

Medical matters

The Kareena Private Hospital Newsletter



Kareena Private Hospital
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Issue 12
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KAREENA
PRIVATE HOSPITAL

CEO Message

The most noticeable thing happening at Kareena since our last Medical Matters issue is the speed with which the Stage 1 of our redevelopment is taking place.

From the outset I would like to pass on the Executives sincere thanks and appreciation to all VMO's for their understanding and support during the very noisy and often inconvenient building works that are going on. Our patients have also been incredibly supportive, inquisitive and appreciative of the upgrades which are taking place.

Even with all the redevelopment work it's particularly pleasing to see our Day Surgery numbers increase ahead of where they have been in the previous 12 months.

As you will see below on top of the redevelopment work we have also been investing in other upgrades to the Hospital, by the time we conclude all the current works at the end of January 2011, Kareena will be a far more advanced facility.

Press Ganey –Survey results

Recent independent surveys of our In-patients and Day Surgical patients asking them about their experiences at Kareena Private have once again confirmed that we are consistently delivering a product and service that meets and often exceeds their expectations.

Across both patient groups, Press Ganey report a statistical order of magnitude improvement over the same survey conducted two years ago across all areas of Kareena which is particularly pleasing for our staff who work so diligently in delivering this care.

New Nurse Call System - Update

Works have finally begun on our new Nurse Call system, "Micall". This state of the Art

Nurse Call system is being commissioned across the whole hospital to enhance clinical safety and place us finally on one communication platform. The "back bone" of the system has now all been installed with commencement of room by room installation starting on the 22nd November. This work will be completed by 20th December.

New Patient Bed lights & Power points - Update

Following a small electrical incident in one of the rooms on Botany in August this year we decided to review the whole facilities over bed lighting and power point (GPO's) requirements. The result of this review is that during November works will be undertaken to install new over bed lights and relocate GPO's (in some instances increase the number of GPO's) across approx 75% of the hospital.

Facility Improvements

Kingsway & DSU

With the first Endoscopy procedure being carried out on Monday 1st November in our new Day Surgical Unit (DSU) Fig 1 we are now able to finish some much need painting, carpeting and the upgrade of hall-way wash basins etc in Kingsway ward and DSU.

These works will complete the ward and room upgrade to Kareena giving our patients the long awaited accommodation consistency that they have been waiting for.



Fig 1. New Procedure Room entrance and Endoscopy Pre-operative holdings bays

Rehabilitation & Hydro Pool

Closing in of the Hydro pool area has begun and things will now start taking shape very quickly. Although there have been delays with this part of the project our developers believe that they will still be able to hand over our new Rehab facility to us by Xmas.

An Architectural rendering of the new Kareena Hydro Therapy complex



8 New Rooms on Botany



The eight (8) new rooms have begun with the floor currently going down. These eight new single rooms will bring our total medical bed numbers

to 34. It is estimated that these eight rooms will be completed and commissioned mid January.

General

On behalf of the Executive and staff at Kareena we would like to thank you all for your fantastic support in 2010, we are extremely excited about the year ahead and all of the new facilities that we will be opening. We are planning to formally open all of these new areas in February 2011 and we hope that you will be able to come along and share this very proud moment with us.

I hope you have a restful and safe Christmas.

Warmest Regards

Tim Daniel

Chief Executive Officer.



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Kareena Private THEATRES
Closed 23 December, 2010
through to
17 January, 2011

The Kareena Private Hospital AGM – held 27 October 2010.

