GP ROUNDS
CENTRAL COAST NEWS
JULY 2019

Gosford Private Hospital
Brisbane Waters Private Hospital
Tuggerah Lakes Private Hospital
members of the Central Coast healthe care group

A NOTE FROM MATT KELLY

HEALTHE CARE REGIONAL MANAGER – CENTRAL COAST

Welcome to our GP Rounds Newsletter!
The purpose of this newsletter is to let you know what is happening with the 3 Healthe Care hospitals on the Central Coast, what our specialists are doing, and what services are growing at our sites.

What an amazing year Healthe Care – Central Coast has had. We have seen the completion of new Rehabilitation and Mental Health facilities at Brisbane Waters Private, the opening of Tuggerah Lakes Private in Kanwal and we are starting extensions at Gosford Private Hospital. All this growth showing a huge vote of confidence for investment.

Tuggerah Lakes Private commenced operations on the 6th of May and was officially opened on the 25th of June. The hospital is already steadily growing its patient numbers and the range of services provided. From the 22nd of July we are pleased to have also welcomed back to the Coast, Glen Auld, who will be taking up the position of CEO at Tuggerah Lakes. Glen has most recently been the CEO at our sister hospital in Chatswood, Hirondelle Private, and will bring his knowledge of the Central Coast to the role.

Gosford Private Hospital is about to commence a $32 million expansion of the theatre complex and inpatient accommodation. This will see two more theatres, expanded Day Surgery and recovery areas and more inpatient private rooms. The development will also deliver a brand new maternity unit and special care nursery.

We have seen the availability of technology at Gosford Private grow this year with the MAKO Robot, micra implantations and state-of-the-art visualisation equipment.
All representing multimillion dollar investment into the services offered right here on the Central Coast.

Our participation in PREMs (Patient Reported Experience Measures) and PROMs (Patient Reported Outcome Measures) projects is giving us greater insight into the services that we offer our patients and Doctors.

Our staff continue to work tirelessly to ensure that the patient is at the centre of everything that we do. They respect that it's a personal event that the patient is going through and that they want to have the best experience possible. We apply best practice to their care and ensure that our positive energy is what our patients remember most from their stay. The patient-centred care model has been a great success for the hospital.

This year both myself and the Director of Nursing – Jennifer McNamara presented at the Cleveland Clinic Patient Experience Summit. We were invited to speak about the fantastic culture that we have and the care that we provide to our patients.

A NOTE FROM KATHY BEVERLEY

BRISBANE WATER PRIVATE HOSPITAL CEO

Brisbane Waters Private has seen the continuing growth of its services and in addition to over $10 million spent in developing the Rehabilitation services, hydro pool and new Hospital reception, we have recently spent over half a million dollars upgrading equipment in Theatres to better service the Coast. Along with a continued focus on orthopedics, general surgery, bariatric, gastroenterology, opthalamic, ENT and plastics, the Hospital has welcomed a number of Dental surgeons to the team to continue to expand in this area.

Whilst meeting the surgical needs of patients, mental health services for both young adult, addictions and mood disorders has also continued to grow and as such we have welcomed the commencement of our first private Child and Adolescent Psychiatrist on the Central Coast who is seeing patients on an outpatient basis. Services are likely to extend in this area including perinatal services and adolescence, meaning many on the Coast no longer need to seek this help in Sydney or Newcastle.

IN THIS EDITION

A NOTE FROM GLEN AULD

TUGGERAH LAKES PRIVATE CEO

Since opening on the 6th of May of this year Tuggerah Lakes Private Hospital has been going from strength to strength. The local community have embraced having a high quality private hospital in their community and are constantly providing exceptionally positive feedback on the facility, the staff and the overall experience. The team has been hard at work and have progressively increased patient numbers and the complexity of the surgical services, while ensuring the best possible outcomes.

The hospital now caters for multiple specialties, including Orthopaedics; Ear, Nose and Throat; Gastroenterology; General Surgery; Colorectal; Gynaecology; Urology; Plastic Surgery; Vascular Surgery and Dental and has recently eclipsed the 1,000 patient mark. The 3 operating theatres are already 98% allocated which is driving us to look at Stage 2 construction which will see more theatres and an expanded service offering.

I am proud to be part of the Healthe Care team with the newest hospital on the Central Coast providing care for the community I live and work in. We are looking forward to working closely with local GP's to provide education and support to deliver best practice patient centred care to the northern sector of the Central Coast.

UPCOMING GP EDUCATION FORUMS

29TH AUGUST – "LETS TALK: LIVER & PERIPHERAL NERVE SYSTEMS"
– Presenters Dr David Parkin & Dr Michael Biggs

29TH AUGUST – FREE COMMUNITY 'WEIGHT LOSS SEMINAR'
– with Dr Oliver Florica at Erina Fair Community Rooms from 10.00am – 2.00pm

5TH SEPTEMBER – FREE COMMUNITY 'WEIGHT LOSS SEMINAR'
– with Dr Oliver Florica at Erina Leagues Club from 6.30pm – 8.30pm

12TH SEPTEMBER – 'ORTHOPAEDICS: PRE OP, POST OP AND REHABILITATION STRATEGIES'
– Presenters Professor Michael Pollack, Dr Simon Hutabarat & Dr Arooge Shafi

18TH SEPTEMBER
– Presenters Dr Sharon Laura, Dr Paul Chen and Dr Mark Louie -Johnsun

26TH OCTOBER – ANNUAL MENTAL HEALTH CONFERENCE

DATE TBA – PRACTICE MANAGER'S CHRISTMAS PARTY

For all enquiries about Education Events and Specialist visits, please contact our Regional GP and Community Relationship Manager, Petrina Waddell, at petrina.waddell@healthecare.com.au

A MULTI-DISCIPLINARY APPROACH TO BARIATRIC SURGERY

- with Bariatric Surgeon, Dr Simon Ghosh

The National Health and Medical Research Council (NHMRC) recognises that the most effective treatment for obesity is weight loss surgery or bariatric surgery, especially for patients with a body mass index (BMI) of >40 and those with weight-related comorbidities with a BMI of 35–40.

Bariatric surgery however, is not just about losing weight. The World Health Organization (WHO) estimates that obesity contributes to 44% of diabetes, 23% of ischaemic heart disease and up to 41% of some cancers.

For long term significant weight loss, surgical intervention alone is not the solution. It takes a team of practitioners working together. When you combine a motivated patient, a supportive GP and dietitian, psychological support, high standard local surgical facilities, an experienced surgical team with continued post-surgical after-care, we know that patients are set up for long term weight loss success and better health outcomes.

It is vital that patients are well informed and understand exactly what the outcomes of surgical intervention will mean for them and how the patient themselves play a pivotal role in the long term success of the procedure. Just as we might ask a patient undergoing reconstructive orthopedic surgery to do some pre-surgery strengthening as well as post-surgery physiotherapy and rehabilitation, we follow a similar plan to ensure positive patient outcomes.

Dr Ghosh will ask patients to lose a small amount of weight prior to surgery to minimise risk following a strict short term diet prepared by Optimum Intake dietitians. We spend time with the patient to understand their lifestyle and expectations to ascertain which procedure will provide the most effective outcome. We then outline a post-surgery care plan and follow up with patients and referring GP's during the following few years to guide the patient to a successful weight loss outcome.

The procedures Dr Simon Ghosh performs are Laparoscopic Sleeve Gastrectomy, Laparoscopic Gastric Bypass Surgery (Roux-en-Y and one-anastomosis gastric bypass OAGB) and revisional bariatric procedures, such as gastric band removal and conversion to bypass and sleeve conversion to bypass. These procedures change the anatomy and in some cases, the physiology of the gastrointestinal tract, which reduces oral intake and/or absorption of calories and aids weight loss. This subsequently helps to treat obesity-related comorbidities.

Although many patients do a fair amount of research themselves GPs will often be the first point of contact for people who are considering bariatric surgery. When considering if surgery is an option it is important to establish the following factors:

1. Age

- Adults
- Post-pubertal adolescent with BMI >40 or >35 with obesity related health problems.

2. Body Weight

- BMI > 40 with no contributing medical issues
- BMI >35 with illness associated with obesity such as type 2 diabetes, hypertension, obstructive sleep apnoea, non-alcoholic fatty liver disease
- BMI 30 – 34.9 with diabetes or metabolic syndrome.

3. Lifestyle

- Pregnancy not planned for within 12 months following surgery
- Appropriate weight loss interventions have been attempted numerous times without any beneficial weight loss
- An understanding of diet related changes required after surgery
- Capacity to understand the associated risks and commitment to ensure long term success.

The amount of weight lost will vary between bariatric procedures, as does the effect on any comorbidities. Recent data from the Bariatric Surgery Registry suggests that expected weight loss at three years after surgery is about 51.2%, and 38% of patients no longer required diabetes management one year after surgery.

