IS THERE REALLY A LINK BETWEEN VASECOTOMY AND PROSTATE CANCER?

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No sooner had we dealt with all the patient enquiries about whether or not fish oil was a problem with prostate cancer risk, the news is once again out that vasectomy is a risk factor for prostate cancer.

The wide scale media reports on the risk of vasectomy for prostate cancer followed the publication (online ahead of print) of a large long-term follow-up cohort study in the Journal of Clinical Oncology on 7 July 2014. The findings are based upon the Health Professionals Follow-Up Study (HPFS) which is a men’s health study that commenced in 1986. The study was funded by the National Cancer Institute and conducted by the Harvard School of Public Health. For this study, 12,321 men who had vasectomies were compared with 37,804 men who had not undergone vasectomy with regard to the risk of subsequently being diagnosed with prostate cancer.

WHAT WERE THE STUDY FINDINGS?

During 24 years of follow-up, a total of 6,032 cases of prostate cancer were diagnosed. About 25% of the cancers were either high-grade (732) or lethal cases (811). After adjusting for confounding factors, men who had a vasectomy had a 10% increased relative risk of developing prostate cancer compared to those who had not undergone vasectomy. When the data was sub-analysed for clinically significant cancer, the increased relative risk of high grade cancer, advanced stage disease or mortality was 22%, 20% and 19% respectively. In other words, there is about a 20% increased relative risk of having a serious prostate cancer.

HOW DO WE INTERPRET THESE FINDINGS?

Firstly, any association between vasectomy and prostate cancer doesn’t make sense. There is no convincing biological reason why any such cause-effect relationship would be plausible.

Secondly, the HPFS study results are out of keeping with the weight of international research findings on the subject. When the same authors first published on the subject in 1993, the results were essentially the same. Subsequent meta-analyses and expert reviews of the literature by professional bodies such as the American Urological Association found that the overall weight of literature to be sufficient to debunk the findings of the 1993 study and come out with the bold statements “vasectomy is not a risk factor” for prostate cancer. In reality, nothing has changed but for the fact that this same study has been published again but with long-term follow-up.

Thirdly, we can make associations look impressive when we talk in terms of relative risk, even if we correct for known biases, as the study authors have done. The absolute difference in prostate cancer diagnosis between the two groups is a mere 0.21%.

Having argued that the risk is low, we do need to consider that this study, in spite of a number of limitations, is one of the most comprehensive on the subject. The HPFS study has been performed by reputable researchers with independent funding and reported with respectably long follow-up.

HOW DO WE ADVISE OUR PATIENTS?

In effect, nothing has changed since the authors first published their findings in 1993. Back then, the study received global news coverage. This pales into insignificance compared to the extensive and lingering online news coverage and social media chatter that exists today. The key thing that has changed is the extent of public awareness about these research findings.

There is no right or wrong answer as to how we should advise our patients. I am not personally convinced of there being a significant link between vasectomy and prostate cancer risk. However, in this age of information technology and declining thresholds for individuals to attribute misfortune to somebody or some entity, my personal leaning would be towards advising our patients that this is sufficiently materially significant to be deterred from undergoing vasectomy.
INJECTABLE COLLAGENASE FOR DUPUYTREN’S DISEASE

Dr Ian Edmunds

DR IAN EDMUNDS MBBS, FRACS(Orth), FAOrthA

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Dupuytren’s disease is a proliferation of the palmar fascia which often leads to flexion contractures of the fingers. It is essentially a hereditary condition, and has a high prevalence amongst people of Anglo-Saxon ancestry. It usually presents from middle-age onwards, and is much more common in men. If the flexion contracture at any joint reaches thirty degrees treatment should be considered because progressive contractures become increasingly disabling and difficult to correct. This is especially true of contractures of the proximal interphalangeal joints.

Surgery remains the gold standard treatment for Dupuytren’s as it achieves good or excellent results in the majority of cases. However the surgery is usually quite intricate and lengthy, in large part due to the intimate relationship between the diseased tissue and the neurovascular structures which display at times quite striking variability. Additionally, this surgery requires general anaesthesia, often has a prolonged rehabilitation and, like all treatments for this condition, does have a recurrence rate. For these reasons alternative treatment options have always been sought. While many have been tried and found wanting, the most recent innovation, collagenase injection, is showing promise of being a breakthrough in non-operative management.

