

INFOCUS



LIFE AFTER MESHES...

**BREAST IMPLANT
ASSOCIATED ANAPLASTIC
LARGE CELL LYMPHOMA**

**BPH'S NEWEST ORTHOPAEDIC
SURGEON PART OF TEAM BEHIND THE
WORLD'S SMALLEST CANNULATED
COMPRESSION SCREW**

ISSUE 17



Brisbane
PRIVATE HOSPITAL



INFOCUS

ISSUE 17

GM UPDATE

BY CLAIRE GAUCI

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Welcome to Edition 17 of our InFocus magazine.

I am excited to share with you the launch of our newly developed Healthscope purpose from Managing Director Gordon Ballantyne - 'we work together for better care.' 'We work together for better care' is the overarching principle that unites and galvanizes us and embodies the incredible work to provide outstanding care to our patients. Importantly, it guides us to what we aspire to do better tomorrow. It is through our commitment to our four strategic pillars: quality clinical outcomes, exceptional patient care, creating extraordinary teams and market leading returns that we will bring our purpose to life.

The other news is Healthscope has entered into an implementation deed with Brookfield under which Brookfield will acquire 100 percent of Healthscope by way of a scheme of arrangement and a simultaneous off-market takeover offer. A meeting is expected in May/June 2019 for shareholders to vote on the transaction. It is business as usual at Healthscope as we work through this process. Our focus continues to be providing our patients best in class, high quality healthcare services.



In this edition we profile the amazing work of Field Orthopaedics as they launch the Field Micro Screw, we thank the Brisbane Orthopaedic Sports Medical Centre (BOSMC) for their hospitality hosting international travelling fellows, we look at alternatives after mesh, updates on breast implants and we welcome our new BPH doctors; Libby Anderson (Upper Limb Orthopaedics), Drew Cronin (Plastic Surgeon) and Jorrie Jordaan (General Surgeon).



BPH'S NEWEST ORTHOPAEDIC SURGEON PART OF TEAM BEHIND THE WORLD'S SMALLEST CANNULATED COMPRESSION SCREW



THE WORLD'S SMALLEST CANNULATED COMPRESSION SCREW

Brisbane Private Hospital's newest orthopaedic surgeon, Dr Libby Anderson, leads a double life. In addition to being an orthopaedic surgeon subspecialising in wrist, hand and microsurgery, Dr Anderson is also a medical device developer who is one of the creators of the world's smallest cannulated compression screw – the Field Micro Screw.

The device made its world debut at Brisbane Private Hospital on 30 January via an operation conducted by Field Micro Screw co-creators Dr Greg Couzens, internationally-renowned hand surgeon and Dr Chris Jeffery, doctor and engineer. It was recently launched at the 2019 AAOS in the US to great response.

Drs Anderson, Couzens and Jeffery are founders of Field Orthopaedics, a rapidly growing Australian Orthopaedic devices company that focuses on the design and manufacturing of orthopaedic devices to address the shortcomings in the trauma, extremities and biological markets.

In addition to her work as an orthopaedic surgeon, Dr Anderson works in collaboration with engineers, researchers and scientists to create a range of orthopaedic devices at Field Orthopaedics that provide evidence-based solutions for longstanding concerns in extremity surgery.

The Field Micro Screw System features a range of 1.5 mm and 2.0 mm diameter cannulated compression screws ranging in length from 6 mm to 16 mm in 1 mm increments, 0.6 mm single trocar K-wires of 70 mm length plus a specifically designed instrument kit, tailored to the insertion of the 1.5 and 2.0 FO Micro Screw.

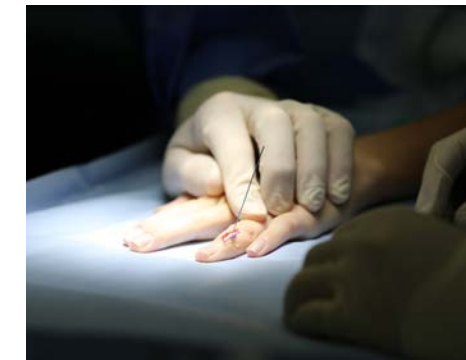
It was created to increase efficiency with the potential to significantly reduce complications in the management of orthopaedic injuries and the fixing of fractures in the hand and wrist.

The original inspiration for the product came from Dr Anderson, who identified the need for a cannulated compression screw in the treatment of very small fragment fractures after she experienced some particularly difficult cases.