Weight loss surgery is not only effective to help treat diabetes or pre diabetic patients. It can also effectively support prevention and in some cases treat the following comorbidities:

Cardiovascular: Hypertension, Atherosclerotic CVD, Myocardial infarction, Stroke, Congestive heart failure and Cardiac arrhythmias.

Metabolic: Type 2 Diabetes, prediabetes, Dyslipidaemia, Non-alcoholic Fatty Liver Disease (NAFLD)/Steatohepatitis.

Pulmonary: Obstructive Sleep Apnoea and Asthma, Musculoskeletal, Degenerative Arthritis, Immobility and Joint Pain.

Reproductive: Polycystic Ovarian Syndrome (female), Infertility and Sexual Dysfunction.

Genitourinary: Impaired Renal Function. Nephrolithiasis and Stress Urinary Incontinence.

Central Nervous System: Impaired Cognition, Headaches and Pseudotumor Cerebri.

Psychosocial: Impaired Quality of Life, Depression, Anxiety and other Psychopathology.

Cancer: Breast cancer, colorectal cancer.

References: https://www.monash.edu/__data/assets/pdf_file/0010/936280/bsr-4th-report-june-2016.pdf
https://www.nhmrc.gov.au/about-us/publications/clinical-practice-guidelines-management-overweight-and-obesity
https://jamanetwork.com/journals/jamasurgery/fullarticle/2456119

Dr Simon Ghosh is a Fellow of the Royal College of Surgeons Australia in General Surgery and has undertaken accredited training in Bariatric Surgery at the Royal Brisbane Hospital & Holy Spirit Private Hospital. Whilst completing his fellowship Dr Ghosh's case load exceeded 500 bariatric procedures.

Coast Surgery is a Central Coast based practice and Dr Simon Ghosh consults from Erina and Tumbi Umbi. He offers Laparoscopic, General and Weight Loss surgical procedures offering patient benefits of no waiting list, no gap for general surgical procedures and bulk billed initial weight loss consultations.

Coast Surgery

Erina
Suite 202, Level 1, Element Building, 200 Central Coast Highway, Erina NSW 2250

Tumbi Umbi
Level 1, HealthPoint, 7 Mingara Drive, Tumbi Umbi NSW 2261

Our opening hours are Monday to Friday: 8.30am to 5pm
Call us: 02 4304 5902 or Fax: 02 8212 5825
Find us on Facebook and Instagram @coastsurgery

WHAT YOU SHOULD TELL PATIENTS **ABOUT HIP REPLACEMENT SURGERY** IN 2019

- with Orthopaedic Surgeon, Dr John Morton

Total Hip Replacement (THR) has been rightly described as "The Operation of the Century!" (Lancet 2007 370)

It has provided long lasting pain relief, consistently improved clinical function and significantly improved quality of life for millions of patients throughout the world. 50,000 Hip Replacements are performed in Australia every year.

Since 2003, every THR has been tracked by the Australian Orthopaedic National Joint Registry (ANOJR). It is currently tracking 600,000 hips. The data obtained has been invaluable and the envy of the world. Every surgeon can obtain a specific analysis of his own results since 2003. Local results here on the Central Coast are as good as or better than the combined Australian results!

THR's results are so good overall because it is the simplest joint in the body, a ball and socket joint. Biomechanically it's easy to replicate.

Key points

- **Age is not a limit to Hip Replacement surgery:** the average age is 68 but due to the durability of the implants, it can be performed in a Teenager with congenital deformity, or a centurion that wants to get back to tennis
- It is the best performing of all Joint Replacements, with well over 90% still working fine at 15 years.
- **Robotic Surgery:** This without doubt, improves the accuracy of Hip Replacement Surgery. Gosford Private Hospital has a MAKO® Robot.
- **Implant Choice:** This is generally based on bone quality. Mostly 'Press Fit' cementless implants are used, but if someone is osteoporotic, bone cement is great.
- **Bearing Surface:** Ceramics and Plastic are pretty much the norm. There was a period where large Metal/Metal bearings were in vogue due to the theoretical risk of low dislocation but there were a lot of problems with metal debris causing early failures, saying that, tennis great Andy Murray recently underwent such surgery.
- **Obesity:** Not great, but potentially very satisfying none the less. Results are worse for obvious reasons as it is harder to do the surgery and the patient puts a lot more load through the implant. Saying that, it is not an absolute contraindication to surgery.

Operative approach

The approach must allow adequate exposure to ensure correct positioning of all components. Mal-position can and will cause early failure. If exposure is marginal, then other methods such as intra-operative X-rays, computer or robotic navigation must be utilised to confirm correct component position and leg length.

Current literature shows no difference between the different approaches in PROM's (Patient Reported Outcome Measures) at 3 months post-surgery, though does show earlier perioperative recovery in some.

Posterior Lateral Approach: Most common approach in Australia. Extensile, with excellent exposure. Muscle splitting and some muscle division. Can be "mini incision". Higher dislocation rate.

Anterior/Lateral: Extensile, with excellent exposure. 2nd most common. Hip abductors are divided requiring repair.

DAA (Direct Anterior Approach): The only true internervous approach, no muscle division or splitting. Excellent exposure though non extensile. Lowest dislocation rate. Reported earlier perioperative recovery.

SuperPath: A "Micro Posterior" approach. Some muscle splitting, no muscle division. Limited exposure mandates accessory intra-operative imaging.

What I do now

Gosford Private purchased the MAKO® Robot two years ago. This is an exciting development with major further potential!

It's suitable for any approach, but lends itself well to the Minimally Invasive Direct Anterior Approach (DAA), my preferred approach. The surgeon pre-operatively plans the placement of all components using specialized CT scan based software in the Robot. After exposing the hip, the surgeon registers the exposed patient's anatomy with the robot. It will very accurately (within 1mm) orientate the preloaded patients CT scan to the real life operation. The surgeon will physically prepare and insert the acetabulum, rigidly guided by the Robotic arm which controls the orientation.

Post-Operative Management

- Nearly all hip approaches now allow immediate mobilization, sitting, rolling in bed and full weight bearing.
- Aim is for discharge 2 to 7 days with single stick in opposite hand. Patient is independent with stairs, toileting etc.

Medium and Long Term

- Sleep in any position.
- Unrestricted walking.
- Bush walking, bicycle riding, social sporting activities (tennis etc), hand to toes.
- Unrestricted sexual positions.
- Avoid: High impact activities (e.g. running) to minimize potential long term wear, ladders due to falls risk (the THR won't break though the supporting bone may).
- Long term follow up is dictated by symptoms and age. Younger patients reviewed periodically. Older patients only if symptoms occur. If symptoms arise, don't be reassured by a normal X-ray report! Arrange a formal Orthopaedic review.

Dr John Morton is a very experienced, established Orthopaedic surgeon on the Central Coast, providing services to all of the Private Hospitals in the area & Gosford District Hospital.

He founded COSI (Coastal Orthopaedics & Sports Injuries) based at Gosford Private Hospital in 2000. He has a keen interest in all major limb joint replacements, shoulder, trauma, sporting & arthroscopic surgery.

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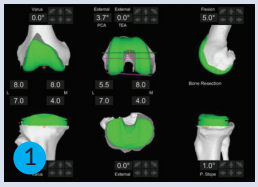
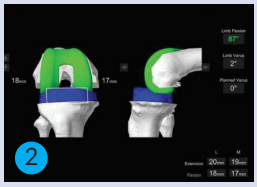
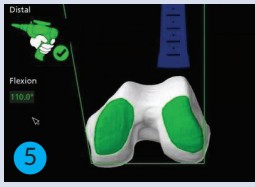
ROBOTIC TOTAL KNEE REPLACEMENT

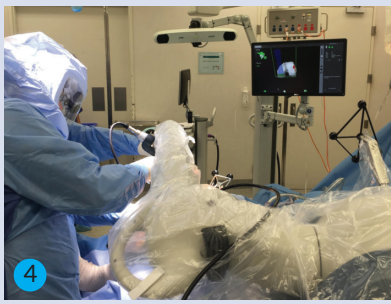
- with Orthopaedic Surgeon, Dr John Limbers

MAKO® robotic arm assisted hip and knee replacement surgery is cutting edge technology that provides each patient with a personalised surgical plan based on the unique anatomy of their hip or knee. It has been developed in the United States over the last 10 years. It has been performed in Australia for unicompartmental knee replacement and total hip replacement in the last few years. The total knee replacement application was launched in Australia in September 2017. The first robotic total knee replacements (apart from clinical trials) in New South Wales were performed in September, 2017.









