Autumn | 2021

The Wesley HOSPITAL
Caring for you for life

Medilink

Medical Professionals direct link
to programs and services at The Wesley

BARIATRIC SURGERY
LIFE SAVING, LIFE CHANGING

SRC CENTER OF EXCELLENCE METABOLIC & BARIATRIC SURGERY

EXCELLENCE IN SAFETY, EFFICACY & EFFICIENCY

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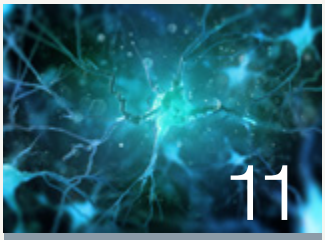
Profile



Neurology

Farewell

Welcome to our first edition of Medilink for 2021

AS HEALTHCARE WORKERS, 2020 BROUGHT US UNPRECEDENTED CHALLENGES WHICH TESTED AND PROVED OUR AGILITY AND ADAPTABILITY, AND HIGHLIGHTED THE DEDICATION AND SACRIFICE OF OUR INDUSTRY.

As we continue to navigate some of those challenges into 2021, our focus here at The Wesley Hospital remains on providing the best possible care for our patients and workplace for our people.

Like you, we are grateful for the positive situation in Queensland, and all being well, look forward to the opportunity this brings us to reconnect closer with you this year.

Fittingly, this year has been declared the International Year of Health and Care Workers by the WHO and celebrates the many roles it takes to deliver great care. We look forward to recognising and thanking our staff throughout the year, including you, our network of GPs.

We are pleased to inform you that our GP Education events are already underway for 2021, with face-to-face events back in business! Take a look at our calendar of online events at **wesley.com.au/for-doctors/for-gps/gp-education-events** and book in early to avoid disappointment.

This year, Queensland Bariatrics will welcome their 10,000th weight loss surgery patient through the door. If you missed out on our Bariatrics CPD event earlier last month, you can learn more about Bariatric surgery and the benefits for your patients on page 6.

To mark Brain Awareness Week from 15 – 21 March, we also recently held a CPD event in the specialist area of Neurological Disorders. Our experienced specialists expand on this with articles on pages 14 – 17.

We also sit down with Upper Gastrointestinal Surgeon, Bariatric Surgeon and General Surgeons, Dr Kevin Chan and Dr David Mitchell to learn more about good candidates for bariatric surgery and how GPs can best support their patients post surgery on page 10.

Also in this edition, we are proud to welcome experienced new specialists to the team at The Wesley; you can view their profiles at the back of this edition. They are available to meet with you in person at your practice to introduce themselves and have a one-on-one discussion. For more information on GP practice visits, please go to page 4 for an introduction to our Business Development Manager, Daniel Rochaix.

Finally, we honour and thank those who have dedicated their careers to medicine and who are hanging up their coats to embark on their retirements. Turn to page 14 for a farewell to our respected colleagues.

We hope this year will be calmer for all and look forward to seeing you all throughout 2021!

Sean Hubbard
General Manager

Business Development update

HI, I'M DANIEL ROCHAIX THE NEW BUSINESS DEVELOPMENT MANAGER FOR THE WESLEY HOSPITAL.

You may see me visiting your practice or walking the halls around the hospital. I'm looking forward to keeping you up-to-date on all of The Wesley's programs, initiatives and educational events, and to connecting you with our VMPs.

It was fantastic to have so many of you dial in to our first CPD event for the year in March discussing bariatric surgery. We hope you will be able to join us at many more events throughout the year. Invitations will be sent out to you via email, so please keep your eyes peeled. Alternatively, please head to The Wesley website for a list of future events and to register.

2021 CPD events will be different to previous years as we aim to combine both online and face-to-face formats. While this change is in response to COVID-19 restrictions, we hope the silver lining to this challenge will be that our regional and remote colleagues, as well as others who cannot physically make it on the night, will have the opportunity to join our educational events.

The Wesley Hospital has a reputation for providing informative and relevant CPD events. To ensure we continue to hit the mark, I would like to invite you to send your ideas for topics or themes via email to Wesley.BDM@uchealth.com.au.

Queensland Bariatrics welcomes 10,000th patient

IN 2021, QUEENSLAND BARIATRICS WILL WELCOME THEIR 10,000TH WEIGHT LOSS SURGERY PATIENT THROUGH THE DOOR. WESLEY OBESITY CLINIC'S FOUNDER, DR GEORGE FIELDING, PERFORMED THE PRACTICE'S FIRST WEIGHT LOSS SURGERY IN 1996. IN 2005, DR BLAIR BOWDEN TOOK OVER THE CLINIC AND QUEENSLAND BARIATRICS WAS BORN.

As more and more Australians suffer with obesity issues, Queensland Bariatrics is working hard to provide modern solutions. While diet and exercise are the first things people should look at to improve their health and weight, surgery can also be an option for tackling related problems such as diabetes, sleep apnoea and depression.

Queensland Bariatrics aims to deliver a comprehensive, patient-centric weight-loss program to help patients achieve long-term success with weight loss surgery. In the past, people often worried about the risks of undergoing weight-loss surgery but patients realise that today, with modern bariatric surgery, the risk of a complication is extremely low.

Australia is now the fifth most obese country in the world, according to a 2017 report by the OECD, with 28 per cent of adults being overweight. This figure is expected to increase to 35 per cent by 2035, according to a report by The University of Sydney.

Dr Blair Bowden trained at Royal Brisbane and Women's Hospital and then travelled to New York to undertake a fellowship in bariatric surgery at New York University. This training has meant that he can offer his patients bariatric surgery with a world standard level of care.

Dr Bowden has been accredited as a Surgeon of Excellence in Metabolic and Bariatric Surgery by international accrediting body, the Surgical Review Corporation (SRC).

The Wesley Hospital was internationally recognised in 2018 by SRC as a Centre of Excellence in both Robotics and Metabolic and Bariatric Surgery.