Dr Anderson took the problem and the possibility of a solution to Drs Couzens and Jeffery, and together they outlined the possibilities of a product through Field



DR LIBBY ANDERSON, ORTHOPAEDIC SURGEON



Orthopaedics that could address this long-term surgical challenge.

“Until now, orthopaedic surgeons have never had a screw this small that goes over a wire. Previously, we have used a wire to hold the provisional reduction of the bone fragments, then drilled a hole alongside this for positioning of the screw for definitive implantation. For cases involving very tiny fractures, there is often not enough real estate to achieve the desired fixation, so the cannulated micro screw solves this problem.”

Dr Anderson says the Field Micro Screw System is a simple device that solves a problem by decreasing the footprint of what is needed for medical implants.

“The Field Micro Screw offers surgeons a simple, effective solution to difficult fractures and difficult cases in small bones, particularly around the hand and wrist.

“Cannulation in this size has not been available on the market until now and for me, it offers a great solution for these difficult cases.

“From a patient perspective, the use of this system will hopefully result in less soft tissue stripping and therefore less scarring and the potential for less stiffness down the track,” she said.

Dr Anderson equally loves the creativity of solving patient cases and creating medical devices that solve orthopaedic issues because they are both driven by creating better outcomes for patients.

“As environments for creativity and solutions, Field Orthopaedics and Brisbane Private Hospital have a lot in common – they are both staffed with enthusiastic people determined to make a difference to those they help and to innovate their industries as much as possible.

“I am looking forward to operating on my patients at Brisbane Private Hospital for its facilities, location and patient care.

“The support we receive for our work with Field Orthopaedics here at Brisbane Private Hospital is also unparalleled, and for me it is the ideal environment to combine both my lives of surgery and medical device development.”

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BIA-ALCL AND BII



ABOVE: DR DREW CRONIN, PLASTIC AND RECONSTRUCTIVE SURGEON

Breast implant associated anaplastic large cell lymphoma (BIA-ALCL) is a rare T-cell lymphoproliferative disorder occurring in patients with breast implants. Although the first case was described in 1997 in the US, over the last five years there has been a sharp increase in public awareness, disease investigation and diagnosed cases. As of March 2019, the worldwide number of reported cases of BIA-ALCL was 688, with 17 reported deaths. Lifetime risk varies depending on implant type, from approximately 1: 2832 women with polyurethane implants, to 1:60,000 for Siltex-textured implants.

WHAT IS IT?

BIA-ALCL is a haematological malignancy that originates in the capsule formed by the body around a breast implant. Whilst systemic ALCL is an aggressive metastatic disease, BIA-ALCL is more akin to cutaneous lymphoma with a largely indolent course, early diagnosis and excellent prognosis when treated promptly. It also has a unique antigenic profile, with all reported cases found to be ALK negative and CD30 positive. The current unified theory of aetiology is that BIA-ALCL is the end pathway of a sub-clinical infection of the breast prosthesis at the time of insertion. Microbiome mapping of the capsules of infected patients have shown the likely organism to be *Ralstonia* spp, a gram-negative bacilli, similar to *H.Pylori* of Gastric Cancer and MALT pathogenesis. Biofilm formation on the textured implant leads to chronic inflammation and increased T cell response. Somatic Gene mutations lead to an eventual monoclonal proliferation of a single malignant T cell population. This monoclonal proliferation eventually becomes BIA-ALCL.

Due to the increased surface area and ability to capture bacteria during implantation and protect biofilm populations in vivo, macrot textured implants have been heavily implicated in BIA-ALCL. Indeed, there have been no reported cases of BIA-ALCL in patients with only smooth implants to date. Because of this, macrot textured implants have recently been banned in France, Canada and the Netherlands. In Australia, the TGA is currently deciding if they will do the same.

WHAT TO LOOK FOR?

There are four factors required in the pathogenesis of ALCL: Patient genetic predisposition to the disease, textured implants, bacterial colonization, and time. Patients with ALCL most commonly present with a late seroma, approximately 10 years after augmentation, or a mass adjacent to a textured implant. In the recorded literature, only 7 patients have presented with bilateral disease, and 24 with lymph node or organ metastases. Any patient that presents with serum or a mass should have an USS-guided aspiration, and the fluid sent for FLO cytometry, and tested for CD30 and ALK antigens. For most patients, a total capsulectomy, explantation and washout of the surgical pocket will be curative.