Robotic Total Knee Replacement Technique

Prior to surgery a CT scan is performed and is used to generate a 3D virtual model of the osteoarthritic knee. This virtual model is loaded into the MAKO® system software. A personalised pre-operative virtual total knee replacement is performed on the 3D CT images before the operation (Figure 1). This plan is then reviewed by the surgeon and modified as necessary before the initial skin incision.

In the operating theatre, the surgeon performs the surgical approach to the knee and inserts navigation pins with attached arrays into the femur and tibia. The anatomy of the knee joint is then mapped with a specialised probe. This information, together with data from the navigation pins, is detected by a specialised camera. The centre of the femoral head and the ankle joint are also registered to allow measurements of the lower limb mechanical axis to be calculated. All this information is then entered into the robotic unit. Varus and valgus stress measurements are then taken in extension and flexion (Figure 2). This is also fed into the robotic unit. Soft tissue releases can be performed, or the position of the femoral and tibial components on the virtual total knee replacement can be modified, to achieve 1-2mm of laxity to varus and valgus stress in flexion and extension. This is considered ideal soft tissue balancing for a total knee replacement. Thus, the surgical plan is modified, based on additional detailed information obtained during surgery, to obtain a perfectly balanced virtual total knee replacement. This is all done before the initial bone resection. The sterile robotic arm is then brought in. The surgeon uses it to perform the femoral and tibial bone cuts without any form of traditional cutting guide (Figures 3 &4). This replicates exactly the perfectly balanced virtual total knee replacement on the patient's CT scan. The tactile, auditory and visual feedback of the robotic arm limits the bone preparation to the diseased areas and allows real time adjustments, while the surgeon monitors the cuts on the robotic unit's screen (Figure 5). Trial femoral and tibial implants are then inserted and the soft tissue balance once again checked with varus and valgus stress measurements in flexion and extension. The definitive total knee replacement implants are then inserted.

The postoperative rehabilitation is the same as for more traditional forms of total knee replacement surgery, with physiotherapy continuing after discharge. Most of the recovery will be obtained in the first 6 weeks, with further recovery continuing for 6 or more months beyond that. It is hoped that the ability of this technique to perform the surgery with less soft tissue dissection and retraction will lead to less post-operative pain and quicker post-operative recovery. There are studies demonstrating less soft tissue damage with knee replacement surgery performed with robotic technology. There is also a clinical study strongly suggesting a more rapid functional recovery following robotic total knee replacement in the first 6 weeks, when compared to traditional total knee replacement techniques. However, this was not Level 1 evidence and further studies will be necessary.

Is Robotic Arthroplasty Technology of Benefit to Patients?

Robotic unicompartmental knee replacement surgery was the first robotic arthroplasty platform to be developed. The rationale was that unicompartmental knee replacement could particularly benefit from the increased accuracy, given the higher failure rate of conventional unicompartmental knee replacement when compared to total knee replacement. Short term data of robotic partial knee replacement has been presented showing a lower incidence of premature failure, when compared to traditional instrumented partial knee replacement techniques. This is not definitive proof of the benefit of robotic unicompartmental knee replacement and further long-term studies will need to be performed.

The acetabular cup placement was examined in robotically assisted and conventional total hip replacement surgery in a comparative study. A statistically significantly increased number (30% higher) of acetabular cups were positioned within the desired range of anteversion and inclination in the robotically assisted cases. Whether this translates into lower revision rates and increased patient satisfaction remains to proven.

Thus, the early data for robotic knee replacement and robotic total hip replacement is encouraging. Robotically assisted total knee replacement surgery provides highly accurate placement and alignment of components, with the potential for significant benefit to patients. Short term and long-term follow-up studies will be needed to establish if this lowers the failure rate of total knee replacement surgery and increases patient satisfaction.

Dr John Limbers is an orthopaedic surgeon who specialises in hip and knee replacement surgery as well as reconstructive foot and ankle surgery. He has particular expertise in Mako robotic anterior total hip replacement surgery and Mako robotic knee replacement surgery. He was the first surgeon in NSW to perform robotic total knee replacement after its worldwide launch in September 2017. He has performed over 400 robotically assisted joint replacements.

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THE DIRECT SUPERIOR APPROACH TO **ROBOTIC HIP REPLACEMENT**

- with Orthopaedic Surgeon, Dr Sarah Hanslow

Robotic assistance and the direct superior approach are recent innovations in hip replacement surgery with the aim of improving patient outcomes. Hip replacement surgery has long been associated with excellent patient outcomes and excellent patient satisfaction rates. Many patients following hip replacement surgery comment that they forget they have had a hip replacement and that they wished they had undergone the surgery years ago! Despite these excellent outcomes there is still a proportion of patients who are not completely satisfied with their surgery for a number of reasons. Robotic surgery has the ability to improve outcomes for these patients.

Dr Hanslow is an orthopaedic surgeon living and working on the Central Coast with rooms at Kanwal Medical Centre and North Gosford.

Dr Hanslow first trained as a general practitioner in the Royal Australian Air Force. Dr Hanslow specialises in hip and knee arthroplasty including robotic assisted surgery, hand and foot and ankle surgery.

Tuggerah Lakes Private Consulting Rooms

Call us: 02 4393 3820 or Fax: 02 4393 3819

Robotic assisted hip replacement

The MAKO® robotic system at Gosford Private Hospital has some reported benefits over conventional approaches to hip replacement. The robotic system is an enhanced planning and targeting system to improve the position of the implants. Improved positioning leads to reduced risk of dislocation, reduced pain postoperatively due to either psoas tendon irritation or chronic bursitis, improved function and improved longevity of the hip replacement. The accuracy of the system allows for the prosthetic components to be inserted with an accuracy of within 1 mm and 1 degree of the planned position. This is a degree of accuracy that is not possible with conventional hip replacement techniques. The benefit of improved positioning is a reduced risk of dislocation or pain due to a poorly positioned acetabular component. The system also allows for accurate assessment of the patient's leg length and hip muscle tension intraoperatively which if restored improves the overall function of the hip replacement.

Robotic planning

Prior to surgery the patient has a low dose CT performed. The CT must be performed using the MAKO® protocol which is currently available at PRP North Gosford. The CT is arranged once the decision to proceed with joint replacement surgery is made. The CT provides the anatomical detail of the hip joint and leg length compared to the other hip. Using this 3D plan the position of the hip components may be planned virtually to restore the hip anatomy and place the components in a position which best suits the patient's individual anatomy. A poorly positioned acetabular component may lead to hip dislocation. It may also lead to ongoing groin pain as the psoas tendon may rub on the front of the poorly positioned acetabular component causing groin pain with any activity that involves lifting the leg. Both of these complications are usually addressed with revision surgery which may be avoided using the MAKO® technology.

Robotic assisted surgery

Robotic assisted surgery may also be used for total and partial knee replacement. The benefits for knee replacement are improved component positioned and an enhanced ability to balance the soft tissues of the knee. This technology provides tools to improve knee replacement that have not been available to orthopaedic surgeons until now. Dr Hanslow is experienced in hip, partial knee and total knee replacement surgery using the MAKO® robot.

Direct Superior Approach

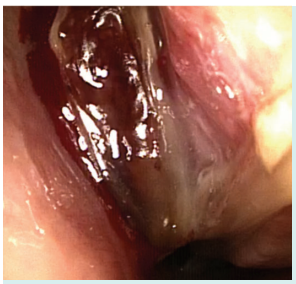
The direct superior approach is an advanced approach to hip replacement. The direct superior approach involves a single incision with innovative instrumentation to reduce intraoperative tissue damage. This muscle sparing approach in particular sparing the iliotibial band and the hip abductors leads to reduced pain, length of stay and improved mobility in the immediate postoperative period. Intraoperative X-ray is not required which may reduce the risk of infection. Studies have shown that increased movement within theatres, such as bringing in bulky X-ray equipment, increases the risk of contamination and the risk of subsequent joint replacement infection. This approach also does not compromise the view of the hip during the surgery allowing for accurate component positioning with robotic and non robotic surgery. The direct superior approach gives the ability to obtain a very accurate repair of the capsule of the hip joint. This is thought improve the proprioceptive feedback from the joint which leads to improved stability in the perioperative period. Therefore there are no strict hip precautions following the direct superior approach. I just ask that the patient be sensible in their activities for the first six weeks. An added benefit of this minimally invasive approach over some others, is that if a greater exposure is required to optimise the hip replacement this approach may be easily converted to a conventional posterior approach without the need for patient repositioning.

UNCOMMON ENT DIAGNOSES

- with Otolaryngologist, Dr Tony Kuo

Case 1: Sinonasal Plasmacytoma (Presented at ASOHNS 2018)

A 57-year-old of Asian lady presented with 2 year history of intermittent small volume epistaxis. Flexible nasendoscopy showed a large, friable, grey-coloured mass originating from the left middle turbinate, obliterating the middle meatus. This lesion was significantly obstructing the left nasal cavity with contact bleeding.



