SUMMER 2015

The Wesley HOSPITAL
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Medilink

Wesley Kids

Spotlight on The Wesley Hospital's Children's Services

Articles in this issue:

Paediatric Resident Medical Officer Dr Alisa Yocom with Ben

Welcome

Dr Luis Prado

Director of Medical Services

Welcome to the summer edition of Medilink. This edition showcases the Wesley's paediatric services and features clinical articles from our new Wesley Visiting Medical Practitioners who specialise in paediatrics.

With the amalgamation of the Royal Children's Hospital and Mater Children's Hospital in South Brisbane, the Wesley is now the largest hospital providing specialist children's health services to Brisbane's northside community.

Paediatrics at The Wesley Hospital has expanded over the past two years and our services, based around family-centred care, include comprehensive inpatient and outpatient general paediatric, sub-specialty medical paediatric, and paediatric surgical services.

We have a dedicated ward catering only to children and adolescents with resident medical officers to assist with the care of our younger patients. We have continued to grow with the addition of specialist inpatient paediatric services including oral food challenges for allergies and insulin pump insertion and management.

Outpatient and day patient services have also expanded to include developmental paediatrics, respiratory and gastroenterology. The hospital now performs paediatric bronchoscopies, endoscopies and colonoscopies.

On a final note, I would like to acknowledge the contribution that Dr Ranald Pascoe has made as the Director of Intensive Care at The Wesley Hospital for the past 20 years. Dr Pascoe steps down as Director in January 2015 as he transitions into retirement but will continue in a clinical role. Ranald most recently received the UnitingCare Health 'Outstanding Service to Others' CEO award for his contribution. I would like to sincerely congratulate Dr Pascoe on this achievement. ■

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

GP Referral Advisory Service

The Wesley Hospital offers a 24/7 referral advisory service to assist GPs in selecting the appropriate specialist in Brisbane for your patients' needs.

For urgent referrals email gp.wesley@uchealth.com.au and we will reply within one hour (during business hours) with appropriate specialist contact details, or call 07 3232 7000 and page the Director of Medical Services on-call at any time.

To assist with your enquiry please provide the following patient details:

- **Clinical background**
- **Presenting complaint**

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The Wesley's Director of Intensive Care Dr Ranald Pascoe receives Outstanding Service to Others Award from UnitingCare CEO Anne Cross.

Dr Denzil Gill, ICU medical officer; Prof Bala Venkatesh, Deputy Director ICU; Dr Ranald Pascoe, Director ICU; Dr Katherine Robinson, ICU medical officer and Dr Thomas Brucklacher, ICU medical officer.

GP Networking and Education

The Wesley Hospital 2015 GP calendar is full of interesting and varied opportunities for GPs to meet VMPs and specialists of the hospital and update their knowledge and skills in a number of areas of medicine. We will once again be holding two of our most popular events - our Continuing Professional Development (CPD) CPR training day and Wesley Women in Medicine High Tea.

More than 50 GPs attended the 2014 CPR day to refresh and update their basic life support skills through simulation and skills-based sessions that gain five RACGP Category 2 points.

On October 18, The Wesley held its inaugural Wesley Women in Medicine High Tea as a networking opportunity for the Wesley's female specialists and our female GP community. The day was a huge success and we have been asked to run similar events every six months. Keep an eye out for our next Women in Medicine event on March 28.

In 2015 we are increasing the number of evening events for GPs to attend and now run the events on Tuesday, Wednesday or Thursday nights for your convenience. Our Saturday Active Learning Modules will continue and our regional program for 2015 will have a vascular and cardiac focus. Please refer to our clinical education calendar on the inside back cover of this edition.

If you are interested in having specialists visit your practice or would like more information on our CPD program, please contact Business Development on 07 3232 7222; or via wendy.zernike@uchealth.com.au or 0428 227 372; or vicki.goss@uchealth.com.au or 0419 020 156. ■

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1 Dr Pauline Joubert, Obstetrician and Gynaecologist and Dr Wen-Yi Chew-Lai, Developmental Paediatrician

2 Dr Jenny Gough, Breast and Endocrine Surgeon and Dr Carina Chow, Colorectal Surgeon

3 Dr Agnieszka Malczewski, Medical Oncologist and Dr Rachel Esler, Urologist

4 General Practitioners Dr Tram Nguyen, Dr Christine Chen, Dr Anh To, Dr Adeline Ng, Dr Graciela Fanning, Dr Katrina Harrison

5 Director of Business and Service Innovation Wendy Zernike, Business Development Manager Vicki Goss and Events Coordinator Simone Kerger

6&7 GPs brush up on their skills at CPR Day

5

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Message from Medical Director of Paediatrics Dr David Coman

Associate Professor David Coman

MBBS MPhil FRACP

Over recent years we have had significant growth in paediatrics at The Wesley Hospital.

We are particularly excited about the comprehensive range of inpatient and outpatient medical and surgical sub-specialty services that are now available for children. We have strategically grown our clinical capabilities and are well placed to provide the highest standard of paediatric care in the private sector.

The Wesley is unique in that we are the only private paediatric service with 24/7 emergency-room support, and dedicated onsite junior medical staff. We have five junior medical staff positions to provide around-the-clock cover, and actively encourage GP trainees to apply for these positions.

Teaching is a vital component of a mature tertiary-level facility, and the paediatric clinicians at the Wesley actively teach medical students from the University of Queensland, Griffith University and Bond University. No other public or private paediatric facility provides our brand of 1:1 student teaching.

Research is encouraged and many of our clinicians are actively involved in clinical and basic science research.

In addition some of our clinicians and nurses volunteer their time and expertise in the third world to provide paediatric clinical support and teaching for colleagues in the Western Provinces of Solomon Islands.

If you would like to discuss any aspect of our paediatric service, please feel free to call me on 07 33715122 or email: david.coman@hotmail.com ■

BELOW: Dr David Coman, Medical Director of Paediatrics, The Wesley Hospital, and Academic Lead for Paediatrics at the UnitingCare Health Clinical School, caring for a patient at the Helena Goldie Hospital in the Solomon Islands.

Q&A with Associate Professor David Coman

1. When did your involvement with the Wesley begin? How long have you been director?

I began my private practise at the Wesley Hospital in 2010 after many years of full time work in the private sector. I have been the Medical Director of Paediatrics since 2012.

2. What is different/special about the Wesley paediatric service?

We have a comprehensive range of medical and paediatric sub-specialties available in our dedicated paediatric ward. One of our capabilities is we cater for the complex medical needs of adolescents, a vulnerable group who get lost in the medical system. The Wesley is unique in that we are the only private hospital with paediatric junior medical staff on site and a fully functional emergency department capable to managing acute paediatric presentations.

Teaching is also an integral part of our service, and we are the only hospital teaching medical students from UQ, Griffith University, and Bond University.

3. What are the five most common childhood illnesses that bring kids to the Wesley?

Asthma, bronchiolitis, febrile illnesses, gastroenteritis, complex care coordination.

4. What are the five most common surgical procedures?

Tonsillectomy, grommets, orthopaedic surgical repair of broken bones, hernia repair.

5. What is the average length of stay for kids at The Wesley Hospital?

We try to keep hospital stays to the minimum for children and their families, incorporating the philosophy of hospital in the home. The average length of stay is two to three days, but children are only discharged when it is safe for them to go home.

6. What paediatric service is in most demand?

General Paediatrics is the corner stone to any children's hospital, any paediatric service, and any paediatric sub-speciality. One of our strengths is the care provided by our general paediatricians and general paediatric surgeons.

7. What is your long-term vision for the service?

I see the paediatric inpatient and outpatient services at The Wesley Hospital growing significantly, especially in the area of elective paediatric surgery.

I would like to see a vibrant and active culture of clinician, nursing, and allied health paediatric research occurring on the campus. Many of the Wesley's paediatric Visiting Medical Practitioners are actively involved in clinical and basic science research.

I think there is significant room to grow the support of research for our Wesley children with the support of generous donations via The Wesley-St Andrew's Research Institute. Every sick child has parents, siblings, grandparents, aunts, uncles, cousins, and friends. Childhood illness touches every family in some way, research and teaching help us improve the lives of children and their families.

8. Why did you become a Paediatrician?

Simple, it's the best job in the world. Children are an amazing source of inspiration, joy, and humility. I see this most of all in the children I care for with rare diseases. Children reflect the best of what's on offer in our humanity and our society - we often lose our way as adults.