WHAT IS BREAST IMPLANT ILLNESS (BII)?

Unlike ALCL, Breast Implant Illness, or BII is still relatively poorly understood and lacking in quality research. The term BII has been applied to a constellation of symptoms attributed by patients to silicone breast implants, including but not limited to:

- CNS - Memory loss, headaches, migraines, tinnitus, vertigo
- MSK - Muscle/Joint pain, numbness, tingling in limbs, neuralgia, slow muscle recovery after exercise
- Immune/Inflammatory - Raynaud's, Hashimoto's, RA, scleroderma, SLE, MCTD, Sjogren's, MS, recurrent infections, toxic shock, chronic fatigue, night sweats, slow healing, food intolerances, lymphadenitis
- GI/GU - Polyuria, liver and kidney disease, decreased libido, UTI, reflux, gastritis, weight loss/gain, dehydration, IBS, metallic taste, globus, dysphagia, pancreatitis, cholecystitis
- Integument - Alopecia, dermatitis, rashes
- Psychological - Anxiety, depression, panic attacks
- CVS - SOB, palpitations, arrhythmia, cardiac pain, cough

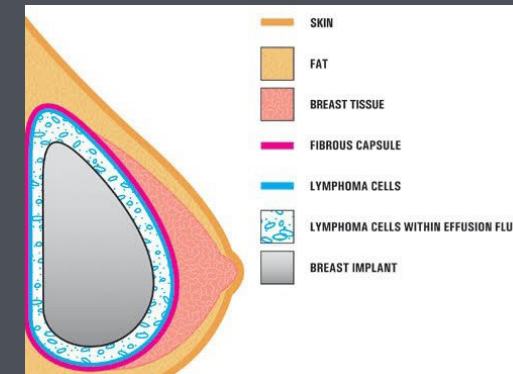
Whilst the exact mechanism of BII is not understood, some believe that silicone or its breakdown products may behave as adjuvants, increasing the response of either the cellular or humoral immune systems to the presence of other antigens. Known adjuvants include Paraffin, petroleum jelly, silicon dioxide, beryllium, aluminium, and bacteria such as *Staphylococcus*, *Nocardia*, *Salmonella*, and *Mycobacterium*.

A rise in patient advocacy groups and the increased access to information and opinion through social media has seen an explosion in the number of patients presenting to GP's and their surgeons concerned about BII. It would be wrong however to be dismissive of these concerns - an absence of evidence of a link is not the same as evidence of absence of a link between implants and these symptoms, particularly given what we now know about textured implants and their effects on the humoral immune system.

They should also be reviewed by their Plastic Surgeon for consideration of explantation. In a recent study, symptomatic patients that did not have serological evidence of any autoimmune disease after implantation had an 80% improvement in physical symptoms and a 93% improvement in psychological well-being after their implants were removed. What this shows is that even though we cannot yet test for BII or fully understand the underlying mechanisms, we can very effectively treat both the physical and psychological symptoms of those patients concerned about BII with simple explantation.

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TESTING FOR BII

It is recommended that any patients presenting with unexplained symptoms to their GP's have the following preliminary blood work:

- FBC
- U&E's
- LFT
- Thyroid function
- CRP/ESR
- Serum IgG, IgM
- Iron studies
- Autoimmune disease markers (ANA/ANCA's etc)

LIFE AFTER MESHES

The treatment of pelvic organ prolapse has come full circle. Traditionally, gynaecological surgeons for many generations were taught to do native tissue repairs for the treatment of this problem. Transvaginal synthetic mesh was also taught but as a backup procedure should the native tissue repair fail. More recently, gynaecologists resorted to mesh for primary prolapse repair.

Throughout my College training I saw countless synthetic meshes come and go. There was an obvious reason for this. The synthetic meshes have higher complication rates with the main concern being erosion of the mesh into the vagina or into the bladder or bowel. This would create problems such as chronic pain, dyspareunia and fistulas which were often difficult to treat.

I decided early in my career to cease performing synthetic mesh surgery. My first preference would be to perform a native tissue repair and, should this fail, I would resort to a biological mesh, such as calf skin collagen. These meshes were not as effective as synthetic meshes but usually did the job and were completely resorbed after a period of time. This meant that erosions and their associated complications were not an issue.

