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ISSUE TEN

Brisbane
PRIVATE HOSPITAL

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ARTIST IMPRESSION OF BRISBANE PRIVATE HOSPITAL EXPANSION

INFOCUS
ISSUE 10

GM UPDATE

BY MAIRI McNEILL

Welcome to our special orthopaedic edition of In Focus where we are shining a spotlight on some of our valued surgeons who help make Brisbane Private Hospital the best private orthopaedic facility in Queensland.

Brisbane Private's long history of working with elite sporting teams will continue after we were named the Brisbane Bullets' official hospital partner. Brisbane Private is renowned for its orthopaedic care and boasts the State's largest team of private orthopaedic specialists. We are thrilled to be partnering with the Brisbane Bullets basketball team and continuing our proud tradition of looking after the health of elite athletes and sporting franchises.

Regarding our major development, works are progressing well with the foundations now complete and construction of the first level of the new building underway.

I would like to thank everyone for their patience during construction and for their continued support of Brisbane Private Hospital.

ABOVE: LOWER LIMB SURGEON, DR DAVID HAYES. RIGHT: UPPER LIMB SURGEON, DR DARREN MARCHANT.

BRISBANE BULLETS
THE TEAM BEHIND THE TEAM

The health of the Brisbane Bullets is in good hands, with Brisbane Private surgeons joining the medical team, ensuring the elite basketball players have access to the best orthopaedic care in Queensland.

Brisbane Private's upper limb surgeon Darren Marchant and lower limb surgeon David Hayes are part of a four-strong medical team, which also includes sports physician and medical coordinator, Dr Matt Hislop of Brisbane Sports and Exercise Medicine Specialists, and physiotherapist Andrew McGough of the Clem Jones Centre.

Both surgeons have a long association with the Bullets. Dr Marchant played for the team in the early 90s and Dr Hayes was its orthopaedic surgeon for eight years before the franchise retired from the National Basketball League in 2008.

Dr Hayes said having an experienced sports medicine team was crucial to a professional sporting franchise.

"An elite sporting team needs an elite medical team for many reasons," said Dr Hayes.

"It's important for a new franchise to establish a professional presence and our extensive experience in this area gives the Bullets credibility as a serious franchise, while ensuring the health and wellbeing of its players, which is paramount."

The Bullets' sports medicine team has a combined 56 years of experience working with elite athletes from across the board including Olympic swimmers and kayakers, Australian cricket players, NRL and ARU players, and international tennis players.

Dr Marchant said this experience with high-level sportspeople and franchises was invaluable.

"Between the sports medicine team, we have worked with many franchises including the Brisbane Broncos, Queensland State of Origin team and Queensland Reds," said Dr Marchant.

"I have also had experience with American franchise sport after working with the San Antonio Spurs and the Dallas Cowboys as part of my Fellowship.

"Our association with these sporting setups means we bring a lot of experience to a newly reformed franchise such as the Brisbane Bullets."

Dr Hayes and Dr Marchant have always been heavily involved with basketball and Dr Hayes said they had a real love for the sport at all levels.

"We have kids that play representative basketball so we've got a personal interest in the sport, which has stimulated our interest in looking after player injuries," said Dr Hayes.

"Darren does a lot of coaching for representative and school basketball and I manage the representative teams.

"We're involved not just as parents, but as coaches and managers, so working with the Bullets is a natural extension of what we normally do every week for junior basketball."

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NON-OPERATIVE MANAGEMENT OF DUPUYTREN CONTRACTURE

HAND AND UPPER LIMB SURGEON
DR STEPHEN COLEMAN

A new non-surgical treatment of Dupuytren disease offers an alternative to traditional surgical methods, providing a conservative and cost effective treatment for patients.

Dupuytren disease, which occurs when the fingers bend towards the palm and cannot fully extend, is a hereditary connective tissue disorder that affects the skin of the palm.

Brisbane Private hand and upper limb surgeon Stephen Coleman is now offering his patients Clostridium histolyticum collagenase treatment for Dupuytren disease as an alternative to surgery.

He said the treatment had provided positive outcomes for his patients, with most requiring just one injection and seeing results in 48 hours.