FAST FACTS Paediatrics at Wesley

+ 900 plus admissions every year
+ comprehensive range of medical and surgical services for children from birth to late teens
+ family-friendly dedicated paediatric and adolescent ward
+ private rooms with ensuites
+ fulltime senior Resident Medical Officer
+ junior medical staff coverage
+ 24/7 emergency department availability
+ children's play facilities and areas that cater for adolescents
+ active unit safety and monitoring system to maximise best care
+ active university teaching programme
+ strong social justice ties, with our doctors and nurses volunteering in the third world
+ dedication to clinical research to improve the health and wellbeing of children

Wesley Kids

CONTINUING TO CARE FOR CHILDREN

Our specialities:

+ General medical conditions
+ General/ ENT surgery
+ Respiratory/Bronchoscopy/Gastroscopy
+ Insulin pump service
+ Paediatric sleep studies
+ Oral food challenges for allergies
+ Orthopaedics

THE WESLEY HOSPITAL • WARD 2W • LEVEL 2 • CHASELY STREET, AUCHENFLOWER QLD 4066

Paediatrics team a dedicated bunch

The Wesley has a vibrant culture of putting children first

Sarah Mueller RN; Pamela Watson CN; Sonia Broadby CNM; Julie Mackay, pastoral care and Dr Alisa Yocom RMO

At the Wesley, providing high quality care for children and adolescents is a top priority.

Enhancing the clinical expertise is a team of highly trained nursing and allied health staff who are experts in caring for sick children.

Sonia Broadby has been Clinical Nurse Manager of the Wesley's paediatric unit (Ward 2W) since April 2013.

She has 18 years experience in paediatrics with a background in paediatric intensive care and paediatric retrievals, more than seven years of management experience, and a Master of the Arts degree from the University of West London. "I am totally committed to the continuous improvement and growth of the Wesley's paediatric service," Sonia said.

This level of dedication is typical within the Wesley paediatric nursing staff. The team comprises 16 experienced paediatric nurses, many with post-graduate qualifications in paediatric nursing. The unit has a dedicated paediatric nurse educator running in-house education programs and staff members have training in paediatric advanced life support, paediatric sleep studies and adolescent oncology.

The unit has a paediatric occupational therapist, a paediatric dietician and paediatric physiotherapists.

"We have a friendly and very dedicated team of nurses who work in partnership with their colleagues to deliver excellent care which is evidenced by consistently excellent patient experience and feedback," Sonia said.

For more information contact Sonia Broadby, Clinical Nurse Manager Paediatrics, on 3232 7054 or 3232 7384; fax 3232 6208 ■

Resident paediatric doctors offer children an extra safety net

As the Wesley Hospital's resident paediatric doctor, Dr Raymond Chuk has to be across a full spectrum of childhood ailments

Dr Chuk worked as a Senior Resident Medical Officer (RMO) in paediatrics at the Royal Children's Hospital for 15 years before coming to the Wesley in July 2013 as the hospital's first full-time paediatric RMO.

When he heard the Wesley needed doctors to work in the children's ward to offer support to Paediatric specialists, nursing staff and patients, he jumped at the opportunity to take on the role.

The Wesley Hospital is the only private paediatric service to have a full-time on-site doctor who specifically looks after children. Along with the hospital's junior doctors Dr Chuk provides the day-to-day care to support our visiting medical practitioners. "My focus is solely on children and that can range from our patients in the special care nursery to the Wesley Emergency Centre to our paediatrics ward," he said.

"We have a very streamlined service – emergency, endoscopy, theatre, recovery are all set up for children. We have all the necessary processes in place to care for a sick child. We have implemented Queensland Health's Children's Early Warning system, not just in the paediatric ward, but right across the hospital to monitor children's progress."

Dealing with seriously ill children quickly before they deteriorate is a high priority for Dr Chuk and the team.

"Children are more resilient but we want to make sure we detect early signs of deterioration as they can go downhill very quickly. You don't have as much warning as with adults, so we have to act fast," he said.

Dr Raymond Chuk, Senior Medical Officer, The Wesley Hospital

"Our Visiting Medical Practitioners work closely with the Wesley Emergency Centre and the children quickly get referred to the right paediatric specialist.

"All paediatric services are established here at the Wesley – respiratory, endocrine, developmental, gastroenterology, allergy, rheumatology - so GPs know we can look after their patients with confidence.

"As a private hospital we provide very comprehensive services for paediatric patients.''

Dr Chuk said the Wesley's paediatric service is getting busier and busier. Specialists were attracted by the support they get here and in the past year more surgeons had started operating lists.

"Specialists like the ease with which they can get things done,'" he said.

"For example, they can get test results from Wesley Medical Imaging on site in a timely manner rather than having to wait for further investigations.

"For more complex patients, we can liaise with the patient's GP and give a more detailed summary as part of our coordinated care."

Dr Chuk leads a team of doctors providing dedicated paediatric care.

"We are strong on medical student education and staff training here at the Wesley – doing a paediatric rotation through our paediatric service helps to set our junior RMOs up for their future GP training. The Wesley works closely with the Royal Australian College of General Practitioners for training opportunities" ■

An established tradition

32 years of paediatrics at the Wesley

Dr Bruce Lewis looks back over his long involvement with services for children at the Wesley

Senior Paediatrician Dr Bruce Lewis

The Wesley has a long tradition of paediatrics with a full children's ward operating since the hospital opened in 1977.

As the hospital's longest serving paediatrician Dr Bruce Lewis has watched the paediatric service grow into the full spectrum service it is today.

"When I moved to the Wesley campus in 1987, there were several visiting paediatricians seeing children in the children's ward, but the hospital did not yet have an emergency department and there was no maternity unit here, despite it being a time of high birth numbers."

Gynaecologists Dr Maurice Webb and Dr John Allan encouraged the hospital board to plan for an expansion of the hospital services into the areas of emergency medicine and women's health.

Early in 1987 Dr Lewis was asked by Dr Reg Williams, a senior obstetrician and gynaecologist, to join a small steering committee tasked with the design of the now approved maternity service at the Wesley.

"Reg was a driving force behind the starting of the maternity unit, from the outset the philosophy being to offer a comprehensive service of the highest standard," Dr Lewis said. "This included the location of the caesarean section operating theatre as an integral part of the delivery suite with the adjacent special care nursery being designed, staffed and equipped to handle all immediate post delivery eventualities."

The opening of the Wesley Emergency Centre in 1994, known ever since as WEC, staffed with specialist emergency physicians and emergency nursing staff, greatly enhanced the access of families to the hospital at times of their children's illness. In consultation with a paediatrician or paediatric surgeon, the diagnostic work-up including any laboratory or imaging assessments is often well underway if not completed before moving into the children's ward. This contrasts markedly with the "pre-WEC" era when, following a phone call from a referring family practitioner or parent, the initial assessment by the paediatrician or surgeon would occur in the treatment room of the children's ward.

"More sub-specialties are available now at the Wesley than ever before. All parents want their child seen as quickly as possible, not months down the track. The beauty of this campus is that, if the need for sub-specialty consultation arises, there are people from various sub-specialties who can be quickly consulted on site."

Since October 2012, the inpatient paediatric service has been enhanced by the employment of full-time paediatric resident medical officers who provide an excellent added dimension to the inpatient service to children, their families and visiting medical staff.

Looking to the future, further growth and complexity is expected at the Wesley in what is now the largest and most comprehensive metropolitan paediatric service north of the Brisbane River. ■

For referrals contact Dr Bruce Lewis on 07 3371 5144 or fax 07 3371 5590

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The Wesley Emergency Centre

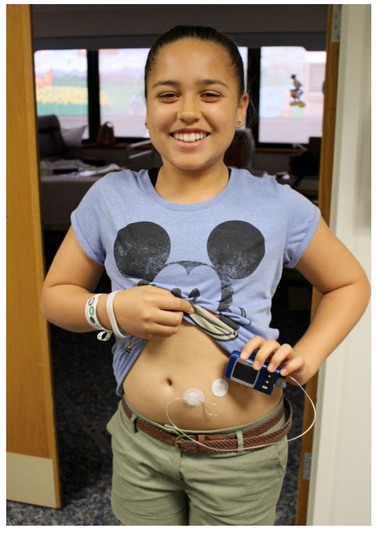
Providing 24/7 care for patients and 24/7 support for GPs

+ 19 emergency beds
+ Dedicated paediatric room
+ Latest patient monitoring equipment
+ Short wait time
+ 15 senior emergency doctors
+ Treatment of a comprehensive spectrum of paediatric presentations
+ 24 hour access to senior paediatricians and access to dedicated paediatric inpatient ward

Call 3232 7333

Insulin pump service makes life simpler for diabetic children

For an increasing number of children with Type One diabetes, an insulin pump – a small portable device that is programmed to deliver the correct amount of insulin – has made routine needles and watching what they eat a thing of the past



TOP: Georgia Marriot with her insulin pump

ABOVE: Dr Andrew Cotterill, pictured with Georgia Marriot and Isabelle Newnham

Since the paediatric insulin pump service began at The Wesley Hospital 12 months ago, paediatric endocrinologist Dr Andrew Cotterill has started 25 pumps and the number is steadily rising.