In view of the mounting complications with mesh and randomised control studies comparing transvaginal meshes with laparoscopic meshes, the TGA rightly

removed all meshes from use in Australia. The great shame of the TGA's response was that meshes with good track records, such as the original TVT and biological meshes were also removed from the market. Since then, some of the meshes have made a return after the product information and instructions for use were amended. Gynaecological surgeons who want to use meshes now need to be specially accredited for each procedure.

So how do we treat pelvic organ prolapse in 2019? Numerous surgeons have decided to cease prolapse surgery altogether yet many have returned to the traditional, tried and tested method of native tissue repair. Approximately 30% of patients will encounter some degree of laxity of the vaginal walls following this type of surgery but only 10% will need reoperation. If the problem persists, then I tend to send the patient to an urogynaecologist for laparoscopic mesh surgery. This is an infrequent event.

For the milder forms of prolapse and incontinence, patients are usually sent to a good pelvic floor specialist physiotherapist. If pelvic floor exercises alone are not enough to treat the prolapse, then vaginal pessaries may be fitted. Alternatively, I have access to a MonaLisa Touch laser in my practice that will treat grade 1 and mild grade 2 prolapses and also treat minor degrees of urinary stress and urge incontinence.



DR ANDY STAMATIOU
GYNAECOLOGIST

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BOSMC AND BPH HOST INTERNATIONAL TRAVELLING FELLOWS



In April, the Brisbane Orthopaedic and Sports Medicine Centre (BOSMC) was privileged to host the Latin American Society of Knee Arthroscopy and Sports Traumatology (SLARD). Led by Dr Peter Myers, the international profile of BOSMC has long attracted surgeons from across the globe to visit and learn pioneering surgical techniques in the field of arthroscopic knee surgery. Aside from the BOSMC Surgical fellowship, which trains junior surgeons for periods of 12 or 6 months terms, numerous groups of international fellows have visited to learn the latest innovations in arthroscopic surgery, and also enjoy Australian hospitality and culture.

The fellows visiting in this group hailed from Argentina, Chile and Bolivia. These surgeons were selected as future leaders in their respective countries, and in their four week tour included BOSMC as well as sites in Sydney, New Zealand, Singapore, Thailand and China.

The fellows were welcomed in Queensland with a trip up Mt Cootha and a tour of Southbank, followed by a meal at one of Brisbane's finest restaurants hosted by Drs Peter Myers, Tim McMeniman, Brett Collins and Tony O'Neill. The following day they were exposed to Koalas, Kangaroos and the odd Platypus at Lone Pine.... but then it was down to business with a scientific session where the host surgeons and the visiting fellows were able to present their latest research. The topics included meniscal root tears, meniscal allograft transplantation, the management of patellofemoral osteoarthritis, and anterolateral ligament reconstruction techniques in ACL surgery.

The final day featured concurrent live surgical sessions run by Dr Myers and Dr Tim McMeniman at Brisbane Private Hospital showcasing both complex knee reconstructive techniques, as well as innovative methods for improving results from surgical soft tissue and cartilage repair. There was a constant flow of questions and exchange of ideas, and all participants enjoyed the sharing of knowledge.

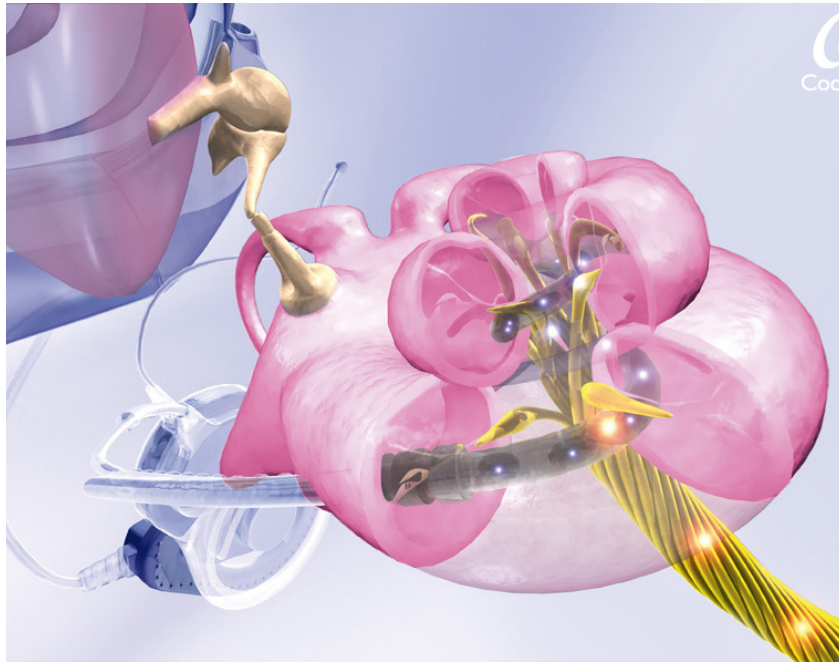
Both the hosts and the visitors learnt much, benefiting patients literally around the world, and forged life-long professional relationships. The BOSMC and Brisbane Private Hospital look forward to the next opportunity to host our international colleagues.

