INFOCUS

BPH ROBOTIC MICROSCOPE FIRST

YOUTH PROGRAM GIVING HOPE FOR THE FUTURE

REDUCE BACK PAIN WITH NEW IMPLANT

ISSUE 18

Brisbane PRIVATE HOSPITAL

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Brisbane Private Hospital
259 Wickham Tce.
Spring Hill, Brisbane 4000

INFOCUS
ISSUE 18

GM UPDATE

BY CLAIRE GAUCI

I would like to welcome our new Healthscope National CEO, Steven Rubic, who has previously been CEO and Managing Director of I-Med since 2012. Healthscope was recently purchased by Brookfield Asset Management and we look forward to working with Brookfield and Steven as they implement innovations to our patient centric service delivery.

Brisbane Private Hospital patients have been benefitting from the new robotic microscope which is the first of its kind in the southern hemisphere. The fully automated robotically controlled digital microscope increases visibility, accuracy and precision for safety during spinal surgery.

Dr Peter Lucas (neurosurgeon) is currently suspended from practising at Brisbane Private Hospital, pending an investigation. Given this is now a police matter, it is inappropriate to comment further. I would like to thank Scott Campbell, Toby Loch-Wilkinson, Adrian Nowitzke, Jeff Webster and Craig Winter, our Brisbane Private neurosurgeons for their assistance in caring for patients affected by the suspension. And I would like to thank Richard Williams, orthopaedic spinal surgeon, for helping also. Please contact me on 3834 6555 if you have any concerns.

Welcome to our new doctors Dihan Aponso (orthopaedic surgeon), Anthony Cheng (general surgeon), Andrew Hughes (general surgeon), Leon Kitipornchai (ENT surgeon), Brooke O'Brien (gynaecologist) Belinda Oddy (psychiatrist). Please find their profiles and contact information at the back of this magazine.

Thank you for your ongoing support of Brisbane Private Hospital.

BPH GETS FIRST ROBOTIC MICROSCOPE OF ITS KIND IN SOUTHERN HEMISPHERE TO INCREASE OPERATION SAFETY FOR SPINAL SURGERY PATIENTS

ABOVE: PAUL LICINA PERFORMS PROCEDURE USING ROBOTIC MICROSCOPE

A fully-automated, robotically-controlled, digital microscope that is the first of its kind in the Southern Hemisphere, is now increasing visibility, accuracy and precision for better safety during spinal surgery at Brisbane Private Hospital.

The Modus V Microscope has a robotic arm that is powered by the same technology that is used on the international space station. A major advancement on former surgical technologies, the microscope's arm and specialised pointer tracks the movement of surgical instruments and positions a high-resolution, digital camera in the surgical field.

Leading spine surgeon Dr. Paul Licina has performed the first procedures using the microscope. Already used in nine operations and expected to initially help an average of six spinal patients per week before being used in other disciplines, the Modus V Microscope is currently helping people with common problems of back pain, pinched nerves and worn-out discs, and also more complex conditions such as scoliosis.

ABOVE: DR PAUL LICINA

The Modus V has a magnification level of 12.5 X optical zoom, allowing surgeons to discern critical anatomy at high levels of superior magnification. Each joint of the surgical robot has 200 degrees of rotation per axis, allowing some extreme surgical positions and near-impossible viewing angles during surgeries.

In addition to supplying high definition imagery, the microscope records all surgical procedures, providing content that can be used for educational and training purposes.

Brisbane Private Hospital General Manager Claire Gauci said the $1m Modus V Microscope was a coup for Brisbane Private Hospital, the first facility in the Southern Hemisphere to purchase this state-of-the-art technology, to advance surgical precision and post-operative patient outcomes.

"As a specialised spinal facility, Brisbane Private Hospital has the operational load to ensure the Modus V is in regular use and we have the theatre size to accommodate this world-leading technology."

"Modus V displays the surgical field on a large screen, providing the whole surgical team with a global view of the patient's spine or brain. It provides advanced visualization of the patient's critical anatomy to enhance a surgeon's decision-making and delivers better patient outcomes."

Dr Licina said the Modus V had a magnification level of 12.5 X optical zoom allowing a surgeon to discern critical anatomy at high levels of magnification (around 10 microns).

"On average a normal red blood cell will have a diameter of around 6-8 microns, or a human hair will have a cross section of around 50 microns. With the use of Modus V, I can visualize critical anatomy, in extremely high resolution, that can be otherwise invisible to the human eye, and that is an advancement on the previous technology we were using in theatre.

"The ergonomics of the Modus V allow me to operate with less fatigue and greater safety because it has the ability to recognise memory positions and automatically move back to them during a surgery if required, eliminating my need to stop operating in order to constantly re-position the microscope.

"It also has the ability to track and focus on surgical instruments I am using, and to follow my movements intuitively, providing superb, clear image quality that means less operating time and a better result for patients."

Ms Gauci said the microscope will initially be used for spinal surgeries with Dr Licina, and will later expand its use to a range of surgical procedures.

FOR MORE INFO AND REFERRALS CONTACT:

Dr Paul Licina
SpinePlus
P: 1300 525 354
F: 1300 525 355
E: Spine@SpinePlus.com.au

Level 7, Specialist Suites
259 Wickham Terrace
Spring Hill, QLD 4000

"Brisbane Private Hospital treats over 20,000 patients each year with the assistance from 700 visiting medical officers and a dedicated team of 500 healthcare professionals. We are very proud to offer patients and surgeons an exciting technological advancement that will result in better healthcare outcomes."

MODUS V MICROSCOPE FAST FACTS:

- First of its kind in Australia and the Southern Hemisphere
- Already operating in Europe, North America and some Asian countries.
- Uses advanced robotic technology from Canadarm2, a robotic arm designed for the production of the international space station
- 12.5x optical zoom
- <10 um resolution
- Up to 65 cm working range
- Large depth of field and field of view to optimize surgical visualization
- 4K digital medical grade monitor
- Weight 320 kg
- Over 5 years' worth of research and development in its creation
- Designed and created in Canada

DAMASCUS HEALTH SERVICES YOUTH PROGRAM **CHANGING PARTICIPANTS' FUTURES**

ABOVE: THERAPIST ANN-MAREE RUNNING DAMASCUS YOUTH PROGRAM

A youth counselling program created specifically for young people aged 18 to 25 at Brisbane Private Hospital's Damascus Health Services since May 2018 is achieving great results under the leadership of Art Therapist Ann-Maree See.

