase of the new linear accelerator (Linac) could not have gone smoother.

"You always expect to have some delays when you set a timeline for commissioning, however with the TrueBeam™ system we have managed to keep right on schedule," he said. "I think this can be put down to excellent engineering from Varian and having a great team at Genesis CancerCare Queensland".



Left to right: Physicists George Warr, Trent Aland , Mark West and Tanya Kairn with the new linear accelerator at the Wesley

The introduction of TrueBeam™ broadens the scope of radiotherapy techniques that can be applied to a range of cancer conditions. This will result in faster, more accurate treatment that improves clinical outcomes for patients.

In conjunction with this development Genesis CancerCare at the Wesley has also commenced Stereotactic Ablative Body Radiotherapy (SABR) for the treatment of early stage lung cancer. When compared to previous techniques, SABR offers improved local control, reduced side effects and requires on average only four treatment sessions.

The introduction of this advanced treatment technique, in combination with TrueBeam™, significantly enhances the management of early stage lung cancer, especially when other treatments are not indicated or available. ■

For more about Genesis CancerCare's new services phone 07 3377 4200 or email: ccq.enquiry@genesiscare.com.au

Specialists recognised at prestigious dinner

On March 21 The Wesley Hospital applauded the hospital's specialists for their significant contributions to Medicine and the hospital at the 2015 VMP Dinner at Gambaro Restaurant & Function Centre.

The highest honour, the Dr Jon Douglas Award, was presented to long-standing Wesley Paediatrician Dr Bruce Lewis "For Outstanding Contribution to The Wesley Hospital by a Visiting Medical Practitioner". Commencing work at the Wesley in 1987, Dr Lewis is our longest serving paediatrician and has been instrumental in growing our dedicated paediatric and adolescent unit into the full spectrum service it is today.

Congratulations to all the doctors recognised for their significant contribution - Dr Bruce Lewis,Dr John Allan, Dr David Colquhoun, Dr Leslie Thompson, Dr John Fraser, Prof Ian Gough, Dr Leslie Nathanson, Dr Francis Tomlinson, Dr Simon Fleming, Dr Ranald Pascoe, Dr Philip Allen, Dr Geoffrey Moore, Dr Anita Taylor, Dr Paul Eliadis and Dr Bernard Mason.

L-R: Dr Jon Douglas; Dr Bruce Lewis; last year's recipient Dr Paul Bartley and Wesley Director of Medical Services Dr Luis Prado with the new honour board located near the Evan & Mary Thomson Auditorium.

New face behind new facial technology

The Wesley Hospital is now home to a maxillofacial surgeon who leads the use of computer-aided technology to revolutionise surgery for facial and dental deformities.

"Max Fac" surgeon Dr Julian Hirst is a leading proponent of computer-aided visualisation technology that transfers surgical guides into the operating theatre.

He employs the Synthes ProPlan CMF orthognathic surgery technique for facial deformity reconstruction and believes the Wesley is an ideal base for Queensland's centre of excellence for virtually-planned orthognathic surgery.

"I'm excited about the future of CAD/CAM (computer-aided design and computer-aided manufacturing) here," Dr Hirst said. "We do a CT of the patient's face and virtually manipulate the images to accurately plan a patient's reconstructive surgery. This provides highly accurate cutting guides and acrylic surgical stents to ensure the patient's surgery is as precise as possible. It also reduces surgery time and can reduce complications."

Pre-operative anterior profile

Dr Hirst works exclusively with Dr Danielle Moses from Wesley Anaesthesia to ensure his patients receive consistent and expert anaesthetic and surgical perioperative care during these complex and life-altering procedures.

"During surgery, the patient's upper, lower or both jaws are cut from the facial skeleton and surgically manipulated to fit the pre-planned surgical positions," Dr Hirst explains.

Post-operative anterior profile

"The complexity stems from the delicacy of dissecting the nervous tissue in the mandible from the surrounding bone so that the patient can still have normal sensation to the lower face after the surgery.

Post-operative lat ceph XR

"In the upper jaw, the nasal and sinus tissues have to be preserved while trimming the surrounding bone and then securing them to the basal skull with titanium plates and screws."

Orthognathic surgery is often several years in the planning as orthodontic alignment of the patient's teeth is usually undertaken for 12 months prior to surgery and three to six months post-surgery.

Post-operative OPG XR

"It's rewarding to see a patient with unfortunate facial cosmetics and disabling dental deformities be transformed into a completely different person," Dr Hirst said. "The transformation is often as emotional as it is physical."

Dr Hirst is also keen to support the Wesley's medical student training to motivate a new generation of maxillofacial surgeons to undertake the demanding but highly rewarding surgical sub-specialty. ■

For more information, contact Dr Hirst via 1300 MY SURGERY or email: info@drjulianhirst.com.au or visit the Stitch My Smile blog.

Proactive insulin pumps first for Queensland diabetics

Diabetes educator Deb Foskett instructs Conrad on how to use his new insulin pump

There are now 118,000 Australians living with type 1 diabetes and 100 per cent of these people require insulin to manage their diabetes.

Ten-year-old Conrad was diagnosed with type 1 diabetes earlier this year and is now the first in Queensland and among the first in the world to receive a new style of insulin pump that proactively monitors and predicts low glucose levels.

Paediatric Endocrinologist Dr Andrew Cotterill provided Conrad with the latest model insulin pump in January at The Wesley Hospital's Paediatric and Adolescent Service.