CT-Paranasal Sinuses demonstrated a large mass with bony erosion centred on the left middle meatus. MRI Paranasal Sinuses again demonstrated this well defined 22x13x20mm left nasal mass originating from middle turbinate. The lesion demonstrated homogenous hypointense T/T2 rim with intermediate to hypointense T2 and intermediate T1 signal , with diffuse mild enhancement which was less intense than surrounding mucosa.

She subsequently underwent endoscopic resection with middle turbinectomy. Features consistent with plasmacytoma were identified. There were no serum or urine M-proteins. Bone marrow biopsy demonstrated 12% abnormal plasma cells, consistent with plasma cell myeloma. CT skeletal survey and MRI spine did not demonstrate any lesions. She subsequently received radiation therapy to the paranasal sinuses.

Pearls:

- Plasmacytomas are malignant haematological neoplasms of plasma cells, characterized by monoclonal proliferation of B cells. Three subsets exist: multiple myeloma, solitary plasmacytoma and extramedullary plasmacytoma (EMP).
- EMPs are the extramedullary form of solitary plasmacytomas and can be found in various soft tissue throughout the body. It is most commonly found within the upper aerodigestive tract, in particular the pharynx and nasal cavity.
- EMPs are rare, with an incidence worldwide of only 0.04 to 3 cases per 100,000.

Dr Tony Kuo is a Senior Otolaryngologist working at Gosford Public/ Private Hospital since 2011 after being awarded the Fellowship of the Royal Australasian College of Surgeons in Otolaryngology/Head & Neck Surgery in 2009 and completed 2 years Fellowship in Head and Neck Reconstruction with Professor Fu-Chan Wei.

Dr Kuo is a Conjoint Lecturer for Macquarie University and Newcastle University Medical School and has published numerous medical research papers in addition to the authorship of a Head and Neck textbook.

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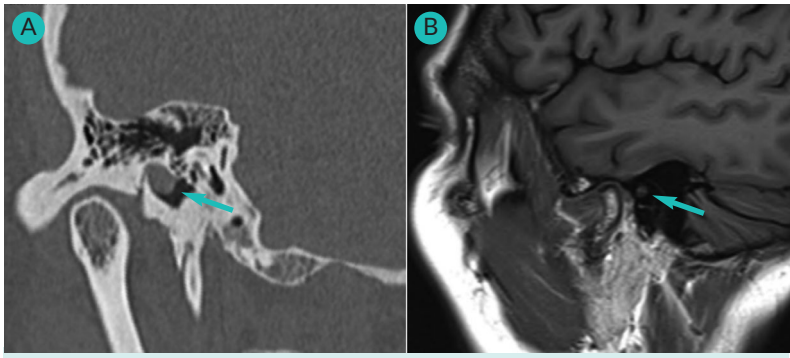
Case 2: Angioleiomyoma of the External Auditory Canal: A Rare Diagnosis (Paper submitted)

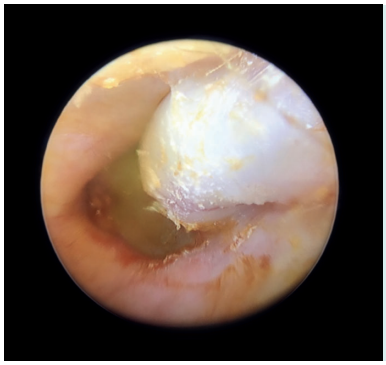
A 59-year-old female presented with hearing loss secondary to wax impaction. Examination demonstrated a mildly tender, opaque mildly vascular soft tissue mass located at the superior aspect of the left external ear canal, obstructing 30-40% of the canal lumen. An audiogram demonstrated mild hearing loss at 8000Hz in the left ear, with all other frequencies normal bilaterally.

CT of petrous temporal bones demonstrated an asymmetric soft tissue thickening measuring 6.5mm in diameter in the bony portion of the left external auditory canal, abutting the tympanic membrane. There was no associated bony erosion. MRI demonstrated a small lesion in the bony portion of her external ear canal. The lesion was isointense to brain parenchyma on both T1 and T2-weighted sequences. There were no features to suggest demyelination.



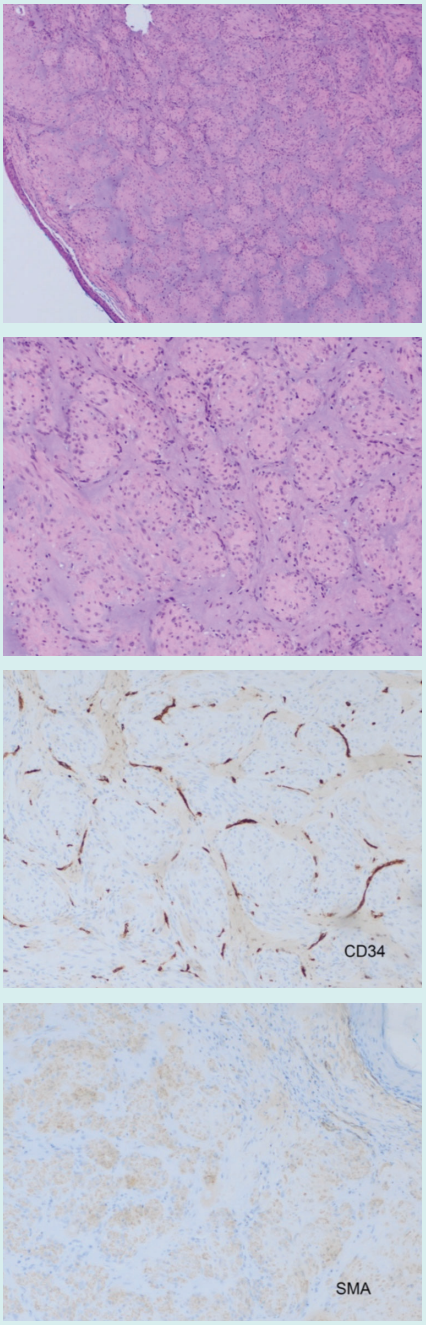
1: CT demonstrating a soft tissue lesion on the superior aspect of the bony ear canal. Sagittal MRI image demonstrating a lesion on the superior aspect of the bony ear canal, isointense to brain parenchyma on T1-weighted sequence (B).

The patient subsequently underwent endoscopic assisted excision of the lesion under general anaesthetic. Intraoperatively, the superiorly based well-circumscribed opaque lesion was visualised arising from the bony-cartilaginous junction, abutting the tympanic membrane. It was partially adherent to the tympanic membrane immediately adjacent to the lateral process of the malleus and the attic. The mass was peeled off the pars flaccida, and a subsequent small attic perforation was repaired with Gelfoam.



2. Intraoperative image of the superiorly-based, opaque external auditory canal lesion

Histopathological analysis demonstrated a mass with closely packed bundles of plump eosinophilic cells. Immunohistochemistry shows diffuse positive staining for smooth muscle actin and negative staining for S100 and desmin. Staining for CD34 highlights the numerous small vessels within the lesion. There was no evidence of significant nuclear pleomorphism or increased mitotic activity. The findings are consistent with angioleiomyoma.



3. Haematoxylin and eosin staining shows a polypoid mass partly covered by attenuated squamous mucosa (A). The mass consists of closely packed bundles of plump eosinophilic cells with scattered small vessels present throughout (B).

Further immunohistochemistry demonstrates diffuse positive staining for smooth muscle actin with negative staining for S100 and Desmin (C). Staining for CD34 highlights numerous small vessels within the lesion (D).

The patient recovered well postoperatively with complete re-epithelisation achieved within 4 weeks of surgery. Attic repair was successful with subjective reduction in tinnitus. Postoperative audiogram showed no significant change.

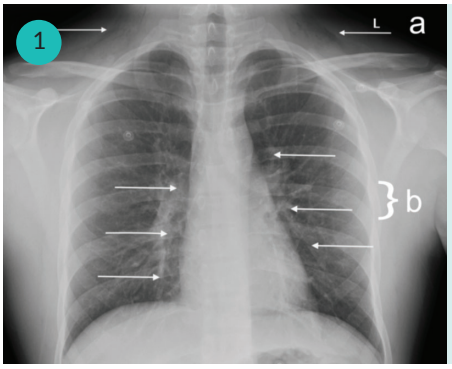
Pearls:

- Angioleiomyomas are benign tumours arising from smooth muscle cells, which typically occur in the alimentary tract, uterus or lower limb in the 3rd to 6th decade of life.
- Tumours of smooth muscle are quite uncommon in the head and neck region. It is very uncommon for a leiomyoma to occur in the external auditory canal.