"An insulin pump is a way of giving insulin that is simple, straight-forward and quick," he says. "It takes the worry and routine needles out of day-to-day living.

"The insulin pump is a small device with a tube connected to the skin like a catheter. It is set to drip steadily in the background giving small, precise, variable amounts of insulin, mimicking the pancreas.

"It looks similar to a mobile phone and sits in the child's pocket or on a special belt. They can choose the colour - pink and blue are popular – and it's waterproof so they can go swimming with it. Once connected, the only thing that needs to be done is to change the internal syringe every two days."

Pumps are best started within a few days of diagnosis of the auto-immune disease.

"If the child starts early, even a couple of weeks after diagnosis, they can have a different perspective on diabetes, because they don't have to experience injections," Dr Cotterill said. "What a relief to not have five or six injections a day or parents having to work out a dose or time. The insulin pump sets them free from that."

Dr Cotterill started an insulin pump for Georgia Marriot, 12, in October and since then his patient has had more choice and freedom. "She can eat whenever she wants and doesn't need to be restricted to certain types to eat," explains her mother.

Most children coming to the Wesley to start an insulin pump stay for one night so the device can be monitored overnight.

"We can provide instruction on the set up and how the device works," Dr Cotterill said. "It is safer and more relaxing for the family to have help close by if required. As follow-up, we can provide extra outpatient support and education with one of the hospital's diabetes nurse educators and dietitians, for example, on how to count carbohydrate intake.

"It is also reassuring for parents to know that if future medical care is required, the Wesley is set up for children with insulin pumps." ■

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

FAST FACTS Diabetes in children

- One in 1000 primary school kids in Australia have Type 1 diabetes
- One in 500 high school kids in Australia have Type 1 diabetes
- 25 out of 100,000 children in Australia get Type 1 diabetes each year
- The rate of increase in new cases of childhood Type 1 diabetes each year is three per cent.
- The number of children with Type 1 diabetes diagnosed each year has doubled in the last 10 years.
- One in 20 chance of developing Type 1 diabetes if you have a relative with the disease.

Wesley maternity patients get extra support at home

The Wesley Hospital Maternity Unit launched its Home Visiting Service this month and mums and bubs in Brisbane are already reaping the benefits

Wesley Maternity Unit midwife Joanne Hardcastle said the initiative provides mums two visits to their home by a Wesley Hospital midwife while their baby is still less than four weeks old.

"Our experienced midwives provide full health checks for mum and baby, feeding support, early parenting education and most importantly, a friendly face to offer encouragement."

Ms Hardcastle, who oversees the Home Visiting Service as the Maternity Clinical Educator, said the team had visited 55 mums within the service's first three weeks of operation.

"Our focus is to educate, support and instil confidence in new mums and ensure they are settling in safely and comfortably with their baby," she said.

"Patients say they appreciate the hands-on support and the ability to raise any early parenting or child development concerns with experienced midwives rather than guesswork or 'Dr Google'."

The service is available to all patients who give birth at the Wesley Maternity Unit and live within about 25 kilometres of the hospital at Auchenflower.

Mums will receive two postnatal visits soon after giving birth to their baby. They can ask any questions that come to mind once they leave hospital. Mums appreciate the extra support in their own home, which gives them peace of mind that everything is progressing well.

Wesley Maternity Unit midwife Joanne Hardcastle with Ainsley Hellen, son Alexander and newborn William

Ms Hardcastle said breastfeeding was one of the main areas where mums needed extra support and patients could be referred to the Maternity Unit's dedicated Lactation Clinic if they required further assistance following the home visits.

The Wesley Hospital Maternity Home Visiting Service is funded by the Queensland Government's $28.9 million Mums and Bubs initiative.

For more information on The Wesley Hospital Maternity Home Visiting Service contact Joanne Hardcastle on 3232 7473

Cryoablation therapy now available at The Wesley Hospital

Cryroablation is a new method being used for the treatment of Paroxysmal Atrial Fibrillation (PAF).

Unlike radiotherapy techniques, cryoablation uses refrigerant instead of heat to isolate the pulmonary vein and freeze tissue to terminate unwanted electrical pathways.

It has similar efficacy in the treatment of PAF as radiofrequency catheter ablation with a cure rate of 70 per cent.

Advantages of cryoablation over radiofrequency catheter ablation:

+ Performed in less time that RF ablation as pulmonary veins can be isolated with a single balloon application
+ A light sedation can be used for patients with high anaesthetic risk
+ Patients tend to make a quicker recovery

Appointments: Dr Deepak Arumugam 3858 8600 · Dr Paul West 3371 8247 · Dr Vince Deen 3876 8285

Sleep studies put parents' worries to rest

Up to 10 per cent of children snore and about a quarter of these children suffer from obstructive sleep apnoea

Obstructive sleep apnoea refers to the narrowing of the airway during sleep which can cause a drop in oxygen and or disruption of dreaming sleep (dreaming sleep is crucial for learning and feeling refreshed after sleep).

Repetitive events occurring during sleep have been shown to have a negative impact on a child's behaviour (typically hyperactive, impulsive or with poorer concentration), development and school performance. More severe cases can be associated with poor growth and strain on the heart.

The best test for obstructive sleep apnoea is a sleep study.

Dr Scott Burgess has been doing overnight sleep studies at the Wesley in Ward 2W since May 2014.

During the study children are managed by one of our experienced paediatric nurses who has undertaken further training in sleep medicine.

The child is attached to monitoring equipment to examine their breathing and the effect of any breathing problems on the child's sleep and blood levels of oxygen and carbon dioxide.

Parents are able to sleep in the same room as their child during the study.

Working in collaboration with Genesis SleepCare, Dr Burgess is able to arrange and report full sleep studies for children aged two years and older. Screening studies are available for younger children. ■

For urgent referrals phone Dr Scott Burgess on 07 3177 2000

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Oral test tackles childhood allergies

The Wesley Hospital has commenced paediatric food challenges with a new service offered to children who may have outgrown a previously diagnosed food allergy

Paediatric Immunologist and Allergist Dr Kim Robertson started performing oral food challenges at the Wesley earlier this year. "The oral food challenge is the gold standard for determining if a patient is allergic to the food," she explains.

"We challenge children who have a history of reaction but are no longer positive on skin prick test for that food, indicating that they may have outgrown the allergy. The other patients challenged have had a mildly positive skin prick test but may have never actually eaten or reacted to that food and don't want to go through life avoiding that food if they are not truly allergic.

"The only way to confirm this is to expose them to the food. If the food in question is a nut, or the child has had anaphylaxis before, I prefer to do the challenge in hospital rather than at home."

Children with allergies are admitted for a morning in the Wesley children's ward for the procedure whereby they are given incremental amounts of the food in question.

"We use a graded process where we feed the child increasing amounts of the food every 20 minutes," Dr Robertson said. "If there is a reaction we can recognise this early and treat the reaction immediately. Kids who are admitted receive one-on-one nursing supervision which is important to monitor for anaphylaxis or severe allergic reaction. I am available on site at the Wesley to see the patient at the start and end of the challenge, and at any point during the morning if there is evidence of reaction."

Being in a hospital can help ease parents' worry that they are giving their child foods that may make them sick, says Dr Robertson, but one of the biggest hurdles can be encouraging the child to eat enough of the food to test.

Dr Kim Robertson with Willow, 3, during her oral food challenge

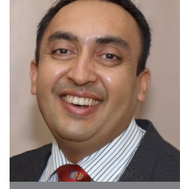
"Older kids can get quite anxious about coming in for a challenge. With the little ones, sometimes it can be difficult for nursing staff to encourage the child to eat enough of the food to challenge them."