The insulin pump, the Medtronic MiniMed 640G System, developed by a doctor in Perth in a world first, is considered the latest breakthrough toward an artificial pancreas for people living with diabetes.

Dr Cotterill said the new style of insulin pump has an additional feature that can continuously monitor glucose levels, providing additional safety for users.

"The pump automatically suspends delivery of insulin when glucose levels are predicted to approach a low limit and resumes delivery once glucose levels recover," Dr Cotterill said.

"The problem with traditional pumps, whilst they deliver a constant rate of insulin to keep glucose levels in the desired range, they can sometimes result in a hypoglycaemic event before suspending insulin.

"This new device, MiniMed 640G, continually tracks glucose levels and shuts off insulin up to 30 minutes prior to a predicted hypoglycaemic event thus preventing it occurring."

Dr Cotterill said in extreme circumstances attacks can result in coma, seizure or even death. Most attacks occur when the patient is asleep.

The small portable device, small enough to fit in a pocket, is connected by a tiny tube inserted under the skin near the waist. It drips steadily giving small, precise amounts of insulin, mimicking the biological function of the pancreas. ■

To make a referral, contact Dr Andrew Cotterill on 07 3393 1916 or fax 3891 7445.

New medical students welcomed at first 'White Coat Ceremony'

UnitingCare Health Chief Medical Officer Dr Luis Prado presented 42 new medical students with their "white coats" during a ceremony in February to mark the start of their time as student clinicians at UnitingCare Health facilities.

The group of third and fourth years from the University of Queensland, Griffith University and Bond University will be based full-time at the UnitingCare Health Clinical School, undertaking training at The Wesley Hospital, St Andrew's War Memorial Hospital and The Sunshine Coast Private Hospital.

Uniquely the Wesley and it sister hospitals provide teaching for students from all three South East Queensland medical schools – The University of Queensland, Griffith University and Bond University - across the three campuses.

Dr Luis Prado said the idea came from his visits to American hospitals where similar ceremonies are an established part of teaching programs. "Wearing a white coat symbolises that in healthcare you work as part of a team to provide excellent patient care, regardless of which university you are studying at or what subjects you are taking."

Wesley Deputy Director of Medical Services Dr Chris Beck, left, and UnitingCare Health Chief Medical Officer Dr Luis Prado, right, with the 2015 cohort of UnitingCare Health medical students.

Dr Prado told the students UnitingCare Health, as a leading private not-for-profit provider of healthcare, hoped to exert a positive influence over the next generation of doctors by providing clinical education.

"Our future medical practitioners have an opportunity to train in some of Queensland's leading private hospitals. I am particularly grateful to our patients who give permission for the students to be involved in their care and to the hospitals' medical specialists who give their time freely to teach the students." ■

Robotic revolution

The Wesley Hospital has enhanced its nation-leading robotics program with the acquisition of the latest generation Da Vinci Xi Surgical Robotic System.

The Wesley Hospital is the only hospital in Australia with two da Vinci robots and the first hospital to acquire the latest generation Da Vinci Xi robotic surgical system, which will enable more patients with complex cancers and diseases to undergo minimally invasive surgery.

The hospital took delivery of the system, known as the Xi robot, late last year to replace one of its third-generation Si robots, and the first surgeries were conducted in February. The Xi is the fourth generation of the da Vinci robot from Intuitive Surgical. It has been in use in the United States since April and was recently approved for use in Australia.

"The Wesley Hospital is pleased to be the first hospital in Australia to have acquired this next generation robotic surgical system," says The Wesley's Director of Medical Services, Dr Luis Prado.

"It will enable our specialists to advance minimally invasive surgical options for patients with diseases and conditions in the areas of urology, gynaecology, colorectal, thoracic, cardiac and upper GI and lower GI surgery. The hospital now has one da Vinci Si and one da Vinci Xi, which means we have the greatest range of technology to suit the most clinical applications of any hospital in Australia."

"We know urology patients are receiving benefits with the robot and we are hoping these benefits will also translate to general surgery"

– Dr David Cavallucci

The technology advances in this new robot offer key versatility," Dr Coughlin said. "The new overhead arm architecture and arm joints give greater access to areas of the abdomen, pelvis and chest from multiple directions. This allows multi-quadrant surgery.

"There are complex surgeries, particularly to treat cancers, which are difficult to do other than as traditional open procedures through a large incision. The Xi robot means these may now be done as minimally invasive surgeries through several small incisions, which offers substantial benefit to patients – less blood loss, less pain, shorter hospital stays and quicker recovery and return to regular activity." ■

"The new overhead arm architecture and arm joints give greater access to areas of the abdomen, pelvis and chest from multiple directions. This allows multi-quadrant surgery."

– Dr Geoff Coughlin

Wesley surgeons break new ground

Since the hospital launched its robotics program in 2010, Wesley surgeons have performed more than 2350 robot-assisted procedures, including several robotic surgical "firsts" in Australia in urology and general surgery.

The Wesley currently has nine specialist surgeons using the da Vinci Surgical System with many more in training. More than 700 da Vinci procedures have been undertaken in the last 12 months.

As the first hospital in Australia to invest in a second da Vinci Si robot in December 2013, the Wesley has consolidated its reputation as a centre of excellence in robotic surgery, particularly in the treatment of prostate cancer. Prostatectomy is the most common procedure performed at the Wesley using the da Vinci surgical robot and minimally invasive robotic surgery has proved to be a safe alternative to open prostatectomy for removing the prostate.