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SURGERY FOR DEAFNESS: THE RISE OF TECHNOLOGY



ABOVE: FIGURE 2

The management of deafness has advanced through several phases. Until the latter 19th century, management of deafness was confined to crude drainage of infection, and the use of hearing “trumpets” and the like.

A second phase saw the development of mastoid surgery, and fenestration surgery for otosclerosis, procedures that employed alteration of anatomy to eliminate disease or to improve hearing.

The third, post-war, phase ushered in stapedectomy and tympanoplasty surgery for conductive deafness. Stapedectomy, using the first commercially developed implants, replaced a stapes that is fixed by otosclerosis and offered an excellent chance of hearing recovery.

Tympanoplasty optimised hearing by both repair of the drum and reconstruction of the ossicular chain. Titanium or hydroxylapatite ossicular replacement implants avoid the bioreactions that troubled earlier implant designs. This phase employed passive devices, simply vibrating to transmit sound.

The fourth phase, over the last 30 years, was that of implantable electronic technology, which addresses conductive, sensorineural and mixed deafness.

Cochlear implants emerged as a viable solution to profound sensorineural deafness in Australia in the 1980s. They act by direct eighth nerve stimulation. (Figure 2) The success of Graeme Clark’s work led to their use in hundreds of thousands. Continuing refinement has resulted in a button-like external processor and a slim implant, with attendant software sophistication. Surgery has evolved to minimal incision methods.



LEFT: FIGURE 4
ABOVE: FIGURE 5

Applied to cases from the six-month to 90-year-old age groups, these implants represent to first technology to have replaced an entire sensory system. Also, the implants are highly beneficial in many cases of unilateral severe nerve deafness.

Concurrently, implants addressed the problem of refractory conductive deafness. Traditional bone conduction hearing aids were cumbersome and uncomfortable. Two patterns of bone conduction implants evolved. The first was the bone-anchored hearing aid (the Cochlear BAHA), (Figure 4) using an inert pedestal fixed to the skull, but activated by a separate stimulator. The initial per-cutaneous pattern (fixed through the skin) was subject to local reaction and was largely superseded by magnetic transcutaneous (intact skin) stimulation.

The later alternative, the Med EL Bonebridge, (Figure 5) is an electronic vibrating implant fixed into the mastoid. This is powered by an external button-like processor via induction coils. The implant is effective, but the percutaneous BAHAs cope better with more severe losses. Both

bone conduction types address conductive or mixed losses with mild or moderate sensorineural levels

When the external ear is unsuitable for hearing aids, active middle ear implants may be used. These are attached to the ossicular chain itself and recreate sound by vibration at this site. The leading device, the Soundbridge, attached to the incus. A tiny “floating mass transducer” vibrates the chain, producing sound. The overall design is otherwise similar to a cochlear implant.

Lastly, in profound sensorineural deafness, when the cochlea or eighth nerve are unsuitable for cochlear implantation, an Auditory Brainstem Implant may be used, but being developmental, these are confined to a very few tertiary centres.

In summary, technology is now advanced to the point where deafness that is unresponsive to surgery or aiding can now be overcome by technological alternatives.

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THE TRUTH ABOUT GALLSTONES

DR JACOBUS JORDAAN, GENERAL SURGEON

In contrast to their miniscule size, gallstones can cause a lot of big issues. They are very common and are present in a quarter to a third of Australian adults over 50. Although most people don't require treatment, some people with gallstones need to have their gallbladder removed through a surgical procedure called a cholecystectomy. Almost 11,000 cholecystectomies were performed in Queensland in 2012-2013.