Dr Robertson says cow's milk, eggs and nuts are the most common childhood food allergies. "Egg is the most common food allergy, and the risk of anaphylaxis is low, so the majority of these challenges are performed at home. The most common food trigger for anaphylaxis is a nut, and these challenges are best conducted in hospital. Other allergies are taken into account, with a third of egg allergic children also being nut allergic, and a third of peanut allergic patients having an allergy to a tree nut. The majority of food allergies in children are not severe and will disappear with time. Nut, seed and seafood allergies are more likely to be lifelong."

With a rising number of children developing allergies, the service is set to keep expanding. "A study looking at hospital admissions for anaphylaxis in the 0 to 4 year age group found that they increased by 400 per cent in the last decade" she said. "In the latest study out of Melbourne close to 10 per cent of 12 month old children reacted to a food on oral challenge."

Hygienic environments with less exposure to infection in early childhood, modern low fibre diets leading to reduced microbial diversity in the gut, changed methods of food processing, timing of introduction of allergenic foods into the baby's diet and vitamin D deficiency are some of the many theories surrounding the increased rates of paediatric food allergy. ■

For referrals contact Dr Kim Robertson on 07 3232 7686 or fax 07 3232 7585



Dr Bhavesh Patel

Paediatric Surgeon

Undescended testes

Surgeon Dr Bhavesh Patel looks at the best management of undescended testes

Undescended testes (UDT) or cryptorchidism is a rather nebulous term given to the condition where testes are not present in the scrotum.

The approximate incidence of undescended testes at birth is four per cent; higher for preterm infants. Spontaneous descent occurs in the majority of cases by the age of three to six months.

Often this condition is detected at the six-week baby check and a referral is made to a paediatric surgeon. It is appropriate to refer any boy with UDT after three months age.

Management decisions are based on distinction between a palpable versus impalpable testis.

A palpable testis is commonly located between the inguinal canal and the scrotum. Starting with simple observation can often identify the location of the testis. Gradually sliding a hand down from the iliac fossa to the groin will enable palpation of most undescended testes. The size, shape, tension and comparison with the other side are noted. A true undescended testis cannot stay at the bottom of the scrotum and often springs back up to the groin. The hemi-scrotum is often noted to be hypoplastic in such cases, as shown in the picture.

In two per cent of cases the testis is ectopic and may be palpated in the perineum, thigh, lateral abdominal wall or suprapubic region.

The impalpable testis may reside within the abdominal cavity between the lower pole of the kidney and the inguinal canal. Occasionally they are present in the groin obscured due to prominent suprapubic fat. In 10-15 per cent of cases the testis has undergone an in-utero accident; termed a vanishing testis. In such cases the contralateral testis enlarges due to compensatory hypertrophy. A patient with a history of unilateral renal agenesis may also have ipsilateral testicular agenesis.

An example of an undescended testis.

Another common complaint is of testes that are very mobile and not always seen or felt within the scrotum. The strong cremasteric reflex pulls them high into the groin. These are retractile testes and usually do not need any procedure. The scrotum is well formed in these cases. Caregivers often will notice the testes down in the scrotum during a warm bath. It is worthwhile observing the child annually and only considering intervention when the testis cannot be brought down to the bottom of the scrotum or when it is never seen in the scrotum. This tends to be most noticeable during the growth phase after six years of age.

Investigations

There is no requirement for routine laboratory work for a boy with palpable testes or a unilateral impalpable testis with a normal penis.

Cases with true bilateral impalpable testes warrant investigation to rule out disorders of sexual differentiation. Early discussion with a paediatric surgeon and/or paediatric endocrinologist is recommended.

Imaging is also not routinely required for palpable or impalpable testes. Ultrasound scans often give false results due to the direct pressure placed on the scrotum to gain a picture, thereby pushing the testes up into the groin. Also the cold gel triggers a strong cremasteric reflex.

More importantly the ultrasound scan does not alter management, as it is dependent on ability to palpate the testis.

Treatment indications and timing

Surgery: Surgery is recommended between 6-12 months age on the basis of preserved fertility, reduced risk of malignancy and torsion. Early literature recommended surgery at 2-13 years of age due to perception of difficulty with a smaller child and less anaesthetic safety. It is now accepted that earlier surgery is safe in the hands of a paediatric surgeon and anaesthetist.

Fertility: Histological studies have shown that early orchiopexy prevents loss of germ cells that occur with increasing age. Boys with bilateral UDT have reduced fertility rates of approximately 50-60 per cent. Unilateral UDT does not seem to result in a significant reduction in fertility.

Cancer: The association between UDT and testicular malignancy is well known. The relative risk of development of malignancy is approximately six-fold for untreated UDT; seminoma being the predominant type. Performing orchiopexy early reduces malignancy risk and allows early detection. It is advisable to teach self examination after the age of 10 as the lifetime risk of malignancy remains 1-3 per cent.

Treatment options

An examination under anaesthetic is performed to enable palpation of the testis.

For palpable testes an inguinal approach is performed. The processus vaginalis is separated off the spermatic cord and allows mobilization and lengthening of the cord. This is analogous to an indirect inguinal hernia repair. The testis is then tunnelled through to the scrotum and placed in a pocket created using the dartos muscle.

Impalpable testes require localisation prior to further management, usually with laparoscopy.

+ Intra-abdominal testes are usually too high to be brought down as a single stage procedure. The testicular artery is too short to stretch through to the scrotum. In these cases a Fowler-Stephens procedure is performed; the testicular vessels are ligated as the first stage to allow development of collateral blood supply from the cremasteric artery and the artery to the vas deferens. The second stage procedure is performed laparoscopically three months later. Originally this was described as a single stage procedure, however staging the procedure allows a better collateral supply and reduced atrophy rate. The current atrophy rate is 5-10 per cent.
+ If the testis is found in the inguinal canal it can then be brought down with an inguinal approach.
+ The vanished testis is detected by identifying vas and vessels ending in a testicular remnant, which is removed and sent for histological confirmation. The contralateral testis is often prophylactically fixated in the scrotum to prevent future risk of torsion.

Post-pubertal boys with an undescended testis may be better treated with orchiectomy due to the higher malignancy potential. This will be discussed at the time of the consultation with the surgeon.

Complications

Wound infection and haematoma are the most common complaint. The scrotal wound is difficult to keep clean due to frequent contact with contents of a dirty nappy.

Specific complications relate to viability of the testis. Depending on technique the atrophy rate can be between 1-10 per cent. Inadvertent injury to the vas deferens is quoted at 0.1 per cent.

Post operative ascent (recurrence) can occur in two per cent. The procedure can be performed again to release the contracted scar tissue that is generally the cause of the non-lengthening spermatic cord.

Follow up

Patients are followed at six weeks, one year and 10 years to discuss self examination and malignancy risk.

Summary

+ Testes should descend by 3-6 months. If not, a referral to a paediatric surgeon is warranted
+ Treatment depends on palpability, so ultrasound scans are not necessary
+ Surgery is successful in 90-100 per cent of cases
+ Long-term follow-up and self-examination is recommended to detect malignant change as early as possible. ■

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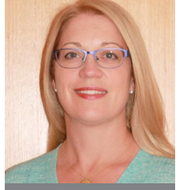
Dealing with persistent or chronic childhood cough



Helen Buntain

Paediatric
Respiratory Physician

Dr Helen Buntain explains why it is important to treat chronic cough

Katie, 18 months old, presents with a moist cough that has been present for six months. There have been very few cough-free days and sleep is often disturbed. She attends daycare and her mother complains she is always being sent home from daycare. She looks well though has a frequent moist cough.

So what – it is just a cough!

There is scant literature about persistent or chronic cough in children over the last four decades despite a reported prevalence of 9.6 per cent in Australian children aged 6-12 years[1] and higher in younger children. Younger children frequently have viral-induced cough and persistent cough is dismissed as "it's just another viral illnesses" or "it's the asthma cough" leading to parental frustration. Furthermore children are frequently sent home from childcare/school, and sleep deprivation is a real issue for the whole family[2]. The burden of chronic cough in children is well documented[3]. Treatment of the cough is associated with a significant reduction in scores of depression, anxiety and emotional distress in parents.

