June / July 2009

MOBIDITY OBBID A: DISEASE, OR A COIC?

We now understand obesity to be a chronic disease that may have an underlying genetic predisposition, including genes such as the FTO gene, PCSK1 gene, and the EPPL1 gene. They have now been identified in humans that appear to predispose a person toward harmful levels of weight gain. Our failure to address the obesity in energy imbalance – appetite is chronically stimulated beyond meeting true energy needs – is our greatest public health failure.

The evidence linking obesity with many common medical problems is so convincing that weight loss surgery is now considered to be an integral part of a patient’s overall management plan. Type-2 diabetes, obstructive sleep apnoea, hypertension, dyslipidaemia, polycystic ovary syndrome, ischaemic heart disease, stroke, cancer (especially breast and colon), chronic kidney disease, liver disease, lower extremity joint pain, and depression are all strongly associated with obesity. A recent study published in the Lancet found that people with BMI above 40 lost nearly 10 years of lifespan, even though those with mild obesity (BMI 30-35) had their life expectancy reduced.

BARITIC SURGERY- SAFE AND EFFECTIVE

Bariatric surgery – (derived from the Greek word meaning weight) has developed enormously over recent years to become a safe and highly effective option for morbid obesity. A major breakthrough has been the laparoscopic adjustable gastric band, which has been in regular practice for the past 10 years, and has assisted more than 60,000 Australians toward better health and quality of life. Its appeal over other weight loss procedures is its superior safety profile and potential reversibility.

The gastric band is placed laparoscopically around the stomach and can be adjusted to the desired size in the outpatient clinic to add or remove the tubing. The band is usually inserted within 24 hours, and one week off work is necessary after waking. Most feel ready to go home within a few days. The procedure typically is its superior safety profile and potential effectiveness. Long-term problems usually present in a subacute way, allowing a planned management approach. The main issues involve: leakage of the band (4%), infection (1%), and problems with the access-port or tubing (5%). Fortunately these problems can generally be corrected, allowing weight loss to continue.

COMPREHENSIVE AND MULTI-DISCIPLINARY AFTERCARE IS ESSENTIAL

Proper obesity management requires a multi-disciplinary team approach, preferably within a dedicated clinic environment. Regular contact with the Surgeon, Dietitian, Nutritionist, Psychologist, General Practitioner, and other specialists enhances weight loss, minimises band-related problems, allows for appropriate monitoring of morbidity markers, and provides the support necessary to make lifelong nutritional and behavioural changes.

sydney Adventist Hospital (SAH) has recently embarked on a hospital-wide initiative to prevent venous thrombo-embolism (VTE). A recent initiative by the National Health and Medical Research Council (‘Stop the Clot’), has highlighted the significant morbidity and mortality associated with VTE. Around 2,000 Australians die each year from VTE. These people are hospitalised each year as a result of deep vein thrombosis (DVT) or pulmonary embolism (PE). VTE remains the most common cause of in-hospital preventable deaths.

VTE prolongs hospital length of stay and increases hospital costs. One of the long-term sequelae of VTE is chronic venous insufficiency which may lead to chronic ulcers, cellulitis, and recurrent venous thrombosis. Worse still, VTE is the most common cause of preventable health care deaths.

The SAH has conducted a hospital-wide audit on the incidence, preventive strategies and mortality associated with VTE. The SAH is performing well against National averages – through we always aim to improve.

WHO IS IT FOR?

Gastric banding may be appropriate for:

1. BMI > 30
2. sustained weight control cannot be achieved through diet and exercise despite genuine attempts
3. obesity has not been caused by another disease or medical disorder
4. age > 16

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INTRODUCTION
The modern era of radical retropubic prostatectomy for early stage prostate cancer was introduced by the landmark anatomical dissections of Walsh & Drake in 1982.

Professor Walsh popularised modern nerve sparing radical prostatectomy in the modern era. His emphasis was on precise anatomical knowledge and excellent surgical technique. Prior to Walsh’s innovative surgical approach, radical prostatectomy was a highly morbid operation with significant morbidity in terms of haemorrhage, high rates of incontinence and erectile dysfunction. Walsh detailed and disseminated the techniques of control of the dorsal vein complex to reduce bleeding and precise localization and preservation of the cavernous nerves responsible for erectile function.

For twenty-five years the Walsh technique has dominated the surgical approach and procedure for early prostate cancer. The application of these precise anatomical and surgical techniques is directly responsible for minimising the haemorrhage, incontinence and erectile dysfunction previously commonly associated with radical prostatectomy.

With the advent of laparoscopic surgery, laparoscopic radical prostatectomy was introduced as a so-called minimally invasive surgical technique. The daVinci robot assisted radical prostatectomy surgical technique was developed and ever since throughout the world, urologists have argued with regard to whether or not this technique is superior to another. Claims of advantages of one surgical technique over another are often based not on science, but on ego, finance and marketing hype from reality. Professor David Penets, Professor of Urology at the Norris Cancer Centre reviewed the available literature and concluded that “while laparoscopic radical prostatectomy is appealing to patients for its cutting edge technology and for being less invasive than the open approach, the evidence to date shows that, in many respects, outcomes following robotic radical prostatectomy are quite similar to those following open radical prostatectomy.”