Clostridium histolyticum bacteria produce collagen degrading enzymes, two of which have been combined and developed for the treatment of Dupuytren’s contracture. The injection (Xiaflex) was only approved by the TGA for use in Australia in October of last year but was approved by the FDA in February 2010, and to date has been used in over 50,000 patients in that country. The treatment involves the injection of approximately 0.25 ml of reconstituted enzyme directly into the cord via a 28 gauge needle (Figure 1). The hand is simply bandaged and, usually the next day, the finger is manipulated into extension under local anaesthetic (Figure 2).

The results of Xiaflex injection treatment have been studied and reported in several publications. Following pilot studies in 2000, 2002 and 2007, the results of double blind placebo controlled trials were published involving 308 patients in 2009 and 66 patients in 2010. All of these studies show similar trends. In summary, contractures of the metacarpophalangeal joint achieved an average correction of between 65% - 91% and an average improvement in range of motion of approximately 40 degrees. At the proximal interphalangeal joint the average correction was between 30% - 48% and the average improvement in range of motion was between 30 and 40 degrees. In these trials patients were allowed to be given up to three injections. Recurrence rates were between 0% - 10% at two years. In 2013, after the release of Xiaflex for general use, the results of a clinical practice data survey of 508 patients were published. This study again showed similar results to the controlled trials, but found that in actual practice most patients were treated with only one injection.

There are some well documented side effects and possible complications from the injection. Bruising, swelling and localised pain are common. There may be a skin tear at the time of the manipulation, the contracture may persist or recur and there have been reports of allergic reaction and, rarely, tendon rupture.

In summary, collagenase injection for the treatment of Dupuytren’s disease is an established alternative to surgery and is showing encouraging results especially in patients who primarily have a contracture of the metacarpophalangeal joint.

Figure 1: Injection of approximately 0.25 ml of reconstituted enzyme directly into the cord.

Figure 2: Extension of finger under local anaesthetic.

References
1. Edmunds I, Chien C. A new surgical approach to Dupuytren’s disease. JHS Euro 2011; 35E(6) 485-489
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DIAGNOSIS AND MANAGEMENT OF PRIMARY HYPERPARATHYROIDISM

Professor Stan Sidhu

INTRODUCTION
Primary hyperparathyroidism (PHPT) is the leading cause of hypercalcemia in the outpatient setting. Its diagnosis is made with the finding of elevated albumin-adjusted serum calcium level along with either an elevated, or a non-suppressed level of parathyroid hormone (PTH). Prior to the advent of the automated serum screening chemistry panel, the majority of patients with PHPT exhibited telltale signs and symptoms of chronic hypercalcemia such as kidney stones, advanced bone disease, chronic constipation, pancreatitis, and a wide array of neuropsychiatric symptoms. In the developed world, however, overt symptoms of hyperparathyroidism are rare and the vast majority of patients are now presenting with subclinical disease. Though there is virtually no debate that any patient with symptomatic hyperparathyroidism would benefit from surgery, the change in disease profile from one of obvious symptomatology to one with more subtle, or in some cases absent findings has led to questions regarding the management of patients with asymptomatic PHPT.

DIAGNOSIS
Diagnosis of PHPT often begins with the incidental finding of hypercalcemia as evidenced by elevated albumin-corrected serum calcium levels. If serum PTH levels are elevated or not suppressed (“abnormally normal”) the diagnosis of PHPT is likely however additional testing is necessary to assess the degree of target organ complications as well as to rule out other causes of hypercalcemia.

- Measurement of Renal Function: Levels of serum creatinine, albumin, and blood urea nitrogen, along with patient demographic characteristics allow for the calculation of glomerular filtration rate (GFR). Declining renal function serves to further fuel PHPT and can lead to accelerated disease progression.

- Measurement of 24-Hour Urine Calcium and Creatinine Level: Aids in ruling out familial hypocalciuric hypercalcemia (FHH), a benign condition due to mutation of the calcium-sensing receptor (CaSR) gene. Calcium:creatinine clearance ratio below 0.01 is indicative of this diagnosis. FHH patients do not benefit from parathyroid surgery.

- Measurement of 25-hydroxyvitamin D: This is commonly decreased in patients with PHPT due to increased catabolism and conversion to 1,25-dihydroxyvitamin D. Low vitamin D levels will further raise PTH and can accelerate disease progression. Also, patients with low vitamin D levels are more likely to suffer from hypocalcemia and hungry bone syndrome following parathyroid surgery.