Dr Prado said the hospital's investment in a second robot was now providing Wesley specialists with the opportunity for further advances in a wider range of procedures beyond urology. In 2014 Wesley surgeons began exploring the potential to perform upper and lower gastrointestinal and gynaecological surgery. In June last year Wesley General Surgeon Dr David Cavallucci performed two "firsts" when he performed a liver resection for cancer and a massive hiatus hernia repair using the robot.

Dr Cavallucci said the liver resection was performed on an 82-year-old patient, who under traditional open treatment would have had to stay twice as long in hospital.

"We know urology patients are receiving benefits with the robot and we are hoping these benefits will also translate to general surgery," he said.

"With more time, understanding and experience we can hope that robotic surgeries will offer shorter operation times, reduced hospital stays, less side effects and overall a better outcome for our patients."

Wesley Colorectal Surgeon Dr Carina Chow said although it is still early days for general, colorectal and gynaecological robotic surgery, the robots have a lot to offer surgeons and their patients.

"The pelvis is a narrow and confined space with corners," she said. "Current laparoscopic instruments are straight, but with a robot you have a better view and have instruments that can actually bend around corners, improving the access and allowing us to perform a better operation.

"We believe we are still to reach the full potential of robotic surgery in this field and once we have a better understanding of the foundations we will be able to push the boundaries further."

The Wesley's second robot is also providing a valuable resource for training, allowing surgeons to explore opportunities for new procedures. The Wesley is the first hospital in Australia to have dual console training, permitting surgeons to work side by side using the robot while they develop their surgical skills. ■

> "We know urology patients are receiving benefits with the robot and we are hoping these benefits will also translate to general surgery"
>
> – Dr David Cavallucci

Wesley specialists lead the way in robotic surgery

UROLOGY
- Dr Geoff Coughlin: Prostatectomy; Partial nephrectomy; Pyeloplasty, Cystectomy (QLD first); Cystectomy with intracorporeal neobladder (Australian first); Pelvic exenteration (Australian first)
- Dr Charles Chabert: Prostatectomy and partial nephrectomy; Pyeloplasty
- Dr Troy Gianduzzo: Prostatectomy and partial nephrectomy
- Dr Boon Kua: Prostatectomy and partial nephrectomy; Pyeloplasty
- Dr John Yaxley: Prostatectomy

UPPER GASTRO-INTENSTINAL
- Dr David Cavallucci: Distal pancreatectomy, Liver resection (Australian first), Hiatus hernia repair (Queensland first), Portal node dissection (Australian first), Adrenalectomy

COLORECTAL
- Dr Carina Chow: Low anterior resection, Rectopexy

GYNAECOLOGY
- Dr Jim Nicklin: Hysterectomy for cancer (QLD first)
- Dr Piksi Singh: Hysterectomy for cancer

Top 5 robotic procedures

1. Prostatectomy
2. Partial nephrectomy
3. Cystectomy
4. Hysterectomies
5. Hepatobiliary procedures

Governor of Queensland opens our operating theatre complex

The newly expanded Dr Russell Stitz Operating Theatre Complex at The Wesley Hospital was officially opened by the His Excellency the Honourable Paul de Jersey AC, Governor of Queensland, on March 7.

The $20 million theatre expansion and upgrade project makes it the largest private hospital operating theatre complex in Queensland, now undertaking up to 750 operations per week.

Dr Luis Prado, the Wesley's Director of Medical Services, said with the addition of the three new, state-of-the-art operating theatres, The Wesley Hospital now houses 19 theatres, including one hybrid theatre, three cardiac catheter laboratories and four endoscopy suites.

The new hybrid theatre is predominantly for vascular surgery and is equipped to provide sophisticated medical imaging, allowing specialists to perform complex surgeries through small incisions, resulting in less discomfort, faster recovery times and fewer risks for patients with multiple medical conditions.

> "We are now the biggest and busiest operating complex in a private hospital in Queensland"

"Advances in x-ray, CT scanning and other medical imaging technologies, and platforms such as the da Vinci surgical system have made it possible to diagnose and treat patients for many diseases through minimally-invasive surgical techniques," Dr Prado said. "In some cases, patients require multiple surgeries and this can now be done in one theatre session rather than in several stages.

"We are now the biggest and busiest operating complex in a private hospital in Queensland and the expansion reflects our continued investment in peri-operative services to meet demand for surgical procedures. We now perform more than 750 operations per week servicing patients from not only the Brisbane metropolitan area but all parts of Queensland."

The Queensland Governor Paul de Jersey inspects one of the Wesley's two da Vinci robots.

The Wesley Operating Theatre Complex has been named in honour of one of Queensland's most esteemed colorectal surgeons, Adjunct Professor Russell Stitz AM, RFD.

UnitingCare Health Executive Director Richard Royle acknowledged the huge contribution made by Dr Stitz over his 45-year career. Dr Stitz retired from surgery in February 2012 but remained active in clinical roles as the Commissioner of the Health Quality and Complaints Commission in Queensland and as Chair of the National Lead Clinicians Group, as well as being on the Board of the Wesley-St Andrews Research Institute. He continued to consult and serve on The Wesley Hospital's Medical Advisory Committee until the end of 2014.

