

INFOCUS



ORTHOPAEDIC EDITION

BUNION SUFFERERS GET
BACK ON THEIR FEET

BALANCING THE KNEE;
BALANCING THE RISK

SOLUTIONS AT HAND
FOR ARTHRITIS PATIENTS

KNEE JOINT RECOVERY THE GOAL

ISSUE TWELVE



Brisbane
PRIVATE HOSPITAL



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INFOCUS

ISSUE 12

GM UPDATE

BY MAIRI McNEILL

Welcome to the 'orthopaedic edition' of In Focus.

At Brisbane Private, we are proud to be home to the largest team of private orthopaedic specialists in Queensland. Each year, we provide thousands of patients, including elite athletes and sporting teams, with exceptional care and outcomes. This edition features some of our valued surgeons who help make this hospital one of the leading private orthopaedic facilities in the State.

With the National Basketball League season about to kick-off, Brisbane Private will again be the official hospital partner of the Brisbane Bullets, with our surgeons, David Hayes and Darren Marchant, forming part of the medical team.

I'd like to congratulate knee surgeon, John Gallagher, who recently returned from Hawaii where he completed the Molokai Challenge - the unofficial world championships of surf ski paddling that involves a 53km paddle from Molokai Island to Oahu across the aptly titled "Channel of Bones".

The facade of our new building is now complete and the street view revealed. We are currently finalising the interior fit-outs and landscaping along Wickham Terrace, with construction set to finish late September. I would like to thank everyone for their patience over the last 14 months during the construction of the new building, and for their continued support of Brisbane Private Hospital.

BALANCING THE KNEE, BALANCING THE RISK



THIS PAGE: KNEE SPECIALIST AND ORTHOPAEDIC SURGEON, DR JOHN GALLAGHER
OPPOSITE PAGE: REAL-TIME PRESSURE MEASUREMENTS DURING TKR SURGERY; X-RAY AFTER TKR WITH VERASENSE DEVICE

It is a long-held conviction by many practitioners that total knee replacements should not be performed on patients under the age of 60, but a new device being trialled by a Brisbane Private surgeon is giving hope to young people with damaged or arthritic knees.

Age is a major factor affecting the outcome of primary total knee replacement (TKR), with revision rates for people under 55 years of age being four times higher than for those aged 75 years or over.

Knee surgeon John Gallagher said surgeons must balance the desire to grant younger patients with arthritic knees an effective solution through knee replacement, against the increased risks they face of premature failure.

With 50,000 total knee replacements (TKR) performed in Australia in 2015, an increase of more than 130 per cent from 2003, Dr Gallagher said it was more important than ever to give patients a knee replacement that will stand the test of time. He believes 'balancing' the knee is key and is trialling a device to assist in this process.

"In spite of all the advances in medicine over the past three decades we are still continuing to wear out our major load bearing joints at increasing rates which, in part, helps to account for the increasing volumes of knee replacements being performed every year," said Dr Gallagher.

"In addition to this, patients are expecting more and more from their implants and procedures, with many patients on their initial presentation insisting that they want their knee restored to "normal" so they can get back to doing "everyday normal activities".

"Sadly, as far as TKRs have come, most patients will never achieve knees that feel like "normal", but I do believe it is possible to improve a patient's ability to do some of their regular activities by taking the time during surgery to ensure the knee is balanced.

"I also believe a balanced knee will potentially allow for a decreased rate of wear and loosening, and if so, may help address a problem we face in dealing with the younger patient with arthritic knees,

who are no longer prepared to manage with non-operative strategies and temporising solutions, but instead are petitioning for knee replacement surgery."

Dr Gallagher said to achieve a balanced knee, surgeons needed to ensure the soft tissue tension around the replacement was close to equal, both medially and laterally, throughout flexion and extension.

To achieve this balance and ensure the knee is not "too tight or too loose", Dr Gallagher undertook a pilot study of 20 patients who underwent TKR using a new pressure sensor built into the trial liner inserted between the trial femoral and tibial components.

The device sends a radiofrequency signal to a computer in the operating theatre, allowing accurate, real time measurement of the soft tissue tension during surgery.

"The technology has allowed me to check and, where necessary, perform releases of the soft tissue restraints and/or revise the bony cuts already performed during surgery in order to achieve a balanced knee," said Dr Gallagher.