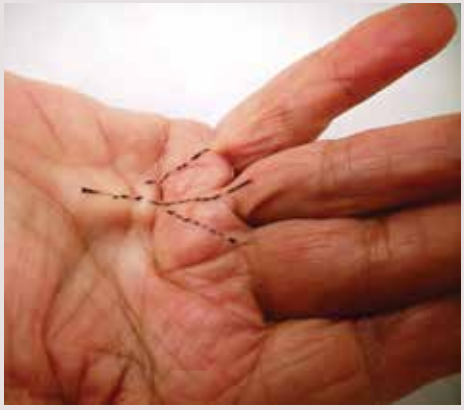
Dr Coleman said the collagenase treatment was a combination of Type 1 and 3 collagenases that hydrolysed collagen and dissolved segments of the Dupuytren cords.

"The collagenase is injected in the mid palm, causing iysis and then disruption which allows improved straightening of the contracted digits," he said.

"It takes effect quickly, with patients able to fully extend their digits within 24 to 72 hours.

"There is no wound following the procedure, swelling reduces and most movement has returned within a week.

"In comparison, the surgical alternative takes up to three weeks for the skin to completely heal and full use of the palmar skin can take several weeks more.



PRE-INJECTION AND ONE WEEK POST INJECTION

"Studies have also shown that should surgery eventually be necessary, it is possible to work with tissues that have been treated with collagenase and can be easier than with tissues previously treated surgically."

Dr Coleman said the collagenase treatment was performed as an outpatient procedure in a doctor's rooms with no need for local anaesthetic and therefore no hospital, anaesthetist or assistant fees.

"Patients can drive immediately after the injection and we have had patients playing golf two or three weeks following the procedure," he said.

"Most patients only require oral pain relief for one to two days after the injection and experience swelling and bruising for a few days, which is significantly shorter than post surgery.

"There are no long-term systemic side effects, nerve injury is very unlikely and most movement has returned one week post collagenase injection, meaning an earlier return to work, sport and normal activities than after surgery.

"It is important to note there are risks associated with incorrect injections, including the possibility of a tendon rupture and anaphylaxis, although extremely rare, so it is important for the patient to choose an experienced hand specialist."

Dr Coleman said while the collagenase treatment was still a relatively new procedure, some studies had been completed and five year results showed recurrence rates were comparable to, or better than, other treatment options.

"In the Cord I and II trials, the collagenase demonstrated a clinically significant benefit with no loss in digit flexion, decreased degree of contracture and an increased range of motion for all joints treated," he said.

"There is still a need for surgery in more advanced cases, and collagenase is not for all Dupuytren patients."

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REVERSE SHOULDER ARTHROPLASTY PRODUCES POSITIVE LONG-TERM RESULTS

UPPER LIMB SURGEON, DR BEN HOPE

The reverse shoulder arthroplasty (RSA) has recently overtaken the traditional anatomical shoulder arthroplasty as the most common shoulder replacement procedure due to its effectiveness in treating a number of conditions.

RSA is a total joint replacement of the shoulder with the ball and socket orientation 'reversed' – a modification that has unique biomechanical advantages.

Initially developed to treat patients with irreparable rotator cuff tears combined with arthritis, the RSA works by making the centre of joint rotation lower and more medial than the normal shoulder, increasing the power of the deltoid muscle and allowing elevation of the shoulder without relying on the rotator cuff.

Brisbane Private upper limb surgeon Ben Hope said the RSA would likely continue as the most common shoulder athroplasty as the effectiveness of its prosthetic design was being shown by its long-term results in the Australian National Joint Registry.

"RSA is primarily used to treat patients with cuff tear arthropathy (CTA), which is where chronic tears of the rotator cuff lead to degeneration of the glenohumeral joint and arthritis," he said.

"In patients with massive tears of the rotator cuff, the shoulder is no longer stabilised and begins to move out of the socket, causing the joint to become arthritic.

"The RSA combines the treatment of arthritis by replacing the degenerated joint and changing the mechanics of the shoulder to treat the irreparable rotator cuff.

"By reversing the anatomy of the shoulder and altering the centre of rotation, it provides some constraint and prevents the shoulder moving upward when the deltoid contracts.