Queensland Bariatrics
Suite 93, Level 5
Sandford Jackson Building
The Wesley Hospital
30 Chasely Street
Auchenflower Qld 4066
T 07 3371 4333
F 07 3870 5466
E info@blairbowden.com.au
www.queenslandbariatrics.com.au

The life changing and saving benefits of weight loss surgery

BY DR BLAIR BOWDEN

WEIGHT LOSS IS MORE SERIOUS THAN JUST FITTING INTO THOSE NEW SKINNY JEANS OR LOOKING GOOD ON OUR BEACH HOLIDAYS, IT HAS THE POTENTIAL TO BE LIFE CHANGING AND LIFE SAVING.

Bariatric surgery has shown to be the most effective treatment of serious medical diseases, from long-term remission of Type 2 Diabetes Mellitus (T2DM), sleep apnoea and hypertension, to improve survival following COVID-19!

Importantly:

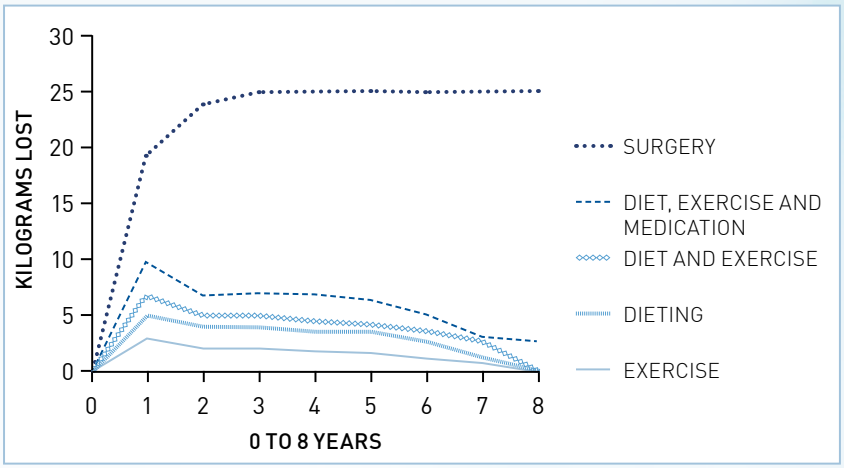
- An intentional weight loss of 9kg showed a 53 per cent reduction of all obesity related deaths
- A reduction in BMI from 40 to 25 increases the average lifespan by 15 years, from 64 to 79 years
- The National Cancer Institute USA (NCI) has estimated that a 1kg weight loss in 2020 would decrease the incidence of cancer in the USA by 100,000 patients.

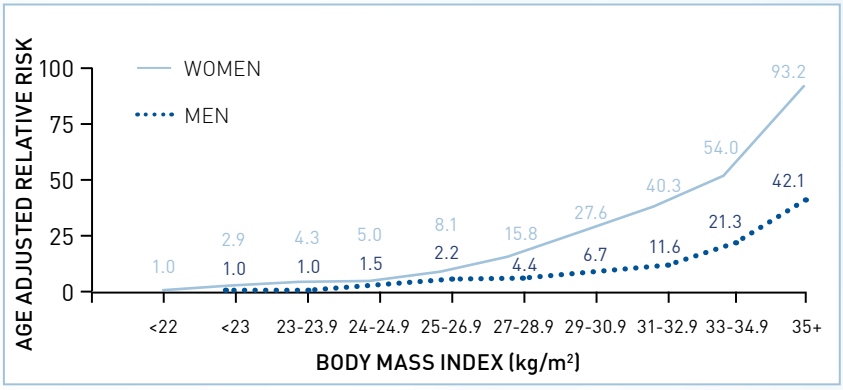
So, no eating that biscuit whilst reading Medilink!

The outcomes of a recent 10-year randomised controlled trial demonstrated that bariatric surgery is more effective than medical therapy in the long-term control of T2DM. 71 per cent of bariatric surgery patients were able to cease all insulin in the first 12 months of the study, while 37.5 per cent remained diabetes free after 10 years compared with zero patients treated with medical therapy. Patients who had undergone bariatric surgery also had a substantially significant lower incidence of diabetic complications including cardiac, renal and neurological effects (Lancet 2015; (386) 694-73).

A Swedish obesity trial, which is one of the most highly regarded obesity surgery studies, showed a 90 per cent reduction in diabetic mortality for bariatric surgery patients with an average mortality dropping from 4.5 per cent at 9 years to 1 per cent.

While there is an initial cost for surgery, the savings to the





community can be significant. It has been estimated that the cost of having T2DM and its complications is approximately $1.8 billion per year. We would save $40 million, in medication costs alone, if all T2DM patients lost just 4kg a year.

In the UK, studies have shown that avoiding T2DM complications with bariatric surgery was expected to save $8,428 per person over a five year timeframe. It also showed that there is a higher resolution of T2DM in patients who have had T2DM for less than 5 years, so early consideration of bariatric surgery is important for all patients with T2DM.

In 2007, the NCI estimated 100,000 patients presented with a cancer that was obesity related. A number of cancers such as oesophageal, stomach, breast, colon, pancreatic, kidney and prostate have an increased incidence with a higher BMI. Further highlighting the serious nature of obesity, some cancers including pancreatic cancer have shown a poorer length of survival in staged matched cohorts with normal weight patients versus overweight patients.

A meta-analysis of 96,460 patients by Wilhelm et al. (Annals of Pharmacology 2014;1-9) showed that the incidence of hypertension increased from 18.2 per cent to 38.4 per cent once BMI was greater than 30. There was resolution of hypertension which occurred in 24,909 patients or 50 per cent ($p>0.00001$) and an improvement (less medication) in 63.7 per cent with bariatric surgery, over the first twelve months.

Urinary incontinence decreased for women from 49.3 per cent to 18.3 per cent, and in men from 21.8 to 9.8 per cent at one year following bariatric surgery in a study by Sudack L et al. which included 2,458 patients (JAMA Internal Medicine 2015; 175 (8) 1378–87).

Most recently, a study from the Cleveland Clinic of 4,365 COVID-19 positive patients, of which 33 had previously had bariatric surgery, revealed prior weight-loss surgery was associated with lower hospital length of stay. Surgical patients were matched with non-surgical patients as a multivariate analysis that showed a prior history of bariatric surgery was associated with a lower hospital admission rate versus control patients with obesity ($p=0.028$). A French study of 82,863 patients showed a substantially significant lower risk of invasive mechanical ventilation and mortality for similar matched co-morbidity post bariatric surgery.