"The test patients are being followed up to assess their function, including lower limb alignment, range of motion and functional knee scores, and so far the early results are very promising, with all patients reporting good knee bending, function and alignment.

"We are also seeing a trend where patients are enjoying a better range of motion, however the number of patients is inadequate to achieve statistical significance.

"Anecdotally, these patients do appear to stop using their crutches and analgesia sooner and regain a steady reciprocating gait faster in most cases than I have seen using traditional technique."

Dr Gallagher said one of these patients was a 50-year-old woman who has had painful arthritic knees since she was an adolescent and had been wheelchair bound for a decade.

He said after her bilateral TKR using the new device, she was able to walk confidently on uneven ground for the first time in her life, and even taken her first bushwalk.

"My hope and belief is that by balancing the knee, we not only help patients achieve that "more normal feeling", but to also allow them to live an active life and increase their likelihood of achieving more demanding lifestyle goals such as skiing and surfing," he said.

"It may also allows us to balance the risk of premature loosening and failure in younger TKR patients."

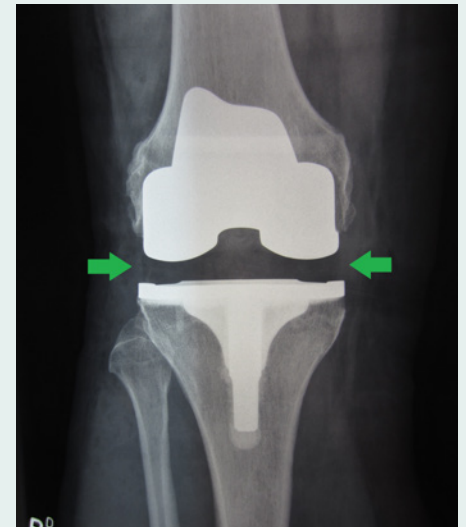
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BUNION SUFFERERS GET BACK ON THEIR FEET

Advances in surgical techniques have reduced pain and improved recovery times for people struggling with debilitating bunions, with most patients able to weight-bear immediately after surgery.

About one in three Australians will develop a bunion in their lifetime, medically identified as Hallux Valgus, but traditionally, surgical treatment has been extremely painful and often unreliable.

However newer techniques are significantly improving the outcomes of bunion surgery, and Brisbane Private orthopaedic surgeon, Terry Saxby, said surgery could be life changing for sufferers.

“Some patients struggle with bunions all of their lives and develop a severe deformity, which can require surgery to help realign the bones and ligaments,” he said.

“Bunions do increase over time, and while the progression is slow, it is advisable to consider surgery before the deformity is too severe.

“Historically, bunion surgery has had a poor reputation, with many people perceiving that the outcome was unreliable and the procedure was very painful.

“However, newer techniques that reduce the size of incisions have gained popularity, and can significantly improve the outcome, getting patients back on their feet, sooner.”

The technique involves the surgeon making three or four small incisions of just a few millimetres under x-ray to reach the bone from various access points.

The surgeon will perform an osteotomy (cutting of the bone) and realign the foot, with a screw inserted across the fracture line to correct the bone deformity. It also often requires soft tissue release or repair to increase the deformity correction.

“Previously, a patient would have to wear a cast and plaster booties post-surgery, but using smaller incisions can speed up wound healing and allow a patient to weight-bear immediately,” said Dr Saxby.

“It means individuals suffering from bunions on both feet can undergo bilateral surgery.

“The vast majority of patients who undergo bunion surgery experience a significant reduction in pain and improvement of alignment of their big toe.

“Despite advancements in surgical techniques, recovery is still significant and there is not one procedure to suit all candidates. It depends upon several factors, including age, severity of deformity, and whether the patient has arthritis.

“Good candidates for surgery include people with significant pain, a moderate to severe deformity, and those who fail to obtain pain relief with a change of footwear or simple medications.

“Bunion surgery should not be carried out for cosmetic reasons alone. Patients can require several weeks off work, and need to wear some type of post-operative shoe for a period of four to six weeks.

“Further, it can take up to six months before an individual returns to full function, including wearing fashionable footwear.

“If there is no pain in the foot before surgery, then this is a contraindication to surgery.”



Dr Saxby said a discussion with a specialist could help determine the best course of treatment.

“If surgery is not necessary, or isn't an option, patients should opt for wider shoes or padding to reduce pain and discomfort,” he said.