"This allows for elevation of the shoulder to be restored even without a functional rotator cuff."

Dr Hope said the positive results achieved by RSA in CTA had led to the expansion of the indications to include treatment of irreparable rotator cuff tears without arthritis and some fractures of the proximal humerus in elderly patients.

"Fractures of the proximal humerus in elderly patients can be very difficult to treat with established techniques of internal fixation or hemiarthroplasty, so reverse arthroplasty is a very effective option with more reliable results," he said.

UPPER LIMB SURGEON, DR BEN HOPE

"RSA also allows treatment of some conditions that have no other solid solution, such as cuff tear arthropathy or irreparable cuff tear in elderly patients.

"For properly selected patients who have symptomatic and disabling rotator cuff deficiency, RSA can result in life-changing improvements in pain, motion, function and patient satisfaction.

"It is also a reliable way to treat some fractures or alleviate pain from arthritis as the design allows for good restoration of elevation at the shoulder but does not restore normal internal or external rotation."

Dr Hope said RSA had similar risks to other types of arthroplasty throughout the body, but that complications were becoming less frequent as surgeons increased their understanding of the procedure and prosthesis.

"Infection, dislocation and wear can all occur, along with loosening of the prosthesis, particularly on the glenoid side," he said.

"The limited bone available in the glenoid can make revision of the RSA glenoid component challenging, and a problem seen in RSA that is not encountered in the anatomic shoulder arthroplasty is scapular notching.

"That said, improvement in prosthesis design and a greater understanding of how to avoid these problems is occurring all the time and complications will continue to become more infrequent as our knowledge and experience grows."

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NEW FUSION TECHNIQUE IMPROVES PATIENT OUTCOMES

Brisbane Private is the first hospital in Queensland studying a new technique for spinal fusion that has increased patient satisfaction and significantly reduced surgical wound size and hospital stay.

The new technique allows the screws to be inserted into the vertebrae medially to laterally, rather than the reverse.

This new method is known as the 'cortical screw technique' and early clinical results show patient outcomes are the same, and in some cases better, than the traditional open pedicle screw technique in posterior lumbar interbody fusion.

Brisbane Private spinal surgeon Paul Licina is one of the first surgeons in Australia to perform the cortical screw technique and said the new method had comparable biomechanical properties to the traditional one, but with a smaller incision.

Dr Licina said this was of great benefit to patients who experienced less pain and a faster recovery, with many discharged from hospital 24 hours earlier than with traditional techniques.

"Early data suggests that the cortical technique is at least equivalent to the traditional technique for posterior lumbar interbody fusion in the peri-operative period, and in some areas, it is superior," he said.

SPINAL SURGEON, DR PAUL LICINA, WITH BRISBANE PRIVATE HOSPITAL'S INTER-OPERATIVE SCANNER

"The cortical technique has proven to have significantly better results in terms of decreased intra-operative muscle dissection and a faster recovery in the immediate postoperative period, which is believed to be a result of the smaller incision.

"Patients who receive the cortical implant are returning to work and normal activities three weeks following surgery, which is approximately two weeks earlier than those who have had a traditional posterior lumbar interbody fusion.

"Patients also use less opioid medications during their inpatient stay, potentially decreasing side effects such as drowsiness, nausea and constipation."

A recent study of 42 patients at Brisbane Private Hospital comparing the cortical to the traditional method showed early patient satisfaction was significantly higher for the cortical implant.

"Results also show that patients who received the cortical implant experienced the same outcomes and quality of life as those who received the traditional surgery after 12 months," said Dr Licina.

Dr Licina said the cortical technique was suited to the same patients as those who were eligible for traditional interbody fusions.

"The surgery is for those that have pain from neural compression, leg pain and back pain," he said.

The study is in the early stages and follow-up of the current cohort of patients will continue to measure the long-term outcomes of the cortical implant.

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TOP: DR PAUL LICINA PERFORMING SURGERY WITH BODY TOM. BOTTOM: DR PAUL LICINA WITH INTERNATIONALLY RENOWNED, EUROPEAN NEUROSURGEON, DR ADISA KURSUMOVIC

TOTAL HIP REPLACEMENT
THE GOLDEN ORTHOPAEDIC OPERATION

ORTHOPAEDIC SURGEON, DR DAVID MORGAN

The total hip replacement (THR) is recognised as the golden orthopaedic operation of the 20th century, with 90 per cent of replaced joints still functioning after 20 years.