Over 25 people have participated in the program, with many sharing anecdotal success such as increased confidence, better socialisation, new and steady employment and sobriety since their involvement.

Running every Wednesday from 8.30am to 2.00pm at Brisbane Private Hospital and catering to groups of six to eight people at a time, the program was created in response to feedback from young people who felt that attending therapy for alcohol and drug dependence with older people diminished their ability to express themselves and therefore benefit from the therapy.

Whilst some of the issues treated in therapy are common challenges for substance abuse recovery across all ages, many of the pressures facing young people such as study pressures, employment and parental relationships are unique to their age group. The program targets early intervention strategies in youth, which is highly recommended for this age group.

THE DEVELOPMENT OF THE YOUTH GROUP WAS PROMPTED BY FACTORS INCLUDING:

- The inability of the young people to relate to adult-related dependence and the issues presented with this;
- many of the youths felt they were unable to identify with adult patients; plus
- many young people expressed that some older people lessened their addiction struggle, saying things like "you're too young to have a problem" and "that's (taking drugs / drinking) what you are meant to be doing", when they didn't realize that at 23 and 24, some young patients have had a problem for 10 years.

Also fuelling the need for the Youth Program was the rapid growth of the Damascus Health Service's private health, in-treatment substance abuse program, which has grown from a 31-bed unit to a 44 bed-unit over two years, and the increased proportion of young people using this service now compared to previously.

Surveys conducted with the Damascus youth participants revealed that even though there were significant benefits for younger participants in the established programs, they felt that they could not relate to the experience of those old enough to be their parents or even grandparents. Some participants even felt that they were the cause of their own parents' suffering and were not comfortable in sharing their very different situations with the older age group.

Younger clients were also not participating in the existing follow-up groups, so the hospital created this more targeted service for them, facilitated by Ms See, to meet their unique characteristics and challenges and to encourage the necessary ongoing group support that comes with the recovery journey for addiction.

A rolling program with stand-alone topics that allows people to join at any time for as little or as long as they need, or as their doctor recommends, the Youth Program uses a combination of techniques from the already existing Damascus program: Cognitive Behavioural Therapy (CBT); Acceptance and Commitment Therapy (ACT); Compassion Focused Therapy (CFT); Art Therapy, and techniques from the ERIC Program: Emotion regulation and impulse control designed by Dr Kate Hall.

Ann-Maree See explained that these strategies and techniques are interwoven into conversations about abstinence from substances, self-harm, trauma, sexuality and body image, as the participants discuss their challenges, making the group process more experiential.

Art materials and music are always available as well as the opportunity to revisit board games that have a personal growth focus and provide healthy substance free by the group participants.

Ms See shared that, "part of the program is encouraging socialisation without the use of their substance and giving our young participants the opportunity to be among peers their age."

She said while the Damascus Health Services' Youth Program was still evolving, feedback from participants about it has been extremely positive. Feedback includes:

- Several participants have commented that in this forum *"they can open up rather than 'hold back' in therapeutic conversations and feel self-conscious and embarrassed in front of the 'adults'. "*
- One participant commented, *"the youth program is an extremely helpful part of my recovery. It provides me with connection to other like-minded individuals who are struggling in similar situations as well as a creative outlet for my struggles. Further the facilitator Ann-Maree can relate to us, and always provides helpful advice and useful and healthy coping strategies. She continually motivates us to stay on track with our recovery goals and lifts our mood. I always leave the youth group feeling like any worries I have are much more manageable and more motivated to continue trying to better myself in any way I can."*
- Another shared, *"I found the Youth program very beneficial for connection with people my age who understand my struggles and recovery with zero judgment. The weekly therapy keeps me on track with my recovery and helps me to unpack and understand my substance abuse. I learn a lot about myself and my thinking which helps me manage myself and my recovery. I am really thankful for the youth program."*

"This type of feedback reflects a core function of the Youth Program, because it lets younger people in recovery address things with others in their age group."

"It creates a feeling of unconditional understanding based on relating to one another more easily and helping each other on their journey to recovery."

And these words from a participant sum up the purpose of the program, *"I found the youth group really good because during my time as an inpatient it gave me a better sense of connection than being upstairs with a mix of people (of different ages), because I was able to socialize with people a similar age group as me. The youth group has also really helped since my discharge as well, because it has kept me socializing with people who are also going through similarly caused, but very different, problems and it works as a form of A.A. in a way."*

"Essentially this young man is saying that although he learned helpful tools and strategies in the in-patient program, the youth program has really helped since his discharge in various ways, and that is a great measure of success for an innovative program like this one."

FOR MORE INFORMATION ON THE DAMASCUS HEALTH SERVICES' YOUTH PROGRAM:
http://www.brisbaneprivatehospital.com.au/damascus-home/damascus
P: 07 3834 6475

DR DAISUKE DEMONSTRATING ASSESSMENT OF KNEE LAXITY DURING SURGERY WITH DR S MAINE AND DR M NUNEZ

AN INTERNATIONAL PERSPECTIVE ON THE PATELLOFEMORAL JOINT

LEFT: DR SHEANNA MAINE ACCEPTING AWARD FOR THE TRAVELLING PATELLOFEMORAL FELLOWSHIP FROM PROFESSOR RYOSUKE KURODA WITH DR TAKEHIKO MATSUSHITA AT KOBE UNIVERSITY HOSPITAL.

ABOVE: DR SHEANNA MAINE:

Lower limb orthopaedic surgeon Dr Sheanna Maine had the prestigious honour of being awarded the ISAKOS Patellofemoral Travelling Fellowship award in 2017.

Dr Maine was selected from a body of international applicants based on her research and interest in the patellofemoral joint, particularly in children and adolescents experiencing recurrent patellar dislocations.

The Fellowship offered Dr Maine the opportunity to meet world leaders in the field of Patellofemoral surgery over a two year period. The aim was to share research ideas and discuss the latest developments in surgical techniques. “Despite Patellofemoral instability being a relatively common problem, our understanding of the factors that lead to the condition can be seen as rudimentary because the issue is so multifactorial” Dr Maine said.