There are significant life changing and potentially life extending benefits of bariatric surgery. We offer our patients a multidisciplinary, comprehensive, patient-centric weight-loss program to help long-term success with weight loss surgery.

Queensland Bariatrics has been recognised as a Centre of Excellence in Metabolic and Bariatric Surgery by the Surgical Review Corporation (SRC) USA.

SRC
CENTER OF EXCELLENCE
METABOLIC & BARIATRIC SURGERY
EXCELLENCE IN SAFETY, EFFICACY & EFFICIENCY


asics

Dr Reza Adib
MD, FRACS, FRCSED

SPECIALTY AREA:
BARIATRIC SURGERY
GENERAL SURGERY
HEPATOBILIARY SURGERY
UPPER GI SURGERY

IN THIS EDITION, WE SIT DOWN FOR A Q&A WITH DR REZA ADIB. DR ADIB HAS STUDIED IN AUSTRALIA, ENGLAND, SCOTLAND, FRANCE AND AUSTRIA AND APPLIED THAT WORLD KNOWLEDGE TO ESTABLISH THE BRISBANE OBESITY CLINIC IN 2006.

Why did you choose to specialise in bariatric surgery?

Morbid obesity is classified as a disease which has largely been unrecognised in the general community due to weight bias. I could see that obesity related diseases were taken more seriously, without any consideration of weight. I wanted to make a change here. By addressing obesity, I am also addressing lots of co-morbidities that occur with being overweight, such as diabetes, hypertension, sleep apnoea and stroke.

How many operations do you perform in a year?

I perform more than 1,000 bariatric procedures each year – more than any other surgeon in Australia.

What has been the greatest technological advancement during your career and what impact has it had on patient outcomes?

There have been many technological advancements in the past few years, in particular improved energy sources within our surgical instruments for sealing/cauterising and stapling, which ensure excellent wound healing and management.

How has the perception of Bariatric surgery changed in the last decade within the medical community and more broadly?

Thankfully through education, the weight bias is shifting. Education and community awareness is improving. I provide many GP and nursing education sessions and am constantly working with International Bariatric Surgical Bodies to further this education. In Australia and New Zealand, we are the major contributor of the national Bariatric Surgery Registry which collates data to improve outcomes.

As a recognised Surgeon of Excellence, what does that mean to you and to your patients?

Being part of the Surgical Review Committee (SRC) means that we are recognised as a Practice (Brisbane Obesity Clinic and The Wesley Hospital) and Surgeon of Excellence. The SRC believes that excellence is not simply an achievement – it is a culture that must be sustained. I am incredibly proud that I have SRC accreditation as it means the intrinsic delivery of safe and effective patient care. We have improved outcomes and reduced complications.

How has the COVID-19 pandemic impacted your patients in the recovery stage? Have there been barriers to weight loss, with less opportunity to get out and exercise and working from home?

Fortunately, COVID-19 has not impacted the recovery of our patients too greatly as we have been able to offer phone and video follow-up consultations with our dietitians who offer constant encouragement and support.

Brisbane Obesity Clinic
Suite 13, Level 10
Evan Thomson Building
The Wesley Hospital
24 Chasely Street
Auchenflower Qld 4066
T 07 3871 2277
F 07 3871 0700
E reception@dradib.com.au
www.brisbaneobesityclinic.com.au

FAST FIVE
WITH DR KEVIN CHAN AND DR DAVID MITCHELL

Dr Kevin Chan is an Upper Gastrointestinal, Bariatric and General Surgeon with special interests in reflux disease, upper gastrointestinal oncology and bariatric surgery.

Dr David Mitchell is an Upper Gastrointestinal, Bariatric and General Surgeon. David participates in on-call general and trauma surgery and has special interests in advanced oesophago-gastric cancer, reflux and bariatric surgery.

Kevin and David work closely together and as part of the team at Total Upper GI Surgery.

1. Who qualifies for bariatric surgery?

Internationally recognised guidelines for bariatric surgery are based primarily on Body Mass Index (BMI) and the presence of obesity related complications. These include but are not limited to type 2 diabetes, hypertension, dyslipidaemia, musculoskeletal disorders, obstructive sleep apnoea, non-alcoholic fatty liver disease, reproductive disorders and idiopathic intracranial hypertension. The eligibility criteria for surgery are:

- individuals with a BMI >40Kg/m2
- individuals with a BMI >35Kg/m2 with one or more obesity related complications.

More recently, the Australian Diabetes Society has endorsed bariatric-metabolic surgery as a proposed treatment option in the algorithm to manage Type 2 Diabetes Mellitus (T2DM). Bariatric-metabolic surgery is recommended for:

- all individuals with T2DM and a BMI > 40 kg/m2
- individuals with BMI 35-40 kg/m2 with inadequate glycaemic control despite lifestyle and optimal medical therapy.

2. Sleeve, roux-en-Y gastric bypass (RYGB), single anastomosis gastric bypass (SAGB) and gastric band. Which is the right operation?

Each bariatric procedure has its pros and cons and there is no 'one-size-fits-all' for bariatric patients. The gastric band was once a popular device, but through experience we know that one in five patients with a band will have a band-related complication at some stage in their lives. They still have a role in weight loss surgery but are not as prominent as they used to be.

A sleeve gastrectomy is a straightforward procedure, but we now know through experience that 20-30 per cent of 'sleeve' patients will develop de novo reflux. Those patients with pre-existing reflux are also prone to worsening of their symptoms post-operatively. An RYGB is a great operation for reflux and weight loss but there are some significant long-term complications that can occur such as nutritional deficiencies, dumping syndrome, chronic LUQ pain and internal hernias. The SAGB is a newer procedure that has the benefits of an RYGB without the risk of internal hernias. There is however a slight risk (two per cent) of bile reflux which may mean this procedure is not suitable for all patients.