"His clinical leadership in colorectal surgery, and of course laparoscopic surgery, is part of the history of medicine in Queensland and Australia," Mr Royle said. "The Wesley Hospital owes its reputation as a pre-eminent centre for colorectal surgery and minimally invasive laparoscopic surgery in large part to Dr Stitz." ■

Dr Piksi Singh

Gynaecological Oncologist

Minimally invasive surgery in gynaecological oncology

Minimally invasive surgery is integral to the modern management of various gynaecological conditions, including gynaecological malignancies. The procedures, including laparoscopy and robotic surgery, have afforded patients the benefits of shorter hospitalisations, smaller incisions, reduced need for analgesics and fewer complications. Wesley Gynaecological Oncologist Dr Piksi Singh outlines the application of laparoscopy and robotics in gynaecological oncology and discusses their respective advantages.

Laparoscopy

Laparoscopy involves the introduction of ports through the abdominal wall to visualise and manipulate organs within the abdominal cavity. Total laparoscopy enables surgeons to select multiple entry points within the abdominal wall, with trocars able to be positioned flexibly depending on the procedure. The instruments have one point of torque at the abdominal wall to facilitate some indirect tactile feedback; however, the ease with which complex movements can be performed is constrained. Moreover, visualisation is 2D, which restricts a surgeon's understanding of spatial relations. Nevertheless, excellent visualisation is usually achieved given the angle and close proximity of the scope to the pelvic organs.

In regards to patient selection, previous abdominal surgery is the predominant reason to exclude a laparoscopic approach, due to the risk of adhesions. Patients with a BMI >45 are in a high-risk group for laparoscopy as access to the peritoneal cavity is difficult and these patients have greater peak airway pressure and are unable to tolerate the Trendelenburg position for extended periods.

The range of gynaecological procedures that can be performed using minimally invasive techniques (both laparoscopy and robotics) is listed in the table below.

Robotics

Robotic assistance can be utilised in patients who are total laparoscopy candidates and can accommodate four to five abdominal port sites. The system consists of four principal components - the surgeon console, the patient side cart, detachable instruments and a 3D visual system (Figure 1). The surgeon sits comfortably at the console, with the binocular 3D vision providing a greater appreciation of the objects in the viewing plane. The detachable instruments have seven degrees of freedom, facilitating a wide range of complex movements. The console filters out any tremors with large movements of the surgeon's hands translating into subtle and precise movements at the site of surgery.

General gynaecology	Gynaecological oncology
• Total hysterectomy • Supracervical hysterectomy • LAVH (Lap assisted vaginal hysterectomy) • Trachelectomy • Salpingo-oophorectomy • Ovarian cystectomy • Myomectomy • Excision of endometriosis • Adhesiolysis • Sacrocolpopexy • Tubal re-anastomosis • Vesico-vaginal fistula repair	• Radical hysterectomy +/- Salpingo-oophorectomy • Pelvic lymph node dissection • Para-aortic lymphadenectomy • Radical trachelectomy • Ovarian transposition • Debulking for ovarian cancers

Table 1: General gynae/gynae oncology procedures performed using minimally invasive techniques

Comparison

Superior depth perception and visualisation associated with robotic procedures can help facilitate more advanced procedures. The system is highly ergonomic, with the surgeon's seated position leading to a significant reduction in operator fatigue. Instead of being held by hand, as in traditional laparoscopy, the video laparoscope is fixed in position by a robotic arm. Coupled with the tremor filtration system, this enables surgeons to carry out finer movements with more precise dissections. Furthermore, the articulating instrument tips used in the robotic procedure have substantially greater rotational abilities and an independent 90-degree articulation of the tip. Consequently, robotic surgery is more intuitive with a shorter learning curve compared to traditional laparoscopy. However, robotically-assisted procedures have certain limitations. The equipment is very large, bulky and expensive. Compared to traditional laparoscopy, vaginal access is limited and the larger port incisions require fascial closure. The system requires additional training of the surgeon and theatre personnel and, in the learning phase, robotic procedures take longer to set-up than the equivalent laparoscopic procedures. Nevertheless, this can be overcome gradually with practice.