- Measurement of bone mineral density (BMD): As PTH drives catabolism of cortical bone, it is recommended that patients are routinely checked for BMD at the distal forearm. Complete BMD testing should also include testing in the lumbar spine and hip.

- Neck ultrasounds and parathyroid sestamibi scans DO NOT establish the diagnosis of PHPT. The diagnosis is made on biochemical grounds. Localising studies help guide decision-making regarding the extent of surgery i.e. focused parathyroidectomy versus four gland exploration.

Recent research has also identified a unique presentation of PHPT known as normocalcemic hyperparathyroidism. These individuals are shown to have persistently elevated PTH despite correction of vitamin D deficiency and normal renal function. These patients may show evidence of low BMD or have history of previous fragility fractures. It is likely that such patients, if followed, will eventually progress to hypercalcemia.

TREATMENT
Surgery remains the only form of definitive management for patients with PHPT. Although there is widespread consensus that all symptomatic patients should be recommended for surgery, asymptomatic patients are often followed until symptoms or signs of advanced disease manifest. In 2009, an international group set forth guidelines regarding the management of asymptomatic disease. 2014 guidelines are due to be released soon. Below are the listed criteria for recommending surgery in asymptomatic patients:

- Age < 50
- Corrected serum calcium greater than 0.25 mmol/L above normal limit
- Calculated creatinine clearance less than 60 mL/min
- BMD T-score < -2.5 at any site and/or any history of previous fragility fracture
- Any patient for whom yearly surveillance of calcium level, renal function, and BMD is not feasible.

CONCLUSION
In the era of routine screening blood chemistry, PHPT has become a silent disease. Its progression can lead to recurrent nephrolithiasis, osteoporosis, increased risk of fragility fractures and a number of poorly characterised neuropsychiatric disorders including fatigue, depression, and cognitive impairment. Recent evidence also suggests accelerated cardiovascular disease in patients with moderate-to-severe disease. Asymptomatic patients falling under the above guidelines should be recommended for surgery. Indeed, even in the absence of the listed criteria, any patient with a biochemical diagnosis of PHPT would benefit from an informed discussion with an expert endocrine surgeon about treatment options and the risks of non-operative versus operative management.
Shoulder arthritis has become a well recognised condition over the last 30 years that can effectively be treated with a primary shoulder replacement with very similar results to the current knee and hip replacements. Unlike hip and knee replacements, for a shoulder replacement to work effectively it requires a well-functioning and intact rotator cuff mechanism to allow shoulder elevation and function. Consequently there are 2 main types of arthritis that affect the shoulder.

1. The most common type is primary osteoarthritis where there is an intact rotator cuff and the second most common type is rotator cuff arthropathy or arthritis. Primary shoulder arthritis can be treated with a standard shoulder replacement whereby the humeral head is replaced with an anatomical metallic head and the damaged glenoid socket is resurfaced with a high-density polyethylene prosthesis. (Figures 1 and 2).

2. Rotator cuff arthropathy occurs when there is arthritis in the shoulder joint associated with an irreparable, retracted rotator cuff tear subsequently causing superior migration of the humeral head so that it starts to articulate with the undersurface of the acromion. (Figure 3.) This condition usually occurs in older individuals and results in a painful shoulder with loss of motion and strength. Often, individuals cannot raise the arm to shoulder level making it difficult to perform routine activities of daily living. This condition previously has been extremely difficult to treat due to loss of the rotator cuff tendons.

TREATMENT FOR ROTATOR CUFF TEAR ARTHROPATHY

Standard primary shoulder replacements cannot be used for this form of arthritis when there are no rotator cuff tendons. If a conventional replacement was used the ball would slowly move superiorly due to no cuff tissue holding it centred in the socket. As a consequence the glenoid replacement would loosen quickly and the conventional replacement would fail. For many years we did not have a good surgical solution to this problem.

The answer to this dilemma was to rethink the mechanics of the shoulder joint and design an artificial shoulder that worked differently to the real shoulder joint. The solution was to reverse the socket and the ball, placing the ball portion of the shoulder where the socket used to be, and the socket where the ball or humeral head used to be (The Reverse shoulder replacement). (Figure 4.) This new design led to a much more stable shoulder joint that could function without a rotator cuff. The artificial joint itself provided more stability by creating a deeper socket that prevented the ball from sliding up and down as the shoulder was raised. The deltoid muscle that covers the shoulder could be used to more effectively lift the arm, providing better function of the shoulder. The final result is a shoulder that functions better, is less painful and can be elevated due to the deltoid muscle rather than relying on rotator cuff muscles.