The following factors increase the risk of developing gallstones:

- Female gender
- Increasing age
- Obesity
- Family history of gallstones
- Medical conditions, such as diabetes and liver cirrhosis
- High-calorie, low-fibre diets
- Certain medications
- Pregnancy
- Rapid weight loss

Lifestyle changes that may reduce the likelihood of development of further gallstones include regular exercise, following a low-calorie, high-fibre diet, and maintaining a healthy weight.

A number of tests can be performed to look for gallstones and determine what treatment options may be suitable. Blood tests determine how the liver is functioning and whether an infection is developing. An abdominal ultrasound can confirm the diagnosis. This radiation-free test visualises the solid abdominal organs and is the first-

line imaging test for gallstones. Other tests include an abdominal CT and MRI scan.

People who don't have pain or other symptoms won't require immediate treatment - they can be managed expectantly. However, if they've had biliary colic or infection (cholecystitis, cholangitis, or pancreatitis), it is recommended to remove the gallbladder with the offending stone.

Gallstones are a common condition. They only need to be treated if they are causing symptoms. There are safe and effective ways to treat gallstones and prevent their recurrence.

Dr Jacobus Jordaan performs minimally invasive surgery for a range of health issues including hernias, reflux, gallstones, thyroid and parathyroid disorders.

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THE BENEFITS OF REMOVING THE GALLBLADDER LAPAROSCOPICALLY RATHER THAN AS AN OPEN PROCEDURE INCLUDE:

- Smaller scars and a superior cosmetic outcome
- Shorter hospital stay
- Reduced blood loss and risk of infection
- Reduced tissue trauma, and therefore reduced pain and discomfort
- Reduced need for pain relief and reduced side effects (such as constipation)
- Faster recover and return to work, with two to three weeks to full recovery, instead of four to six weeks

DR JACOBUS JORDAAN & DR NOVA JORDAAN

THERESA LENDS A HELPING HAND TO SOLOMON ISLANDS



Theresa O'Doherty first visited the Solomon Islands in May 2013 for a one off trip and has been twice a year ever since!

Theresa works in Brisbane Private Hospital's Endoscopy Unit and her husband Mark Fletcher is a GP. They have 3 children and they both work fulltime and it initially seemed too difficult to get away to the Solomons but they fell in love with the place and the people.

The mission is to expand the limited healthcare options available to the Marovo Lagoon community with a focus on the Seghe Hospital. Seghe Hospital had no power or running water until 2008.

The missions are self-funded by the volunteers and coordinated by the Marovo Medical Foundation which was founded by American doctor Suzanne Miller and Alan Daly. Marovo Lagoon is a remote part of the Solomon Islands with a population of 30 000 people. In late 2017 an Australian branch on the Marovo Medical Foundation was established so donations can be made directly.

There are no doctors or surgical nurses in Marovo Lagoon and very limited medical supplies so they do their best with what they

have. They do any job that needs to be done. The volunteers take as many supplies and medications as they are able to carry with them.

The local nursing staff work long hard hours in the hospital but are always happy and smiling. Theresa is honoured to be welcomed into the hearts and homes of the Marovo people. Each medical mission treats about 1000 people in 10 days including 60 operations ranging from large procedures such as thyroidectomies to small hernia repairs and lump removals.

The Marovo medical missions are held twice a year in May and November and are attended by a team of 25 volunteer doctors, dentists, nurses, pharmacists, allied health and non-medical personnel. The team treat a wide range of acute ailments as well as ongoing care for chronic disease patients such as diabetes and hypertension.

The tours give approximately 90% of the Marovo population access to doctor care every 6 months, covering an area of 1700 square kilometers.

FOR FURTHER INFORMATION, PLEASE VISIT:
www.solutionspamarovo.org

DR LIBBY ANDERSON

ORTHOPAEDIC SURGEON
BCom BSc MBBS FRACS FAOrthA



Dr Libby Anderson is an orthopaedic surgeon subspecialising in Wrist, Hand & Microsurgery. After obtaining dual Bachelors degrees in Commerce and Biomedical Science from the University of Queensland in 2004, Dr Anderson went on to complete her Bachelor of Medicine/Bachelor of Surgery in 2008, also at the University of Queensland.