3. My patient has terrible reflux following a sleeve gastrectomy, can anything be done about it?

Like we mentioned before, reflux following a sleeve gastrectomy is common in up to 20-30 per cent of patients. The cause of this is multifactorial but ultimately comes down to increased pressures in the remnant gastric tube leading to reflux of gastric contents into the oesophagus. Surgery may also disrupt the phreno-oesophageal ligaments which can lead to the development of a hiatus hernia, further contributing to reflux. Some patients may have improved symptom control with a PPI, but ultimately they may require conversion to a Roux-en-Y gastric bypass to remedy their symptoms.

4. How can GPs best support their patient post-bariatric surgery?

Post-op bariatric patients have a unique set of long-term complications that require follow-up. They are at risk of nutritional deficiencies and require regular screening blood tests in the first year following surgery to ensure any deficiencies are replaced appropriately. With weight loss, many patients are able to wean or cease their anti-hypertensive, anti-cholesterol and anti-diabetic medications and this will need to be monitored and adjusted accordingly. Patients will also need to be monitored for complications of weight loss surgery as they may not be aware of what to look out for themselves.

5. What multidisciplinary care do you provide for patients requiring bariatric surgery?

Bariatric surgery requires more than just surgery to achieve the best patient outcomes. Surgery plays a role, but it is lifestyle and behavioural modifications that ultimately decides whether a patient is able to achieve their weight loss goals. We believe in a multidisciplinary approach and all patients undergoing weight loss surgery are required to see one of our dieticians before and after surgery. They are given advice on the expected post-operative dietary course and also ideas on the types of foods that can be eaten after surgery.

Our practice also engages a psychologist where indicated as some patients may have underlying psychological issues that may make surgery inappropriate.

We also have a strong relationship with an endocrinologist who can assist with managing patients who may have challenging co-morbidities. Some patients may not be suitable for surgery and are given the option of pharmacological therapy which our endocrinologist manages for us.

The Wesley Hospital Bariatric Surgeons

FOR MORE THAN 20 YEARS, THE WESLEY HAS BEEN PROVIDING BARIATRIC SURGERY USING ADVANCED PROCEDURES AND SURGICAL TREATMENT FOR CLINICALLY OBESE PEOPLE. OUR WEIGHT-LOSS SURGERY SPECIALISTS ASSIST PATIENTS TO ACHIEVE SUSTAINED WEIGHT LOSS, IMPROVE SERIOUS MEDICAL CONDITIONS AND QUALITY OF LIFE.

Dr Reza Adib MD, FRACS, FRCSED

SPECIALTY

Bariatric Surgery, General Surgery, Hepatobiliary Surgery, Upper GI Surgery

T 07 3871 2277 W www.brisbaneobesityclinic.com.au

Dr Blair Bowden MBBS, FRACS

SPECIALTY

Bariatric Surgery, General Surgery, Hepatobiliary Surgery, Upper GI Surgery

T 07 3371 4333 W www.queenslandbariatrics.com.au

Dr Kevin Chan B.PHARM MBBS FRACS

SPECIALTY

Bariatric Surgery, General Surgery, Upper GI Surgery

T 07 3350 2533 W www.totaluppergisurgery.com.au

Dr Ben Dodd BSC, MBBS, MSC, FRCS, FRACS

SPECIALTY

Bariatric Surgery, General Surgery

T 07 3367 1126 W www.brisuppergi.com.au

Dr Ian Martin MBBS (QLD), FRACS

SPECIALTY

Bariatric Surgery, General Surgery, Hepatobiliary Surgery, Upper GI Surgery

T 07 3720 9057 W www.drianmartin.com.au

Dr David Mitchell BSc MBBS FRACS

SPECIALTY

Bariatric Surgery, General Surgery, Upper GI Surgery

T 07 3350 2533 W www.totaluppergisurgery.com.au

Dr Nicholas O'Rourke MBBS (QLD), FRACS

SPECIALTY

Bariatric Surgery, General Surgery, Hepatobiliary Surgery

T 07 3876 7455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Management of brain metastasis

BY DR HAMISH ALEXANDER
NEUROSURGEON AND SPINAL SURGEON

DR HAMISH ALEXANDER IS A NEUROSURGEON AND SPINAL SURGEON AT BRIZ BRAIN & SPINE. HE HAS COMPREHENSIVE EXPERIENCE IN ALL ASPECTS OF CRANIAL AND SPINE SURGERY WITH A SPECIAL INTEREST IN NEURO-ONCOLOGY.

Metastatic tumors are the most common neoplasm in the brain, occuring in 24-45 per cent of all cancer patients and accounting for 20 per cent of cancer deaths annually.

These rates are on the increase due to a boost in survival of patients with cancer because of modern therapies, along with increased availability of advanced imaging techniques for early detection.

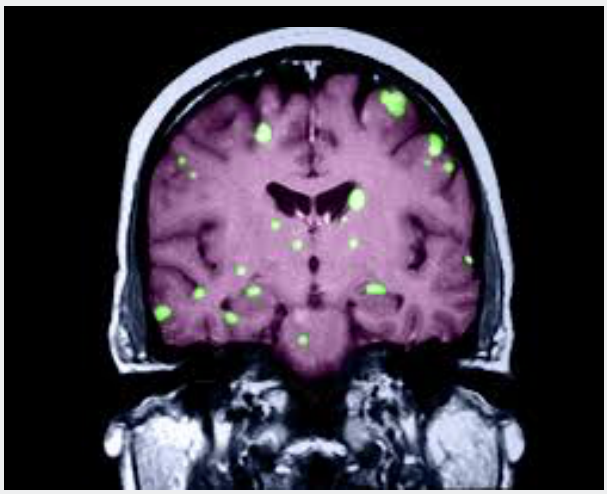
Newer therapies, such as immunotherapy, prolong overall survival in some cancers such as Melanoma, but many other chemotherapy drugs penetrate the CNS poorly, leaving the brain a safe haven for tumor growth.