While the majority of cough is merely troublesome without consequence, it may also be the sole presenting symptom of an underlying respiratory disease in which delayed diagnosis is associated with chronic respiratory morbidity.

What triggers cough?

Cough is a protective reflex in response to foreign material in the bronchial tree and assists mucociliary clearance of secretions. Cough receptors are present from the pharynx to the terminal bronchioles (as well as the external auditory canal, pericardium, stomach and oesophagus). The afferent nerves regulating cough include airway mechanoreceptors (activated by inhaled particulate and accumulated secretions), and airway C-fibers (activated by bradykinin, prostaglandin E2 (PGE2), capsaicin, and other irritants). Both bradykinin and PGE2 are found to be elevated in disease state (asthma, gastro-oesophageal reflux, allergic rhinitis).

Cough and viral infections – the natural history

Acute cough in children is usually due to a viral upper respiratory tract infection (URTI). During the first two to three years of a child being exposed to the greater community (daycare, kindergarten or school), they will experience 7-10 URTIs/ year. Several studies have documented the natural history of cough in children. A prospective cohort study of 256 children (aged 0–4 years) with cough for ≤28 days, without asthma, observed cough resolved in 50 per cent of children within 10 days and 90 per cent within 25 days[4]. A longitudinal community study of 600 families, reported a mean respiratory symptom duration of 5.5-6.8 days in children <10 years old[5]. De Blasio et al[6] and Mitra et al[7] observed complete resolution of cough within 21 days in 221 and 223 study participants respectively. A systematic review[8] of the natural history of cough report 10-20 per cent had either a runny nose or cough at three weeks.

The majority of the data collected in these studies was parent-held diaries.

From this information, guidelines have defined

(i) acute cough as <14 days,

(ii) subacute cough – 14-28 days and

(iii) chronic cough after 4-6 weeks.

Aetiology of chronic cough

The causes of cough in children are different to those in adults. An Australian-based multicenter study (five major hospitals and three rural-remote clinics)[9] managed 346 children with chronic according to a cough algorithm[10]. Persistent bacterial bronchitis (PBB) was identified as the primary aetiology in 41 per cent (Figure 1), followed by asthma and then bronchiectasis (confirmed with chest CT scan). Additionally there are several causes of cough unique to young children (Table 1)[11]. These are uncommon though, if missed, are associated with long-term irreversible damage to the airways and respiratory morbidity.

Guidelines have been produced nationally and internationally for the management of chronic cough in children[11-13]. A thorough history and clinical examination assist in differentiating the possible contributors and causes. The physical quality of the cough provides important information (Table 2).

Aetiology of prolonged acute cough/ subacute cough

A. Post viral or post-infectious cough

(i) Infants with acute bronchiolitis – RSV bronchiolitis is a common infection in those <1 year presenting clinically with dry cough, tachypnoea, crackles and wheeze. The median duration of symptoms is 12 days with 18 per cent remaining symptomatic at 21 days, reducing to nine per cent by 28 days[14].

At 28 days, cough was the predominant symptom. In those who have a persisting moist cough beyond six weeks would be considered abnormal.

(ii) Pertussis infection – is well known to cause a paroxysmal and protracted cough, which tends to be dry in nature. Paroxysmal cough is associated with other respiratory viruses. The presence of posttussive emesis and inspiratory whoop modestly increase the likelihood of pertussis infection. Additional laboratory testing should be collected in suspected cases for contact tracing and treatment.

(iii) Children recovering from complicated acute pneumonia

(iv) Rhinosinusitis – defined as nasal secretion +/- cough (wet or dry) for >10 days. Treatment with Augmentin has been shown to be beneficial. Chronic symptoms (4-8 weeks) without a purulent discharge is usually associated with allergy.

B. Foreign body – should be suspected in those with a history of choking followed by persisting cough or non-resolving pneumonia.

Specific conditions associated with chronic cough

Persistent bacterial bronchitis (PBB) is defined as the presence of a moist cough in the absence of other chest signs, resolution of symptoms with appropriate use of antibiotics (two weeks) and absence of an alternative cause for specific cough[15]. Some individuals respond to a longer course (ie four weeks). Left untreated, PBB is thought to be the first phase in the evolution of suppurative lung disease and subsequently bronchiectasis. The pathophysiology is not fully understood though presently is thought due to the combination of impaired mucociliary clearance and the presence of chronic bacterial infection, causing the release of mediators, such as proteases and free radicals, causing bronchial-wall injury and dilatation over time. Research is ongoing assessing the host immune response in these individuals. This process has been demonstrated in other conditions such as cystic fibrosis and ciliary dyskinesia.

If PBB fails to respond to antibiotics or recurs within months of initial treatment, further investigation is warranted to exclude other causes[15].

Bronchiectasis was identified as the cause of chronic cough in nine per cent of patients (Figure 1)[9]. Goyal et al[16] reported that children who's cough persists after four weeks of appropriate antibiotics have a 83 per cent chance of bronchiectasis being present on CT chest scan.

Asthma is the second commonest cause of cough in children. In the early phase of the illness the cough is "tight" and exacerbated by exercise or change in environmental temperature. Recovery with viral illnesses is often reported by parents to be slower than those without asthma. Respiratory function testing is challenging in those <7 years and thus not available to assist diagnosis. Additional suggestive features of asthma include a positive family history or other atopic symptoms. Inhaled corticosteroids take two to four weeks to have maximal effect and thus a four-week treatment trial is required to assess effective. Failure of the cough to resolve after a four-week trial should raise suspicions about the correctness of the diagnosis.

Tracheomalacia is a reduction in the diameter of the trachea of > 50 per cent (Figure 2). There is a higher incidence associated with cardiac anomalies (vascular rings and Conotruncal disorders), tracheoesophageal fistula and various syndromes including Down's syndrome, VATER and CHARGE associations. Tracheomalacia is associated with a higher incidence of PBB [17].

Those with tracheomalacia have a "barky" cough, similar to that heard with croup. Those who present repeatedly with a barky cough +/- stridor or are still experiencing croup > five years old may have tracheomalacia and warrant confirmation of the diagnosis.

Environmental factors

Cigarette smoke is a well documented contributor/irritator of the airway and supporting those close to the patient to quit smoking is important.

Rare causes of chronic cough, which if missed have significant long-term respiratory morbidity[11].
1. Congenital airway abnormality – laryngeal cleft, tracheoesophageal fistula, tracheal stenosis
2. Foreign body inhalation
3. Infection – lung abscess, tuberculosis
4. Suppurative lung disease – cystic fibrosis, primary ciliary dyskinesis, immune deficiency

Table 1. Rare causes of chronic cough

Cough Type	Suggested underlying process
Barking / brassy	Croup Tracheomalacia Habit cough
Honking	Psychogenic
Paroxysmal +/- inspiratory whoop	Pertussis, parapertussis
Staccato	Chlamydia in infants
Chronic wet/moist cough – worse in mornings	Suppurative lung disease (PBB, cystic fibrosis, ciliary dyskinesis)

Table 2. Different types of cough and the associated condition

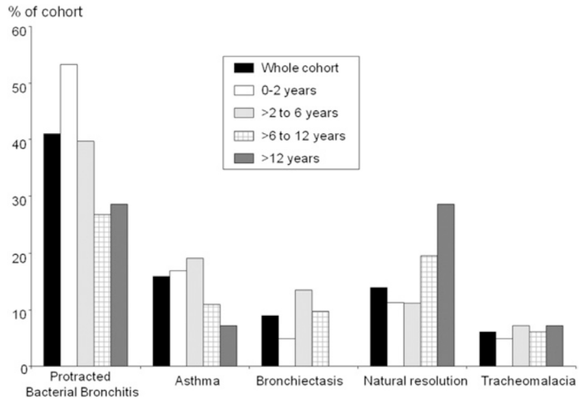


Figure1. Distribution of the five most frequent diagnoses, grouped according to age categories[9].

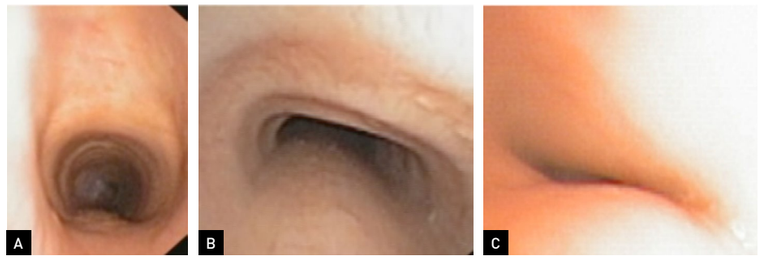


Figure 2. By view of the trachea. A: normal trachea with 'C' shaped tracheal rings. B: Moderate tracheomalacia with flattening of the anterior tracheal wall and widening of the par membranosa (posterior muscular wall). C: Severe tracheomalacia with near complete closure of the trachea.