The reverse total shoulder replacement arthroplasty now enables experienced shoulder surgeons to treat patients with conditions that previously had no surgical solution. These conditions include rotator cuff tear arthropathy, instability of the shoulder with anterosuperior escape, patients who have had previous shoulder replacements that have failed or become loose and older patients with very severe fractures of the humeral head.

The reverse shoulder replacement was originally designed in France in the late 1980s and has slowly become available in Australia since the early 2000s. With newer designs and a better understanding of the mechanics of the prosthesis, the outcome from such surgery has become much more predictable and with less complications for patients.

The two hour surgical time is similar to the conventional procedure and the outcome in terms of range of motion, pain relief and function is also becoming similar. Use of the arm is started within one week of the operation. Extensive therapy is not needed with reverse shoulder surgery and a lot of the rehabilitation is done by the patient themselves. The reverse shoulder replacement does not restore the ability of the shoulder to perform heavy work or sport but has helped relieve pain and improve function in a previously unanswered surgical condition.
SPINE SURGERY: LESS IS MORE

Dr Andrew Kam

INTRODUCTION
With an ageing population, degenerative spinal conditions are becoming more prevalent, and may necessitate more operations. Spinal surgery is seeing a large increase in the number of operations performed. The cost of spinal surgery has exponentially increased over the last two decades. With ageing, the degenerative process results in more patients suffering from lumbar canal stenosis causing neurogenic claudication and radicular pain. A number of patients will also develop kyphoscoliosis and sagittal imbalance.

WHY OPERATE?
The decision to operate is at the discretion of the surgeon and patient. For every patient seen, there will be a difference of opinions as to whether surgery should be performed or not, and what operation would best achieve the best outcome for the patient. Ultimately, patients with neurological deficit and/or crippling pain that has failed conservative treatment would be the obvious candidate for surgery. Patients, whose quality of life for work duties, home commitments, recreational, social, and intimate activities, are badly affected, are also potential candidates for surgery.

WHAT IS MINIMALLY INVASIVE/LESS INVASIVE SPINE SURGERY?
Spinal surgery has continued to evolve in a very rapid fashion over the last 20 years. There is a significant learning curve. The introduction of pedicle screws for internal fixation of the spine revolutionised the management of patients suffering from trauma and tumour. Today, we see the application of these techniques in degenerative spinal disorders. The surgical approach to the spine is going through a phase of less invasive/destructive muscle-sparing techniques. With these techniques, patients are suffering less blood loss during surgery, less pain following surgery and less infection, resulting in a faster recovery. These techniques are not necessarily keyhole surgery, but they do minimise the collateral damage to the paraspinal muscle, preserve the muscle attachments, and avoid muscle scarring and atrophy.

CRITICS
At best, decompressing the nerve root has seen 90% - 95% chance of improving radicular symptoms. When it comes to axial pain, the results fall down to 60% - 75% chance of improving the symptoms. With these outcomes, there is a significant portion of patients that would not necessarily do well with surgery. They will always have some long-term intermittent pain after surgery. Spinal surgery should always be considered only as a 'last resort' surgery. All conservative non-surgical techniques should be exhausted before a patient is considered for surgery.

1990s. A mini lateral trans-psoas approach to the lumbar spine was popularised in 1998 (XLIF, DLIF). Mini posterior lumbar interbody fusion (MIS-PF) was described in 2002. In 2006, mini transforaminal lumbar interbody fusion (MIS-TLIF) was described.

DON'T BE FooLED!
The use of percutaneous pedicle screw fixation with the assistance of intraoperative fluoroscopy, and newer image guided technologies (O-Arm™, Mazor Renaissance™) has given us the ability to internally fixate the spine through small stab incisions. These image guided systems are currently applicable only to the insertion of the percutaneous pedicle screw, but the discectomy, decompression, preparation of the bone graft bed, and the success of the fusion is still very much dependent on the surgeons technique and skill. The biggest factors that affect the success of a spinal operation is the art of patient selection, and skill in performing the operation to address the problem in hand. True Robotic Spinal Surgery is yet to be perfected and yet to be proven.