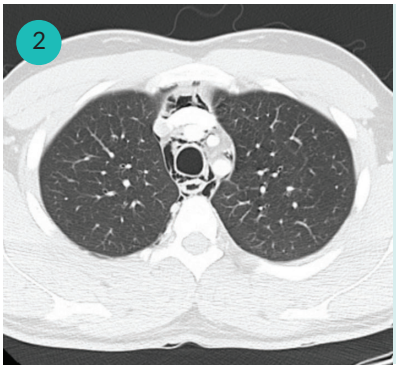
Case 3: Retropharyngeal emphysema with cocaine and ecstasy use (Presented at RACS meeting 2019)

A 21-year-old male presented to Emergency with sudden onset pleuritic chest pain and subcutaneous emphysema with no cardiorespiratory or trauma history. The patient did use nasally inhaled cocaine and ecstasy 20 hours prior to presentation. On examination, he was tachycardic, hyperreflexic and hyperthermic, with bilateral supraclavicular subcutaneous emphysema.

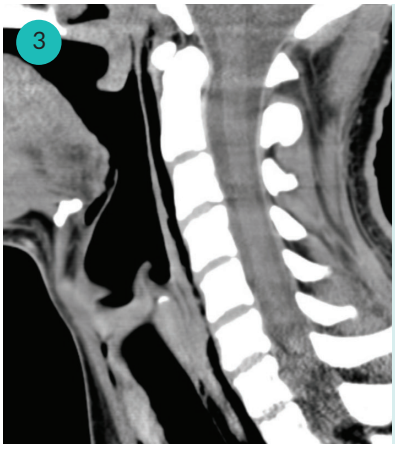
Flexible nasendoscopy showed normal anatomy and airway. Chest x-ray showed evidence of pneumomediastinum and subcutaneous emphysema. CT scan revealed extensive retropharyngeal emphysema extending from the base of skull to the aortic arch. There was no pneumothorax or pneumorrhachis, and gastrograffin swallow the following day showed no evidence of oesophageal perforation. Blood tests were unremarkable. He was admitted to hospital for observation and discharged 2 days later with no complications.



CXR demonstrating (a) supraclavicular subcutaneous emphysema and (b) pneumomediastinum with pericardial shadowing



Axial CT showing free gas surrounding hilar structures including the aortic arch



Sagittal CT showing retropharyngeal emphysema from skull base into mediastinum

Pearls:

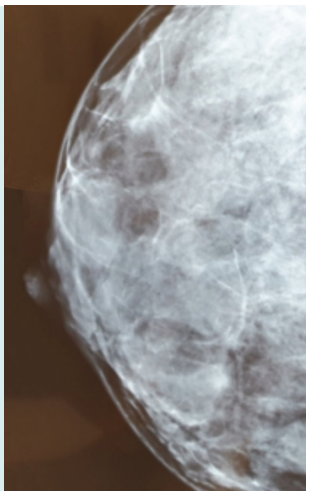
- Given the prevalence of both cocaine and MDMA in our society, this case emphasises the need for an otolaryngologist to take a careful history and examination when assessing patients with SPM and subcutaneous emphysema.
- Appropriate investigations are recommended to exclude serious complications such as oesophageal perforation or pneumothorax.

BREAST CANCER

- with Breast, Thyroid and General Surgeon, Dr Sharon Laura

Breast Density and Breast Cancer

Breast density refers to how much glandular tissue there is in the breast, related to the fatty tissue. For most women, breasts become less dense over time, especially after menopause. For some, breast density remains high. Breast density is graded BIRADS 1 to 4, with 4 being the highest breast density. BIRADS 4 breasts look mostly white on a mammogram. Cancers also look white on a mammogram, so cancers can blend into the background tissue, making them harder to detect. High breast density is now recognised as a risk factor for breast cancer. The ideal screening programme for these patients remains controversial. Digital mammogram tomography and ultrasound annually could be considered for patients of screening age. MRI could be discussed as an alternative to a mammogram, especially for a patient under 50 years old. Ideally the patient should see their GP for a formal annual breast examination. The patient should perform breast self-examination monthly and see their doctor promptly if there are any changes / lumps.



Mammogram of breast tissue.

For most women, breasts become less dense over time, especially after menopause. For some, breast density remains high.

Breast Cancer Gene Testing

If a patient has a significant family history of breast cancer, they may be eligible for a Medicare rebated breast MRI annually. To obtain the Medicare rebate, the MRI needs to be requested by a Breast Specialist. Significant family history includes multiple first or second degree relatives on the same side of the family with either breast or ovarian cancer, or both. Family members diagnosed less than 50 years old and especially less than 40 years old, is significant. Ashkenazi Jewish ancestry is also a risk factor. Any male breast cancer relative is also a risk. If concerned about your patient's family history and breast cancer risk, they should be referred to a geneticist and a breast surgeon. It is most helpful if the geneticist tests an affected family member. If they test positive, the test is offered to other family members. Although your unaffected patient could pay for a gene test, a negative result is not reassuring in this context.

Breast Biopsy - Fine needle or core?

Any new breast lesion that is not a simple cyst should be considered for biopsy. If the lesion is thought to be a complex cyst, a fine needle biopsy would be ideal. This will hopefully demonstrate collapse of the lesion at the time of biopsy, confirming its cystic nature. If the lesion is solid, a core biopsy will give much more information about the nature of the lesion and is less likely to be insufficient. A core biopsy will also confirm if a malignant lesion is invasive or non-invasive, helping plan surgery to decide if lymph nodes require removal.

Smoking and Breast Cancer

Some studies suggest an association with smoking and breast cancer, especially for young women. Smoking is linked to increased risk of complications from breast surgery, with poorer healing and a higher risk of infection. It is important that our patients stop smoking before breast reconstructive surgery or there is a higher risk of skin or nipple necrosis. Smoking is discouraged during radiotherapy as it could increase the risk of lung cancer. Smoking can increase the risk of blood clots, already higher in the peri-operative period and for patients taking Tamoxifen or undergoing chemotherapy. Let's all work together to encourage our patients to quit!

The importance of Vitamin D for our Breast Cancer patients

Adequate levels of Vitamin D are important for bone strength. Most post-menopausal breast cancer patients will be on an Aromatase inhibitor for at least 5 years. Over time, a side effect can be reducing bone density. For this reason, a bone density study is recommended every 2 years when on Aromatase inhibitors. Normal levels of Vitamin D aids calcium absorption from the gastro-intestinal tract and allows calcium delivery into the bones to keep them strong.

Dr Sharon Laura provides a wide range of general surgical services for women and men on the Central Coast, in both the private and public sector.

Areas of specialty include:

- Breast surgery and oncoplastic breast surgery
- Thyroid and parathyroid surgery
- General and laparoscopic surgery
- Upper endoscopy and colonoscopy

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AWARD WINNING PRIVATE MATERNITY CARE, RIGHT HERE ON THE CENTRAL COAST

Gosford Private Hospital has recently introduced an Australian-first model of care to support neonates within its private Maternity Unit. The on-site and on-call Paediatric model, known as the Gosford Private Paediatric Specialist Network (GPPSN), was developed in response to a shortage of experienced Paediatrician and Neonatologist specialists on the Central Coast.

Under the model, highly skilled Paediatricians and Neonatologists provide 24 hour, 365 day a year coverage for the Unit, with an on-site consultation offered for each newborn baby every day during their hospital stay. The service is delivered at a low $100 out-of-pocket cost to parents, due to Medicare rebates, while delivering individualised and responsive care to this highly specialised and ever changing cohort of patients.

Renowned, highly experienced Paediatricians and Neonatologists from throughout New South Wales have been attracted to Gosford Private as a result of the GPPSN, facilitating shared knowledge between the Specialists, whilst also improving the knowledge and skill base of the staff. This has been complemented by improved facilities and equipment at the Hospital, including the introduction of a Bubble CPAP machine to ventilate children in the Special Care Nursery.

The GPPSN has increased the support for families and babies locally, including improving the ability to identify and treat high risk babies on-site, without them having to transfer to hospitals in Sydney or Newcastle as they had previously.

Research shows that early interventions in the neonate's life can directly impact childhood development including diabetes, obesity and development milestones. GPPSN focuses on maintaining all aspects of the health and wellbeing of all neonates. Through access to expert advice, all parents are provided nutritional advice, psychosocial advice and information on successful preventative health initiatives including vaccinations. By partnering with consumers and engaging with them daily at the bedside, GPPSN has ensured tailored care is provided based on the emerging needs of each neonate.

In recognition of the new model, GPPSN recently won the 2019 Gosford, Erina and Coastal Chamber of Commerce and Industry Award for Excellence in Innovation, and will now be a Finalist at the 2019 Central Coast Business Awards in October.

Nurturing, woman-centred Maternity Care

Gosford Private recognises that right from the beginning of life, the importance of safe, tranquil and comfortable spaces plays an important role in our sense of health, belonging and wellbeing.

