GP News

ISSUE 2 / JULY 2020

Welcome from the CEO

I want to extend a big thank-you to GPs, the community and our incredible healthcare staff for your ongoing support during the COVID-19 pandemic. It's been a difficult time for many, and, as we have seen recently, the presence of coronavirus continues to challenge our health systems. As we settle into a long-term approach to the pandemic, I am heartened by the way in which I have seen us all pull together, and I am confident that we will continue to do our utmost in the months ahead to look after one another.

In this edition of our GP newsletter, we include an important GP survey that will gather your feedback about our services and future education programs. I encourage you to participate so that we can respond to your needs and those of your patients by adapting our services accordingly.

Stories in this edition of our GP newsletter show the high level of care at Hawkesbury District Health Service matches that of tertiary medicine in many fields while allowing patients to remain in their community as they receive care. Investment in new technologies, skilled surgeons and specialists, and support from a broad range of healthcare staff bring outstanding care to the small and intimate setting of our hospital.

We look forward to continuing our strong relationship with GPs.

Strephon Billinghurst

GP Survey 2020

Click here to access the survey. It should take less than 5 minutes.

CLOSING 31 JULY 2020.
GO INTO A DRAW TO WIN A $500 VISA PREPAID GIFT CARD.

Online RACGP Accredited GP Events

Click here to register

Your local Specialists

Click here to view

ST JOHN OF GOD Health Care

Hawkesbury District Health Service

Re-thinking lateral hip pain in ageing patients

Lateral hip pain has always been thought of as trochanteric bursitis but is mostly due to hip tendon degeneration. It commonly requires surgical reconstruction, which can reliably and effectively relieve symptoms.

The spontaneous onset of lateral hip pain in the over fifties is most commonly diagnosed as trochanteric bursitis. Recent improvements in our understanding of this condition confirm it is actually a problem of the underlying tendons which is why treatment of the bursa alone often results in only short-term pain relief, says Dr Michael Walsh, Orthopaedic Surgeon at Hawkesbury District Health Service.

"Trochanteric or 'lateral hip' pain is rarely due to bursitis," said Dr Walsh. "True trochanteric bursitis is actually quite a rare problem and is more often seen in young athletes. In the older patients who may have been diagnosed with bursitis but are not responding to physiotherapy or cortisone injections, it is important to consider the possibility of degenerative tendon disease.

"Much like Plantar Fasciitis, which is similarly not an inflammation problem, but a degenerative condition, the tendons separate from the bone due to normal wear and tear causing mechanical symptoms such as pain with walking or when lying on the affected side. It is also important not to think of it as hip arthritis, which is a very different problem."

Gluteal tendon degeneration does not improve with time or exercise but is slowly and progressively incapacitating. It produces a gait that is often described as a waddle by family members and pain on the lateral side of the thigh – caused by the separated tendons rubbing on the bone. This results in considerable incapacity with reduced mobility and eventually the need to use a walking stick.

A successful gluteal tendon reconstruction to reattach the pair of tendons involved can provide sufferers with dramatic and substantial pain relief because it deals directly with the problem. At surgery, the tendons are exposed and the damaged area removed, leaving a clean healthier tendon surface. After also preparing the bone surface, the tendons are reattached with large sutures passed through multiple tunnels in the bone.

Recovery is about six to twelve weeks post-operatively depending on duration of symptoms.

Dr Walsh is known nationally and internationally for his work in this field and has successfully completed more than a thousand hip tendon procedures at Hawkesbury Hospital over many years.

"Patients come from all over the country to have this procedure done at Hawkesbury," he said. "We have an excellent team here at Hawkesbury because we have been working together for a very long time and have established a good understanding of each member's role. We are offering world-class surgery at Hawkesbury Hospital, and I'm proud of the level of surgical care we provide."

"Dr Walsh is known nationally and internationally for his work in this field and has successfully completed more than a thousand hip tendon procedures at Hawkesbury Hospital over many years."

"Trochanteric bursitis has always been considered a chronic and intractable condition. Improved understanding of the problem has changed this. When physiotherapy, chiropractic treatment and cortisone injections don't relieve symptoms, the problem is almost certainly separation of the tendons from their bony attachment.