The benefits of reducing collateral damage to the paraspinal muscles results in less blood loss during surgery, which therefore reduces the physiological stress on the frail patient. The reduced pain and less use of analgesia, also means a faster recovery for the patient. I have no doubt that these less invasive/less destructive approaches to the spine, whether performed on their own or combined with the traditional open technique will improve patient outcomes. I believe that these techniques will become standard practice for spine surgeons in the future, the way laparoscopic cholecystectomy is now gold standard and the open cholecystectomy is historical.
OSTEOARTHRITIS OF THE ANKLE

Dr John Limbers

Osteoarthritis of the ankle (ankle OA) is a cause of pain and dysfunction for many Australians. Compared to the hip and knee, primary ankle OA is uncommon. Previous trauma is the most common origin of ankle OA. Therefore, patients with ankle OA will often be younger than those with hip or knee OA. Secondary ankle OA is also associated with a number of other disorders, such as rheumatoid arthritis, haemochromatosis, haemophilia, gout, neuropathic disease, avascular necrosis and infection.

The functional limitations of patients with ankle OA are significant. Pain can be severe and is often felt as an ache within the ankle joint. It may be more localised, such as across the front of the ankle or anterolaterally. It can also be more generalised, around the whole hindfoot complex. It tends to be worse in cold weather. The pain is normally with walking. It is often worst for the first few steps (start-up pain). In more severe cases the patient develops rest and night pain. Recreation and daily functions become severely limited. Stiffness, swelling, deformity and instability are also common symptoms. In early stages the pain may be purely from osteophytes causing impingement pain at the anterior ankle on squatting and walking up hills, with little or no pain in the ankle joint itself.

Diagnosis is usually confirmed with weight bearing AP, mortise and lateral X-rays (Figure 1). These show loss of joint space, osteophytes, subarticular sclerosis and occasionally cyst formation. It is important to specifically order weight bearing views, as supine X-rays often underestimate the severity. Nuclear medicine and MRI scans can aid in diagnosis but are not routinely necessary.

Symptoms can often be controlled with regular paracetamol, adding stronger analgesics and NSAIDs as necessary. Some patients report symptomatic relief with glucosamine and chondroitin sulphate, but these do not alter disease progression. Other measures include physiotherapy for range of motion and strengthening, hydrotherapy, measures include physiotherapy for range of motion and strengthening, hydrotherapy, weight loss and use of a walking stick. A low profile ankle brace (usually fitted by a physiotherapist) can also help. Referral to a podiatrist for cushioning orthotics and shoes with a stiff sole and rocker bottom can also help. Referral to a podiatrist for cushioning orthotics and shoes with a stiff sole and rocker bottom can provide prolonged relief. Injections of local anaesthetic and cortisone help for several months in some cases.

Surgery may be necessary if these measures fail. In early cases, with anterior impingement pain from osteophytes and very mild loss of articular cartilage within the joint (Figure 2), ankle arthroscopy can help by removing the anterior impinging spurs.

In more severe, incapacitating cases the operation of choice is normally an ankle arthrodesis (Figure 3). The ankle joint is prepared back to bleeding bone and held with screws. The joint then fuses over 12 weeks. Patients mobilise touch weight bearing in a boot or plaster for 6 weeks, followed by a second 6 weeks of gradual weight bearing in a boot. At 12 weeks the patient can walk in supportive shoes, with any limp resolving over the following 3 months. This procedure leads to excellent pain relief in approximately 90% of cases and a normal walking pattern, as observed by relatives and friends. The lack of movement in the ankle joint is compensated for by movement in the surrounding hindfoot joints, with 30% of dorsiflexion and plantarflexion being maintained as a result.

Total ankle replacement (Figure 4) can also lead to excellent pain relief, with the advantage that ankle movement is retained. This leads to a more normal gait pattern and less stress on surrounding joints, resulting in a lower incidence of later hindfoot osteoarthritis. The disadvantage of ankle replacement is that pain relief is not quite as reliable as ankle arthrodesis. In addition, they can loosen over time. The incidence of loosening is higher than that of hip and knee replacements, and revision options are more difficult, in part due to the small size and poor vascularity of the talus. The ideal candidate for an ankle replacement is an older, lower demand patient without significant deformity or instability. Ankle replacement is also particularly useful in cases of previous hindfoot arthrodesis, where an ankle arthrodesis may result in debilitating stiffness.
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To find a San Specialist visit www.sah.org.au.
• The cornerstone of Sydney Adventist Hospital’s $200 million Redevelopment – the new L.W. Clark Tower – has opened in a staged process. Levels 11,10 and 8 are open with new theatres to be open mid-September.