We thank the outgoing members of the Medical Advisory Committee namely Dr. Andrew Bean, Dr. Mark Ridhalgh, Dr. Mark Sader, & Dr. Eli Kleiner

The newly formed Medical Advisory Committee

Dr Chris Dedousis	Chair & Medicine/Physicians
Dr Gerard Testa	Deputy Chair & Urology
Dr Amjed Aziz	Intensivist
Dr Frank Chu	General Surgery
Prof. Peter Gonski	Aged Care & Rehabilitation
Dr Matthew Hall	Gastroenterology
Dr Anthony Leong	Orthopaedics
Dr Andrew Ng	Respiratory Medicine
Dr Angela Playoust	Anaesthetics
Dr David Sherring	Dentistry/ Faciomaxillary
Dr Ian Simpson	Obstetrics & Gynaecology
Dr Robert Smith	Cardiology
Dr Edward Smith	ENT
Dr Glen Stephens	Paediatrics
Dr Rod Tyrell	General Practice

GP Education 2011

March '11 Rehab & Orthopaedics

May '11 Best Practice Cardiology

June '11 Urology & Men's Health Update

August '11 Advances in Day Surgical Procedures

October '11 All Things Laproscopic



The place for resection of

Over the past two decades, major advances in surgical and non surgical treatments for liver cancer have changed our clinical practice. This is particularly true for hepatic colorectal metastases where surgical resection, possible in about 20% of cases, offers five-year survival rates of 40-60% compared with 1-2% for patients with non-resectable disease. Perioperative mortality is around 2% and most patients are discharged within seven days of surgery. The decisions around surgery and optimal use of other treatments require thorough workup by the liver surgeon working with the radiologist, hepatologist, medical oncologist and radiotherapist – complex decision making that offers some obvious benefits.

The first step is to determine the type of primary tumour and accurately stage the disease, particularly extrahepatic disease, and if liver resection is favoured, then determine if it is technically feasible. This often requires:

- Thorough patient history and examination.
- Blood tests – FBC, UECr, LFT, Coags, CEA, AFP, CA19-9, Ca-125
- Tests to determine the primary site e.g. mammogram, bone scan, endoscopy.
- CT scanning of the abdomen, pelvis, and chest.
- PET scans are now routinely performed in patients with isolated liver metastases. It is extremely useful in diagnosis patients with extra-hepatic disease.
- MRI is increasing being utilised for patients with indeterminate liver lesions.
- BIOPSY should NOT be routinely performed in patients with resectable liver disease. Studies have shown a 10% decrease in survival at 4 years

A number of critical factors play a part in determining patient suitability for hepatic resection.

Primary tumour

Patients with colorectal metastases have greater resectability rates and five-year survival rates than those with non-colorectal metastases or primary liver cancer. However, there are exceptions. Those with metastases from neuroendocrine or carcinoid tumours have five-year survivals at least as good as those with colorectal metastases. In selected

cases, hepatocellular carcinomas (HCC) can be treated with liver transplantation or resection (e.g. the fibrolamellar variant of HCC is eminently curable). Occasionally, metastases from breast cancer or melanoma can also be treated effectively with hepatic resection. On the other hand, metastases from pancreatic or gastric primaries would rarely be considered for resection.

For patients who have synchronous hepatic metastases with a colorectal primary (about 3.5% of patients), it is often possible to resect both at the same operation.

Extrahepatic disease

Widespread metastatic disease (e.g. peritoneal, bone, lung, etc) usually precludes resection. However, sometimes extrahepatic disease can be resected in conjunction with hepatic resection (e.g. local invasion of the diaphragm, inferior vena cava or bowel). Even a small number of lung metastases may be ablated with percutaneous radiofrequency probes under local anaesthesia, in conjunction with hepatic resection.

Extent of hepatic disease

It is no longer accurate to use milestones such as "four hepatic metastases" or the "presence of bilobar disease" as indicating irresectable disease – further careful evaluation is needed.

In general, up to 75% of the liver may be safely resected, irrespective of the number of metastases or their distribution. The remaining liver will undergo hypertrophy and hyperplasia to expand and fill most of the resected volume within 2 to 3 months.

In some cases, the portal vein supplying the volume of liver to be resected may be embolised several weeks prior to surgery. This causes hypertrophy of the unembolised non-tumorous liver segment, which may facilitate resection of >75% of the initial liver volume.