The recent re-styling of the hospital's Maternity Unit with warm, natural elements ensures all families are able to relax in a comfortable environment, promoting a feeling of security and being 'at home'.

A growing body of evidence exists demonstrating positive outcomes for women when birthing in a 'homelike' environment. The medicalised, highly technological environment of hospitals can unknowingly concern families and increase anxieties. Fear is counterproductive to labour, so the importance of an environment which supports security, safety, warmth and comfort is beneficial.

At Gosford Private, our qualified and experienced Midwifery team understand that an atmosphere promoting peace and calm for your baby's birth supports the release of endorphins, and promotes a satisfying and joyous experience.

Combined with the 'homelike' environment, the introduction of warm baths and water immersion births helps to promote freedom to move and promote many therapeutic benefits, including feelings of positivity and increased satisfaction.

After birth, women and their partners are provided ongoing, compassionate care within the Maternity Unit, supporting each family's sense of purpose, belonging and personal growth. This includes partners 'rooming in' with new mothers, complimentary manicures/pedicures, a High Materni-Tea twice a week, a weekly movie night, and the provision of meals through the couple's week-long stay.

Gosford Private provides an atmosphere designed to empower women to feel safe and nurtured, while remaining under the care of their chosen Specialist.

Gosford Private Maternity MUM, Robyn Gasparotto, was recently presented with a Luye Life Sciences 25 Year Award for her exceptional commitment to patient-centred care. The International Award recognises the innovative programs and service-developments introduced by Robyn and her team at Gosford Private Maternity over the past 18 months.

Dr Jini Mandapati is one of the five experienced Obstetrician/ Gynaecologists at Gosford Private Hospital. Jini has over 20 years' experience providing one-on-one care in all aspects of obstetrics and gynaecology, managing pregnancies and delivering babies for women who have straight forward or complicated pregnancies. Jini's woman-centred care for all families includes outstanding clinical expertise, compassion and knowledge.

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INTRODUCTION TO THEORIES BEHIND INFANT MENTAL HEALTH

- with Psychiatrist, Dr Sangeetha Makielan

Bowlby's attachment theory (Bowlby, 1969)[1] introduced that the infants' early relationships with parents are internalised as 'working models' for later relationships. These early attachment relationships are represented by proximity seeking behaviour by the infant when there is a perceived threat such as the presence of unfamiliar people, surroundings, sudden noises, hunger, tiredness and illness. Infant's explorations begin from the 'secure base' of the parent, in general when the level of perceived threat is low.

The interpersonal world of the infant might begin to be moulded in the first weeks depending on the consistency, tenderness and delight in the parent's behaviours. (Stern, 1985)[2]

Winnicott (1964)[3] is remembered for his most insightful statement "There is no such thing as a baby," suggests that an infant does not exist by himself/herself but is in essence part of a dyadic relationship with his mother. He observed that the child of a distressed mother can only live reactively. Infants life is halted, in the hope that a real relationship with the parent will become possible in the future. Most are left forever longing for the parental care they never received.

Selma Fraiberg (1980)[4] coined the term 'parent–infant psychotherapy' to describe the treatment of disturbances in the infant–parent relationship in the first 3 years of life. This approach is based on the perception that parents may re-enact with their young child discords with their own attachment figures that remain unresolved. According to Fraiberg (1980), it is necessary for a parent to identify, remember and confront the underlying emotional pain associated with childhood experiences in order to positively change the parent–infant relationship. As the mother gains insight into past experiences and empathy for her own feelings, she is better able to empathize with her infant's needs and feelings.

Allan Schore (2001)[5] described the mechanisms by which the mother in a highly dysregulated, traumatised state would negatively imprint the infant's early developing right brain. The caregiver will also mediate the transition between these emotional states. Mirroring by the attuned caretaker amplifies the infant's emotional state. In physics, when two systems match it creates what is called "resonance," whereby the amplitude of each system is increased, comparable to face-to-face play between an infant and an attuned caretaker who creates emotional resonance and amplifies joy.

Together, infant and mother move from low arousal to high positive arousal which helps the infant to extend his window of tolerance for intense positive emotions, a key developmental task.

Infant mental health relies on perinatal mental health and hence it is very important for us to identify the needs and support the families at the early stages.

Watch this space for more infant and perinatal mental health presentations organised by Brisbane Waters Private Hospital.

1. Bowlby, J. (1969). Attachment and Loss. Vol. 1: Attachment. New York: Basic Books.
2. Stern, D. (1985). The Interpersonal World of the Infant. New York: Basic Books.
3. Winnicott, D. W. (1964). The relationship of a mother to her baby at the beginning. In The Family and Individual Development, ed. D. W. Winnicott, pp. 17–18. London: Tavistock
4. Fraiberg, S. (1980). Clinical studies in infant mental health. New York: Basic Books.
5. Schore, A. N. (2001a). The effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. Infant Mental Health Journal, 22, 7–66

Dr Sangeetha Makielan is an accredited member of the Faculty of Child & Adolescent Psychiatry. She sees children under the age of 18, perinatal and postnatal mothers and families of the children and mothers.

Specialities:

- Child and Adolescent Psychiatry
- Perinatal and Infant Psychiatry – Antenatal & Postnatal depression and Postpartum Psychosis, etc.
- Adjustment difficulties with pregnancy or parenting
- Grief associated with fertility and perinatal loss
- Psychotherapy - Individual, Parent-Child, Family Therapy

Dr Sangeetha Makielan

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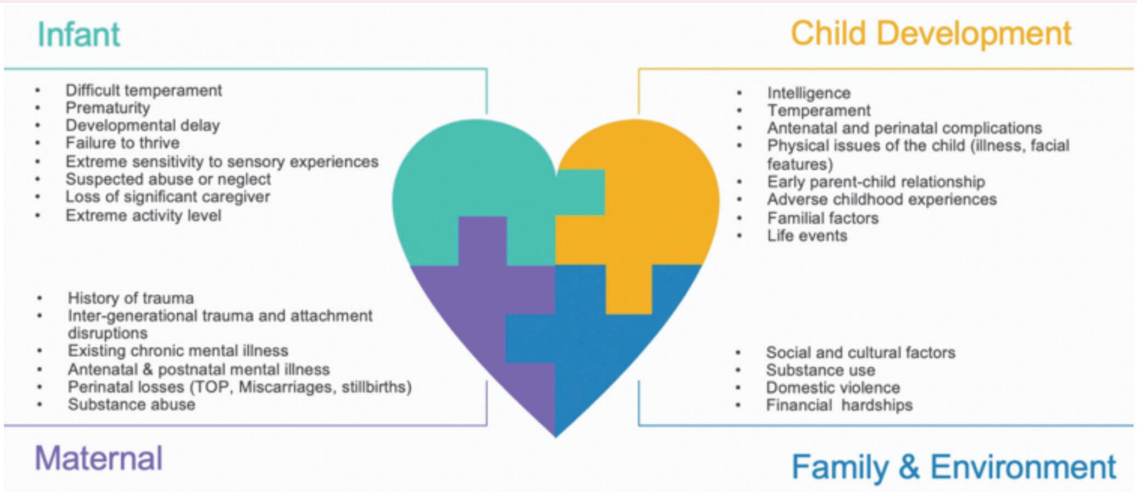
Key factors in infant and perinatal mental health



HOW DO WE, OR DO WE NEED TO, TREAT ATHEROSCLEROTIC RENAL ARTERY STENOSIS?

- with Nephrologist, Dr Karthik Kumar

Atherosclerotic renal artery stenosis (ARAS) can present as one of four major clinical syndromes viz, silent renal artery stenosis (RAS), ischaemic nephropathy (IN), renovascular hypertension and flash pulmonary edema (FPE). Ischemic nephropathy represents CKD secondary to chronic renal hypoperfusion from renal artery stenosis.

RAS is the cause of end stage kidney disease in10-15% of patients commencing renal replacement therapy. RVH refers to high blood pressure secondary to neuro-hormonal cascades from renal artery stenosis.

RAS versus RVH

Although used Interchangeably, it is crucial to differentiate RAS from RVH. RAS is an anatomical diagnosis while RVH is a pathophysiological consequence of a hemodynamically significant renal artery stenosis. This begs the questions, is every renal artery stenosis hemodynamically significant, and if not, how do we identify a renal artery stenosis that is hemodynamically significant? The answer to this question will identify patients with RAS who would benefit from renal artery revascularisation (RAR).

How to define criticality of RAS

Critical RAS is present when there is a reduction in perfusion pressure sufficient to activate intra-renal renin- angiotensin system (IRAS). Activation of IRAS cascades to RVH, pro inflammatory and athero-oxldative state that culminates in progressive renal scarring, decline in GFR and persistent hypertension.