“There are so many factors that influence the way the kneecap interacts with the knee. The shape of our bones, the strength of our muscles and ligaments, not to mention the interaction and control of these entities by our brains when we run and jump. Proper rehabilitation following injury is therefore critical. Muscle strength and activation is the only thing a patient has any control over. In many cases, good rehabilitation can stabilise a misbehaving patella, however at its worst, it can be like trying to balance a tennis ball on a basketball and no amount of physiotherapy will confer stability to the joint.”

Dr Maine who also specialises in Paediatric Orthopaedics and Deformity correction surgery feels strongly that children with recurrent dislocations should not be dismissed.

“Children in particular are sometimes advised that nothing can be done to help them until they are adults. They are left to suffer through their teenage years with severe functional disability. Some children are ostracised from their peers and can become withdrawn depressed and suicidal. At a minimum, correction of lower limb alignment using techniques such as guided growth can give these children some relief in symptoms until definitive surgery can be performed.”

The fellowship took place over 2 years with visits to University of Minnesota, Johns Hopkins, Banff Sports Medicine Institute, Hospital for Special Surgery and Kobe University Hospital. “It was reassuring to see that the techniques we perform in Australia are at least as good as those performed in these world renowned centres” she said.

FOR MORE INFORMATION AND REFERRALS CONTACT:

Dr Sheanna Maine
P: 07 3177 2779
F: 07 3188 7649
E: reception@maineorthopaedics.com.au

OBSTRUCTIVE SLEEP APNOEA: NEW SURGICAL OPTIONS BECOME A REALITY FOR BRISBANE PRIVATE HOSPITAL PATIENTS

ABOVE:
SLEEP APNOEA DEVICES:
CPAP AND MANDIBULAR ADVANCEMENT SPLINTS (MAS)

Dr Leon Kitipornchai is the first Queensland ENT surgeon to complete subspecialty training in upper airway reconstructive surgery to treat OSA and Snoring. He is Brisbane Private Hospital's newest ENT surgeon and is employing modern evidence-based methods to identify and treat patients suffering from Snoring and OSA.

Untreated Obstructive Sleep Apnoea (OSA) has been closely linked to multiple poor health outcomes, including cardiovascular complications and stroke. Whilst it is often associated with OSA, Snoring is often an overlooked symptom which is separately reported by over 20% of Australians and can often be a motivator for treatment independent of the health risk of OSA. Snoring can be extremely socially problematic, leading to bed partner sleep disruption, disharmony, conflict and bed separation.

Devices such as CPAP and Mandibular Advancement Splints (MAS) have been shown to be efficacious at mitigating OSA and snoring in the sleep lab. However, real-life effectiveness can be limited by patient adherence. As a chronic, highly heterogenous disease, OSA treatment should be personalised to the patient, based on their medical comorbidities, disease severity, body habitus, anatomy and preference amongst many other factors. Personalised assessment and treatment of patients by trained specialists allows for improved patient outcomes and long-term solutions to their problems.

Whilst traditionally considered salvage therapy, upper airway surgery is a treatment option for a group of desperate patients who would otherwise be left untreated. Modern airway surgeons need to be able to adapt a suite of multilevel procedures such as the Australian modified UPPP, Transpalatal Advancement Pharyngoplasty (TPAP), Midline Partial Glossectomy to individualise surgery for each patient. These methods are focused on reconstruction, expansion and stabilisation of the airway behind the soft palate and tongue, as opposed to traditional resective methods which often result in more problems than benefits.

In carefully selected patients, multilevel upper airway surgery has been shown to be cost effective, and to reliably improve OSA parameters, snoring and excessive daytime sleepiness. Identifying these patients is contingent upon careful assessment, upper airway endoscopy and a discussion of treatment goals with the patient and their partner. Alternatively, combination therapy can sometimes be a practical solution, as Upper Airway surgery and Nasal Surgery can facilitate and improve adherence to CPAP and Mandibular Advancement therapies.

Australian sleep surgeons are international leaders in Upper Airway Surgery for OSA. Dr Kitipornchai is part of a national network of sleep surgeons working together to improve patient outcomes by refining surgical techniques, gathering evidence of treatment efficacy and investigating innovative therapies. Locally, he works closely with Sleep Specialists, General Practitioners, Specialist Dentists, Bariatric specialists, Maxillofacial Surgeons and Sleep Psychologists to treat complex OSA patients in a multidisciplinary and holistic manner.

ENT SURGEON: DR LEON KITIPORNCHAI

Dr Kitipornchai is currently making arrangements to participate in a multicentre trial of the world's first bilateral mini-Hypoglossal Nerve Stimulator, potentially opening up an exciting new avenue of therapy for his patients. Internationally, patients have had access to these devices for over 5 years and a strong body of evidence has demonstrated improved quality of life and OSA disease measures following implantation.

FOR MORE INFORMATION AND REFERRALS CONTACT:

Dr Leon Kitipornchai
CompleteENT

Level 1, 135 Wickham Terrace
Spring Hill, QLD 4000
P: 07 3905 5999
F: 07 3056 3221
E: info@completeent.com.au

DR TOBY LOCH-WILKINSON FIRST IN AUSTRALIA AND OUTSIDE USA TO REDUCE BACK PAIN WITH NEW TITANIUM IMPLANT

DR TOBY LOCH-WILKINSON

Brisbane Private Hospital neurosurgeon Dr Toby Loch-Wilkinson is the first in Australia and outside of the USA to use a new 3D-printed titanium spinal implant that mimics the natural porousness, functionality and stiffness of human bone. The implant helps to accelerate bone growth, speed up recovery times and reduce pain following spinal fusion surgery, which is a commonly performed procedure for degenerative lumbar spinal conditions.

The futuristic Modulus technology used by Brisbane neurosurgeon Dr Toby Loch-Wilkinson is 'coral-like' and features a unique wicking mechanism to draw the bone forming cells through it as part of the bone fusion process.

Spinal fusion is a surgical 'welding' procedure used to correct problems with the bones and nerves of the spine where two or more vertebrae are fused together to heal into a single, solid bone to treat

ABOVE: MODULUS ANTERIOR TLIF

instability or to alleviate compression of the spinal canal or nerves.

If fusion is successful, the patient's symptoms of chronic back or leg pain will be resolved. Successfully achieving a solid bony fusion is critical to the success of the procedure.