When equivalent series are compared, open versus robotic prostatectomy cases over the same period of time, reported rates for open prostatectomy were slightly less than for robotic prostatectomy. Robotic claims of less scarring and earlier recovery are not evident in clinical practice.

The robotic technique is performed under a general anaesthetic and involves the placement of one daVinci robotic device ports into the patient’s abdomen. The cumulative length of these incisions is significantly less than the traditional radical prostatectomy incision used for open surgery. The operating surgeons sit in a remote console and manipulate the laparoscopic instruments in a master-slave technique.

For those men who require active medical management, choice of management becomes the issue. The choice between surgery and radiation therapy depends on many factors including patient age, patient co-morbidities, lower urinary tract symptoms and tumour characteristics. Younger men with organ confined disease and clinically men with outflow obstructive symptoms are best managed by radical prostatectomy. Such men need to choose between open surgery, laparoscopic or robotic assisted laparoscopic radical prostatectomy.

The risks of radical prostatectomy regardless of the method used are to cure the cancer, preserve continence and maintain potency. 

OPEN RADICAL RETRO-PUBIC PROSTATECTOMY
Open radical retropubic prostatectomy may be performed as a low anterior vertical midline incision or by a horizontal lower abdominal incision. The length of the operation is 1.7 hours on average for open surgery, which is performed under general anaesthesia, the patient lies on the back, the bladder is drained and thereafter the dorsal vein complex is divided, the neurovascular bundles are subjected to early bilateral release and the urethra divided. The prostate is carefully separated from the anterior rectal wall in the modern era and is divided with the seminal vesicles. The bladder neck is sharply incised to offer the assistant the urachal orifices and the bladder neck surface re-epithelialised by advancement of the bladder mucosa. A precision anastomosis is performed over a urachal catheter.

In preparation for the surgery two units of antiblastic blood are taken from the patient in case a blood transfusion is necessary. Post-operative antibiotic requirements are minimal with the majority of patients requiring narcotic analgesia for twenty-four hours has been the gold standard. Most men are discharged from hospital on the third post-operative day.

ROBOT ASSISTED RADICAL PROSTATECTOMY
The robotic technique is performed under a general anaesthetic and involves the placement of one daVinci robotic device ports into the patient’s abdomen. The cumulative length of these incisions is significantly less than the traditional radical prostatectomy incision used for open surgery. The operating surgeons sit in a remote console and manipulate the laparoscopic instruments in a master-slave technique.

It is necessary for a surgical assistant to stand by the patient’s bedside in order to introduce laparoscopic instrumentation into the operating field. The surgical technique used is similar to that described for the open approach. However, the prostate and bladder are dissected by a virtual type of robotic device mobilising from above and pulled up to facilitate separation from the membranous urethra. This technique during robotic surgery is thought to be responsible for the ultrarapid delayed in return to community association with this technique. After the prostate has been removed, the bladder neck is closed over the urethra using a urethral catheter in the same way as for open surgery.

Unlike open radical prostatectomy, robotic assisted laparoscopic radical prostatectomy technique is performed via the perineum.

An anastomotic leak can therefore lead to urinary infection and as such, it is important to have a radical surgical approach in terms of the dorsal venous complex. Blood loss during the robotic procedure is generally less than with open surgery, though the use of autologous blood during open surgery maximises the minor advantage.

OPEN SURGERY VERSUS THE ROBOT
Multiple surgical series have now been published comparing open versus radical assisted laparoscopic radical prostatectomy. These studies seek to distinguish fact from fiction, marketing hype from reality.

These studies seek to distinguish fact from fiction, marketing hype from reality. "Prostate harvesting" to service large robot units. The time taken for open surgery, external beam radiation therapy or protocol whilst men with high risk features if indicated and thereafter, accurate long term outcomes for men with early prostate cancer in need of active intervention.

Each surgeon should perform radical retropubic prostatectomy in the manner that in his hands is best able to guarantee the patient the best prospect of a satisfactory outcome.References available upon request.

News from the San

NEW AFFILIATED DOCTORS

• Dr Murad Ateur - Rehabilitation
• Dr Patrick Kha - Medical Oncology
• Dr Lewis Macdon - ICU Specialist
• Dr Lisa Pfitzner - Anaesthesia
• Dr Chau Wai Tan - Haematology
• Dr Susan Wright - Cardiology / Endocardiology
• Dr Zork Avakian - Surgical Assistant
• Dr Chung Ling - Surgical Assistant
• Dr Alice Hoang - Surgical Assistant

NEW SAN PATHOLOGY COLLECTION CENTRE is now open at 1 / 2 Hillcrest Road Penrith Hils. Queries 9980 6834 or 9487 9500.

AS PART OF THE NATIONAL HAND HYGIENE INITIATIVE the San held a successful and colourful Hand Hygiene awareness week from 20-24th April 2009. The week of activities and education promoted the importance of hand hygiene amongst staff, patients and visitors.

SUBSIDISED MOTEL STYLE ACCOMMODATION is available for country or out of area visitors to Sydney having medical treatment at any Sydney hospital. The accommodation is at Jacaranda Lodge in the San complex, and is a Director of the Prostate Cancer Foundation of Australia and is a Director of the Prostate Cancer Foundation of Australia. The Centre caters for patients with Cancer, Multiple Scleros, Chorea, stroke, neurological and other disorders and diseases. The unit is staffed with specialist oncology and haematology-trained nurses. Contact 9487 9991.

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