WHAT DOES THE RESEARCH SHOW?

Recent publication of this work in the peer reviewed Journal of Arthroplasty describes the largest series of its kind on the long-term outcomes of the gluteal tendon reconstruction procedure. Authored by Dr Michael Walsh and colleagues, the findings demonstrate that at the 5 to 10-year follow-up of 200 patients who have had the procedure, 92 per cent have maintained the improvement experienced in the immediate time post-surgery.

CONTACT
Dr Michael Walsh
MBBS, FRACS, FAOrthoA CPL(H)
Orthopaedic Surgeon
Call 02 4587 7284

Hawkesbury demonstrates surgical excellence in thyroid surgery

More than 100 successful thyroidectomies performed at the Hawkesbury District Health Service over a three-year period have saved lives for patients with severe thyroid disease and demonstrates the Hospital's ability to offer specialist expertise at world-standard levels.

When an ultrasound found a nodule on Maria Lopez's thyroid, she was referred to endocrine and oncology surgeon Dr Shadi Faraj, who determined that surgery was the best treatment.

"When I made the decision to have the thyroidectomy, I was quite nervous," said Maria. "I'm still quite young, and had never had an operation, so it was all unexpected and new to me. My biggest concern was the potential loss of my voice.

"Dr Faraj patiently answered all my questions."

A resident of the area, Maria chose St John of God Hawkesbury District Health Service for the procedure. Dr Faraj recently performed his 100th thyroidectomy there – an impressive milestone for a small hospital.

The high volume of procedures completed by Dr Faraj was made possible by the Hospital's investment in a state-of-the art intraoperative nerve monitoring (NIM) system, which monitors important nerves in the neck during surgery.

"Nerve monitoring is essential for good outcomes for thyroid procedures," said Dr Faraj, who has advanced training in various surgical approaches. "Bleeding from vessels in the neck and damage to the recurrent laryngeal nerves are the biggest risks of thyroid surgery. Being able to visualise and identify nerves during the procedure with the NIM system makes this operation significantly safer.

"At Hawkesbury, we have the top-of-the-range NIM technology, which means we offer the same level of care and technology as do the large teaching hospitals in Sydney."

The Hospital has also established a dedicated thyroid ward – for both public and private patients – with nurses specially trained in post-operative care for thyroid patients.

Thyroid surgery is generally safe and successful, with a low complication rate. At Hawkesbury, the combination of a highly experienced surgeon, advanced technology and skilled nursing staff all contribute to its outstanding record in this procedure.

The delicate operative approach used for Maria's surgery meant she was left with just a small barely visible incision on her neck and within a few days, her life – and her voice – were back to normal.

"I'm very happy that it's over and everything went so well," said Maria. "The Hospital is small and different. It's a gentle place."

For Dr Faraj, it's rewarding to treat patients like Maria. "With the increasing availability of ultrasounds and other diagnostic imaging, more patients like Maria are being diagnosed with thyroid abnormalities," said Dr Faraj. "Early diagnosis means that treatment can ultimately save lives.

"To provide thyroidectomy patients with specialist expertise at world-standard levels in their own community is very gratifying. For a small hospital like ours, it's a great achievement."

CONTACT

Dr Shadi Faraj
MBBS, FRACS
Endocrine and Oncology Surgeon
Call 02 9802 6555

The subtle cases of hypertension during pregnancy

The careful assessment of hypertension at different stages of pregnancy is important, given that subtle cases can be missed. Hawkesbury District Health Services's Dr Batool Nadim, obstetrician and educator specialising in this area, highlights the key points GPs should be aware of.

At what point is a woman considered to have hypertension?

While a blood pressure reading of 140/90 is considered hypertension, women with a reading of 130/80 need to be watched very carefully – especially in the presence of other risk factors like high BMI, smoking, previous history of hypertension in pregnancy and other diseases like antiphospholipid syndrome.

White coat hypertension is a common presentation and not necessarily a benign condition. Around 40% of these women will progress to gestational hypertension after 20 weeks and 8% to pre-eclampsia.It is important to do 24 hour blood pressure monitoring when women fall into this category.