Brisbane Private orthopaedic surgeon David Morgan said the highly successful intervention was voted the most important orthopaedic advancement of the 1900s, and was the procedure that changed the most lives, most positively with the least patient impact.

"Some people say the THR is not just the most successful orthopaedic operation of the 20th century, but the most successful operation full stop," he said.

"It has positively changed millions of lives with minimal disruption to the patient.

"The procedure can be performed for many indications, the surgery only takes an hour and a half, most patients walk the same day and are out of hospital within a week.

"The operation is life changing for those suffering from a restricted or degenerated hip. There is no need to relegate someone to a wheelchair when they can have this highly effective operation and be back to acceptable function in four to six weeks."

Dr Morgan said there were many variables and surgical preferences that could affect the outcome of THR, and that the key to success was to use the many options wisely.

He said it was important to take into consideration the patient's biology, age and ability to rehabilitate before deciding which option to use.

"It is crucial to make sure the surgical choice fits the patient – not that the patient fits it," he said.

"At my private practice, we are universal surgeons. Rather than being wedded to one surgical approach, one implant, or one type of fixation, we tailor the operation, with all of those variables, to the individual patient."

Dr Morgan said different surgical approaches and whether to cement the implants were highly debated topics, but studies showed no significant difference in patient outcomes regardless of method.

"In my opinion, the operative approach, be it anterior or posterior, is solely a marketing tool," he said.

"While I prefer to use the posterior approach, studies show there is no difference in outcomes, discomfort, mobilisation rates or long-term survivorship.

"Another option is to cement the implant. Like the surgical approach, results show the outcomes are the same after 20 years, so again it becomes a preference of the surgeon.

"It is important to think about a possible need for revision surgery at the time of the primary replacement. The use of bone cement has the potential to make revision more difficult. There has been an international move away from the use of cement for this and other reasons.

"Having said that, sometimes you have to cement if the patient is older and osteoporotic.

"The fact is, cement, like many other surgical options, is a material, not a technique. It should be used wisely and appropriately – not necessarily all the time, and not necessarily never."

Dr Morgan said his advice to GPs and patients was to pick the right time in their life for surgery, and the right surgeon for their needs.

"Get the right surgeon, for the right patient, at the right time and you'll get the right result," he said.

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ABOVE: ORTHOPAEDIC SURGEONS, DR GUAGUIN GAMBOA AND DR DAVID MORGAN OF QUEENSLAND HIPS AND KNEES

ORTHOPAEDIC SURGEON, DR GAUGUIN GAMBOA USES 3D TECHNOLOGY IN HIP REPLACEMENT SURGERY

3D TECHNOLOGY IMPROVES MANAGEMENT OF BONE LOSS IN REVISION HIP REPLACEMENT SURGERY

Advancements in 3D printing and imaging are giving surgeons a better understanding of the bone loss anatomy, resulting in less complications and better outcomes for patients needing revision hip replacement surgery.

The technology allows for production of highly-accurate 3D models of the native pelvis from which custom-made implants are created. These implants can now be manufactured ahead of time, allowing for more solid pre-operative planning and accurate positioning of implants that fit the patient's bone perfectly.

Brisbane Private orthopaedic surgeon Gauguin Gamboa said the fact surgeons now had improved knowledge of the bone loss anatomy prior to surgery was a significant improvement.

"Not knowing the bone loss anatomy prior to surgery has been one of the major obstacles in revision hip replacement surgery," he said.

"In the past, it was not until the operation phase when it was discovered whether there was enough bone for an implant to be successfully fixed.

"Off-the-shelf supportive cages were used to help manage these problems, however they were difficult to use and did not fit the host bone perfectly.

"The new 3D printed implants are user-friendly for surgeons, and a perfect fit for patients."

Dr Gamboa said total hip replacement implants had come a long way with the assistance of modern technology. He said the new implants allowed for options such as the type of material, fixation and level of constraint, which highly simplified the procedure and allowed for quicker and safer operations with more predictable outcomes.