Treatment options

Cough suppressants

There is no evidence that over-the-counter medications are effective[18]. A teaspoon of honey has been shown to be more effective than placebo in a randomised controlled trial and is safe.

Codeine-based medications will suppress the cough, with associated drowsiness and constipation. There is no place for the routine use of codeine-based medications to suppress cough.

Inhaled corticosteroids

If the diagnosis is suggestive of asthma and there is a positive response to Ventolin, inhaled corticosteroids may be indicated.

Antibiotics

In the presence of features suggestive of PBB, a trial of antibiotics for two to six weeks is appropriate. The organisms isolated consist of a mixture of streptococcus species, Neisseria species, Moraxella catarrhalis, Haemophilus influenza and staphylococcus[15]. Resistance patterns will depend on the individual's prior antibiotic exposure, though Augmentin Duo is usually adequate.

Why is it important to treat?

Aggressive management with airway clearance and antibiotics for those with more established disease is known to stabilize lung function and disease progression[19]. Furthermore, treatment has been documented to lead to an improvement of the bronchial dilatation/bronchiectasis or arrest progression of disease [20,21].

Summary

Chronic cough in children in the absence of other clinical signs may be the only sign of an underlying chronic lung disease or progress to a chronic suppurative lung disease and bronchiectasis. Guidelines have been established to guide the investigative, treatment and referral process. It is important to ensure complete resolution of a cough. ■

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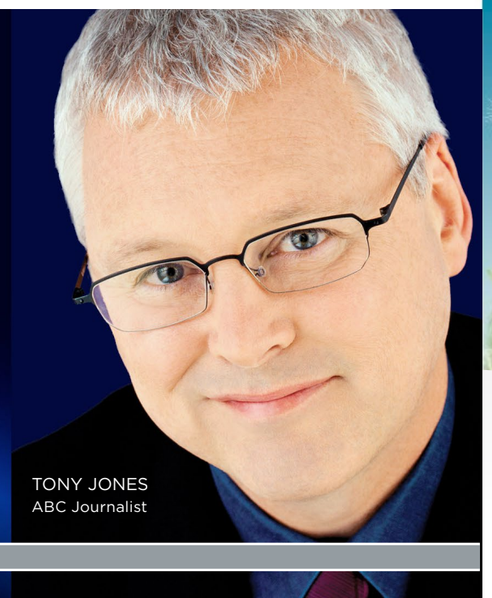

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A/Prof David Coman

Paediatrician, Metabolic Physician, Clinical Geneticist

Dr David Coman graduated from the University of Queensland in 1995. He gained wide exposure to general paediatrics, neonatology, clinical genetics and metabolic medicine through training positions in Brisbane, Rockhampton, Melbourne, the United Kingdom and Ireland.

Dr Coman has an active interest in research and is currently involved in multiple research projects aimed at novel disease discovery, improved diagnostic testing and treatments for children with Inherited Genetic Disorders.

He is actively involved in the teaching of medical students and paediatric trainees. He currently holds academic appointments at The University of Queensland, Griffith University and Bond University.

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Dr Johanna Holt

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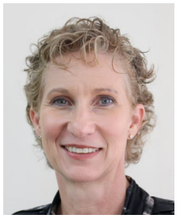

Dr Johanna Holt is a General Paediatrician who has worked at the Wesley Medical Centre and The Wesley Hospital since 1997. Dr Holt trained at the Royal Children's Hospital, Royal Women's Hospital and North Brisbane Health District in General Paediatrics, undertaking fellowships in Neonatal Medicine, and Community and Developmental Paediatrics.

She now practices across the breadth of paediatrics - from care of the premature and newborn, to care of infants and children with general medical problems, and to care of children with significant developmental problems and learning difficulties.

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Dr Bruce Lewis

Paediatrician

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He has a special interest in neonatology, general paediatrics, newborns and pre-term births.

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Dr David Moore

Paediatrician

Dr David Moore is a Paediatrician with special interest in neonatal management and management of children less than five years of age.

For a long period of time Dr Moore was on the on-call roster at the Mater Mother's Neonatal Intensive Care and now continues to practice neonatal medicine and general paediatric medicine in his private practice based at the Wesley.

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Dr Marion Thomas

Paediatrician

Dr Marion Thomas is a Paediatrician with more than 22 years experience in paediatrics, both in the UK and Australia.

Dr Thomas's area of speciality is children and adolescents up to 14 years, across the spectrum of general paediatrics with an emphasis on family-centred holistic care.

She is interested in complex children with developmental delay and special needs and early feeding and nutritional problems.

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Directory: Paediatric Sub-specialty

Allergy and Immunology

Dr Kim Robertson

Paediatric Allergist and Clinical Immunologist

Dr Kim Robertson is a specialist in paediatric allergy and clinical immunology and her professional areas of interest include the diagnosis and management of paediatric food and insect allergies, eczema and allergic rhinitis.

She also performs diagnostic skin prick testing and intradermal testing, as well as oral food challenges and allergen immunotherapy.

Dr Robertson's research interests include adrenaline autoinjector (Epipen) practices in allergy clinic patients.

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Cardiology

Dr Robert Justo

Paediatrician

Dr Robert Justo has provided a consultative service with Heart Care Partners at the Wesley Hospital since 1998. He has extensive experience in all fields of general paediatric cardiology.

Dr Justo graduated in Medicine from the University of Queensland and trained in paediatric cardiology at the Hospital for Sick Children, Toronto. He is Director of Cardiology at The Lady Cilento Children's Hospital, with areas of special interest including interventional cardiology and familial hypercholesterolaemia.

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Sleep Disorders

Dr Scott Burgess

Paediatric Sleep Physician

Dr Scott Burgess PhD FRACP is a Paediatric Sleep Physician who is keen to assist with the management of medical and behavioural sleep problems in children of all ages (0 to 16 years). This may include snoring and obstructive sleep apnoea, difficulties falling or staying asleep, restless sleep, parasomnias, narcolepsy and investigation of tiredness.

Private sleep studies may be performed at the Wesley Hospital in children aged two years and older following a consultation with Dr Burgess.

Scott is dedicated to the provision of a timely professional service and is available to discuss a patient or review urgent cases as required. Telehealth consultations are available for non-metropolitan patients.

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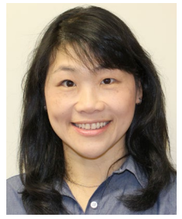

Dr Wen-Yi Chew-Lai is a Developmental Paediatrician with a special interest in children with developmental delays, learning difficulties, autism and attention deficit disorder.

She has dual training in both general paediatrics and community child health encompassing developmental paediatrics, child protection and population health.

Other languages spoken include Malay and Cantonese. Dr Chew-Lai obtained her Master of Public Health in 2011 and has undertaken Autism Diagnostic Observation Schedule (ADOS) training.

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Endocrinology

New Specialist

Dr Andrew Cotterill

Paediatric Endocrinologist

Dr Andrew Cotterill is a specialist medical physician, recognised internationally as an expert in diagnosing and treating endocrine disorders in babies, children and adolescents.

Dr Cotterill trained in adult and children's medicine and became a paediatrician in 1988 and an accredited paediatric endocrinologist in 1993. He holds medical qualifications from the UK and Australia.

He has headed up the Mater Children's Hospital's paediatric endocrinology unit since 1996 and leads the public hospital transition of Mater and Royal Children's Hospitals' paediatric endocrinology departments ahead of the opening of the Queensland Children's Hospital in 2014.

Over the years, Dr Cotterill has held regular outreach clinics at regional Queensland centres such as Bundaberg, Rockhampton and Gladstone where there is no local paediatric endocrinologist.

Dr Cotterill is a past president of the Australian Paediatric Endocrine Group which fosters a sharing of research and clinical care among paediatric endocrinologists across Australia and New Zealand.

He is an associate professor at the University of Queensland, sharing his knowledge with a new generation of doctors.

Dr Cotterill is married with three children, now grown into wonderful adults.