There is evidence to suggest that 70% stenosis and a trans-lesional peak pressure gradient of 20mmHg can result in activation of IRAS. However these criteria fail to identify patients who would have physiological recovery of RVH and its downstream cardiac and neuro-humeral consequences following renal revascularisation.

Hence, radiological success and anatomical restoration of blood flow should not be the sole goal for renal angioplasty or stenting. It's crucial to include resolution of RVH, delaying progression of IN, preventing FPE and total renal artery occlusion and reduction in cardiovascular events and death.

What do trials say?

Uncontrolled trials and RCTs (DRASTIC, ASTRAL, STAR) have suggested revascularisation, not beneficial in achieving a variety of goals including resolution of hypertension and slowing decline in GFR. These trials have been criticised for design, methodological issues and patient recruitment criteria.

CORAL study(2015;RCT, n = 947,5 year follow up) compared optimal medical therapy (OMT) with a combination of optimal medical therapy and revascularisation. It looked at hard renal and cardiovascular end points. Severe RAS was defined by duplex or angiographic criteria (>60%). OMT included stringent glycaemic and hypertension control (< 149/90), antiplatelet and lipid lowering therapy. It concluded that revascularisation did not confer an additional benefit to prevention of clinical events when added to OMT in patients with ARAS with hypertension or CKD. This trial was criticised for methodological issues. This study was not powered to look at the benefits of revascularisation over OMT in specific subgroups of refractory, accelerated or malignant hypertension, rapid decline In GFR attributable to RAS, RAS with solitary or transplant kidney or bilateral RAS.

A recent Cochrane review suggested RAR was not superior to OMT for the treatment of ARAS. However, RAR did have an insignificant impact on diastolic blood pressure and reduction in antihypertensive requirement.

1. Predictors for poor renal recovery and resolution of RVH post revascularisation

- Elderly patient
- Chronic hypertension
- Heavy protelnuria
- Advanced renal insufficiency (EGFR < 45ml/min)
- Ostial renal artery stenosis
- Marked renal atrophy (bipolar length <7cm)
- Duplex criteria: Resistive index (RI) of >0.8 (renal scarring)
- Absent nephrogram on contrast imaging/ Impaired cortical blood flow
- Renal biopsy: Marked nephro-arterlosclerosis

2. Predictors of resolution of RVH post revascularisation

- Renal size >9cm
- >70% stenosis
- Duplex ultrasound: RI of <0.6, Renal artery: aorticpeal systolic ratio: >2.5:1
- Trans-lesional peak pressure gradient
- >20mmHg and mean pressure gradient >10mmHg
- Elevated BNP pre-revascularisation

3. Indications for RAR in patients with critical RAS (>70%)

- Refractory hypertension (3 or more medications)
- Worsening GFR
- Contralateral renal artery occlusion
- Bilateral critical RAS or RAS to solitary kidney
- Cardiac (flash pulmonary oedema, heart failure, angina pectoris)

Conclusion

RAS and RVH should not be used interchangeably. Success of revascularisation should be assessed against resolution of hard clinical end outcomes and not with radiological recovery.

Despite the paucity of evidence, revascularisation may still have a role in selected cohort of severe ARAS (Table 3).

We still await a properly designed trial that determines the added advantage of RAR when added to OMT in a carefully selected patient cohort.

Dr Karthik Kumar is a nephrologist and transplant physician with special interest in secondary hypertension , duplex reno-vascular ultrasound, and sepsis in peritoneal dialysis.

He has contributed to the CARI guidelines on renal artery stenosis and to the implementation phase of CARI guidelines on infection prevention in peritoneal dialysis.

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PRESERVATION RHINOPLASTY: A NEW PARADIGM

- with Plastic, Reconstructive and Aesthetic Surgeon, Dr Mohammad Mohaghegh

Rhinoplasty surgery is inclined to progress in generational eras, which are often linked with milestone publications and concurrent popularisation of innovative surgical methods. Sheen established his position as the greatest rhinoplasty surgeon since Joseph by his epic text Aesthetic Rhinoplasty in 1987. He summarised three main concepts. First, Sheen considered the rhinoplasty as an actual aesthetic procedure which needs preoperative analysis, operative planning and surgical execution. Second, in primary rhinoplasty, he substituted Joseph's reduction-only concepts with a balanced approach merging reduction and grafting. Third, he radically improved the previously gloomy results for secondary rhinoplasty. Now it was possible to achieve a functional and aesthetically appealing nose, rather than simply performing a "nose job" quickly.

The open approach rhinoplasty became an alternative option to closed approach rhinoplasty, which had reached the height of its clinical use. Rhinoplasty surgeons quickly embraced the open approach following the successful work by Goodman, Anderson, Daniel, Gunter. There were three reasons behind this transition. First, enhanced visualisation for analysis, surgery and teaching were available through the open approach. Second, newly designed techniques were developed which were deemed either unachievable or technically challenging by the closed approach. Examples of this are: tip suturing, advanced septal reconstruction and mid-vault reconstruction. Third, the open approach was recognised as being more applicable for a variety of nose types, such as broader ethnic groups. This also meant that the learning curve for younger surgeons became shortened.

As the most commonly performed aesthetic surgical procedure, rhinoplasty surgery became very popular. Although aesthetic and functional results were improved, minor revisions and major secondary rhinoplasties still existed. The epic text Structural Rhinoplasty: Lessons Learned in 30 years, by Triumi summarised his experiences with open structural rhinoplasty. By drawing from three decades of experience using reduction rhinoplasty techniques, Triumi showed how excellent early outcomes were compromised with the passage of time. It is necessary, in order for a structure to resist the power of contracture, to have a structural support. Triumi's principle of stabilising the base first, and building outward using multiple grafts taken from ribs, is illustrated in multiple difficult cases.

Notwithstanding this triumph, we need to analyse the reasons why an experienced surgeon performing a primary rhinoplasty would create complications that require secondary revision with the morbidity of a rib graft. The answer is that the rhinoplasty must be performed in a fundamentally different way – this leads to the next revolution – preservation rhinoplasty. This process replaces the resection with preservation, excision with manipulation, and secondary rib reconstruction, with minimum revisions. Recent anatomical studies, newly developed tip suture techniques and finer surgical techniques, form the basis of preservation rhinoplasty.

Our understanding of nasal anatomy and its application in nasal aesthetic and surgical techniques has changed greatly through the last decade. The arrangement of soft tissue coverage including the nasal ligaments and osseocartilaginous vault are the two most fascinating. The nasal ligaments, which act as a crucial functional and aesthetic driver, have previously been ignored. For example, stabilisation of the internal valve is achieved by the help of the vertical scroll ligament through the transversalis muscle. Though surgical repairing of the vertical scroll ligament can highlight the alar groove and sustain its function; anatomical study has shown persuasively that bony hump is a combination of cartilaginous vault, which needs to be preserved, and an overlying thin "boney cap" which can be simply rust away. Furthermore, the keystone which can be altered from convex to straight by removing its underlying cartilaginous septal support, is a semi-mobile chondrosseous joint.

Cakir recognised that by using a closed approach he could attain similar results with more control and less morbidity. Preserving the nasal ligaments and manipulating the cartilages with limited resection are the aims. In comparison to conventional techniques, he has found with the subperichondrial approach there is less postoperative morbidity (swelling, numbness) and far simpler revision. Cephalic alar preservation and alar tensioning are two additional examples of his fundamental changes. Conventionally, an automatic step in tip rhinoplasty surgery was to excise the cephalic lateral crus. Yet, Ozmen et al and Gruber et al have shown less alar notching and less need for alar rim graft by preserving the entire lateral crus. Alar malposition always considered as one of the most challenging tip deformities and being treated by alar transposition and lateral crural strut grafts. Cakir and Davis have proven that it is not essential to transpose the alar cartilage and that medial tensioning is sufficient to ablate alar resection or additional grafts.

Dorsal resection is considered the most fundamental component of any traditional rhinoplasty. It requires a combination of osteotomies and midvault reconstruction after destroying the keystone area. The majority of rib graft usage in secondary cases are for dorsal reconstruction. Saban has updated the push down operation which preserves the dorsum, similar to Goodman's popularisation of Rethi's open approach. The need for immediate midvault repair is minimised using Saban's technique of dorsal preservation and permits a minor revision rather than major rib graft secondary rhinoplasty.

Over time, we will be able to expand the indications, refine new surgical techniques, and solve the inevitable problems, as we are only at the beginning of this revolution. Our patients will receive greater predictability with less risk, and consequently benefit from this advancement. Preservation rhinoplasty will reduce the risk of a bad result or "nose job looks", which is the main reason why patients don't seek rhinoplasty, and will lead to simple revisions rather than major secondary procedures, both compelling reasons why surgeons should choose the preservation rhinoplasty approach.