Bunions, which are known to be hereditary, occur when the great toe angles towards the lesser toes, producing a bony lump on the inside of the foot. The condition often affects middle-aged women, but juvenile bunions are not uncommon.

Surgery can be carried out as a day case or an overnight stay in hospital, with the procedure usually taking less than an hour to perform on one foot.

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ARE WORKCOVER PATIENTS SUITABLE FOR SPINAL FUSIONS?



ORTHOPAEDIC SPINAL SURGEON, DR PAUL LICINA

There is a well-established consensus that WorkCover patients have poorer outcomes after spinal fusion surgery when compared with private patients, however the literature doesn't take into account specific clinical presentations, according to a Brisbane Private surgeon.

Orthopaedic spinal surgeon Paul Licina recently reviewed the outcomes of more than 500 of his previous lumbar interbody fusion patients and compared WorkCover and private patients, finding that those with predominant leg pain had equivalent improvement to private patients.

Dr Licina said that published literature showed the involvement of compensation and litigation adversely affected reported patient outcomes, though not necessarily radiographical or clinical outcomes.

He said the problem was the literature looked at the WorkCover population as a whole, without taking into account the individual patients and their specific clinical presentations.

"It is a commonly accepted view patients under a WorkCover claim have poorer outcomes from treatment, especially spinal fusions, however there are a lot of factors contributing to these results - many of which are emotional or psychological," he said.

"Our records show WorkCover patients who are back-pain predominant don't do as well post-surgery as private patients; yet those who are leg-pain predominate have equal improvement to private patients.

"This demonstrates if the patient has predominant leg pain, their WorkCover status should not exclude them from surgery."

Over a 10 year period from January 2006 to December 2015, Dr Licina performed 507 lumbar interbody fusions. Patient Reported Outcomes of disability and pain (leg and back) were recorded pre-operatively and at six weeks and six months post-operatively.

Surgery was performed for degenerative conditions including discogenic lower back pain, spondylolistheses, and recurrent disc herniation. Groups were analysed as either WorkCover or Private, and as Leg Pain Dominant, Back Pain Dominant, or Back and Leg Pain Equal.

WorkCover patients made up just over eight percent of the 507 lumbar interbody fusion patient cohort.

Dr Licina said his comprehensive follow-up records confirmed overall, WorkCover patients had less improvement in their self-reported disability scores; especially if they were back-pain predominant, but very few were subjectively worse.

He said a WorkCover claim was an important factor to consider when assessing whether a patient was suitable for surgery, but steps could be taken to increase the chance of a positive outcome.

"The presence of a compensation claim, or legal action, plays a part in the decision-making of the surgeon, and GPs need to be able to counsel their patients about such decisions," he said.

"It is important for GPs to be aware of the factors affecting WorkCover patients involved in compensation or litigation and the effect on post-surgery outcomes, such as the significant emotional and financial stress a claim can cause for a patient and the possible impact on their employability in the future.

"To this end, the best course of treatment for WorkCover patients battling severe spinal problems is a multi-disciplinary approach to help reduce this stress, provide optimal clinical care, and minimise the impact through psychological and emotional support.

"Our research shows when this holistic approach is taken, good results can be achieved with careful patient selection. You must be mindful of the WorkCover aspects and address them appropriately.

"Patients also need to be made a part of the treatment process and included in any decision-making with the view of obtaining the best possible outcomes. For some patients this will involve surgery and for others it will not.

"Ultimately, we should not exclude WorkCover patients from care, just because the common perception is their outcomes won't be as good as private patients."

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KNEE JOINT PRESERVATION THE GOAL

Preserving the structure and function of the knee is crucial to reducing the risk of end stage, severe osteoarthritis in young people, according to Brisbane Private orthopaedic surgeon Tim McMeniman.

The orthopaedic surgeon, who has a special interest in sports injuries and works with elite athletes and teams including the Brisbane Broncos and Queensland Reds, said when dealing with joint damage and early arthritis in younger adults he aimed to prevent the need for total knee replacement using both surgical and non-surgical techniques.

"We know that the outcomes of joint arthroplasty in these patients are less than ideal, and in active patients with significant disease there are other options available," said Dr McMeniman.

"Non-surgical management of any condition is often preferable as we work towards enabling the patient to maintain the lifespan of their own knee.