Spinal surgeons typically use high-performance plastic (PEEK) implants for spinal fusions because the material is less rigid than metal.

Whilst this previously prevented the implant from cutting into bone, the plastic spacer does not participate in the bone growth process or 'fusion'. Instead it makes the two vertebrae either side of the implant grow around rather than through it, requiring a longer time to fuse and more processes to help fusion occur.

Dr Toby Loch-Wilkinson has a particular interest in chemistry, polymers and the surface technology of spinal implants and is using the Modulus implant for Posterior Lumbar Interbody Fusion operations with great success. "I have been interested in materials science and in particular, the mechanical and surface properties of implants since I was an undergraduate studying polymer chemistry. I'm always seeking to find better solutions for my patients suffering pain and structural problems with their spine, who require lumbar fusions," Dr Loch-Wilkinson said.

"The Modulus titanium implant is molded closer to the form and stiffness of human bone than plastic. Combined with the wicking mechanism, this results in a strong mechanical interlock between the patient's own bone and the implant, creating what I call a 'functional fusion' even before the bone has completely fused across the gap between the bones. It really is the best of both worlds.

"In my experience I have found that patients who receive this implant are reporting less pain at their post-surgery follow-up appointments than patients receiving traditional PEEK plastic implants.

"When fusion happens faster, pain is alleviated sooner, there is less requirement for pain medication and my patients can return to their normal or improved functionality, compared to when they were suffering chronic back pain from disc

BELOW: MODULUS OBLIQUE TLIF

ABOVE: MODULUS XLIF

degeneration, nerve pain and instability of their spines."

Low back pain affects approximately 16% of the Australian population, and rates are highest among people aged 65–74 years. Most back problems are managed non-surgically. Spinal surgery is considered for patients with severe chronic low back pain or spinal nerve pain from disc degeneration or spinal instability after more conservative treatment options have failed for three or more months. *

*https://www.safetyandquality.gov.au/sites/default/files/migrated/4.3-Lumbar-spinal-fusion.pdf

FOR MORE INFORMATION AND REFERRALS CONTACT:

Dr Toby Loch-Wilkinson

Level 4, Front Building
Brisbane Private Hospital
259 Wickham Tce
Spring Hill QLD 4000
P: 07 3832 8866
E: toby@sbnn.com.au

ABOVE: DR MATTHEW PETERS

Dr Peters was invited to attend a one-day global scientific meeting in California earlier this year, and found the meeting to be interesting and informative.

“The meeting was made up of twenty-four plastic surgeons from across the globe, and discussion was around emerging breast implant technologies and prototypes, and what they might mean for patients. It was a wonderful opportunity to marry the research-based engineering to the creative approach we plastic surgeons utilise.”

“Talking with my patients there exists quite a range of knowledge when it comes to breast augmentation techniques and the technology of breast implants. Many are focused on the technique alone – above the muscle, under the muscle, dual plane, through the armpit, under the fold – the implant being viewed as the device to fill the pocket to the desired size.”

Dr Peters describes a change in the types of questions typically asked by patients considering breast augmentation from how will it be done to what type of breast implant will be used.

“A shift is occurring though, with progressively more interest being paid to the implants and their safety than ever before. Whence previously I felt my advice pertaining to the implant I wished to use was being viewed as ‘part of the process,’ I now feel that the patients are very interested in what is being used.”

So why the change? Dr Peters attests this to new research and a surge in discussions both in the media and on social networking sites about the safety of breast implants.

“Recent research advances have determined that certain types of breast implants have been linked to a rare form of cancer called Anaplastic Large Cell Lymphoma (ALCL). Macrotextured implants have the highest degree of risk, with a precipitous decline in incidence subsequently seen in microtextured implants and no observed occurrences in nanotextured or smooth implants (to date). “

“‘Breast implant illness,’ a symptom complex described in relation to the presence of breast implants in oneself is another concern present in today’s literature. When coupled to our increasing awareness of our own role in maintaining health and wellness it is no surprise that the technological details of the products in use is being questioned.”

So what is old, what is new and what is coming? According to Dr Peters, silicone remains the product of choice for both the outer shell and the inner fill of breast implants, however saline implants are still accessible.

“Available shell surfaces include smooth, micro or nanotextured implants as well as inner gels in different degrees of firmness. There are round and anatomical shapes, with suture-tab technology being added to the new nanotextured anatomical implants to stop them from rotating.”

“Future developments are focusing on minimising the risk of ALCL whilst maximising the comfort and reliability of the implant – reduced weight, stronger shells, dynamic gels with a more natural feel and movement are just some of the focus points.”

Dr Peters recommends a detailed consultation and assessment with a qualified FRACS specialist plastic surgeon to provides patients with the best available implant option for them.

“I take into account the look desired, the patients body and how the implant will interact to achieve this look. I also consider the degree of physical activity the patient undertakes when determining what option is best. Patients are encouraged to be open and honest, and ask as many questions as they need to. Breast augmentation is elective surgery and they need to be confident with the decision that they make.”

THE EVER CHANGING TECHNOLOGY OF BREAST AUGMENTATION

FOR FURTHER INFORMATION AND REFERRALS CONTACT:

Dr Matthew Peters
Valley Plastic Surgery
51 Ballow Street
Fortitude Valley QLD 4006
Ph: (07) 3488 8118
E: info@valleyplasticsurgery.com.au

TOTAL HIP REPLACEMENTS: FROM THE FRONT OR BACK?

DR GAUGUIN GAMBOA, FRACS, FAOA, FPOA

Total hip replacements are among, if not the most successful of all operations today. Despite surgery being originally being considered a highly invasive, destructive, and painful procedure, with a limited lifespan of success; contemporary implants, instrumentation, technologies and technics have allowed for a reproducibly minimally invasive and durable reconstruction with minimal pain and rapid recovery.

While advancements come in many forms, ranging from implant design and materials to navigation and robotics, as well as perioperative care, including rehabilitation and structured pain control protocols, an area of interest that has become openly introduced to the general public is the "new" muscle sparing total hip replacement "from the front".

WHAT IS THE DIRECT ANTERIOR APPROACH (DAA)?