Vascular & biliary involvement

After resection, the remaining liver must have adequate venous and biliary drainage so the position of the tumour with respect to the hepatic veins and bile ducts is carefully assessed preoperatively. Close proximity to or involvement of hepatic venous drainage or the inferior vena cava does not necessarily preclude resection, as these veins may be

liver metastases

By Dr Francis C K Chu, General, Laparoscopic & Hepatobiliary surgeon.

reconstructed with an autologous saphenous vein graft. Likewise, post resection portal and arterial supply can also be maintained with appropriate venous reconstruction grafts. Involvement of biliary drainage can often be overcome by biliary reconstruction using small bowel, also known as hepaticojejunostomy.

Quality of remaining parenchyma

Prior chemotherapy and radiotherapy, or a history of alcoholism may result in cirrhosis and reduced hepatic reserve. In such cases, less parenchyma is resectable due to the risk of postoperative liver failure, and pre-surgical options such as portal embolisation may be contraindicated. Preoperative assessment of liver function using indocyanine green metabolism may be needed.

Patient factors

Co-morbidities, age, and patient wishes are obvious considerations. If the decision is to proceed to surgery, there is no need for other treatment modalities to be given preoperatively. Of course, the 80% of patients with non-resectable disease must rely on these modalities alone.

Other treatment options

Chemotherapy is the backbone of treatment for patients with unresectable liver metastases. Newer systemic chemotherapeutic agents and the development of biologic agents have seen tumour response rates increase to 80%, with median survivals of 2 years. Good symptom palliation can be achieved, and tumours may be down staged to allow hepatic resection in some cases.

Radiotherapy may be by external beam or relatively new selective internal radiation therapy (SIRT). This latter treatment infuses radioactive Yttrium microspheres into hepatic arterial system to selectively embolise within liver tumours, where they deposit their radiation dose. The procedure is done via a percutaneous femoral artery catheter fed into the hepatic artery. Early studies suggest a possible survival benefit of about 3-6 months (further studies are in progress), together with excellent palliation and few side effects. This treatment can also downstage tumours to allow resection.

Radiofrequency ablation involves the radiologically guided placement of probes that apply a radiofrequency field to isolated liver tumours, resulting in their thermal ablation. This technique is best for tumours <3 cm but has a high recurrence rate though may confer a small survival benefit— best for patients unfit for surgery and with a small number of isolated lesions.



Dr Francis Chu is a Consultant General Surgeon specialising in advanced laparoscopic techniques for gallstone and hernia management. His main interest is liver resections for primary and metastatic disease.

He has VMO appointments in Sutherland, Kareena, St George Public and Private Hospitals.

Dr Chu spent 3 years undergoing surgical training in both St George and Sutherland Hospitals. He then had 3 years of post fellowship training at Nepean, RPAH and University of Cincinnati, Ohio.

He is on the NSW Cancer Institute HCC advisory committee and is part of the St George Hospital Hepatoma Clinic, which is a multidisciplinary team consisting of Liver surgeons, hepatologist, oncologists, radiologist and allied health staff dedicated to the management of patients with liver cancer.

Dr Chu has published over 30 papers in international peer reviewed journals on all aspects of liver cancer management and is a reviewer European Journal of Surgical Oncology.

He lives in Sans Souci with his wife and little boy.

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Dr Francis C K Chu
MBBS Hons, FRACS

Consultant General,
Laparoscopic &
Hepatobiliary Surgeon

Endoscopy in the digital age

Video endoscopy has been available since 1990. There has been a steady improvement in the quality of the images over the years and the current endoscopes provide excellent resolution with the ability to magnify the image, apply narrow band imaging (NBI), capture digital images and also video clips. Narrow band imaging is a new endoscopic technology which uses optical filters to illuminate the mucosa with light from a selected or narrow band of the optical spectrum. The filtered light (blue in colour) preferentially enhances the mucosal surface and in particular the network of superficial capillaries. This helps identify adenomas on the mucosa, dysplastic lesions in Barrett's oesophagus and also dysplastic lesions in chronic colitis. It can also be used (with magnification) as a screening test for assessing the villi in the second part of the duodenum as a screening test for coeliac disease. This does not replace small bowel biopsy before committing a person to a lifelong gluten free diet, but it can greatly reduce the number of normal small bowel biopsies that are performed. NBI is initiated by simply pressing a switch on the endoscope.