"The recent availability of prostheses with large heads, dual mobility and semi-constrained articulation has seen a significant reduction in dislocations," he said.

"Previously, in order to reduce dislocation, capture liners were used, which were highly constrained and applied excessive force to the locking mechanism, causing early failure.

"Earlier implants also presented a higher risk for complications such as infection and neurovascular injury, but the new high-tech implants, augments and patient-specific prostheses allow for a much easier reconstruction of bone loss with less likelihood of failure."

Dr Gamboa said during revision hip surgery, both implantation and removal of the implant were necessary, requiring a larger dissection. He said this could lead to increased tissue release, but improved techniques and technology meant there were now tools available that allowed for a streamlined and safer removal of the previous prosthesis.

"Modern technology has allowed for a much higher likelihood of a successful and complication-free clinical outcome for revision hip replacement surgery and I am excited to see what will be possible in the future," said Dr Gamboa.

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PRESSURE SENSOR GIVES SURGEONS NEW FEEL FOR KNEES

A new pressure sensor is helping surgeons take some of the guess work out of knee replacement surgery by giving them a scientific indicator to measure what is usually left up to 'feel'.

The device allows surgeons to check and, where necessary, perform fractionated releases of the soft tissue restraints and/or revise the bony cuts performed during a total knee replacement (TKR) in order to achieve a balanced knee.

The trial components have radiofrequency pressure sensors built into the liner-insert positioned between the femoral and tibial component, allowing the surgeon to accurately measure the tension of the soft tissue during surgery.

Brisbane Private orthopaedic surgeon John Gallagher, who has started trialling the device in his practice, said it would help surgeons achieve more consistent results by more reliably "balancing the knee", which is an essential part of the artistry of knee replacement surgery.

"The new device allows us to test our sense of feel against an accurate and objective measure, giving us a number that is independent of what we think, or feel, is right," he said.

"Most surgeons can reliably achieve correct sizing and positioning of knee replacement implants that look good on an X-ray, but this doesn't necessarily result in patients having a knee replacement that they are happy with.

"At the moment, so many elements of knee replacement surgery are dictated by what it feels like for the surgeon, but not what it feels like for the patient.

"To bridge that gap, we've now got a tool that will allow us to get some feedback at the time of surgery.

"My plan is to record these pieces of data and marry it up with how the patient feels post-surgery.

"If we look at those numbers over time, it may allow us to improve our technique and hopefully achieve better results for our patients."

Dr Gallagher said previous studies had shown that approximately 20 per cent of patients were unhappy with their knee replacement for one reason or another, with complaints including that their knee felt "tight", "unsteady" or "clunky", which are outcomes that can arise from a poorly balanced knee.

"What we have not been readily able to do in the past is record the tension in flexion and extension in absolute numbers and then compare this to how a patient feels about their knee, for example, if a knee feels "too loose" or "too tight," he said.

"This device has the potential to increase the likelihood of giving patients a steady and stable knee, which as a consequence, may lead to a replacement that will last longer."

Dr Gallagher said in most cases there were four key elements to a knee replacement that needed to be performed correctly in order to overcome previous deformity, restore the correct alignment and have a well functioning knee replacement. These elements are accurate bony cuts, the removal of bone spurs, soft tissue balancing and the correct-sizing of the polyethylene liner.

He said the pressure sensor allowed the last two steps to be performed with confidence, using real-time feedback to see the individual pressures in the different zones of the knee when the knee is extended and in flexion, and when different-sized liners are inserted.

"There are a lot of steps in TKR and whilst this doesn't address all of them, it helps the ones we can't see, or "the unknown", and this is one particular area where I believe knee replacement surgery can be done better," he said.

"This single tool may help remove some of the remaining challenges associated with knee replacement surgery.

"If proven to be reliable, this device may gain general acceptance and widespread usage which could increase the patient satisfaction rate of TKR."

Dr Gallagher is currently analysing intra-operative data on a preliminary series of patients who have undergone TKR using the Verasense device, before using this technique under trial conditions in patients who are undergoing bilateral, simultaneous total knee replacements.