Dr Anderson spent her junior doctor years from 2009 - 2011 at Princess Alexandra Hospital Brisbane and then proceeded on to the Orthopaedic training program in 2012. Her registrar years were spent training at Prince Charles Hospital, Redcliffe Hospital, Ipswich General Hospital, Princess Alexandra Hospital, Queensland Childrens' Hospital and Royal Brisbane Hospital. Dr Anderson had a keen interest in Hand & Microsurgery throughout her training. On the completion of successful training, she obtained her Fellowship in Orthopaedic Surgery from the Royal Australasian College of Surgeons.

In 2017, Dr Anderson returned to Princess Alexandra Hospital as the Hand Fellow and completed 6 months of subspecialty Hand Surgery training under the supervision of the Brisbane Hand & Upper Limb Fellowship Institute. She then completed a further 12 months of subspecialty Hand, Wrist & Microsurgical training at the Regional Hand Centre, Middlemore Hospital, Auckland as part of the Plastics, Reconstruction & Hand Surgery Unit. Following this total of 18 months of post Fellowship subspecialty training, Dr Anderson was awarded the PFET

qualification (Post Fellowship Education & Training) in Hand Surgery from the Australian Hand Surgical Society (AHSS).

Dr Anderson is currently works as a consultant upper limb orthopaedic surgeon at Princess Alexandra Hospital and will start private practice at Brisbane Hand & Upper Limb Clinic located at Brisbane Private Hospital from March 2019.

Dr Anderson actively participates in research projects and enjoys the rigour of academically following her patients' outcomes. Her research currently focuses on the areas of her particular surgical acumen, namely hand and wrist trauma, carpal instability and arthritis. She regularly presents at conferences, prepares papers for journal submission and is active in projects as a member of the Brisbane Hand and Upper Limb Research Institute. She is involved in teaching medical students and junior doctors and finds mentoring the next generation of surgeons to be particularly rewarding.

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DR DREW CRONIN

PLASTIC AND RECONSTRUCTIVE SURGEON
MBBS FRACS (Plast.)



Dr Drew Cronin is a fully trained and certified Queensland Plastic and Reconstructive Surgeon. Originally from the Gold Coast, Dr Cronin undertook his postgraduate medical studies at Griffith University, where he was the inaugural Class President of the Griffith University Medical Society, helped establish the University's 'Hope4Health' charitable arm, and graduated as a member of the 'Golden Key' for academic excellence. Dr Cronin completed his internship and residency at the Gold Coast Hospital, and spent three years in registrar positions in General Surgery, Ears, Nose and Throat Surgery and Plastic Surgery before successfully applying to the Plastic and Reconstructive Surgery training program in Brisbane.

Dr Cronin's training involved rotations through the Princess Alexandra Hospital, Royal Brisbane and Women's Hospital, Gold Coast University Hospital, Mater Brisbane Hospital and the Lady Cilento Children's Hospital, where he underwent specialist training in complex skin cancer excision and reconstruction, Breast reconstruction, Head and Neck cancer excision and reconstruction, and Hand surgery.

Dr Cronin has as active interest in teaching, research, and health advocacy. He is an Associate Lecturer at the University of Queensland School of Medicine, and in 2016 was winner of the prestigious Emmett Prize, awarded for most outstanding registrar research in Australia and New Zealand. Dr Cronin has presented research at National and International conferences in areas including Breast Reconstruction,

Skin cancer, Hand Surgery, and Head and Neck Reconstruction. He is also on the Doctor's advisory board for Avant, Australia's largest MDO. He is a member of the Royal Australasian College of Surgeons (RACS), The Australian Society of Plastic Surgeons (ASPS), and the Royal Australian College of Aesthetic Plastic Surgeons (ASAPS).

Since obtaining his Fellowship, Dr Cronin has worked in both Public and Private Hospitals in Brisbane. He is currently a Visiting Medical Officer at The Royal Brisbane and Women's Hospital, where he performs Skin Cancer, Breast Surgery and Head and Neck Cancer Reconstruction. Privately, he has appointments as a VMO at Brisbane Private Hospital, The Mater Hospital, Westside Day Hospital, Samford Road Day Hospital and Spring Hill Day Hospital.

Outside of work, Dr Cronin enjoys spending time with his wife and their young family. They enjoy an active lifestyle, and love taking their daughter boating, fishing, and playing at the beach. As a previous representative at the Youth Olympics for Rowing, and a volunteer lifesaver with 10 year's experience, Dr Cronin loves to get back in the boat, on the river or in the surf, when possible.