It is interesting how the direct anterior approach (DAA) to the hip has become known to the public as the "new" hip replacement. The approach is perceived to be superior and pain-free. In reality, the approach was first described almost 140 years ago and was first used for some form of arthroplasty 70 years ago. There was very limited use through the decades then after, but always had following in France and Switzerland. It was however in the 1990's when instrument advancements allowed for the approach to have reproducible access when performing total hip replacements.

The public perception partly comes from device manufacturers who have deviated from simply attracting surgeons to use certain implants and instruments specifically designed for the approach into marketing directly to the general public. Unfortunately, contributory would be surgeons themselves, who, in some instances have used the approach as part of marketing and promotion of individual practices. Certainly, while marketing per se is part and parcel of any practice, there has been numerous aggressive campaigns, particularly outside of Brisbane, that may sometimes provide false claims or misleading information.

SO HOW DOES DAA COMPARE TO OTHER APPROACHES?

In Australia, by far, the most common approach to the hip for replacements would be the so-called "posterior approach", which gets to the hip "from the back". This is a tried and tested approach, that in itself, has become less and less invasive in the last decades. Not only does this approach provide a predictably good exposure of the joint, the advancements have also allowed this operation to be relatively painless and with a reasonably quick recovery. More importantly, the extensile approach is the workhorse for more complex reconstructions and provides excellent access to both the acetabular and femoral sides. While there are other modestly popular approaches other than DAA, the posterior approach remains to be the "gold standard" by which all other approaches are compared to.

So what is the big deal with the anterior approach? In essence, the approach gains access to the joint by going between muscles rather than through it. Thus, muscle splitting and cutting isn't routinely performed, although some form of tendon release may be necessary in certain cases. Theoretically, this allows for less pain, and quicker muscle reactivation, allowing for easier early mobilization and less muscle trauma.

The fact is, there is always an advantage and disadvantage for various techniques. The problem is delineating actual proven results to theoretical advantages. This article hopes to distinguish the two. I will also hope to provide insight on why I choose what I use, which surprisingly may not necessarily be due to superiority of one approach to another

WHAT ARE THE ADVANTAGES OF THE DIRECT ANTERIOR APPROACH?

Interestingly, despite the fact that DAA truly is relatively muscle sparing compared to a posterior approach, I do not personally see this as the major advantage of the approach. Current literature certainly support that function with DAA is superior to other approaches in the first 2-6 weeks after surgery. This to me is not that important, having a hip replacement is "like being in a marathon and not a sprint". In the end, results in the first few weeks are not as important as long-term results. There is no supporting definitive evidence of one approach providing superior functional results in the long term.

The main attraction to DAA for me is the proven lower dislocation risk. The risk for dislocation in a posterior approach is usually pegged between 0.5 – 2% in most literature. The reported risk for dislocation using DAA is at least half of that of posterior. Given that dislocations are one of the major banes of having a hip replacement, this advantage is certainly the most attractive to me.

Another important advantage of DAA is the ability to easily perform intra-operative x-rays. While this advantage may not be important to many surgeons, as I believe (without certainty) that only a minority of surgeons take x-rays in theatre, such an advantage would diminish the likelihood of other complications such as component malposition and leg length discrepancy. Although taking intra-operative x-rays would potentially increase surgical time marginally, a fairly accurate assessment of component position would also decrease the likelihood of dislocations.

Another advantage of the DAA is a proven decrease in blood loss. Again, this may not usually be critical as blood transfusion for primary hip replacements are rare in a posterior approach anyway.

Lastly, evidence does support a less likelihood for sciatic or peroneal nerve injury in DAA, although it does open the low but definite risk for a femoral nerve palsy and the approach certainly has a considerable risk for injury to the lateral femoral cutaneous nerve.

WHAT ARE THE DISADVANTAGES OF THE DIRECT ANTERIOR APPROACH?

Unfortunately, the major disadvantage of DAA is that it simply is a more technically demanding approach. While there is no doubt that the operation becomes almost just as easy as a posterior approach in capable hands after adequate experience, the key word here is “experience”. Evidence clearly demonstrate a steeper learning curve with DAA in that it is more likely problems would be encountered by the surgeon with the approach at least in the first 50 cases. These difficulties may or may not translate to other complications such as malposition, infection, dislocation, and fracture. In particular, intra-operative fractures have been known to be a perioperative complication that is significantly more common with DAA.

Another problem with DAA is that the basic approach is not very extensile, particularly in the femoral side. While an adequate view of the anatomic structures can also be achieved, it would not be of the same level of visibility as the posterior approach. Thus, for those with little experience on the approach, landmarks that aid in achieving appropriate implant placement may not be as useful, again potentially contributing to implant malposition. More importantly, inability to elegantly have good exposure would lead to inadvertent soft tissue trauma, which would obviate the potential advantage of the approach.

The difficulty with performing surgery through DAA may make certain patients less ideal for this approach. While obesity is a factor, other deformities and certain body types may be also pose problems for this approach.

Complex surgeries therefore are not ideally performed using this approach, and if problems such as fractures occur, expansion of the approach may be required in order to achieve a satisfactory result. Unfortunately, again, confidence in expanding the approach is not universal in surgeons, as this is gained through experience.

Another disadvantage is the need for specialized instrumentation to perform the operation with maximum efficiency and safety. While regular instruments would still allow for reasonable access to completion of surgery, the ease by which this is achieved requires implants and instruments designed for the approach.

WHAT IS MY CURRENT PREFERENCE AND WHY?

I personally have shifted towards DAA at this point in my practice. While I initially selected certain patients as inappropriate candidates for the approach, I very much do not select anymore and use it in virtually every case. It is interesting that the choice is not because of definite superiority of the approach as there are also some disdvantages, but more due to advantages that are particularly attractive to me as per my personal preferences.

I therefore do not routinely inform patients of my preferred approach and only tell them if they specifically ask. I would also defer claiming this to be a better approach in all information I provide patients, both in their operation information kits and information found in our website.

The most obvious reason for choosing DAA that is supported by general literature is the potential for lower dislocation rate. This is of course in the assumption that the difficulties that may be encountered have not led to malposition or aggressive soft tissue release.

In particular, I find the approach as much more elegant. The actual approach is actually much easier and faster than posterior with a lot less blood in the field. The difficulties are usually after the actual approach and is related to bone preparation and implant positioning. I particularly like coming in with the field being very clean. Wound closure is also much simpler and faster.