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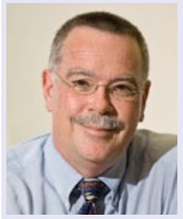

Professor Geoffrey Cleghorn is a Paediatric Gastroenterologist and Deputy Head of the School of Medicine and Professor of Paediatrics and Child Health at The University of Queensland. He is currently the senior paediatrician in the Children's Nutrition Research Centre of The University of Queensland at the Royal Children's Hospital in Brisbane. His research interests include the use of energy expenditure and body composition analysis in a number of disease states including chronic liver disease, cystic fibrosis and general nutritional rehabilitation.

He has been involved in many of the historical and seminal advances in paediatric liver transplantation including the world's first successful living-related-donor liver transplant and the development of the liver cut-down technique now universally known as the "Brisbane Technique". Research from the Queensland Liver Transplant Service has highlighted the importance of nutrition in these patients and is now acknowledged internationally.

Professor Cleghorn has developed an extensive network of associations throughout Asia and has a very high profile within this region.

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Dr Richard Muir

Paediatric Gastroenterologist

Dr Richard Muir is a Paediatric Gastroenterologist who began practicing at The Wesley Hospital in 2012. He has a special interest in inflammatory bowel disease, eosinophilic oesophagitis and coeliac disease.

Dr Muir graduated in Medicine from the University of Queensland and trained in Paediatric Gastroenterology at the Royal Children's Hospital and Mater Children's Hospital.

He was the recipient of a Royal Children's Hospital Foundation Clinical Fellowship Grant and has trained extensively in all areas of paediatric gastroenterology including diagnostic and therapeutic endoscopy.

Paddington Medical Rooms
161 Given Terrace
Paddington Q 4064
T 07 3367 1065
F 07 3367 1075
E referrals@paedsgastro.com.au
www.paddingtonmedicalrooms.com
www.wesley.com.au

Directory: Paediatric Sub-specialty

Haematology & Oncology

Dr John Bashford

Clinical Haematologist and Medical Oncologist

John Bashford is a Clinical Haematologist and Medical Oncologist with a special interest in adolescent and young adults. He has more than 20 years experience at the Wesley in treating complex malignancies in conjunction with orthopaedic and thoracic specialists.

Dr Bashford has a particular interest in stem cell transplantation, multiple myeloma, and sarcoma.

His qualifications include a Bachelor of Science, Bachelor of Medicine and Surgery (Honours). He is also a Fellow of the Royal Australasian College of Physicians and the Royal College of Pathologists of Australasia.

Wesley Medical Centre
Level 1, Haematology and Oncology Clinic
40 Chasely St
Auchenflower Q 4066
T 07 3737 4500
F 07 3737 4601
E drbashford.secretary@iconcancercare.com.au
www.iconcancercare.com.au
www.wesley.com.au

Respiratory Physicians

New Specialist

Dr Helen Buntain

Paediatric Respiratory Physician

Dr Helen Buntain is a Paediatric Respiratory Physician with an interest in the management of children's lung disorders including asthma, cough, chest infections and airway lesions in children from birth to 18 years of age. She has extensive experience in performing flexible bronchoscopy to diagnose airway lesions and structural abnormalities.

Dr Buntain graduated from the University of Queensland in 1993. She commenced her paediatric training in 1996 at the Royal Children's Hospital, Brisbane, and was awarded the FRACP examination medal for Paediatrics in 1998. Following this she was awarded a Clinical Fellowship to commence specialist training as a Paediatric Respiratory Physician. During her sub-specialty training, Dr Buntain completed a PhD in cystic fibrosis.

Dr Buntain was awarded her FRACP (paediatrics) in 2003. Her specialist training in respiratory medicine was completed in 2004, and her PhD was awarded in 2006.

In 2007, Dr Buntain was employed as a Staff Medical Specialist at the Royal Children's Hospital and in 2014 began practice at The Wesley Hospital.

Dr Buntain is a member of the following societies: Australasian College of Physicians; Thoracic Society of Australia; Australian Paediatric Respiratory Group; American Thoracic Society; Australian Medical Association.

Wesley Medical Centre
Sessional Suites
40 Chasley St
Auchenflower Q 4066
T 07 3871 3224
F 07 3720 2414
E reception@drbuntain.com.au
www.drbuntain.com.au
www.wesley.com.au

Dr Nigel Dore

Paediatrician

Dr Nigel Dore is a Paediatrician with a focus in paediatric respiratory medicine. Dr Dore has a special interest in asthma, bronchilitis and pneumonia and has been practicing at the Wesley since 1998.

Dr Dore completed his medical degree at the University of Queensland and is a member of the Asthma Foundation of Queensland.

Cadogan House
1382 Sandgate Rd
Nundah Q 4012
T 07 3266 8155
F 07 3266 8145
E nigel.dore@bigpond.com

Paediatric Rheumotology

Dr Navid Adib

Paediatrician

Dr Adib is a Paediatrician specialising in Rheumatology and has been practicing at The Wesley Hospital since 2006.

Dr Adib's areas of interest include paediatric rheumatology, musculoskeletal and inflammatory disorders, juvenile arthritis, juvenile dermatomyositis, lupus and morphea.

Evan Thomson Building
Level 10, Suite 3
24 Chasely St
Auchenflower Q 4066
T 07 3870 1029
F 07 3871 0700
E navidadib@qldpaedrheum.com.au

Directory: Paediatric Surgery

Paediatric Surgeons

New Specialist

Dr Bhavesh Patel

Paediatric Surgeon

The Wesley Hospital is pleased to welcome Paediatric Surgeon Dr Bhavesh Patel to the hospital's extensive team of medical specialists.

As well as The Wesley Hospital, he holds appointments at Lady Cilento Children's Hospital (previously known as Royal Children's Hospital), Mater Children's Private Brisbane, Nambour General Hospital, Nambour Selangor Private Hospital and Sunshine Coast University Private Hospital.

Dr Patel was brought up in New Zealand and trained in major centres including Auckland, Wellington and Hamilton before moving to Australia and completing his training in Brisbane and Sydney.

A keen teacher, he is an active senior lecturer with the University of Queensland School of Medicine, a faculty member of the Academy of Surgical Educators with the Royal Australasian College of Surgeons and a co-founder of the Australasian Paediatric Surgery Research Interest Group.

He holds memberships with the Australia and New Zealand Association of Paediatric Surgeons; Society of Paediatric Urologists of New Zealand and Australia (SPUNZA); International Paediatric Endosurgery Group; Australia and New Zealand Burns Association and the International Children's Continence Society.

Wesley Medical Centre
Suite 30, Level 2
40 Chasely St
Auchenflower Q 4066
T 07 3333 1616
F 07 3319 6412
E bpatel@paedsurgery.com
www.betterkids.com.au
www.wesley.com.au

Dr Peter Borzi

Paediatric Surgeon

Dr Peter Borzi is a Paediatric Surgeon with a speciality in general surgery and paediatric urology. He has been practicing at The Wesley Hospital since 1993. Taylor Medical Centre
40 Annerley Rd
Woolloongabba Q 4102
T 07 3846 3915
F 07 3891 7445
E p.borzi@bigpond.net.au

Dr Christopher Bourke

Paediatric Surgeon

Dr Christopher Bourke is a Paediatric Surgeon with a speciality in neonatal surgery and thoracic paediatric surgery. Dr Bourke has been practicing at The Wesley Hospital since 2004.

Dr Bourke is a member of the Australian and New Zealand Association of Paediatric Surgeons and the International Paediatric Endosurgery Group.

Taylor Medical Centre
40 Annerley Rd
Woolloongabba Q 4102
T 07 3255 2195
F 07 3891 7445

Dr Kelvin Choo

Paediatric Surgeon

Dr Kelvin Choo is a Paediatric Surgeon with a speciality in neonatal, hepato-biliary and thoracic surgery as well as burns. He has been practicing at The Wesley Hospital since 2004.

Dr Choo completed his training in paediatric surgery in Brisbane, Melbourne and in the United Kingdom. He has been a consultant paediatric surgeon in Brisbane since 2004 and holds appointments at the Mater Children's Hospital, the Royal Children's Hospital, The Wesley Hospital and Logan Hospital.