Endoscopy is now performed in dedicated procedure rooms within an integrated day surgery unit. Background ultraviolet illumination in the endoscopy suite makes it easier to see small polyps. Carbon dioxide is used to insufflate the bowel. This greatly improves patient comfort during recovery as carbon dioxide is absorbed 30 times more quickly across the mucosal capillaries than air and excreted rapidly via the lungs. This reduces the cramps and bloating felt by some patients (perhaps

30%) after the procedure, especially if they have severe diverticular disease, a history of irritable bowel syndrome or have had a prolonged procedure.

Endobase is an image management and reporting program which is used in conjunction with the Olympus video endoscopes. It greatly enhances the reports produced from the endoscopy suite, since it has the capability of producing type written report incorporating the digital images of the endoscopy, such as a caecal view, or perhaps a polyp before and after polypectomy or views of diverticular disease, colitis or cancer.

Digital images of the procedure can be archived easily and video clips can be taken of the endoscopy. These are easily viewed and edited on a computer with Windows Media Player. For those patients requiring surgery a video clip of the endoscopy can easily be forwarded along with the surgical referral. A picture is worth a thousand words!!

In time, the reports will be transmitted via email and incorporated into the General Practitioners clinical programmes without the need for scanning. Other benefits of this enhanced system will be in clinical review, auditing and quality control. It will also enable the endoscopist to easily review the digital images of a previous endoscopy, especially when there are diagnostic challenges or therapeutic concerns.

Dr. Alastair Tait
Gastroenterologist

Meet our Ga

Dr. Tony Donaghy

MBBS, PhD, FRACP

Ph: 9531 6660

Special Interest: Gastroenterology & Hepatology, including the investigation of abdominal pain, rectal bleeding and abnormal liver tests.

Dr. Donaghy specialises in Gastroenterology, Hepatology and disorders of clinical nutrition.

Dr. Rob Elliott

MB, BS (Hons) (Syd)

Ph: 9524 7114

Special Interest: Gastroenterology

Dr Elliott has performed regular Endoscopy and Colonoscopy lists at Kareena Hospital for twenty years and is highly experienced in diagnostic and therapeutic procedures of the gastrointestinal system. Dr Elliott also diagnoses and treats diseases related to the liver.

Dr. John Freiman

MBBCh, FRACP, PhD

Ph 9525 4899

Special Interest: Gastroenterology & Hepatology

Dr. John Freiman specialises in Gastroenterology and hepatology. He is a highly experienced Endoscopist performing routine gastroscopes and colonoscopies as well as complicated interventional procedures. Dr. Frieman has a particular expertise in hepatology and viral hepatitis having obtained his PhD in the field of viral hepatitis.

gastroenterologists

Further details available on
www.kareenaprivate.com.au/our-doctors



Dr. Matthew Hall

MBBS, FRACP

Ph: 9525 4222

Special Interests: Gastroenterology & Hepatology

Dr Matthew Hall is a specialist Gastroenterologist performing gastroscopy and colonoscopy at Kareena Private Hospital. Dr. Hall also performs "pillcam" to investigate small bowel disorders. He has an interest in health maintenance and is interested in the management of liver diseases.



Dr. Alastair Tait

MB, BS (Hons I), FRACP

Ph: 9524 0229

Special Interest: Gastroenterology

Dr Alastair Tait is a specialist Gastroenterologist who has practiced in Miranda since 1984. Dr Tait deals with all aspects of clinical gastroenterology and has a particular interest in the diagnosis and treatment of colitis and Crohn's disease. He is a highly experienced endoscopist performing both gastroscopies and colonoscopies.



Dr. Jason Hui

MBBS (Hons & Medal), FRACP, PhD

Ph: 9524 0229 & 9526 2248

Special Interest: Gastroenterology, Endoscopy & Hepatology

Dr. Jason Hui graduated from Sydney University with the university medal. He underwent training in gastroenterology and interventional endoscopy at Westmead and St. George Hospitals. He then completed a PhD in hepatology. Dr. Hui performs more than 2000 endoscopic procedures annually. He has admitting rights to the Sutherland Hospital and is a conjoint senior lecturer with the University of New South Wales.