The deal sealer for me is being able to perform the surgery with x-rays. While this may be perceived as unnecessary and only for novices, there is actually a great deal of security gained by this capability. Implant placement and sizing simply ceases to be guesswork without the need for more sophisticated and expensive technologies such as navigation and robotics. The option allows for predictable concentric acetabular reaming leading to predictably stable implants. Limb length, offset, and potential complications such as fractures may also be easily assessed. Again, while surgeon experience may diminish the importance of such an advantage, I find that my personal satisfaction and security after each procedure has never been so high.

Interestingly as well, for no particular reason, it seems that patient satisfaction is higher. I am a bit sceptical with regards to this as I am not convinced that the increased satisfaction is due to superiority of the approach, but probably simply because of what patients perceive and see. Possibly the simple fact that they have had an anterior approach that has been promoted heavily to the public or the fact that they have a small incision matters to them. Whatever the reason, it seems that polling for my patients to whom I have done one hip from the back and the other from front seem to favor the one approached from the front as their preferred hip.

Other reasons for my preference are probably intangible to many. The theatre flow, operative time, and even the miniature incisions simply make the operation more exciting and enjoyable for me. While this of course, has nothing at all to do with final results, these are factors that certainly elevate overall team morale.

WHAT IS THE VERDICT?

One of my mentors always told me that whichever way I prefer to do an operation, the important thing is to do it well. All approaches provide satisfactory results, and many factors come into play when a surgeon chooses to go one way or the other. It is however important to utilize the safest way that the surgeon is most comfortable and happy with. This is what will lead to a satisfactory patient result. From my perspective, at this stage, I have found the DAA as the best approach in my hands. It is not without saying that it is still possible that future experiences may still change my mind, as alternative approaches also provide satisfactory results.

FOR MORE INFORMATION AND REFERRALS CONTACT:

QLD Hips & Knees
P: 07 3832 1652
F: 07 3832 1039
E: office@qldhipsandknees.com.au
W: www.qld hipsandknees.com.au

Suite 1, Level 8 Specialist Centre
Brisbane Private Hospital
259 Wickham Terrace
Spring Hill QLD 4000

RIGHT: DR GAUGUIN GAMBOA

WILMA WALSH FITS A CUSTOM-MADE SPLINT ON A PARTICIPANT WHILE RUBY STRAUSS LOOKS ON

NEW RANDOMISED CLINICAL TRIAL **LAUNCHED AT BRISBANE PRIVATE HOSPITAL**

Researchers from the Brisbane Hand and Upper Limb Research Institute (BHULRI) have launched a randomised clinical trial studying the effect of non-surgical management on triangular fibrocartilage complex injuries. The trial, led by specialist orthopaedic surgeon Dr Greg Couzens, is examining the best treatment available to patients with this type of wrist injury.

The triangular fibrocartilage complex, or TFCC, is a ligament structure that plays a vital role in stabilising the wrist. Injuries to the TFCC are frequently seen in professions or sports which involve twisting, force or high impact to the wrist, such as carpentry, tennis and gymnastics. When the TFCC is injured people can experience pain at the wrist, which limits normal use of the wrist and hand. Prompt attention and treatment is crucial to give a quick and complete recovery the best chance. Inadequate or delayed treatment may result in unwanted time off work or precious time away from training and competition for athletes.

While surgery is often required for people with severe or complex injuries to the TFCC, non-surgical management is generally the first approach. Routine treatments available include hand therapy and exercises, wearing a splint and getting a cortisone injection. Right now, there is not enough evidence to support the use of one treatment over another for patients with TFCC injuries. Without solid evidence, clinicians can only rely on their own experience.

The transdisciplinary team of investigators led by Dr Couzens aims to establish which of the common treatments in use is most effective for the management of TFCC injuries. Ms Wilma Walsh, Director of Extend Rehabilitation and a founder of the Australian Hand Therapy Association, has developed an exercise treatment protocol for all participants. Instrumental to the roll out of this exciting project is Ms Ruby Strauss, who will run the study as part of her postgraduate studies at Queensland University of Technology.

“This study has the potential to make a difference for so many people; from athletes to labourers. I am looking forward to finding out which treatment works best,” said Ms Strauss who also works as a full-time research assistant at BHURLI. Participants in this study will be randomly assigned to one of four treatment groups. All participants will see a hand therapist and follow an exercise protocol for three months. In addition to the hand therapy, depending on the group to which they are assigned, participants may also receive a custom-made splint and/or cortisone injection at no additional cost.

People with TFCC injuries or health professionals who wish to know more are encouraged to get in touch with the Brisbane Hand and Upper Limb Research Institute by calling (07) 3834 6488 or by emailing research@upperlimb.com

FOR MORE INFORMATION CONTACT:

Brisbane Hand and Upper Limb Research Institute
Level 9, 259 Wickham Terrace
BRISBANE QLD 4001
Phone: +61 7 3834 6488

BRISBANE PRIVATE HOSPITAL SETS NEW STANDARD FOR HOSPITAL FOOD

We are very excited to share the news of our new catering menu commencing at Brisbane Private Hospital!

Healthscope has appointed the standard approach team to manage the roll out of a healthy, visually appealing and modern menu, which will be rolled out nationally across our 43 hospitals. They will visit every Healthscope hospital in Australia to roll out the new menu, train staff and implement the new way of cooking and delivering "hospital food". The team includes John O'Shea, Executive Chef, Gold Coast Private, Troy Hockey, Catering Manager, Brisbane Private Hospital, Diet Analyst, Rhys Lyons and Healthscope's National Support Services Manager Leanne Taylor.

The new menu has been created in collaboration with dietitians and includes pumpkin and kaffir lime risotto with baby spinach, lemon pepper fish with grilled asparagus, confit tomato and hollandaise sauce and much more – yum!

O'Shea said the menu had been carefully created to offer meals that are nutrient-dense, satisfying and flavoursome.

"In the mornings we focus on foods that boost the metabolism and include low-GI grains for lasting energy; lunch offers meals that are energising and easily digestible; while for dinner patients can expect warm, nourishing dishes that are comforting and satisfying," he said.