Taylor Medical Centre
40 Annerley Rd
Woolloongabba Q 4102
T 07 3393 2451
F 07 3891 7445
E k.choo@bigpond.net.au

ENT Surgeons

Dr Julieanne Agnew

ENT Surgeon
Suite 104
101 Wickham Tce
Brisbane 4000
T 07 3832 1244
F 07 3839 0876
E practicemanager@brizent.com

Dr James Earnshaw

ENT Surgeon
Ballow Chambers
121 Wickham Tce
Brisbane 4000
T 07 3839 4179
F 07 3831 7143
E Reception@EarnshawENT.com.au

Dr Andrew Lomas

ENT Surgeon
3/113 Wickham Tce
Brisbane 4000
T 07 3839 8977
F 07 3839 1672

Dr Simon Nasser

ENT Surgeon
Suite 6, Level 9
Evan Thomson Building
24 Chasely St
Auchenflower 4066
T 07 3870 4455
F 07 3870 4488
E reception@wesleyent.com.au

Dr Anthony Parker

ENT Surgeon
225 Wickham Tce
Brisbane 4000
T 07 3831 2355
F 07 3831 2201
E tony@parkersurgical.com

Dr Brian Wilson-Boyd

ENT Surgeon
Suite 88, Level 5
Sandford Jackson Building
30 Chasely St
Auchenflower 4066
T 07 3371 9000
F 07 3371 9100
E ent@wilsonboyd.com.au
www.ent-surgeon.com.au

Meet our new Visiting Medical Practitioners

Dr Hans Goossen

Urologist & Andrologist

Dr Hans Goossen will commence consulting and operating at The Wesley Hospital in January 2015.

He has special interests in men's health (erectile dysfunction and penile implant surgery, Peyronie's disease, male infertility), penile and urethral reconstruction, prosthetic surgery, and benign and malignant conditions of the penis and scrotum.

Dr Goossen graduated in 1999 from the Catholic University of Nijmegen, the Netherlands, with a MBBS and a Physician's degree. In Australia, he completed his Surgery and specialist Urology training at the major teaching hospitals in Brisbane with a special interest in oncology, laparoscopy, stone management and urethral reconstruction. Subsequently he attended the University College Hospital, London, for a two year Fellowship in the specialty of andrology, focussing on male genital oncology and reconstruction, male infertility, prosthetic surgery and Peyronie's disease.

Dr Goossen is a member of the International Society of Sexual Medicine (ISSM), the European Society of Sexual Medicine (ESSM), the Urological Society of Australia and New Zealand (USANZ), the Royal Australasian College of Surgeons (RACS), and the European Association of Urology (EAU).

Stoneham House
14 Stoneham Street
Stones Corner, Q 4120
P 07 3847 8601
F 07 3324 2546
E hg@andrologymatters.com.au

Dr Jivesh D Choudhary

Cardiothoracic Surgeon

Dr Jivesh Choudhary is a Cardiothoracic Surgeon with considerable experience in adult cardiac surgery, thoracic surgery, minimally invasive surgery, heart failure and arrhythmia management requiring the insertion of implantable devices.

Originally from India, he completed his post-graduation in general surgery from Gujarat University in 1994. He obtained specialist qualifications as a cardiothoracic surgeon (Mch) from Delhi University in 2000 and worked as a consultant in Apollo Hospital, a 695-bed internationally accredited tertiary care centre, for three years.

Dr Choundhary arrived in Australia in 2003 and has worked as a consultant at the Royal Hobart Hospital, Canberra Hospital and John Hunter Hospital.

He is involved in research and teaching with the Critical Care Research Group, Queensland University of Technology (QUT) and Newcastle University.

As a fellow at the Prince Charles Hospital, he was involved in heart and lung transplantation, ventricular assist device implantation and the management of patients on ECMO.

In addition to his practice at the Wesley, Dr Choundhary will be conducting peripheral clinics in Toowoomba, Armidale and Newcastle.

Wesley Medical Centre
Suite 30, Level 2
40 Chasely St
Auchenflower Q 4066
T 1300 115 551 or 0430 130 478
E vedanta.heart@outlook.com
www.vedantacardiacare.com
www.wesley.com.au

Dr Joseph Schoeman

General Urologist

The Wesley Hospital is pleased to welcome Dr Joseph Schoeman to its extensive team of medical specialists.

Dr Schoeman comes to the Wesley with considerable experience in General Urology with a particular focus on incontinence in both male and female patients. He maintains a passion for ureteric and renal calculi management, optimizing the combined use of up-to-date endoscopic equipment with laser technology.

As part of his holistic practice he also offers Oncology treatment in the form of a traditional Radical Retropubic Prostatectomy, Robotic Prostatectomy and Laparoscopic Radical Nephrectomy.

Dr Jo Schoeman obtained his undergraduate degree, MBChB, at the University of Pretoria, South Africa, in 1993. He went on to complete his first Urology Fellowship (FCS), College of Urologists of South Africa in 2003 and migrated to Australia in 2007.

After becoming a Fellow in laparoscopic urology surgery in Melbourne, he entered private and public General Urology practice. He was the sole urologist in Bundaberg for five years and still visits weekly.

Dr Schoeman is also part of the recently opened Pelvic Medicine Centre, a new and unique venture at the St Andrew's War Memorial Hospital.

St Andrew's War Memorial Hospital
457 Wickham Terrace,
Spring Hill, Q 4000
T 07 3831 9049
F 07 3834 4399

Clinical Education 2015

	Local CPD	ALM The Wesley Hospital	Regional CPD	Special Events
February	19 FEBRUARY Urology (non cancer) 25 FEBRUARY Neurology/Neurosurgery			11 FEBRUARY Practice Nurses
March	17 MARCH Gastroentrology	14 MARCH Infertility/Obstetric/ Gynaecology	WEEK OF 23 MARCH Cairns	
April	30 APRIL Paediatric			
May	13 MAY ENT 26 MAY Orthopeadic	16 MAY Emergency Medicine		
June	16 JUNE Vascular		WEEK OF 22 JUNE Bundaberg	13 JUNE Q&A with Tony Jones
July	15 JULY Cardiology 29 JULY Cardiac Audit Dinner		WEEK OF 27 JULY Rockhampton	16 JULY Practice Nurses
August	6 AUGUST Emergency Medicine 26 AUGUST Plastic and Maxillofacial	22 AUGUST Minimally Invasive Surgery		
September	1 SEPTEMBER Breast and Endocrine 16 SEPTEMBER Thoracic and Sleep		WEEK OF 7 SEPTEMBER Maryborough/Hervey Bay	12-13 SEPTEMBER Private Practice Conference
October	13 OCTOBER Oncology and Palliative Care 21 OCTOBER Surgical Audit Dinner 29 OCTOBER Gynaecology/Uro/Oncology	13-16 OCTOBER Clinical Week 17 OCTOBER CPR Training Day - Emergency Medicine	WEEK OF 19 OCTOBER Gladstone	
November	11 NOVEMBER Prostate Cancer	14 NOVEMBER Cardiology/Vascular Surgery		4 NOVEMBER Practice Nurses

Vicki Goss
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Fax 3232 7932
www.wesley.com.au

Please note: Topics and dates are subject to change

The Wesley HOSPITAL

Wesley Breast Clinic
Urgent Referral Service

Every year more than 23,000 patients attend The Wesley Breast Clinic for screening and diagnostic assessments.

Doctor Hotline
07 3232 7085
www.wesley.com.au/breastclinic

The Clinic offers:

- 14 medical practitioners trained in breast health and procedures
- Urgent referral service to the Diagnostic Clinic. (In most cases, patients are seen within 24 hours)
- Diagnostic results delivered on the same day or next working day
- Quick turnaround for routine mammograms
- Saturday and after-hours screening appointments
- All follow-up management is available on the Wesley campus.

Quality Images.
Expert Radiologists.
Accurate Diagnosis.

Our areas of expertise include:

- Digital mammography
- On-site MRI with the capability to perform MR guided biopsy
- Ultrasound examinations
- Fine needle biopsy and cyst aspirations
- Core biopsies including vacuum-assisted core biopsies

Doctor hotline	Call **07 3232 7085** or fax **07 3217 8840** for urgent appointments or email: wesleybreastclinic@uchealth.com.au
FAST referrals	Download referral template at wesley.com.au Click on Wesley Breast Clinic tab then follow the instructions for your practice software. Return referral via Medical Objects or fax **07 3217 8840**
Patient bookings	Call **07 3232 7202** for a prompt appointment or **Practice enquiries** on **07 3232 7067.**