"A multidisciplinary approach is always required, and I work with a large number of sports physicians and specialist

physiotherapists to provide patients with a management program that combines physiotherapy with regular low-impact exercise regimes focusing on activity modification, strength and, where necessary, weight loss.

"Non-surgical management may also incorporate new and more novel technologies, such as viscosupplementation and platelet rich plasma injections, and in more severe cases, orthoses.

"If an active patient's condition cannot be managed through conservative methods, surgical intervention should ideally focus on preserving the joint through techniques such as meniscus and cartilage repair, joint reconstruction, realignment osteotomy and in rare cases, meniscus transplantation.

"The aim is to prevent arthroplasty in younger patients while minimising symptoms and maximising function so they can return to daily activities and recreation successfully."

Dr McMeniman said he applied the same principles and techniques to the general population as he did for athletes.

"Education is extremely important. Whether you're an elite athlete or not, arming yourself with information about the nature of your condition, as well as your treatment, is the key to recovery," he said.

"I discuss all the finer details with my patients, including the pros and cons of different treatment options, as well as reinforce the importance of appropriate rehabilitation following intervention. This is vital to maximising outcomes."

Dr McMeniman said while his approach to treatment was the same across the board, the general population required more support in the recovery phase to ensure the best possible outcome.

"Athletes have easy access to all the resources and support needed to give them the best chance of a fast and full recovery," he said.

"Unfortunately, this may not always be the case for the average person. If you are not a professional sportsperson, your focus is usually not solely on recovering from injury, and the rehabilitation phase can be much harder as you have other considerations, such as returning to work.



LOWER LIMB AND ORTHOPAEDIC SURGEON, DR TIM MCMENIMAN

"I believe rehabilitation and recovery is every bit as important as the surgery itself. To this end, my practice focuses on this phase of the process to ensure all my patients achieve the same results - be they an elite sports person or otherwise."

Dr McMeniman is also a medical lecturer at the University of Queensland, is heavily involved in research and education and has had extensive training in orthopaedics and sports medicine both in the United Kingdom and Australia. His special interest is in the management of complex knee injuries, injuries in professional athletes, meniscus preservation and transplantation and reconstructive surgery.

At his private practice, Brisbane Orthopaedic and Sport Medicine Centre (BOSMC), Dr McMeniman specialises in treating sports injuries of the lower limb, knee arthroscopy, and joint replacement of the knee and hip.

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SOLUTIONS ARE AT HAND FOR ARTHRITIS PATIENTS

Patients need to be better educated about the techniques and procedures available to manage arthritis, to dispel the misconception that 'nothing can be done' to treat the condition.

Brisbane Private Hand and Upper Limb surgeon Dr David Gilpin said that there were two forms of arthritis affecting the hand; the most common being osteoarthritis, with a smaller group of patients suffering from inflammatory arthritis, of which rheumatoid arthritis is the most classic example.

Dr Gilpin said although there are newer medical treatments that could significantly reduce the symptoms and progression of rheumatoid arthritis, there was still a place for surgical treatments in unresponsive cases.

"With respect to osteoarthritis, there needs to be better education around symptoms, as many people mistake carpal tunnel syndrome for arthritis. The symptoms of carpal tunnel syndrome are usually numbness or paraesthesia, whereas arthritis presents with pain and stiffness in affected joints," he said.

"Once correctly diagnosed, patients can opt for surgical or non-surgical treatment depending on the joint or joints involved and the patient's level of symptoms.

"There are a number of non-surgical treatments which make life easier for patients who have arthritis in the hand.


"Non-surgical treatment revolves around simple measures including regular slow release Paracetamol, pulsed courses of anti-inflammatories, massage and heat application to affected areas, steroid injections and in the case of the thumb, a push brace for support and stability.

"There are also a number of useful resources available including aids and household modifications provided by the Arthritis Foundation and Life Tec, which educate and support patients in making necessary lifestyle changes."

Dr Gilpin said that while there was currently no significant evidence that stem cells or other biological treatments were effective, this may change over the next decade.

He said surgical techniques offer excellent outcomes with respect to significant pain, with 95% of patients reporting an improvement in pain level.

"Current practice is to either fuse the joint for stability or, if greater mobility is required, to undertake a joint arthroplasty," he said.