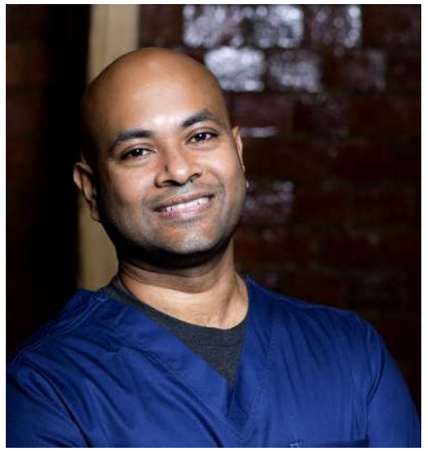
"Offering patients at least a few options at each mealtime, regardless of their dietary requirements, is something we feel is important, and our two-week rotating menu guarantees there is good variety, even for long-term patients and those on restricted diets.

Watch this space!

DR DIHAN APONSO

SPINAL SURGEON

MBChB, FRACS, FAOrthA



Dr Dihan Aponso is an Orthopaedic Spinal Surgeon.

Dr Aponso offers a comprehensive practice in all aspects of spinal disorders and would welcome the opportunity to help with any patient's neck or back problems that you feel could benefit from further review.

Originating and having completed his medical and orthopaedic training in New Zealand, Dr Aponso has completed both local and international spinal surgical training.

Dr Aponso's special interests in spine surgery are cervical and lumbar degenerative and deformity conditions including scoliosis surgery. He believes that a key part of his role is to identify the problem while working collaboratively to empower patients with knowledge about their condition and how best to manage symptoms in the long term

He now offers his spinal surgery services at Brisbane Private Hospital and also holds a public appointment at the Princess Alexandra Hospital as an orthopaedic spine surgeon.

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

TO ARRANGE AN APPOINTMENT FOR YOUR PATIENT WITH DR APONSO, PLEASE CONTACT:

Phone: 07 3278 2662
Fax: 07 3607 2467
Email: reception@qldspine.com
Website: www.qldspine.com

DR ANTHONY CHENG

BARIATRIC SURGEON
MBChB, MRCSEd, FRACS, FACS

Dr Anthony Cheng is a Specialist Bariatric, Hepatic-Pancreatic-Biliary (HPB) and General surgery.

He has extensive experiences in laparoscopic sleeve gastrectomy, roux-en-Y gastric bypass, and minigastric bypass. His special interest is in complex revision bariatric procedures such as gastric band-to-bypass. He performed Queensland's first total robotic sleeve gastrectomy and roux-en-Y gastric bypass.

Dr Cheng qualified as a General Surgeon in 2010 and became a fellow of the Royal Australasian College of Surgeons. He then underwent post-fellowship training in HPB and Bariatric surgery in Adelaide, Brisbane and the United Kingdom.

Dr Cheng consults at the Mater Medical Centre and operates both at Brisbane Private Hospital and Mater Private Hospital, Brisbane. Together with his multidisciplinary team, Dr Cheng provides an affable, personal and holistic bariatric surgery services to help patients achieving their weight loss goals. Since 2015, Dr Cheng is in-charge of the Queensland Statewide Bariatric Surgery Initiative in Metro South Health.

Apart from bariatric surgery, Dr Cheng is also an expert in hernia surgery, gallbladder surgery, antireflux procedures and hepato-pancreatic-biliary surgery. He is an endoscopist accredited with the Gastroenterological Society of Australia, experienced in both gastroscopy and colonoscopy.

Dr Cheng is a Senior Lecturer of the University of Queensland and an examiner for the Royal Australasian College of Surgeons. He is a registered medical practitioner in the United Kingdom and a registered specialist surgeon in Hong Kong. Besides English, Dr Cheng is fluent in Mandarin and Cantonese.

TO ARRANGE AN APPOINTMENT FOR YOUR PATIENT WITH DR CHENG, PLEASE CONTACT:

Medical Objects: 281274MF (CHENG, Anthony)
Phone: 07 3010 5780
Fax: 07 3010 5781
Email: drcheng@brisbanesurgical.com.au

DR ANDREW HUGHES

GENERAL SURGEON
MBBS, FRACS

Dr Andrew Hughes is a General Surgeon with specific interests in minimally invasive surgery - laparoscopy and robotics - including gallstone disease, hernia surgery, anti-reflux surgery and colonic resections for malignancy and benign conditions. He works collaboratively with Gastroenterologists in these areas to ensure optimal outcomes for patients. Other interests include melanoma, particularly sentinel lymph node biopsy, and thyroid surgery.

Dr Hughes has had varied roles within the Royal Australasian College of Surgeons, running the training registrar education program for 10 years concurrent with representation on the Qld Training Board in General Surgery. He is a Senior Lecturer with the University of Queensland, with experience in teaching at various levels, from student to post-fellowship specialty training. He enjoys GP and hospital education activities. He is a current Director of General Surgeons Australia.

Dr Hughes trained locally at Princess Alexandra Hospital, and has been a Consultant surgeon at The Prince Charles Hospital since 2007, and in part-time private practice since then on the north side of Brisbane.

Dr Hughes consults at Brisbane Private Hospital and North West Private Hospital.

TO ARRANGE AN APPOINTMENT FOR YOUR PATIENT WITH DR HUGHES, PLEASE CONTACT:

Phone: 07 3353 6500
Fax: 07 3353 9600
Email: reception@curatius.com.au

LEON KITIPORNCHAI

ENT SURGEON
BEng, MBBS, MEpi, FRACS

Dr Leon Kitipornchai is an ENT surgeon subspecialised in Obstructive Sleep Apnoea and Snoring Surgery. Born and raised in Brisbane, he received his Bachelors, postgraduate Medical and subsequent Masters degrees from the University of Queensland. After completing his ENT training in Queensland, he was awarded his Fellowship in Otolaryngology Head and Neck Surgery from the Royal Australian College of Surgeons. Subsequently, he completed a post-fellowship clinical and research post with Professor Stuart MacKay in Wollongong with a subspecialisation focus on Obstructive Sleep Apnoea in children and adults as well as Thyroid and Parathyroid surgery.

Dr Kitipornchai is currently completing a Master of Medicine (Sleep Medicine) qualification at the University of Sydney. He is a Senior Lecturer (clinical) with the University of Queensland who is actively involved in education of medical students, training ENT registrars and ongoing research in the field of sleep surgery. On the topic of surgery for Sleep Apnoea, he has multiple international publications, a book chapter, and has been an invited speaker at national conferences and courses. He is a member of the Royal Australasian College of Surgeons, the Australian Society of Otolaryngology Head and Neck Surgery, the Australian Medical Association, the International Surgical Sleep Society and the Australasian Sleep Association.