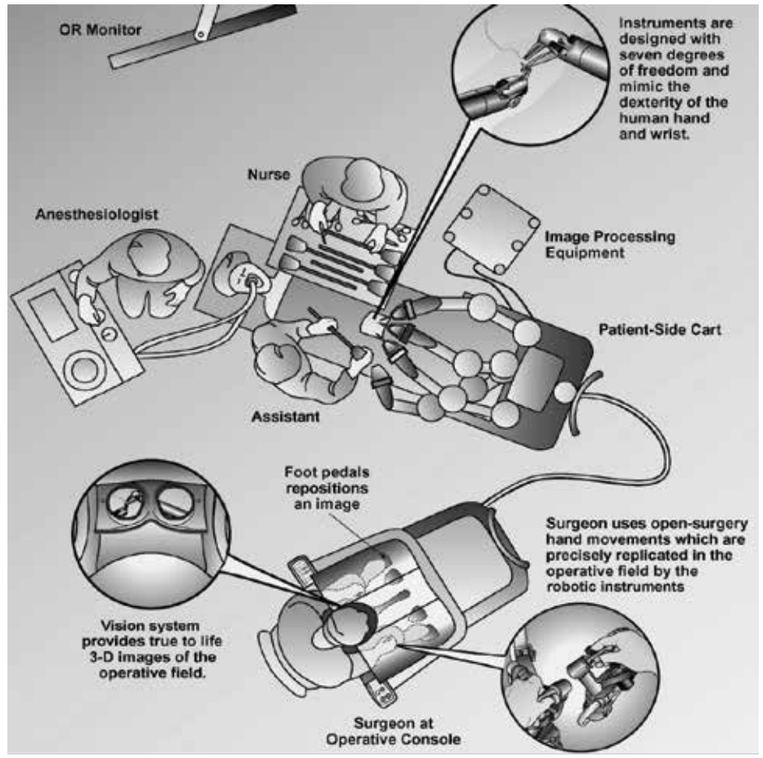


Figure 1: Da Vinci system in a gynaecological surgery

Clinically, given the newness of the technology, there is limited data to compare the long-term outcomes of robotic surgery with conventional laparoscopy. Current studies have demonstrated that procedures which are difficult to carry out laparoscopically - such as treatment of advanced endometriosis, procedures that require extensive suturing (eg: myomectomies, tubal reanastomosis) or oncological operations - can be performed with greater ease using robotic assistance. Magrina et al. in 2008 published a prospective study comparing the outcomes of patients undergoing radical hysterectomy and lymph node dissection by robotics, laparoscopy and laparotomy. The mean operating time for a robotic, laparoscopic and radical hysterectomy per laparotomy was 190, 220 and 167 minutes, respectively; the mean blood loss was 133, 208 and 444 mL respectively; the mean number of removed lymph nodes was 26, 26 and 28, respectively, and the mean hospital stay was 1.7, 2.4 and 3.6 days, respectively.[1] There were no significant differences in intra- or postoperative complications among the three groups. With a mean follow up of 2.5 years, no recurrence was observed in the cohort of cervical cancer patients. The study concluded that laparoscopy and robotics were preferable to laparotomy for patients requiring radical hysterectomy, with considerable advantages such as shorter operating times and hospital stay noted for robotics over laparoscopy.

The 2014 Cochrane meta-analysis noted that whilst there has not been a randomised controlled study involving Robotic-Assisted Surgery (RAS) in gynaecological malignancies; for endometrial and cervical cancers, there are several non-randomised studies confirming excellent results with RAS, including good lymph node yield, low blood loss, comparable operative time, low complication and conversion rates and short hospital stays. Case reports have also suggested robotic-assisted trachelectomy may be a good option for patients seeking to preserve fertility, because it allows detailed visualisation of the vasculature and parametrial tissues (connective tissue and fat adjacent to the uterus) which must be isolated during the procedure. The use of RAS and conventional laparoscopy for ovarian cancer is uncommon because of the difficulty associated with extensive exploration in both the abdomen and pelvis simultaneously. Nevertheless, there is some evidence suggesting RAS and laparoscopy are feasible in early stage (Stage I) disease.[2]

Conclusion

Robotic-assisted procedures have become the standard for the surgical management of gynaecological malignancies in many centres throughout the United States and Europe. The technology has significant advantages over traditional laparoscopy and has shown promising results in the limited clinical trial completed to date. The biggest barrier to the technology's adoption is cost, especially the expenses associated with the disposable and limited use robotic instruments. However, these are expected to decrease as the technology is acquired by an increasing number of centres and as supply of instruments increases. The technology has the potential to significantly improve patient outcomes and the results of further evidence-based long-term outcome evaluations comparing the robotic procedure with laparoscopy and open surgery are eagerly awaited.

References:

1. Magrina JF, Kho RM, Weaver AL, Montero RP, Magtibay PM. Robotic radical hysterectomy: Comparison with laparoscopy and laparotomy. Gynecol Oncol 2008; 13: 13.
2. Liu H, Lawrie TA, Lu D, Song H, Wang L, Shi G. Robot-assisted surgery in gynaecology. Cochrane Database of Systematic Reviews 2014, Issue 12. Art. No.: CD011422. DOI: 10.1002/14651858.CD011422

Dr Piksi Singh is a Gynaecological Oncologist who specialises in the management of all known and suspected cancers of the female genital tract, colposcopy and pre-invasive conditions of cervix, vagina and vulva.

Wesley Sessional Rooms
Suite 30, Level 2
Wesley Medical Centre
40 Chasely St
Auchenflower Q 4066
T 07 3841 5588
E drpsingh.reception@gmail.com

Cow's milk protein allergy in infancy

Allergy to cow's milk is a common occurrence in children. Paediatrician Dr Kate Russell explains how it can be best managed.

Dr Kate Russell

Paediatrician

Case study

A six-week-old baby (MO) presents to his General Practitioner with a history of being very unsettled, crying at night after feeds and opening his bowel 10-12 times per day. While regular weights had not been taken during this time, his birth weight was on the 50th centile and he was below the 25th centile at time of presentation. He was also seen by his paediatrician at this time, who made a provisional diagnosis of CMPA and recommended that his mother eliminate dairy from her diet. She took this advice and after one week he was a much more settled baby, slept better and had less frequent bowel motions. Over the next few months MO's weight increased and became closer to the 50th centile. At the age of 11 months, dairy in the form of cheese was given to MO with no ill effects. He is now a happy and healthy two-year-old who drinks milk and eats cheese and yoghurt every day.