"I want to work out whether the device has a role or not, by comparing a TKR using the traditional technique with one using this new technique, and letting the patient be the judge, as ultimately they know what feels best for them," he said.

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LOWER LIMB SURGEON, DR JOHN GALLAGHER IS TRIALLING A NEW DEVICE TO ASSIST WITH TOTAL KNEE REPLACEMENTS

SOFTWARE PROGRAM AIDS IN ORTHOPAEDIC RESEARCH

ORTHOPAEDIC SURGEON, DR BRETT COLLINS, IS USING NEW SOFTWARE TO TRACK PATIENT OUTCOMES

A program that collects patient data is helping surgeons track the outcomes of orthopaedic surgery, playing a valuable role in patient care and clinical research.

Brisbane Private orthopaedic surgeon Brett Collins has been using Standardised Orthopaedic Clinical Research and Treatment Evaluation Software (SOCRATES) to track his knee surgery patients for the past 12 months and said it gave surgeons a tool to measure the success of their operations and analyse results to refine technique.

He said he shared data with a number of doctors at Brisbane Orthopaedic Sports Medicine Centre (BOSMC) to gain a better understanding of the variables contributing to patient outcomes.

"SOCRATES is an important tool that allows us to conduct research, and with strength in numbers, we have a larger pool of data that increases the power of our conclusions," he said.

"The program allows us to follow-up our results in the short and long term, and analyse the outcomes to ensure we are getting the results we hope for, and if not, to continue to develop our technique.

"It gives us the ability to compare different treatments, operative techniques, surgical preferences and implants and determine which produce better patient outcomes, and, if relevant, which combinations of techniques and treatments yield the best results."

The program is designed around a series of questionnaires relevant to each condition and uses validated scoring systems that are recognised world wide.

The patient is questioned pre and post operatively regarding issues surrounding pain, function, activities of daily living and return to sport.

Patients are followed up at various intervals, depending on the operation they received, and are re-scored and re-validated.

"We monitor all patients over the long-term but the emphasis changes depending on the condition," said Dr Collins.

"For example we track an ACL reconstruction more regularly over the first one and two years to monitor things like return to sport and function; with joint replacements, there is follow-up in the short term but it's the long-term results we are most interested in.

"This comprehensive patient follow-up, that comes in the form of an online questionnaire meaning patients don't always need to come and see us, also provides an opportunity to flag any potential problems early.

"Not only is the program a valuable research tool for surgeons, it also enables us to give patients more information about their procedure and how others have responded to it. This helps us in guiding patient expectations."

SOCRATES has a number of clinical modules including patient outcome scores, clinical examination, intra-operative details, complications, co-morbidities and concomitant therapy.

Dr Collins said it also included extensive data analysis capabilities and detailed reporting.

"The program enables us to look at different groups of patients from various demographics with different conditions and variables," he said.

"We can look at our own individual data or the pooled data, which is a great auditing tool for our own surgical development.

"We've also involved medical students and training registrars who have gained valuable insights by having access to, and interpreting the data."

Dr Collins is currently using SOCRATES to audit ACL reconstructions, total knee replacements, meniscal repairs and osteotomies.

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DR COLLINS IS USING SOCRATES TO AUDIT ACL RECONSTRUCTIONS, TOTAL KNEE REPLACEMENTS, MENISCAL REPAIRS AND OSTEOTOMIES.


stryker
stryker
Hipac

NOT ALL ANKLE SPRAINS ARE THE SAME

Ankle sprains are the most common form of sporting injury, however each sprain can differ slightly in the structure of the damage, making it important for doctors to determine the type of injury to avoid further harm and offer the most appropriate treatment.

There are three types of ankle sprains: lateral ankle ligaments – which is the most common; medial ligament injury – which can occur with an eversion-type injury; and a high ankle sprain – which is associated with an injury to the syndesmosis, the ligament between the fibula and the tibia.

Brisbane Private Hospital lower limb surgeon Terry Saxby said while it was often difficult in the acute situation to accurately assess the extent of the injury due to bruising and swelling, it was crucial to thoroughly investigate the sprain.

"Initial management of a sprain should include history and examination and, if there is any area of localised tenderness, appropriate plain x-rays to exclude fractures," he said.