Dr Mohammad Mohaghegh spent more than 20 years of rigorous general surgery and plastic surgery training, including a MPHil degree, before being awarded his FRACS in Plastic and Reconstructive surgery.

He has a strong interest in Rhinoplasty and breast surgery including aesthetic and reconstruction but his expertise covers a large variety of procedures in Plastic, Reconstructive and Aesthetic Surgery. Locally he operates at Gosford Private Hospital and Brisbane Waters Private Hospital.

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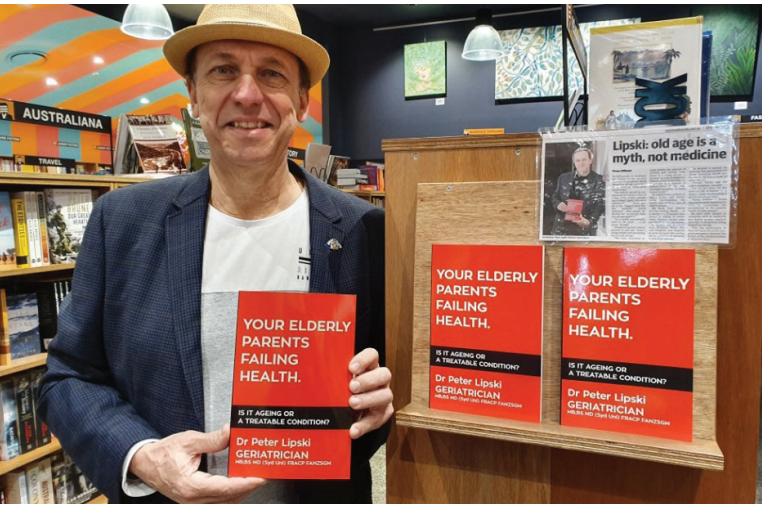
YOUR ELDERLY PARENTS FAILING HEALTH. **IS IT AGEING OR A TREATABLE CONDITION?**

- with Geriatrician, Dr Peter Lipski



This new book is the first to highlight that "Old Age" is a myth, not medicine, and that many older Australians are denied proper medical care due to their symptoms being blamed on "old age".

This is the biggest change in Aged Care in over 37 years by challenging ageism, negative attitudes to the elderly and providing holistic comprehensive medical care. Australians will be shocked and surprised by what they read in this book!

Dr Peter Lipski's new book discusses how holistic medical care at any age can alleviate symptoms resulting from treatable medical conditions, can provide massive cost savings to Governments and better health outcomes with improved medical care of the elderly.

Dr Peter Lipski's areas of special interest include:

- Frail elderly with multiple medical problems.
- Geriatric malnutrition.
- Adverse drug reactions in the elderly.
- Falls and balance disorders in the elderly.
- Delirium/confusion in the elderly.
- Dementia.
- Medical fitness to drive assessments for the elderly.
- Swallowing disorders in the elderly.
- Osteoporosis with fractures.
- Incontinence.
- Peri-operative medical assessments.
- Cognitive capacity assessments.

Dr Peter Lipski
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His new book warning about the impact of ageism and negative stereotypes on the medical care of older people is a must read for all in the aged care sector.

Dr Lipski considers ignorance and blaming "old age" for everything from breathlessness to confusion as the greatest risk to the health of the elderly.

In fact, he asserts that this ageist attitude can mean older people are denied proper medical care which could improve their day to day function and quality of life.

He hasn't written a text book. This is predominantly a guide for older people and their families, but it has plenty of information that can be used by anyone involved in the care of older people.

Dr Lipski delivers an overview based on nearly four decades of experience in geriatric medicine and describes the common issues and questions asked of him by patients and their families. He suggests how they can be dealt with to help older people live the best life possible in their years ahead.

Dr Lipski describes common challenges in the health of the elderly including:

- Malnutrition and starvation of the elderly.
- Adverse drug reactions - the commonest cause for preventable hospital emergency department presentations.
- Over treatment of diabetic frail elderly.
- Incorrect measurement of Blood Pressure by Doctors, Nurses and Hospitals.
- Impaired older drivers and the burden of drivers with dementia.
- Failure of Single Organ Medicine to deal with the frail elderly effectively.
- Blaming serious treatable medical conditions on "old age".
- How to prevent falls in the elderly.
- Warning signs of acute confusion and why it is so commonly missed and not treated.
- Why Surgeons should not be operating on frail older patients alone.

He highlights malnutrition as one of the greatest challenges facing the health system because it contributes to serious complications and early death, but is preventable.

Older patients can have spectacular improvements in their symptoms and condition with simple holistic medical treatment. The cost savings for better health care for the elderly are estimated at $3billion per year from Dr Lipski's "White Paper" (2007) which was endorsed by State Ministers for Health and Ageing .

This book fills a huge gap in the public's knowledge and challenges negative stereotypes that cause elderly people to suffer unnecessary distress, illness and loss of function.

Many people have experienced the frustration of seeking help for the declining health and general function of older family or friends only to be told it's just "old age" that is causing their dizziness, falls, confusion, malnutrition, urinary incontinence, breathlessness and swollen ankles.

It is far too common to be told "what do you expect - he is 89 years old you know", says Dr Lipski. In his book he explains how even the most frail elderly people can have dramatic improvements from comprehensive care, accurate diagnoses, attention to detail, getting the simple things right, and treating reversible factors.

ADMIN UPDATES

Prior to admission to either Brisbane Waters Private Hospital, Gosford Private Hospital or Tuggerah Lakes Private Hospital, all patients will have a membership eligibility check conducted with their relevant Health Fund. This will determine if the patient is covered for admission and if there is any out of pocket expenses relating to the hospital admission. It is recommended that all patients consult with their health fund prior to admission which will also confirm any expenses.

Patients not covered by Private Health Insurance are required to obtain an Uninsured estimate well in advance of their surgery. Surgeons will provide the patient with the relevant MBS Item Number which is required for the estimate. Patients are requested to contact the hospital to obtain an estimate:

Brisbane Waters Private Hospital
Phone: 02 4341 9522
Email: frontdesk.brisbanewaters@healthecare.com.au

Gosford Private Hospital
Phone: 02 4324 7111
Email: gos.preadmission@healthecare.com.au

Tuggerah Lakes Private Hospital
Phone: 02 4310 9100
Email: enquiry.tlph@healthecare.com.au

These fees are payable 7 days prior to admission date. Please contact the relevant hospital for further information.

Admission Documentation

The patient's admission booklet is to be submitted to the relevant hospital at least two weeks prior to the admission date.

On the day of admission patients are required to complete a few mandatory admission checks, such as confirming date of birth, address and next of kin details. Of course there is always some paperwork to sign as well. Patients will be asked to sign an "**Informed Financial Consent**" which outlines the expected financial implications to the patient and their health fund. In addition they will sign a "**National Claim Form**" – this will give us authority to claim the hospital stay from the fund on behalf of the patient.

Our Administration Staff are always on hand to assist with these documents and only too happy to help patients that need assistance.

Online Mental Health Referrals now available

The Central Coast Clinic at Brisbane Waters Private Hospital has now made it easier than ever to make Mental Health inpatient and day patient referrals.

The Clinic is now accepting direct patient referrals from GPs/Specialists through the website at **centralcoastclinic.com.au/doctors/gp-specialist-mental-health-admission-referral-form**

TUGGERAH LAKES PRIVATE HOSPITAL
COMMUNITY OPEN DAY

OPEN DAY
Saturday
21st September
10am - 1pm

Visit the Central Coast's newest hospital, including:

- Behind-the-scenes tours
- Meet the Team
- Children's entertainment
- Giveaways & Prizes
- Sausage Sizzle and more...

Tuggerah Lakes
Private Hospital
a member of the healthe.care group

Cnr Pacific Highway and Craigie Avenue, Kanwal
(directly opposite Wyong Public Hospital)
tuggerahlakesprivate.com.au

Annual Mental Health Conference
Saturday 26th October 2019

Venue: Crowne Plaza Terrigal Pine Tree Ln, Terrigal 2260
Time: 11.30am for a 12.30 start. Working lunch provided

SAVE THE DATE

Renowned Keynote Speakers

Dr Greg Pearson
Psychiatrist
Director of the Central Coast Clinic at Brisbane Waters Private Hospital and Director of the Hills Clinic

Dr Mark Cross
Psychiatrist
Author of 'Changing Minds', SBS TV Show 'Changing Minds'

Dr Ted Cassidy
Psychiatrist
Co-founder of The Hills Clinic in Sydney and Co-founded TMS Australia

Dr Tanveer Ahmed
Psychiatrist
Author of two books, The Exotic Rissole and Fragile Nation. Often appears in media, most recently Channel 9's 60 Minutes - Gaming Addictions in Adolescents

Brisbane Waters
Private Hospital
a member of the healthe.care group

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