Dr Kitipornchai consults at Wickham Tce Spring Hill, North Lakes, Wesley and Springfield, and operates at Brisbane Private Hospital.

FOR MORE INFORMATION OR REFERRALS CONTACT:

CompleteENT
Level 1, 135 Wickham Terrace
Spring Hill, QLD 4000

P: 07 3905 5999
F: 07 3056 3221
E: info@completeent.com.au

DR BROOKE O'BRIEN

OBSTETRICIAN & GYNAECOLOGIST
MedSc, MBBS (Hons), FRANZCOG, IFEPAG

Dr Brooke O'Brien is a dedicated specialist who is committed to providing the best gynaecological health care to women of all ages. She believes that every woman has the right to an individualised, professional and compassionate approach to their health. Brooke has a relaxed and caring bedside manner, allowing patients to feel comfortable to discuss any concerns.

Dr Brooke O'Brien is a qualified specialist female Obstetrician & Gynaecologist and has worked in tertiary hospitals right across Australia. Brooke practises in all areas of Obstetrics and Gynaecology, and Paediatric and Adolescent Gynaecology (PAG), making her one of only a few specialists in Australia to be qualified in this area. Brooke has obtained an International Fellowship in PAG and has spoken internationally and published numerous research articles in her work in this field. As a mother herself, Brooke has a unique way of building trust and rapport with her younger patients.

In addition to her work at Northside Gynaecology, Brooke teaches and maintains an active role in the instruction and examination of training specialists through the Royal Australian and New Zealand College of Obstetricians and Gyanecologists (RANZCOG). Brooke also mentors medical students through the University of Queensland, where she is currently a Senior Lecturer. She keeps up to date in the latest in women's health by attending annual conferences and courses.

In her spare time, Brooke enjoys spending time with her husband and her two daughters. She loves to cook and enjoys good food and walking her two dogs with her family.

Dr O'Brien operates from Brisbane Private Hospital

TO ARRANGE AN APPOINTMENT FOR YOUR PATIENT WITH DR BROOKE O'BRIEN, PLEASE CONTACT:

Practice Address:
Northside Gynaecology
4/538 Gympie Road, Kedron Q 4031

Phone: 1300 780 138
Fax: 07 3054 0497
admin@northsidegynaecology.com.au
www.northsidegynaecology.com.au

BELINDA ODDY

PSYCHIATRIST
MBBS, B.Med.Sci, FRANZCP, Cert. Consul-Liaison Psych

Dr Belinda Oddy is a consultant psychiatrist who has recently commenced private practice in addition to working at the RBWH as a Consultation-Liaison Psychiatrist and at the Biala Alcohol and Other Drugs Service. She has recently worked at the RBWH as a pain medicine fellow and is progressing towards fellowship through the Faculty of Pain Medicine, ANZCA.

Areas of Interest include:

- Addiction Psychiatry
- Chronic Pain
- Mood Disorders
- Anxiety Disorders
- The interplay between psychological and physical health

TO ARRANGE AN APPOINTMENT FOR YOUR PATIENT WITH DR ODDY, PLEASE CONTACT:

City Specialists Clinic
Level 8 / 225 Wickham Terrace
Spring Hill QLD 4000
Ph: (07) 3831 1869

DR NIGEL PINTO

VASCULAR SURGEON
BAPPSC (MED SC), MBBS, FRACS (VASC)

Dr Nigel Pinto was raised in Brisbane and attained a Bachelor of Medical Science at QUT. He proceeded to the University of Queensland receiving two memorial prizes on graduation with a Bachelor of Medicine and Bachelor of Surgery.

Dr Pinto completed his residency years in the major surgical hospitals of Brisbane before finalising his speciality training in vascular surgery in secondments both locally at the Royal Brisbane and Princess Alexandra Hospitals and overseas in New Zealand. During this period Dr Pinto attained specialist skills in open and minimally invasive endovascular techniques for both arterial and venous disease along with renal access work. He was awarded Fellowship of the Royal Australasian College of Surgeons in Vascular Surgery and commenced working as a Consultant Vascular Surgeon at The Royal Brisbane and Women's Hospital and The Prince Charles Hospital in 2017.

Dr Pinto has endeavoured to remain at the forefront of new techniques and specialty innovation attending both national and international expert-led forums. He has published multiple times himself, been awarded competitive grants for further research and presented his findings at both national and international meetings. Dr Pinto currently holds the academic positions of Chief

Clinical Scientist at the Herston Biofabrication Institute and Senior Lecturer with the University of Queensland.

Areas of Interest include:

- Aortic aneurysmal and occlusive disease
- Minimally invasive treatment of lower limb occlusive disease
- Diabetic foot disease
- Minimally invasive treatment of venous disease
- Renal access.

Dr Pinto consults at Brisbane Private Hospital, Sunnybank Private Hospital and Chermside.

TO ARRANGE AN APPOINTMENT FOR YOUR PATIENT WITH DR PINTO, PLEASE CONTACT:

Brisbane Private Hospital
Sessional Rooms
259 Wickham Terrace
Spring Hill QLD 4000
Phone: 07 3193 3385
Fax: 07 3319 6393
Email: admin@pintovascular.com.au

GP EDUCATION DAY: DAMASCUS DRUG AND ALCOHOL GP SEMINAR

GPs are invited to join us for this RACGP Category 2 education event:

SATURDAY, 12TH OCTOBER 2019

8.00AM - 12.30PM

VENUE:

Damascus Day Rooms
Level A, Brisbane Private Hospital
259 Wickham Terrace
Spring Hill QLD 4000

INFORMATION:

To register and for further information, please visit:

www.damascuseducation2019.eventbrite.com.au

RACGP | QI&CPD 2017–19 Accredited Activity Provider

Brisbane Private Hospital is the city's leading inner city hospital treating over 20,000 patients each year.

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

Brisbane
PRIVATE HOSPITAL

259 Wickham Terrace
Brisbane QLD 4000

P: 07 3834 6111
F: 07 3834 6596
W: www.brisbaneprivatehospital.com.au