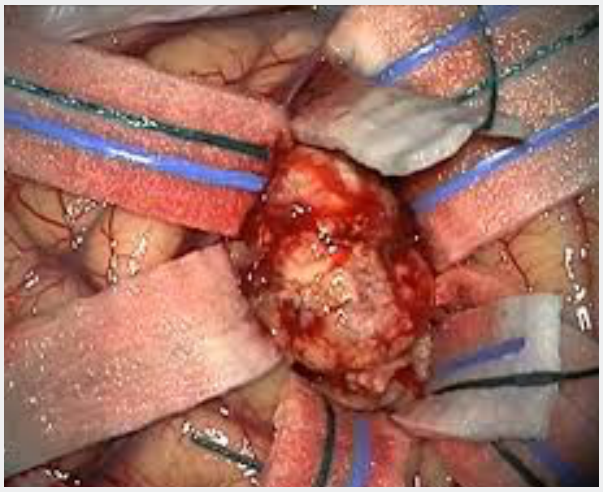
Approximately 60 per cent of patients with brain metastases will present with subacute symptoms. Symptoms are usually related to the location of the tumor and may include headaches, seizures, cognitive or motor dysfunction.

Radiological investigation provides information on tumor burden in the brain and associated structures, in addition to the rest of the body, and is an integral part in formulating the treatment plan. CT brain is the initial investigation in most cases and a useful screening tool.

Further imaging studies should include, CT or PET to assess systemic disease and MRI to better define the anatomy of the tumour and assess for other cerebral lesions. Up to 75 per cent of patients with brain metastasis will have multiple lesions.

Initial medical management of metastatic disease focuses on the treatment of symptoms such





IMAGING SHOWING BRAIN METASTASES

as headache from cerebral oedema with corticosteroids (dexamethsone) or seizures with anti-convulsants.

Most brain metastasis are not chemosensitive and treatment mainstays are surgery and radiotherapy.

Radiation therapy includes whole brain radiotherapy (WBRT) and stereotactic radiosurgery (SRS).

SRS is becoming a preferred treatment modality due to a more favorable side effect profile and better local control rates up to 95 per cent. It is also frequently used to treat the resection cavity of brain metastasis post-surgery.

Surgical resection is considered standard care for solitary metastases larger than three centimeters and in non-eloquent areas of the brain in patients with good performance status, controlled systemic disease.

Surgery is also an option in cases where there is a dominant symptomatic lesion with multiple other asymptomatic lesions.

Surgery is contraindicated in the case of radiosensitive tumor (e.g., small-cell lung tumor), patient life expectancy less than 3 months, and usually in patients with multiple lesions.

The development of brain metastasis represents a difficult and significant time for any patient. As always the treatment must be tailored to the individual patient's needs and requires the collaboration of neurosurgeons, oncologists, and General Practitioners.

Dr Hamish Alexander
BrizBrain and Spine
Bowen Hills Medical Specialist Centre
Suite 1, 16 Thompson Street
Bowen Hills QLD 4006
T 07 3833 2500
F 07 3833 2511
E info@brizbrain.com.au
www.brizbrain.com.au

Stereotactic body radiotherapy at The Wesley Hospital

BY DR ART KAMINSKI
ONCOLOGIST

ADVANCES IN RADIOTHERAPY HARDWARE AND SOFTWARE HAVE RESULTED IN THE AVAILABILITY OF RADIOTHERAPY TREATMENTS THAT ARE MORE EFFECTIVE IN CONTROLLING TUMOURS WHEN COMPARED TO TRADITIONAL TECHNIQUES.

Stereotactic ablative body radiotherapy (SABR) is one such treatment option. This form of radiotherapy delivers a higher than usual dose with each treatment visit, translating into improved tumour control above and beyond conventional techniques. This also permits the delivery of treatment over a shorter time frame, usually across one or two weeks as opposed to longer courses. Finally, the improved accuracy of SABR reduces the dose delivered to normal tissues resulting in fewer side effects.

GenesisCare at The Wesley Hospital has been utilising SABR since 2013. This programme was built on a foundation of cranial stereotactic radiotherapy that has been in use at GenesisCare at The Wesley for three decades now.

The SABR programme evolved to meet a need to treat patients with thoracic malignancies not suitable for surgical resection. Many of these were primary lung cancers in patients with significant co-morbidities, including poor lung function. This is in a context of primary lung cancer being responsible for more cancer related deaths in the Western world than any other malignancy. Of course, there were also many patients with cancer metastatic to the lungs, often with more than one lesion requiring treatment. This remains the case today, where up to three lesions in the chest may successfully be treated with SABR in the one sitting.

Over the past decade the GenesisCare SABR programme at The Wesley Hospital has expanded to include treatment of tumours arising in (or in some cases metastatic to) the liver, kidney, prostate, bone, and lymph nodes. At present, GenesisCare at The Wesley Hospital, on average, treats at least one tumour deposit per week with the stereotactic technique.

There is a strong body of evidence that suggests treatment with this technique is not only useful in producing local tumour control, but in fact improves survival when compared to conventional treatment. At present this principle is being applied to patients with a satisfactory performance status and no more than five metastases. There are ongoing trials investigating the utility of this modality in patients with up to ten metastases. Prior to commencing the SABR journey, each patient's case is discussed at the GenesisCare SABR chart round to confirm their suitability. Discussion with a radiation oncologist of patients who may benefit from SABR is strongly encouraged.