What are the important moments during pregnancy when GPs should be extra vigilant?

I must emphasise the importance of accurate measurement of blood pressure with accurate cuff size and, preferably, mercury sphygmomanometers. The automised machines have wide inter-individual errors. Measurements should be taken in the same arm every time as 8% of women have at least 10 mmhg difference in systolic and 2% in diastolic blood pressure measurements between the two arms.

During mid-pregnancy (between 20¬–24 weeks gestation), blood pressure should drop due to physiological changes of pregnancy. However, this is sometimes missed by GPs. If blood pressure does not drop by 10 mmhg, it is important to monitor a woman very closely.

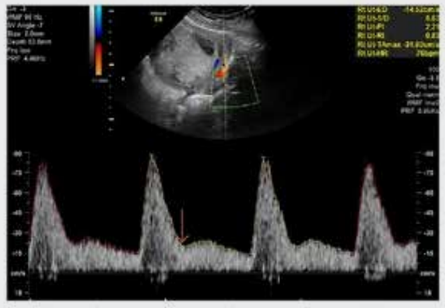
Gestational hypertension carries a recurrence risk of 16–47% in subsequent pregnancy with a 7% chance of developing pre-eclampsia. Low dose aspirin of 100 mg/d has been found to significantly reduce this risk if started before the 16th week of gestation – but not afterward. As GPs are often the first health professional to make contact with women once pregnant, it is important to take a detailed history or obtain records from previous pregnancies to determine a woman's absolute risk in developing hypertensive disorder in pregnancy and then to initiate the appropriate investigation and subsequent referral.

Is there a method to predict development of pre-eclampsia or its sequelae?

There is no 100% accurate way to predict those pregnancies that will develop hypertensive disorders from those that will not. There are several suggested screening protocols. The most important first step is to identify the risk factors with proper detailed history looking for previous history of high blood pressure, high BMI, family history and other pre-existing disorders like diabetes or antiphospholipid syndrome.

Recent advances in Ultrasound resolution and technique have enabled the addition of uterine artery pulsitality index PI and notching to the standard first trimester routine scan. Uterine artery Doppler studies combined with maternal characteristics can predict up to 48% of women who will develop pre-eclampsia later in pregnancy.

Most recently, in 2019, the detection of low placental growth factor (PGIF) was found to be a strong indicator of developing pre-eclampsia at less than 37 weeks gestation and is currently added to the other biochemical markers routinely done at the first trimester screening test.



Ultrasound of uterine artery showing notching

Why are the kidneys so important, and when to check them?

One of the important organs that are greatly affected by pre-eclampsia is the kidneys. The relative risk of having end stage renal disease is 4.3 (CI 95% 3.3–5.6) and is much higher than other complications such as developing chronic hypertension RR 3.7 (CI 95% 2–7.5).

As most women enter pregnancy at a young age, having renal impairment which is chronic debilitating disease, will impact their life and has the potential to get worse with subsequent pregnancies. Early recognition of renal involvement during the course of the disease is very important to reduce this risk.

Blood test abnormalities should be interpreted using pregnancy-specific ranges, some of which are gestation dependent. Serum/plasma creatinine usually falls in normal pregnancy and levels even at the upper end of the normal range (70–100 umol/L) may indicate impaired renal function. Serum/plasma creatinine (along with other parameters) is an indicator of adverse maternal outcome in pre-eclampsia particularly in the presence of proteinuria.

A urinary dipstick is not accurate in detecting significant proteinurea with reported sensitivity of 22–82% . The presence of 2+ or 3+ proteinuria or repeated +1 dipstick testing increases both sensitivity and specificity and, therefore, should be assumed to represent significant proteinuria until proven otherwise by confirmatory tests.

A spot urine protein/creatinine cut-off level of 30 mg/mmol is recommended for confirmation or exclusion of proteinuria when pre-eclampsia is suspected.

When should a GP refer to an obstetrician?

All pregnant women with high blood pressures are considered 'high risk' and should be referred to obstetric specialist care. On the other hand, stable women can be managed with shared care and continuous liaison with an obstetrician.