A portrait of Dr. David Gilpin, a middle-aged man with short brown hair, smiling warmly. He is wearing a dark blue and red vertically striped dress shirt and a red tie with a paisley pattern. The background is a soft-focus outdoor scene with green foliage and a bright sky.

"Arthroplasty procedures offer the hope of better functional outcomes with newer treatment materials such as pyrocarbon, which potentially offers greater longevity than conventional material used for such implants.

"While these surgical procedures do not restore full function as multiple joints are often involved, they do significantly improve the quality of life for most patients.

"Many things can be done to ameliorate the symptoms of arthritis, it is simply a matter of patients working hand in hand with their medical professional to remain educated about the latest treatments and management techniques available."

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ROBOT-ASSISTED HIP & KNEE REPLACEMENT SURGERY

WILL THIS BE THE NEW STANDARD?



Robot-assisted surgery may be the future of hip and knee replacement, according to Brisbane Private hip and knee surgeon, Gauguin Gamboa.

Dr Gamboa said robot-assisted surgery allowed greater accuracy in execution, however careful planning prior to surgery was imperative.

"While robotic surgery offers many potential benefits, it is important that the technology is viewed only as a 'tool' to assist with the procedure," he said.

"The technology combines the ability to pre-operatively plan using accurate CT images, translate plans to 'real-time' surgery and modify the plan intra-operatively as required.

"However while robot-assisted surgery allows greater accuracy in execution, it is important to remember that the robotic arm is only a tool that allows surgeons to execute a resection with minimal deviation from the plan."

Dr Gamboa said while there had been various surgical technologies that had been developed in the past, not all had stood the test of time due to cost, complexity of the procedure, or lack of clear clinical benefit.

He said the advantage of robot-assisted surgery compared to previous technology was that modifications could be easily made based on the state of soft tissues and other intra-operative factors.

"This means the surgeon is able to go through their usual operative decision-making process and apply it to the operation in real time," he said.

"While robot-assisted surgery certainly provides superior accuracy, there is no guarantee that this will translate to improved clinical results.

"Studies have shown that robot-assisted surgery generally results in more precise execution compared with traditional instrumentation and the use of simple computer navigation, yet there is no definitive proof that this increased accuracy leads to better clinical outcomes."

Dr Gamboa said the key to a good outcome, particularly with knees, was the surgeon's understanding of the 'best' way to place an implant - an issue which is still the subject of active debate.

"Robotic surgery is likely to be more commonly used for knee replacements. Requirements for hip replacement surgery are very different from knee surgery, as hip surgery is more 'forgiving' and may not necessarily require the level of accuracy needed in knee surgery," he said.

"Surgeons are increasingly working towards achieving an implant position to mimic the presumed anatomy of the knee prior to the disease process for an optimal outcome.

"Traditionally, resection is based on trying to achieve an 'ideal' mechanical axis throughout the limb, with adjustments made based on the tension of soft tissues.

"However, the current thinking is that surgeons should aim to understand the patient's anatomy prior to the onset of arthritis, and aim for a resection that represents a 'halfway' point between the healthy and diseased joint.

"This means surgeons need to take a highly individual approach to surgical planning, rather than simply relying on robot-assisted execution."

While the use of robots is often deemed as a potential path to an era where surgeons could be replaced by machines, Dr Gamboa believes that on the contrary, the use of robots is likely to further 'empower' surgeons in their decision-making process.

"It is promising that current robotic platforms allow surgeons to perform operations based on their usual decision-making process, both pre-operative and intra-operative, and apply any required adjustments with ease and accuracy," he said.

"While the actual bone resection is performed by a machine, the thinking and decision-making process has never been more human and philosophical, as the robot provides a means for the surgeon to execute what they believe is the optimum way to implant an artificial joint.

"Robot-assisted surgery may potentially become standard practice in the future. Like most technologies however, it remains to be seen whether its advantages lead to better clinical outcomes."

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WHEN IS AN ANKLE SPRAIN NOT AN ANKLE SPRAIN?



LOWER LIMB SURGEON, DR DOUG KING

The majority of ankle sprains carry a good prognosis but GPs need to be alert to the symptoms of other conditions that can masquerade as a sprain, according to lower limb surgeon Doug King.

The Brisbane Private specialist said while the majority of ankle sprains were likely to recover without a requirement for surgery, delays in recovery might indicate there is something more sinister.