"All sprains need to be treated with ice and elevation and severe sprains might require support in the form of an ankle brace or CAM walker."

Dr Saxby said there were three phases of treatment – rest and protection of the ankle to reduce swelling and pain; restoring motion strength and flexibility; and maintenance exercises to allow for return to sport.

"These treatment phases can occur quickly, with minor sprains only taking approximately one to two weeks, however this can take up to 12 weeks in more severe injuries," he said.

"If an ankle sprain does not recover or is not improving after four to six weeks, further assessment is needed, and an MRI scan in this situation can be very valuable."

Dr Saxby said it was best for GPs to wait one to two months after the injury before recommending an MRI.

"MRI scans and ultrasounds in the acute stage are usually not helpful because an ultrasound will simply confirm that the lateral ligaments are ruptured, which is clinically obvious; and an MRI scan will show increased activity in multiple areas which may mask underlying injuries," he said.

"If the ankle is not improving in the first couple of months, GPs should then order an MRI which can detect complications such as missed fractures including lateral process fracture, posterior process fracture and anterior process of calcaneus fracture.

"An MRI will demonstrate injuries to the syndesmotic ligaments or the tibio-fibula ligaments, and syndesmotic injuries need to be treated differently to a normal ankle sprain.

"Surgery for ankle sprains is indicated in those cases of chronic instability and in some cases of fracture including anterior process and lateral process, as well as osteochondral lesion of talus."

Dr Saxby said ankle sprains were divided into Grade I (minor), Grade II (moderate) and Grade III (severe or complete tear).

"it is important to determine the type of injury to avoid further harm," he said.

"Most sprains are minor and recovery is relatively straight-forward with simple RICE (rest, ice, compression, elevation).

"Moderate and severe sprains can lead to long-term problems including ongoing instability so management needs to include follow-up to ensure complete recovery.

"If there is ongoing episodes of giving way, a physiotherapy rehabilitation program needs to be undertaken, and if this fails, then surgery is an option.

"Grade III sprains involving a complete tear of a ligament does not necessarily require surgery but needs to receive the usual rehabilitation.

"Even Grade III high ankle sprains have a 95 per cent chance of a successful outcome with non-operative treatment."

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OPPOSITE: LOWER LIMB SURGEON, DR TERRY SAXBY

BRISBANE PRIVATE IMAGING SECURES MEDICARE LICENSE

Brisbane Private Imaging has aquired a full Medicare license and is now offering patients a new cost-effective, high quality and easily accessible '3-Tesla' MRI scanning service.

The 3-Tesla MRI is the most advanced and powerful MRI scanner available and is known to produce images of a superior quality to the standard 1.5 Tesla MRI system.

Patients referred from their Specialist or GP will receive a Medicare rebate for eligible medical conditions. Pensioners and healthcare card holders will be bulk billed where eligible.

Brisbane Private Imaging liaison manager Jenny Auguste said the centre's new Medicare license would assist more patients in receiving an improved diagnostic service at an affordable price.

"The new eligibility scheme allows for high quality, cost-effective healthcare to all patients in need of the 3-Tesla MRI scan," she said.

"The 3-Tesla MRI scan is a superior imaging service which boasts excellent soft tissue resolution and multiplanar capabilities, which results in a more precise picture to allow for an accurate diagnosis.

"Acquiring the Medicare licence to provide greater patient access to this service was an important step for Brisbane Private Imaging, which will help us to continue the expansion of our busy practice six years after opening our doors."

The 3-Tesla magnet is a wide bore machine suitable for larger patients or those who suffer from claustrophobia. Sedation is available on request to minimise distress or discomfort.

Brisbane Private Imaging offers same-day appointments and has extended its operating hours to ensure timely treatment for all patients.

FOR FURTHER INFORMATION CONTACT:

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Specialist Centre Brisbane Private Hospital
259 Wickham Terrace Brisbane

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TOP TO BOTTOM: THE 3 TESLA MRI SCANNER AT BRISBANE PRIVATE IMAGING

THE 3-TESLA MRI SCANNER AT BRISBANE PRIVATE IMAGING

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.

Brisbane
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