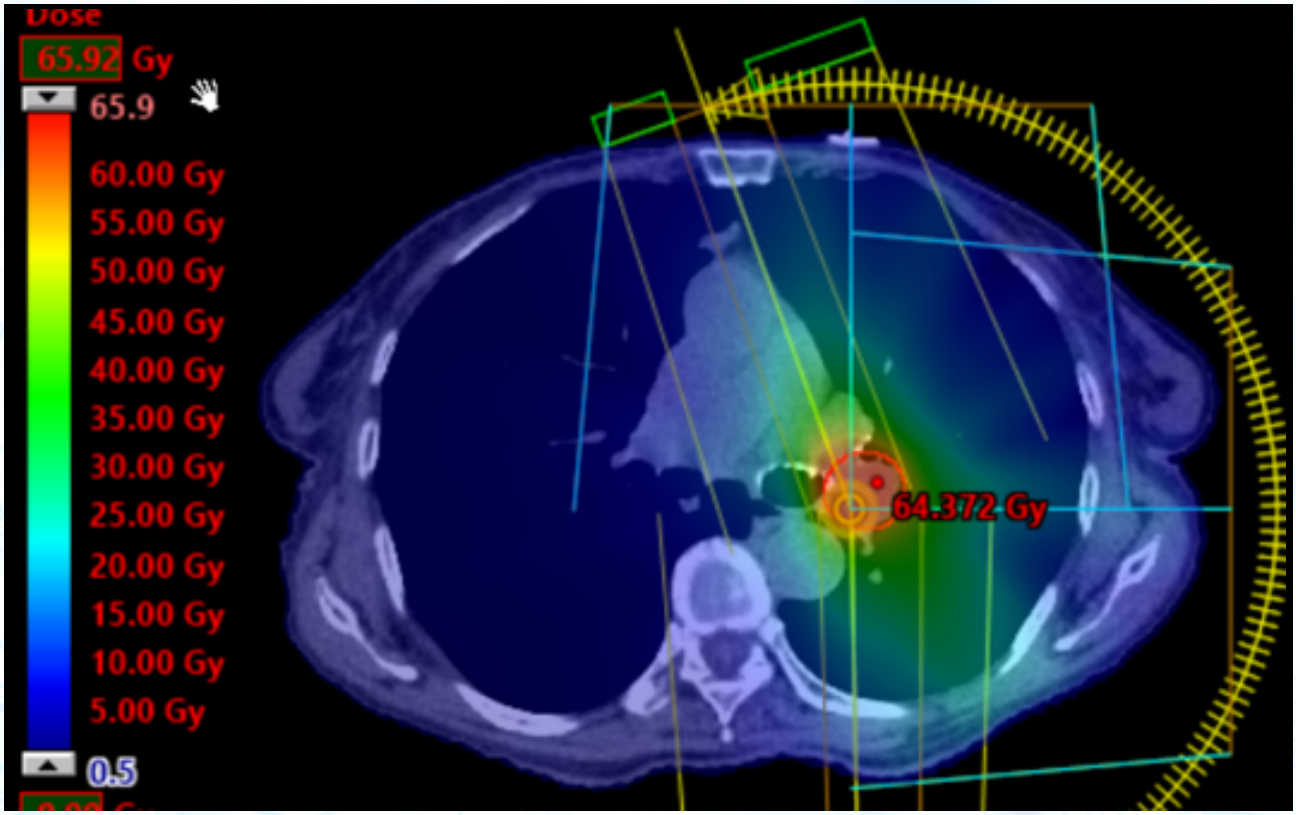
Dr Art Kaminski
Genesis Care Queensland
Suite 1, Level G
The Wesley Medical Centre
40 Chasely Street
Auchenflower QLD 4066
T 07 3377 4200
F 07 3377 4210
E receptiononcologywesley@genesiscare.com
www.genesiscare.com/au/treatment/cancer

References:

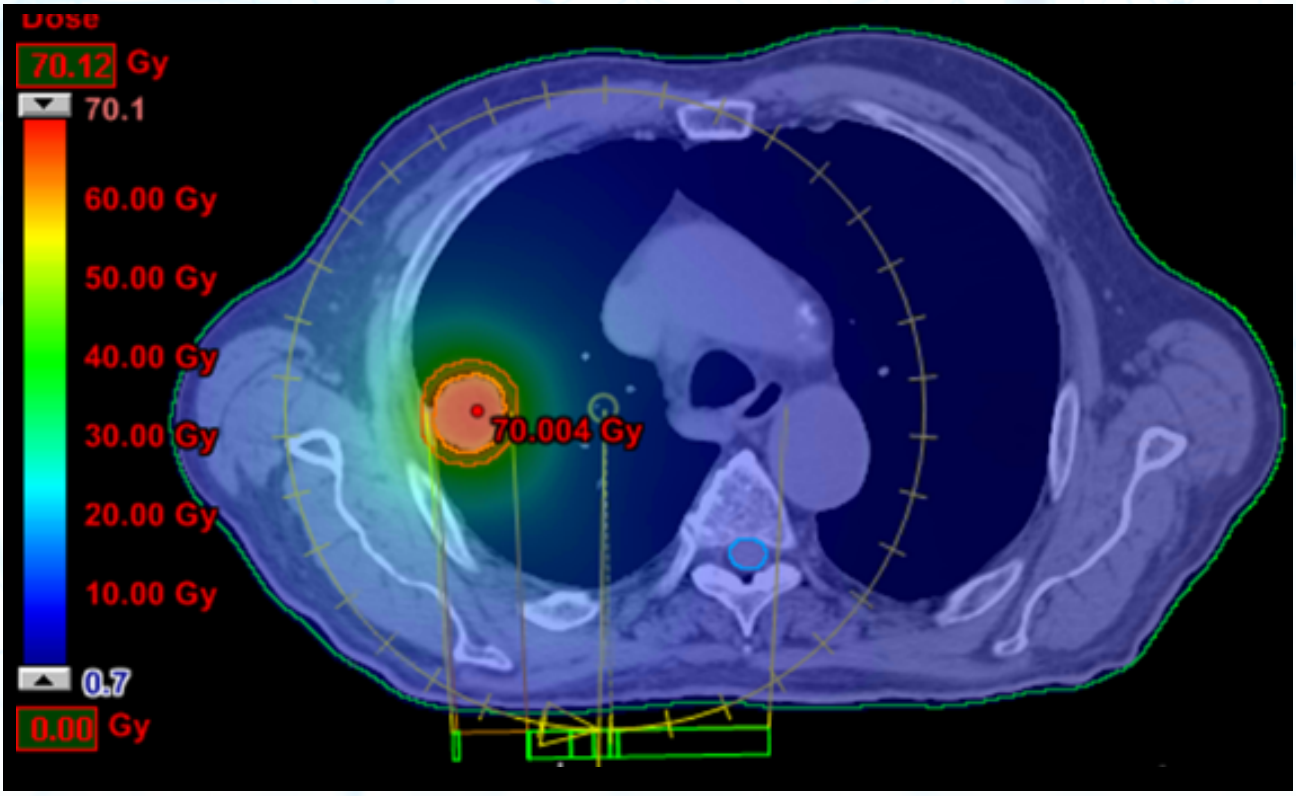
1. **Stereotactic ablative radiotherapy versus standard of care palliative treatment in patients with oligometastatic cancers (SABR-COMET): a randomised, phase 2, open-label trial**
David A Palma MD, Robert Olson MD, Stephen Harrow PhD, Stewart Gaede, PhD, Alexander V Louie MD, Cornelis Haasbeek MD et al.