Cow's milk protein allergy (CMPA) is defined as an abnormal reaction by the body's immune system to proteins found in cow's milk. It can be divided into two types depending on the immune mechanism and timing of reaction, and each is associated with different symptoms. IgE-mediated CMPA (immediate reaction) occurs within two hours of drinking cow's milk and causes symptoms seen with allergies (hives, rashes, wheezing, runny nose). In non-IgE mediated CMPA, symptoms happen later, from 48 hours to one week after drinking cow's milk. The incidence of CMPA is estimated at around two per cent of children under two years of age.

History

There are many signs and symptoms of CMPA and these usually develop within one week of exposure to cow's milk. Most infants will show signs that involve the skin or the gastrointestinal (GI) system. The latter can include vomiting, abdominal pain, blood in the stools and diarrhoea. Eczema and hives are the common skin manifestations. Babies can also present with wheezing, irritability, facial swelling and poor growth due to poor absorption of nutrients. Red flags include tiredness or lethargy, fevers, severe vomiting or diarrhoea, not tolerating any feeds, weight loss and blood in the stools. These symptoms are varied, can range from mild to severe, and overlap with several other conditions.

Differential diagnosis

Differential diagnoses include, but are not limited to: anatomic abnormalities; coeliac disease (in babies over six months); pancreatic insufficiency (such as in cystic fibrosis); metabolic disorders; malignancy; and infections. An assessment should also be done as to whether the child suffers from concurrent conditions as it is estimated 15-20 per cent of children with CMPA also have gastro-oesophageal reflux disease.

Investigation and management

A full history (including family history of atopy) and examination are important in making the diagnosis of CMPA. In terms of investigations, stools can be checked for blood, however this is not specific. Often a diagnosis is made after seeing how the patient responds to elimination of cow's milk from the diet. Blood tests (RAST), skin prick testing and endoscopy are not always helpful, but may be recommended to help exclude other causes for the patient's symptoms.

The treatment is elimination of all food containing cow's milk from the diet. For breast-fed infants the mother must exclude all dairy and soy products from her diet. Consultation with a dietician is recommended to help with reading food labels as milk proteins can be found in foods that you wouldn't expect. Foods containing casein, whey, lactalbumin and others need to be excluded from the maternal diet and she should be commenced on a calcium supplement. For bottle-fed babies extensively hydrolyzed formulas (for example Alfare, Pepti-Junior) are used as these are able to be digested without an immune reaction in most infants. A small percentage will require amino-acid based formulas (eg Neocate). Giving goat's milk, sheep's milk or soy milk is not advised as many infants will have similar allergic reaction due to cross-reactivity to the proteins in these drinks.

Prognosis

The good news is most (90 per cent) children have resolution of their allergy symptoms by six years of age. Fifty per cent of them will tolerate re-introduction of milk products in their diet (or their mother's diet) after 6-12 months. This should be done slowly and they should be watched for the development of signs and symptoms occurring up to one week after exposure. ■

Further information and references

- Guidelines for the diagnosis and management of cow's milk protein allergy in infants. Y Vandenplus et al. Arch Dis Child 2007; 92:902–908. (This article has a good summary as well as algorithms for the diagnosis and treatment of both breast-fed and formula-fed infants. It is available online free through the BMJ journals unlocked scheme.).
- The Royal Children's Hospital Melbourne website www.rch.org.au/uploadedfiles/main/content/allergy/cows_milk_allergy.pdf
- www.gikids.org/content/103/en/ This site has a parent friendly two-page PDF fact sheet.

Dr Kate Russell is a General Paediatrician with an interest in child development and infant health.

Wesley Paeditatric Sessional Rooms
Level 2, Main Hospital Building
451 Coronation Drive
Auchenflower Q 4066
T 07 3232 7759
E katerussellpaed@gmail.com

Dr Wen-Yi Chew-Lai

Paediatrician

Could it be autism? A case study

One in 160 Australian children aged between six and 12 years has an autism spectrum disorder, according to a recent study. Paediatrician Dr Wen-Yi Chew-Lai looks at the questions to consider if you suspect autism.

A couple presents with their two-and-a-half-year-old daughter, their only child, with speech and language delays. Her mother reports that she is very "shy" and does not play with other children. She enjoys lining things up, is a fussy eater and sleeps well as long as they follow her bedtime routine.

So, what are the possibilities? An isolated speech and language disorder, global developmental delay, anxiety, reactive attachment disorder, social (pragmatic) communication disorder or could it be autism? Before proceeding, it is important to know what normal development is, and when to be concerned. Useful sites include raisingchildren.net.au and The Red Flag – Early Intervention Referral Guide for Children 0-5 years - health.qld.gov.au/rich/professionals/brochures/red_flag.pdf

As with any presentation, a thorough history of the pregnancy, birth, past and current medical/surgical history, family history, social history, developmental milestones, sleep, diet, allergies and immunisation status is important. Has there been any feeding issues or regression in this child's development? Has the family sought therapy or any assessments e.g. hearing test?

What do her parents mean by "speech and language delays"? Does the child have an expressive language (ability to express herself and get the meaning across verbally) and/or receptive language (ability to understand and process spoken or written language) delay? If she is not able to communicate verbally, does she use nonverbal ways to communicate e.g. gesturing, pointing, eye contact?

"She does not spontaneously show affection but will hug her parents and grandparents when they initiate it."

She is "shy" and does not play with other children. Is this because of her poor verbal communication skills, or is she anxious? What are her social skills like? How often does she get to play and interact with other children? If she does not initiate play with others, will she join in with others when invited, or does she avoid engaging with other children? Does she get upset when there are too many children around and when it is noisy? What about her play skills? Does she have rituals? In this case, how does she react when you stop her from lining things up, or if the line were disturbed? Does she have an obsession with any particular toy or object?