HIGH-RISK PREGNANCIES CAN BE WELL MANAGED AT HAWKESBURY

Hawkesbury District Health Services has the capability to manage high-risk pregnancies with tertiary-level obstetric consultants looking after women one on one during and after pregnancy. Services are affordable, and the small and intimate hospital setting offers a peaceful and calm environment.

Dr Batool Nadim performs high-level tertiary ultrasound and is experienced in advanced laparosopy for endoscopy. Dr Anmar Mariud is also part of the private obstetric service at HDHS, supported by Dr Ralph Nader and Dr Richa Gulati undertaking public work.

CONTACT

Dr Batool Nadim
MBCHB, MSc, FRANZCOG, DDU
Obstetrician and Gynaecologist
Call 02 8883 2091

Using Algorithms in decision making for treatment of acute knee injuries

Knee injuries are the most common acute orthopaedic presentation in general practice. But what are the challenges present at this early stage of diagnosis and how do you manage them accurately?

"Often, diagnosis is obscured by the presenting symptomatology and the difficulty in examining a painful knee," said Dr Qurashi. "Fortunately, in most cases, diagnostic imaging is readily available and can help give us a swift diagnosis.

"However, once a diagnosis is reached, there's still a decision to be made on which patients need urgent review, which patients require rest, and which patients can commence physiotherapy rehabilitation."

Dr Qurashi and his team have designed the algorithm on the next page to help GPs navigate this process and streamline the progression of care.

DR SOL QURASHI

Dr Sol Qurashi is an orthopaedic surgeon specialising in hip and knee surgery. His background includes fellowships at the prestigious Charite Klinik in Germany, where he learned advanced techniques in knee ligament reconstruction and knee replacement surgery.