He said it could be difficult to determine when to be concerned regarding the probable outcome following ankle sprain injuries, but GPs should be aware of the markers.

"Ankle injuries are common and for isolated lateral ankle ligament injuries the prognosis is generally good," he said.

"However, if patients are not recovering as expected, then further investigations are indicated.

"A number of conditions can masquerade as or co-exist with lateral ankle ligament injuries and delay recovery.

"These conditions include fractures, tendon injury, retinaculum avulsions, syndesmotic injury, impingement syndromes and nerve injury."

Dr King said it was important to listen to the patient and undertake thorough investigations.

"Patients often know something is not right; it is reasonable for them to expect a recovery that allows resumption of many of their normal activities, with some limitation, by six to eight weeks following injury," he said.

"During this time they should be on a progressive trajectory for recovery. If a patient fails to recover as expected, other injuries and an alternate diagnosis should be considered."

Dr King said initial assessment should include as detailed an examination as the patient's condition allows and should be re-assessed as pain and swelling settles.

"If imaging is indicated, plain x-rays are an available first line of investigation but they should not be relied on to exclude fractures and other injuries," he said.

"If x-rays are normal and there are ongoing clinical concerns other imaging should be considered.

"Cross sectional imaging and/or specialist referral is indicated when the presentation is atypical, there are unexpected imaging findings or there is failure to recover as expected."

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MARKERS FOR CONCERN

- » Pain, tenderness, bruising and swelling not related to the lateral ankle joint itself (forefoot heel, midfoot or knee/ lower leg)
- » Tenderness in the region of the distal tibiofibular joint
- » Bone tenderness about the ankle
- » Inability to weight bear initially and then at follow up
- » Medial and lateral sided or generalised ankle joint pain and swelling that does not settle
- » Failure to recover as expected during treatment
- » Neurological compromise
- » A persistent feeling of unreliability or ankle giving way
- » Persistent loss of ankle motion or persistent effusion/ swelling
- » Catching and clicking
- » Abnormality of tendon function with or without pain (Achilles, tibialis anterior, tibialis posterior and peroneals)
- » An unusual appearance on x-ray
- » Recurrent ankle sprains during the recovery period

LATEST TECHNOLOGY CRITICAL FOR DETECTION

Surgeons at Brisbane Private have direct access to a full suite of imaging and diagnostic technology through Brisbane Private Imaging (BPI), allowing for faster and more accurate diagnosis and treatment for their patients.

Radiologist John McGuire said BPI's experienced team of radiologists and staff continued to meet the growing demand for innovative diagnostic services in orthopaedics and many other specialised areas of medical imaging.

"Imaging plays a critical role in the detection and diagnosis of orthopaedic conditions and BPI's 3-Tesla (3T), wide bore Magnetic Resonance Imaging (MRI) machine gives surgeons greater diagnostic accuracy, faster scanning, reduced noise and increased comfort for patients," he said.

"Regarded as the optimal choice in MRI, the 3T magnet provides substantially higher quality imaging than the conventional 1.5 Tesla magnet.

"It is the superior choice in the diagnosis of orthopaedic conditions, as increased resolution allows enhanced visualisation of articular cartilage and smaller joints, ligaments, tendons and nerves in the body; and the integrated coils offer precision and flexibility for imaging of shoulders and other extremities."

Dr McGuire said other modalities offered within the department, particularly Musculoskeletal Ultrasound and Diagnostic CT, also provided surgeons with access to the latest technology.

"Ultrasound is able to provide a dynamic image of soft tissues (tendon/muscle/ligament) that may complement MRI imaging," he said.

"Ultrasound can also be utilised for dual diagnosis and therapeutic guided injection at the same appointment.

"The department's multi-slice CT scanner is able to diagnose orthopaedic and musculoskeletal injuries with the ability to provide excellent anatomical bony detail and the capacity to generate 2D and 3D reconstructions.

"CT is the modality of choice if contraindications exist for MRI. Therapeutic injections can also be performed under CT guidance, including nerve root and facet blocks, epidural injections and radiofrequency ablations."

BPI liaison manager, Jen Auguste said that BPI's ethos of exceptional patient care means same-day appointments and results are often available for both ultrasound (including guided injections) and Diagnostic CT.