Dr. Ben Terkasher

MBBS (BSc), FRACP

Ph: 9525 4899

Special Interests: Gastroenterology and liver diseases

Dr. Ben Terkasher specialises in Gastroenterology and liver diseases. He completed a fellowship in interventional endoscopy in 2008 and performs a wide range of endoscopic procedures including gastroscopy, colonoscopy, ERCP and Endoscopic Ultrasound.

Ultra-low Anterior Resection of the Rectum

Personal perspective

Advances in surgical stapler technology have made ultra-low anterior resection of the rectum much easier and allow anastomoses to be made immediately above the anal sphincters and so preserving continence in patients who might have otherwise required a permanent stoma.

If it is possible to remove a carcinoma of the rectum with a margin of normal tissue and preserve the anal sphincters the anastomosis is usually made with staples because of the difficulty of access for hand suturing in the depths of the pelvis, particularly in males. After full mobilisation of the rectum down to the level of the levator ani muscles the Johnson and Johnson Contour Curved Cutter Stapler is used to apply 4 rows of staples and divide the rectum between the staple lines. The sigmoid colon is then anastomosed to the rectum by using a circular stapling device. Because healing of such low stapled rectal anastomoses could be compromised by the passage of faeces it is routine to divert the faecal stream by forming a temporary loop ileostomy. This is usually closed after 2 to 3 months when the patient has fully recovered from the surgery. The ileostomy also allows early commencement of oral nutrition and early discharge from hospital as it begins working well before a rectal anastomosis would be functional.



sterile staplin



“The excellent results of this type of surgery at the Kareena Private Hospital is due to the efforts of all the staff members concerned.”

The excellent results of this type of surgery at the Kareena Private Hospital is due to the efforts of all the staff members concerned. Patients requiring bowel surgery and a stoma are seen pre-operatively by the stoma therapist, Louise Harding. Education and support is provided to such an extent that the patients are fully aware and very grateful.

Chest physiotherapy and early mobilisation after surgery are essential and of vital importance for the avoidance of post-operative chest infections and deep vein thrombosis. All my patients are seen daily by Physiotherapists and are kept active and happy during their admission.

Advances in post-operative pain management also have had an obvious effect of outcomes. My patients are routinely managed with Pain Busters. These are fine plastic catheters that are inserted into the extra-peritoneal spaces at the end of the operation and are used to administer local anaesthetic during the first few post-operative days. Local anaesthetic is routinely administered into the wound edges at the end of surgery and the results are obvious. Ask one of my Surgical Registrars who asked me to remove his acutely inflamed appendix after he had finished a night shift at the Sutherland Hospital a few years ago. Local anaesthetic was infiltrated into the appendicectomy wound at the end of the operation. He woke up with no pain until the local anaesthetic wore off. He then had quite severe pain until he was given analgesia. It clearly demonstrated to us all just how important wound analgesia is.

The most recent significant advantage of being a patient care at the Kareena Private Hospital is the quality of care provided to post-operative patients by the staff of the High Dependency Unit (HDU). The nurses have always provided excellent care but now

the hospital has Intensive Care Specialists, Drs Aziz, Bennett, Aneman & Bhonagiri. They see all patients in the HDU and provide a level of care that allows operations to be carried out or conditions to be treated that previously would not have been contemplated in a local private hospital.

The post-operative care continues in Kingsway ward, the surgical ward where patients are nursed by the Kingsway team of nurses. They are kept active and happy by the dedicated and professional nurses.

Joseph Lizzio General Surgeon

MB BS (Syd) LLB (UNSW) FRACS

- Visiting Medical Officer in General Surgery – Sutherland Hospital since 1986
- Admitting Medical Officer – Kareena Private Hospital since 1986
- Admitting Medical Officer – President Private Hospital since 1986
- Part-time Medical Advisor – Avant Mutual Group Limited since 2004
- Practising Certificate – The Law Society of NSW since 2007
- Chairman of NSW Regional Committee of the Royal Australasian College of Surgeons – 2010 - 2012