What about her fussiness with food? Does she have sensory aversions or other sensory seeking behaviours? What is her bedtime routine and what happens when there is a change in her daily routine?

Her parents reveal that the pregnancy and birth were uncomplicated. She is healthy, has no allergies or sleeps issues, and is fully immunised. There is no family history of developmental delays, medical or mental health issues. She has had a hearing test which was normal. Her parents report that she has always been a "quiet" and well behaved child. She does not spontaneously show affection but will hug her parents and grandparents when they initiate it. She has never babbled, does not have any words, does not appear to understand simple instructions, and does not always respond to her name. She does not point or gesture to her needs and does not consistently give eye contact. There are no concerns with her vision. Her parents report that she tends to play on her own when they are with friends or family, and that she has limited play skills. She has a ritual of lining things up. She does not have an obvious obsession, but she does get rather upset when routine is changed. She does not like certain food textures, and becomes upset with certain noises. There are no concerns with her gross motor and fine motor skills, and there does not appear to be any regression. She started attending child care six months ago.

Her child care group leaders report that she does not engage with any of the carers nor peers. She avoids eye contact, and repeatedly lines things up in class. She does not join in group activities, and becomes upset when the class is too noisy. She does not transition well between activities and does not like change in routines.

On observation, her eye contact is fleeting. She does not respond to her name, has poor joint attention (ability to follow eye gaze or pointing and identify intention) and made no vocalisation. She wanders around the room and does not engage with yourself or her parents. Although she appears excited with bubble play, she does not request for more from yourself or her parents when you stop. There are no obsessions or rituals noted.

Mild gross motor and fine motor delays were noted, however this may not be a true reflection of her abilities due to her lack of engagement. Physical examination was unremarkable. ■

Reference:

1. Blumberg S.J., Bamlett M.D., Koran M. D. et al. Changes in Prevalence of Parent-reported Autism Spectrum Disorder in School-aged U.S. Children: 2007 to 2011–2012. National Health Statistics Reports 2013 National Health Statistics Reports; no 65. Hyattsville, MD: National Center for Health Statistics.2013.

Dr Wen-Yi Chew-Lai is a Developmental Paediatrician with a special interest in children with developmental delays, autism, attention deficit disorder and learning difficulties.

Wesley Paeditatric Sessional Rooms
Level 2, Main Hospital Building
451 Coronation Drive
Auchenflower Q 4066
T 07 3232 7759
F 07 3232 7585

Autism spectrum disorder (ASD)

Based on her poor social communication skills (poor eye contact, speech and language delay, poor engagement), and history of repetitive, restricted patterns of behaviours (ritual of lining things up, inflexibility to routine changes, sensory issues) she is likely to have an autism spectrum disorder (ASD).

Autism Queensland has cited a prevalence study by the Australian Advisory Board on autism spectrum disorders (2007) which concluded that one in 160 Australian children aged between six and 12 years have an autism spectrum disorder. A recent study in America estimated the prevalence of ASD in children 6-17 years of age to be around two per cent[1]. Apart from a minority of children with a specific genetic condition, the exact aetiology remains unknown.

Current diagnosis of ASD is based on DSM-V criteria, which include persistent deficits in social communication and social interaction across multiple contexts, as well as restricted, repetitive patterns of behaviours, interests or activities (Please refer to the DSM-V for full criteria). This new single diagnosis replaces the different subdivisions in DSM-IV, which include autistic disorder, Asperger's disorder and pervasive developmental disorder – not otherwise specified.

Several assessment tools for ASD are available, including the Autism Diagnostic Observation Schedule (ADOS) which is a semi-structured observational assessment and the Autism Diagnostic Interview – Revised (ADI-R) which is a structured interview. They are however not to be used in isolation.

An early intervention funding package of up to $12,000 is currently available for children diagnosed with an ASD before their sixth birthday. For those children between six and 13 years of age, separate Medicare items are available for them to access Allied Health assessments and treatment.

For more information, please visit: www.autismqld.com.au/page/98/Autism-Advisor-Program

www.positivepartnerships.com.au/resources-culturally-and-linguistically-diverse-communities

When to refer for palliative care

Dr Ralph McConaghy

Palliative Medicine specialist

GPs play a critical role in meeting the community's palliative care needs. Director of The Wesley Hospital Palliative Care Service Dr Ralph McConaghy explains the benefits of early integration of palliative care into disease management – and not just for the dying.

Palliative care is specialised care for patients with a life threatening illness. It does not require the patient to be at the very end of life, although this erroneous belief is still widely held. Of course high quality end-of-life care remains a core component of palliative care practice. It is an active and comprehensive form of care and the goal is to prevent and relieve suffering for patients and families, regardless of the stage of disease or the need for other therapies. Understanding how the illness affects the patient's life mentally and physically is a critical aspect of this area of medicine.

There are parallels between palliative medicine and good quality general practice: both disciplines are committed to treating the person, not just the disease and have a holistic view of the patient.

Early integration of palliative care into disease management alongside standard care has been demonstrated in randomised controlled trials to show improved quality of life, mood, caregiver distress and end-of-life care. Evidence also suggests the possibility of improved survival. Patients with early palliative care involvement have fewer emergency department visits, fewer ICU admissions and more time at home.