RADIOLOGIST, DR JOHN MCGUIRE, AT BRISBANE PRIVATE IMAGING

"This service is made possible by a team of on-site, highly experienced radiologists, all of whom have a specialised interest in orthopaedic and/or musculoskeletal radiology," she said.

"Their expertise, combined with the support of technical and administrative staff, allow for an accurate and speedy diagnosis for both referrers and their patients."

In August 2016, Brisbane Private Imaging secured a full Medicare License for MRI scans, denoting patient access to a Medicare rebate for all rebateable items, including bulk billing for pensioners and health care card holders.

For GP referrers, specified clinical conditions set under the MBS will also attract a rebate for their patient's MRI scans. This includes imaging of the spine, knees, hips, elbows, wrists and head.

Ultrasounds referred by GPs may be charged at the schedule fee.

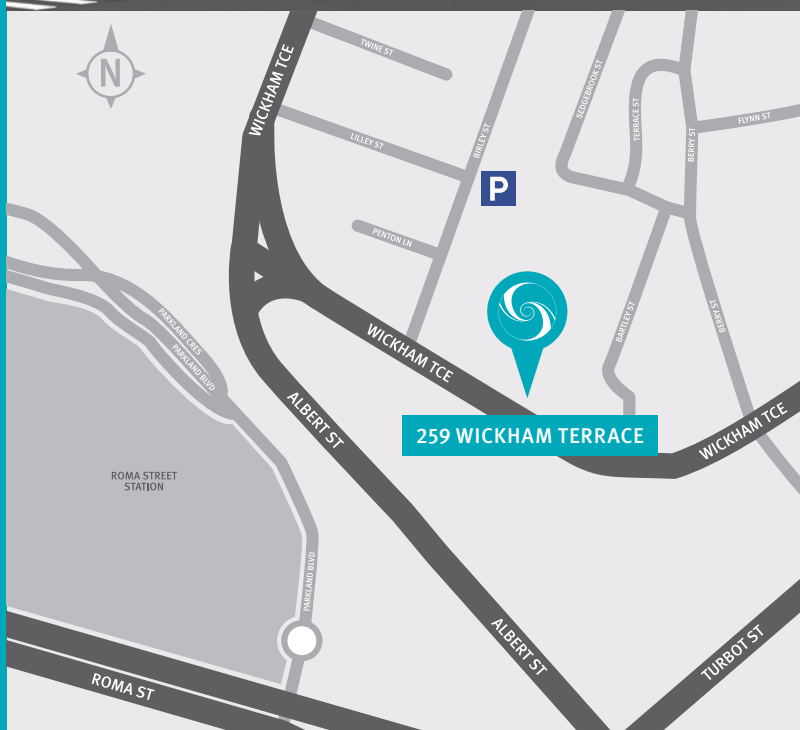
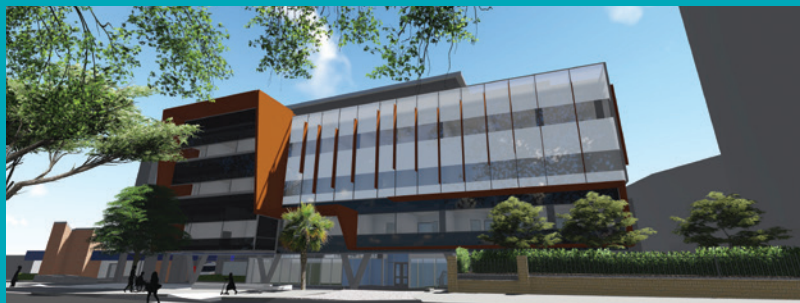
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Brisbane Private Hospital is the city's leading inner city hospital treating over 20,000 patients each year, with the assistance of over 700 visiting medical officers and a team of 500 professional employees.

Our 150 bed private hospital is conveniently located at the top of the Wickham Terrace, Brisbane's busiest medical precinct, in the heart of the CBD.

Brisbane Private Hospital offers a unique combination of specialist medical and surgical services, 24 hour Intensive Care Unit medical coverage and full time intensive care specialists. Our theatre complex performs over 15,000 procedures each year.

Our doctors are among Australia's leaders in research and practise and are committed to providing expert care in fields such as orthopaedics, neurosurgery, spinal surgery, urology, ear, nose and throat, colorectal surgery, general surgery, rehabilitation, gynaecology and fertility.



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