• Reaffirming the San as the largest private, and the largest not-for-profit hospital in NSW, the 12-storey tower has been built to provide a new Maternity, Women’s Health and Children’s Unit, an Integrated Cancer Centre and a Healing Garden, and with existing facilities provides total capacity for over 550 inpatient beds, another 300+ day beds, and up to 24 operating theatres. Previously opened features of the Redevelopment include the almost 900 space multi-deck car park, stunning new arrivals area and Clinical Education Centre. See www.sah.org.au/devt.

• L.W. Clark Tower is named in honour of current CEO Dr Leon Clark. Other former members of the San community remembered include Director of Nursing Wendy Woofter (level 11), Matron Rita Rowe (level 6), Neurosurgeon Dr John Grant AO OBE (level 7), Surgeon Dr Charles Sharpe OAM (level 8), and members of the Knight (level 9) and Baldwin (level 10) family’s. In the existing facilities the former South Wing of the H.E. Clifford Tower is now known as the Kress Building after doctors Daniel and Lauretta Kress [Dr Lauretta Kress delivered the first San baby in January 1903].

• The official opening of the L.W. Clark tower will be celebrated during October this year.

• The San is the first and only private hospital in NSW performing endobronchial ultrasound, a minimally invasive procedure used to diagnose stages of lung cancer, infections, and other diseases.

• The Sanlink Bus from Hornsby to the hospital via Normanhurst, Woodlands Estate and Thornleigh, has increased frequency on weekdays and introduced a new Saturday service. See the new timetable www.shorelink.com.au/files/timetables/589.pdf.

• Volunteer medical teams coordinated by the San’s humanitarian aid program ‘Open Heart International’ operated in Myanmar since 1986. See www.ohi.org.au.

• The San entered the 2014 Medline Pink Glove Dance Competition. The narrative video ‘Hope for Everyone’ features staff and the community dancing to promote awareness of breast cancer. Watch the video and vote at www.pinkglovedance.com.au from September 9-23.


• San Radiology is participating in the Dragons Abreast Festival for breast cancer awareness on October 11. Sponsor the San Dragons at www.dragonsabreastfestival.com.au.

• Retired San Palliative Care Specialist, Dr Yvonne McMaster was awarded an Order of Australia Medal in the general division in the Queen’s Birthday Honours list for her advocacy for palliative care issues.

• Cardiothoracic Surgeon Professor Tristan Yan is the first doctor in Australia performing the Bentall’s procedure using a Minimally Invasive approach (Mini-Bentall’s). The procedure was first performed at the San in July.

• AHCL CEO Dr Leon Clark and ARI CEO A/Prof Ross Grant presented papers “How do we Develop a Model of Health Care rather than just Disease Management in our Health Care Institutions”, “Integration of Lifestyle Medicine in a Tertiary Teaching Hospital Context” and “Free Radicals a key link between Nutrition, Lifestyle and the NCDs” at a recent Global Conference on Lifestyle and Health in Geneva, Switzerland.

• The San is the first private hospital in the State to join the NSW Government Sustainability Advantage Program to improve environmental practices and help reduce the Hospital’s carbon footprint.

• SAH Rhinoplasty Specialist Surgeon, Dr Gillian Dunlop had her paper ‘Bronzino and the Evolution of a Portrait, Barbara Williams’ published in JAMA Facial Plastic Surgery in July.

SAH GRAND ROUNDS [all GP’s invited.]

Tuesday 28 October
A/Prof Arthur Richardson and A/Prof Gavin Marx –Pancreatic Cancer

Monday 10 November
Dr Melissa Doolan, Dr Kumud Dhital and Dr Reza Mouazzeni – Chronic thromboembolic pulmonary hypertension

Monday 24 November
A/Prof Brian Jones – Helicobacter pylori

Grand ROUNDS are held in the Tulloch Building in the Level 2 Conference Room from 12.30 – 13.30pm. (Light refreshments available from 12.00pm. Please register on arrival.)

GP CONFERENCES [CPD points available with proof of attendance]
October 29 Oncology
November 26 Ophthalmology

FREE PUBLIC FORUM [everyone welcome]
November 5 Men’s Health

Dates and topics are subject to change. Contact 9487 9871 to register or visit www.sah.org.au for further details.