Early integration of palliative care into traditional treatment streams has now been endorsed by the World Health Organisation and the American Society of Clinical Oncologists (ASCO). Integration of palliative care into treatment for other life threatening illnesses (e.g. LVF, COPD) is also now becoming increasingly endorsed by specialist colleges.

Evidence suggests early discussion of palliative care and/or referral is acceptable to patients and does not cause psychological harm, particularly so when couched in terms of symptom control and psychological support through the patient's treatment.

Palliative care interventions have been shown to mediate several variables including improving patient education; providing improved autonomy for choices in care (including the preparation of an Advanced Care Plan); aiding in control of physical symptoms – not just pain; assisting in the management of pre-existing comorbidities and aiding the detection and treatment of depression.

Specialist medical palliative care is required when:

- The GP feels "out of their depth"
- The patient or family makes such a request
- Complex pain and "non-pain" physical symptoms remain unresolved
- Difficult pharmacological or interventional management is indicated e.g. rotation of narcotics, initiation of methadone or ketamine, coeliac plexus block, insertion of drainage catheter systems for pleural effusions or ascites
- High conflict or complex communication issues exist
- Assistance with clarification of goals of care and appropriate treatment options is required e.g. tracheostomy, PEG placement, IACD implantation
- Multifaceted psychological or spiritual distress is identified
- Difficult end-of-life care circumstances are anticipated or arise
- Patient identifies a desire for end-of-life care to take place in hospital rather than at home.

Delayed referral entails huge physical and emotional cost to patients and family, and financial costs to the health system.

GPs have a critical role in the identification and management of palliative care needs. It is a satisfying and significant role, adding to the "community value" of the GP. Palliative care (while not identified as such) has always been a part of traditional general practice long before the evolution of a "specialty" in this field.

GPs are well placed to be the "team leader" of community-based palliative care. This can be achieved by providing continuity and coordination of care, giving early consideration to treatment goals following the development of advanced disease. It also involves encouraging advanced care planning, advocating for their patient, providing early palliative care interventions especially for symptom control, undertaking patient education and supporting caregivers.

Making time, building a trusting relationship, being proactive in communication and speaking with treating specialists ensures the GP maintains their rightful place in the care of those with advanced illness.

Referral for specialist assistance should occur when the GP feels 'out of their depth', complex pain and physical symptoms remain unresolved, interventional management may be indicated, high conflict or complex communication issues exist, clarification of the goals of care is required, difficult end-of-life care circumstances are anticipated, or the patient identifies a desire for end-of-life care to take place in hospital. ■

Dr Ralph McConaghy is Director of the Wesley Palliative Care Service.

Level 4, Main Hospital Building
451 Coronation Drive
Auchenflower Q 4066
T 07 3232 7103

Clinical Education 2015

The Wesley HOSPITAL

	Local CPD	ALM The Wesley Hospital	Regional CPD	Special Events
April	30 APRIL Paediatrics			
May	13 MAY ENT	23 MAY Emergency Medicine	7 MAY Gold Coast	
	26 MAY Orthopeadics			
June	23 JUNE Vascular		16 JUNE Bundaberg	13 JUNE Q&A with Tony Jones
July	15 JULY Cardiology	18 JULY Men & Women's Health Advances in Robotic	27 JULY Rockhampton	16 JULY Practice Nurse Education
August	6 AUGUST Emergency Medicine	22 AUGUST Cardiology / Vascular Surgery		
	26 AUGUST Plastic and Maxillofacial			
September	1 SEPTEMBER Breast and Endocrine		8 SEPTEMBER Maryborough/Hervey Bay	12-13 SEPTEMBER Private Practice Conference
	16 SEPTEMBER Thoracic and Sleep			
October	13 OCTOBER Oncology and Palliative Care	17 OCTOBER CPR Training Day	21 OCTOBER Gladstone	7 OCTOBER Practice Nurse Education
	29 OCTOBER Gynaecology/Uro/Oncology			13-16 OCTOBER Clinical Week
November	11 NOVEMBER Prostate Cancer	14 NOVEMBER Minimally Invasive Surgery		

For further information call Vicki Goss on 0419 020 156

Please note: Topics and dates are subject to change

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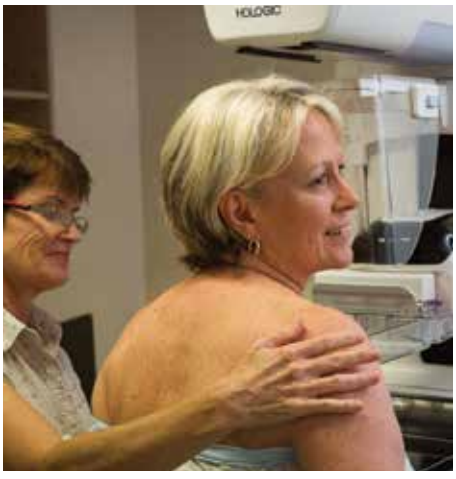

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A typical scenario
Less worry, less waiting

Monday - Sandra goes to GP after finding a lump in her breast in the shower. GP calls Wesley Breast Clinic GP hotline. Booked in for an appointment that day. All imaging and tissue sampling performed. Told Clinic doctor will ring her with her results the next day. Told results will be also sent to the GP the next day.

Tuesday - Sandra advised by Clinic doctor of her results and results are conveyed to the GP. Plan of action begins.