2. **Stereotactic ablative radiotherapy for the comprehensive treatment of 4-10 oligometastatic tumors (SABR-COMET-10): study protocol for a randomized phase III trial**
David A Palma 1, Robert Olson 2, Stephen Harrow 3, Rohann J M Correa 4, Famke Schneiders 5, Cornelis J A Haasbeek 5, George B Rodrigues 4, Michael Lock 4, Brian P Yaremko 4, Glenn S Bauman 4, Belal Ahmad 4, Devin Schellenberg 2, Mitchell Liu 2, Stewart Gaede 4, Joanna Laba 4, Liam Mulroy 6, Sashendra Senthi 7, Alexander V Louie 8, Anand Swaminath 9, Anthony Chalmers 10, Andrew Warner 4, Ben J Slotman 5, Tanja D de Gruijl 5, Alison Allan 4, Suresh Senan 5

SABR AND CONVENTIONAL PLAN COMPARISON



CONVENTIONAL TREATMENT WHERE THE INTERMEDIATE DOSE IS SPREAD OVER A WIDE AREA



STEREOTACTIC TREATMENT WHERE THE HIGH DOSE IS CONTAINED WITHIN THE TUMOUR AND THE INTERMEDIATE DOSE CONFORMS MORE CLOSELY TO THE TUMOUR

Farewell Dr Leigh Atkinson: a pioneer of pain management at The Wesley Hospital

AFTER 20 YEARS AS DIRECTOR OF THE WESLEY HOSPITAL'S PAIN AND SPINE CENTRE, DR ATKINSON RETIRED FROM PRACTICE IN DECEMBER 2020.

Dr Atkinson has been the cornerstone of neurosurgery in Brisbane for a generation and had a significant influence on the development of Pain Medicine.

He trained a large number of neurosurgeons in Queensland; was awarded Fellowship of the Royal Australasian College of Surgeons (Neurosurgeons) in 1971, a Fellowship of the Australian Faculty of Rehabilitation Medicine (RACP) in 1980, and Fellowship of the Faculty of Pain Medicine (FPM) at the Australian and New Zealand College of Anesthetists in 1999, in addition to numerous other national and international accolades.

He had a special interest in the non-interventional approach to managing persistent pain, through The Wesley's Pain Management rehabilitation programs. Dr Atkinson has been pivotal in ensuring Queenslanders have access to chronic pain services in both the private and public arenas. We have been very fortunate to have Dr Atkinson at The Wesley for the past two decades, as Director of the Wesley Pain Unit since 2001.

Thank you, from The Wesley staff and patients for your tireless work, focusing on the expansion and improvement of pain management services across Queensland.

The Wesley Pain & Spine Centre
The Wesley Hospital
East Wing - Level B1
451 Coronation Drive,
Auchenflower Qld 4066
T 07 3232 6190
F 07 3232 6189
E twh.rehabcentre@uchealth.com.au

We also acknowledge the retirement of the following doctors and thank them for their contribution to The Wesley Hospital.

Dr Douglas Killer

In 1986, Dr Douglas Killer was appointed Medical Superintendent of The Wesley Hospital.

From 1998 to 2001, he was Executive Director Medical Services for the Wesley Group of Hospitals, a position he relinquished when this group was incorporated into the Uniting Health Care group of hospitals. From that time, he continued as the Executive Director Medical Services for The Wesley Hospital until June 2004.

Dr Killer was a member of the UnitingCare Human Research Ethics committee from its inception until his retirement from the committee in December 2020. During that time, he performed the roles of Chair and also Executive Officer. Dr Killer continues to contribute to UnitingCare Health in a teaching role at the Clinical School.

Dr Neville Sandford

Dr Neville Sandford was principal member of Gastrointestinal Endoscopy (GIE) which started at The Wesley Hospital in 1985.

Dr Sandford was a valued and respected member of the gastroenterology community. He was instrumental in guiding and supporting the growth and success of GIE and gastroenterology as a whole.

He will be missed by all staff and doctors at GIE and The Wesley Hospital and we wish him all the best for his future endeavours in his retirement.

GIE is now under the leadership of A/Prof David Hewett and A/Prof Daniel Worthley.

New Visiting Medical Practitioners

A/Prof Benjamin Chua
Radiation Oncology

The Wesley Medical Centre
Suite 1, 40 Chasely Street
Auchenflower QLD 4066
T 07 3377 4200
F 07 3371 4210

A/Prof. Ben Chua is a consultant Radiation Oncologist.

He obtained his radiation oncology fellowship in 2015 after training in Queensland and regional New South Wales, including a fellowship in head & neck cancer. He also has an interest in complex skin, CNS and haematological malignancies.

Ben has a conjoint appointment at the University of Queensland with an active academic portfolio, including over $2m in competitive grant funding, supervision of higher degree students, leadership of clinical trials as a chairperson and principal investigator, publications in international medical journals and presentations at international meetings.

Dr Ross Fowler
Urology

Total Care Urology
Wesley Medical Centre
Sessional Suites
40 Chasely Street
Auchenflower QLD 4066
T 07 3184 6488
F 07 3184 6498
E rfowler@totalcareurology.com.au

Dr Ross Fowler is a consultant Urological Surgeon with sub-specialty fellowship training in robotic, laparoscopic and open management of prostate, kidney and bladder cancer.

He is also highly skilled in minimally invasive management and prevention of complex urinary stone disease using techniques such as Supine PCNL and Endoscopic combined intrarenal surgery (ECIRS). Ross takes a friendly approach to his care; he enjoys getting to know his patients, helping them understand their urological condition and making them feel as comfortable as possible.