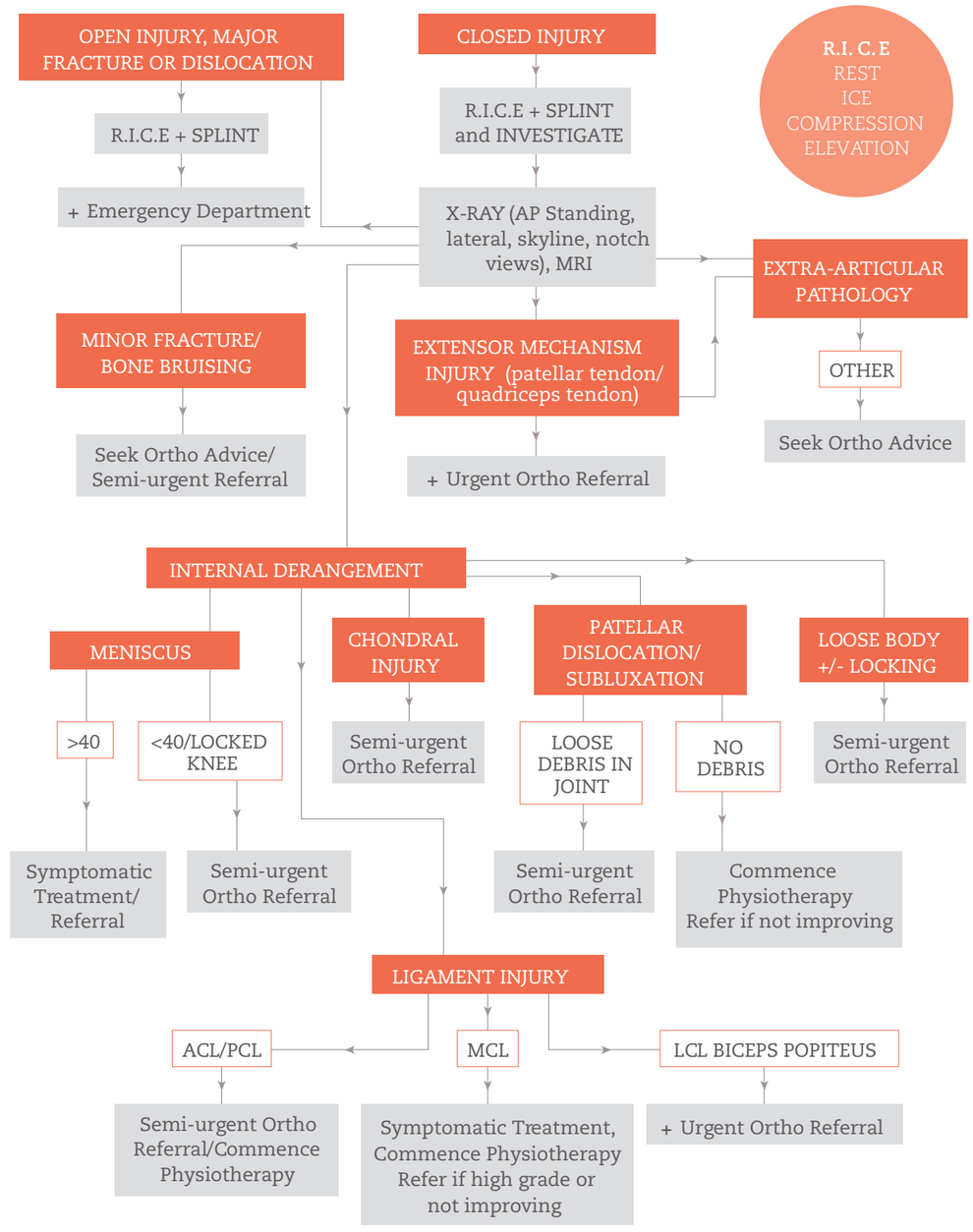
CONTACT

Dr Sol Qurashi
MB BS, FRACS (ORTH)
Orthopaedic Surgeon
Call 02 4577 5855

ACUTE PAINFUL SWOLLEN KNEE

TRAUMATIC

MANAGEMENT ALGORITHM



DIAGRAM

Is ultrasound for inguinal hernia over-prescribed?

Evidence from a recent study – forthcoming in the Australian Health Review suggests that in an overwhelming majority of cases, ultrasounds do not alter the diagnosis and management of inguinal hernias in cases that are clinically obvious.

Dr Thomas Aczel and Dr Prashanth Naidoo have conducted a study looking at the role of ultrasound in the surgical treatment of inguinal hernias.

"As a surgeon, over many years, I've seen a significant number of ultrasounds that do not alter my diagnosis or management," said Dr Aczel, a long-standing General Surgeon at Hawkesbury District Health Service. "With the vast majority of clinical assessments by GPs being accurate, and subsequently corroborated by the surgeon, the value of the ultrasound – and its cost to our health care system – is questionable."

Dr Naidoo said that while Australia has no formal diagnostic guidelines for ultrasound in the diagnosis of inguinal hernias, the Choosing Wisely Australia initiative recommends ultrasound not be used for the further investigation of clinically apparent inguinal hernias.

"However, no quantified evidence base exists for this recommendation, so we aimed to collect evidence to quantify the problem of patients having ultrasounds for inguinal hernias that are clinically obvious."

"We surveyed surgeons to determine whether appropriately selected patients had a clinically obvious inguinal hernia, whether they had an ultrasound to confirm the clinical diagnosis, and whether the ultrasound altered the surgeon's diagnosis or management plan."

The survey was conducted over three NSW hospitals and 150 responses were received. Results showed that almost every inguinal hernia presentation was clinically obvious as examined by the operating surgeon.

Researchers also found that almost 1 in 2 patients who presented with clinically obvious inguinal hernias received an ultrasound and that almost all were ordered by GPs on first practice. When an ultrasound was ordered, results showed that the test/scan did not alter the diagnosis or management in the overwhelming majority of patients, suggesting that there is low therapeutic value in the use of ultrasound for these patients.

"We extrapolated Medicare data to estimate the cost to the public health system, with calculations showing a significant financial burden," said Dr Naidoo.

"Once published, we look forward to this evidence contributing to Australian guidelines for the assessment of inguinal hernia and related savings to the Medicare system."

CONTACT
Dr Thomas Aczel
MBBS FRACS
General Surgeon
Call 02 4578 2111