Areas of Interest include and expertise include:

- Skin Cancer Excision and Reconstruction
- Aesthetic and Reconstructive Breast Surgery
- Abdominoplasty and Body Contouring Surgery
- Head and Neck Cancer Reconstruction
- Hand Surgery

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GP EDUCATION DAY: PLASTICS

GPs are invited to join us for this Category 2 CPD Seminar

SATURDAY, 22ND JUNE 2019

8.00AM - 12.30PM

VENUE:

Brisbane Private Hospital
Damascus Unit
Level A, Brisbane Private Hospital
259 Wickham Terrace, Spring Hill QLD 4000
Free parking is available under the hospital (entry via Birley or Lilley Streets)

SPEAKERS:

Dr Cam Mackay
Dr Drew Cronin
Dr Matthew Peters
Dr Sam Yang

TOPICS WILL INCLUDE:

- Skin Cancer Reconstruction
- Dupuytren's Disease
- Scar Management
- Surgery Post Massive Weight Loss
- Breast Reduction Surgery

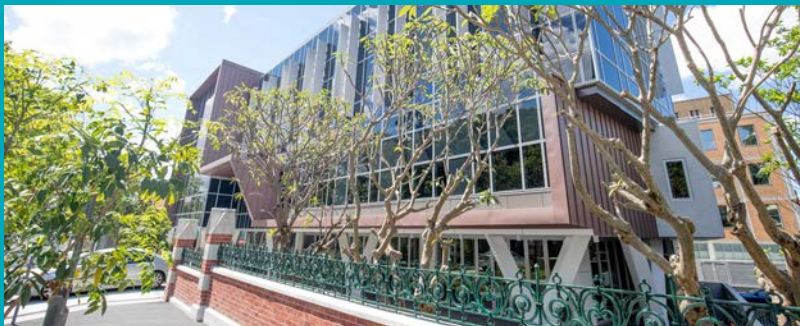
REGISTRATION:

Please register online via Eventbrite at:
<https://bphplastics.eventbrite.com.au>

If you have any questions about this event, please contact Lisa Foley
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E: lisa.foley@healthscope.com.au



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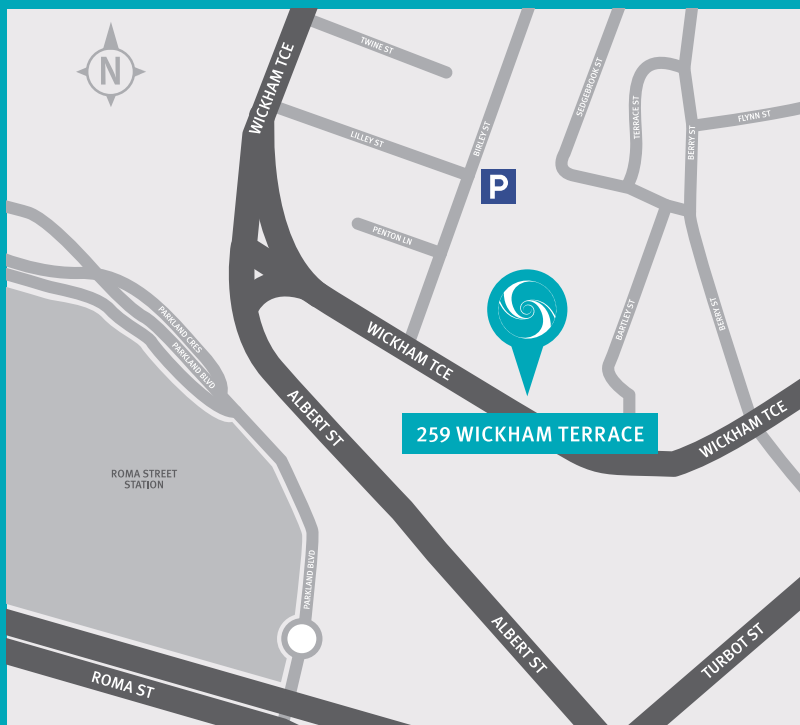


Brisbane Private Hospital is the city's leading inner city hospital treating over 20,000 patients each year.

Our 181-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, drug and alcohol rehabilitation, urology, ear, nose and throat, general surgery, rehabilitation, gynaecology, plastic surgery and endoscopy.



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