After graduating from the University of Queensland School of Medicine in 2009, Ross completed his advanced surgical training in Urology and was awarded a Fellowship of the Royal Australasian College of Surgeons (FRACS) and the Urological Society of Australia and New Zealand (USANZ). He then undertook an additional one-year international fellowship in robotic and laparoscopic urological oncology in the UK at the Royal Berkshire Hospital, one of only a few prestigious centres accredited by the European Robotic Urology Section (ERUS) for training robotic surgeons. During his time there he gained extensive experience in the surgical management of prostate, bladder and kidney cancers. He performed minimally invasive techniques using the Da Vinci robot including the novel "Retzius sparing prostatectomy" for improved early return of urinary continence. He also trained in robotic cystectomy, partial nephrectomy and reconstruction. As part of his oncology training he also performed single stage low dose rate Brachytherapy seed insertion for specific prostate cancer patients.

Dr Rishendran Naidoo
Cardiothoracic Surgery

Brisbane Heart & Lung Surgery
Suite 303, Level 2,
St Andrew's Place
33 North Street
Spring Hill QLD 4000

T 07 3309 300

E thoracic_surgery@yahoo.com.au

Dr Rishendran Naidoo is a cardiothoracic Surgeon.

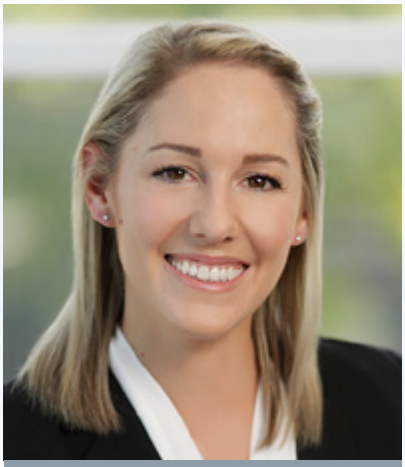
Originally from Durban, South Africa, having completed his basic medical training and specialist training in cardio-thoracic surgery there, attaining the Fellowship of the College of Cardiothoracic Surgeons in 2005 and subsequently the Master of Medicine (MMED) in Cardiothoracic Surgery in 2008.

After relocating to Australia in 2006, Rishendran completed the Fellowship of the Royal Australasian College of Surgeons in 2010, starting as a staff specialist in November 2010 at The Prince Charles Hospital.

He is currently the Acting Director of Cardiothoracic Surgery at Prince Charles Hospital and also have a VMP appointment at St Andrew's Hospital, Spring Hill.

His practice involves adult cardiac and general thoracic surgery and is part of the lung transplant programme.

Interests include minimally invasive thoracic surgery - thoracoscopic lung resection and mediastinal surgery, total arterial coronary surgery and mitral valve surgery.



Dr Danaë Papachristos
Rheumatology

Suite 77, Level 4
Sandford Jackson Building
The Wesley Hospital
30 Chasely St
Auchenflower QLD 4066

T 07 3870 3166

F 07 3371 6650

E reception@drdanae.com.au

After graduating from the University of Melbourne in 2012, Dr Danaë Papachristos completed basic physician training at St. Vincent's Hospital in Melbourne.

She then undertook her advanced specialty training in rheumatology at both St Vincent's Hospital and the Royal Melbourne Hospital, where she gained extensive experience in scleroderma, systemic lupus erythematosus, rheumatoid arthritis, spondyloarthritis and biologic therapies.

Recently Danaë has completed a clinical and research fellowship in Systemic Lupus Erythematosus at the renowned University of Toronto Lupus Clinic in Canada.

She returned to Australia and moved to Brisbane in 2020, and she now consults in the Sandford Jackson Building at The Wesley Hospital.

Danaë has a special interest in systemic connective tissue diseases, vasculitis and rheumatoid arthritis. She is a member of the Australian Rheumatology Association.

Dr Ranjith Ralapanawa
General Medicine

Suite 30, Level 2
The Wesley Medical Centre
40 Chasely Street
Auchenflower QLD 4066

T 07 3870 0185
F 07 3036 5837
E drrreception@gmail.com

Dr Ranjith Ralapanawa is a specialist General Medicine physician.

Dr Ralapanawa recently relocated from Rockhampton, setting up his practice in Brisbane and bringing a wealth of experience to The Wesley Hospital.

He graduated from the University of Peradeniya, Sri Lanka in 1995 and has completed his post graduate training in General/ Internal Medicine at the Post Graduate Institute of Medicine, University of Colombo, Sri Lanka in 2006.

Ranjith completed his FRACP (Fellowship of the Royal Australasian College of Physicians) in 2013 and is currently working as a Specialist Physician (General Medicine) at The Wesley Hospital in Brisbane and at The Mater and Hillcrest Hospitals in Rockhampton.

He has extensive experience in the management of complex medical cases/diagnostic dilemmas and maintains an interest in all aspects of General & Acute Care Medicine including hypertension, diabetes, stroke and perioperative medicine.

In 2018, he completed his Perioperative Medicine course (Monash University).

Ranjith is a Senior Lecturer with the University of Queensland and is involved in the teaching programs of General and Acute care medicine for medical students, JHOs and Registrars (Physician Trainees).

Dr Daniel Schweitzer
Neurology

Suite 24, Level 2
The Wesley Medical Centre
40 Chasely Street
Auchenflower QLD 4066

T 07 3871 0033
F 07 3371 0522
E neurologyreception@impactmedical.com.au

Dr Daniel Schweitzer is a General Neurologist.

In addition to general neurology, his special interests are Cognitive Neurology, Clinical Electrophysiology and Neurophysiology, inpatient consultations and the clinical intersections of Neurology and Psychiatry. He performs and interprets nerve conduction studies, EMG and EEG.

He undertook his Neurology training in Queensland and New South Wales and completed a PhD in Medicine and Philosophy at the University of Queensland. He has forged collaborations with Psychiatry and in particular, developed the Neuropsychiatry Certificate at the Mater Hospital.

He has multiple publications in peer reviewed journals and has ongoing interests in research in the area of cognition across neurological conditions.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19 Longland Street
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P: 07 3193 7777
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