by Associate Professor Nigel Hope

MINIMALLY INVASIVE HIP REPLACEMENT

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M B B S, M S (S A N Z), FR A C S

A/PROF NIGEL HOPE

by Dr Charles Nelson

STRESS ECHOCARDIOGRAPHY

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An Exercise Stress Echogram (Stress Echo) includes on Exercise Stress ECG and, in some cases, the echo images of the left ventricle (LV) are acquired pre and immediately post exercise. Thus all the diagnostic and prognostic information which is not readily available to that obtained from the Stress ECG but in fact makes a much greater contribution to the accuracy of the test. The co-operation of Stress ECG and clinical information combined.

The comprehensiveness of the resting component varies. My practice is to perform a full echocardiogram including valves, pericardial effusion and aorta. This provides useful information and avoids confusion and misleading errors.

Stress Echo detects ischaemia through decreased contractility of the left ventricle (hypokinesis) in segments of LV affected by ischaemia. Hypokinesis occurs at a lower threshold of stress than either ECOG changes or angina. Unlike Stress ECG, Stress Echo can localise and quantify ischaemia. Pre-and post LV images are reviewed with specialised computer software to evaluate changes of feature that facilitate interpretation, playing the images side-by-side on continuous loops, rate and the “adjustment” of the post images so that the contraction of the LV in pre- and post images is synchronised, freeze-frame and slow motion.

For patients unable to exercise due to orthopaedic or pulmonary problems, Dobutamine stress echo can be performed with the patient in bed. Dobutamine increases the heart rate and contractility of the heart and therefore can stress the heart without exercise. Dobutamine is a short acting agent and is cleared from the patient’s system in 10 minutes.

The specificity and sensitivity of Stress Echo for detection of coronary disease (as arbitrarily defined on invasive angiography) is quite high, up to 95% (mean 79%) respectively, with a pre-test probability of the populations being studied of the disease, and different sensitivity and specificities are superior to plain Exercise ECG.

Dr Charles Nelson is a fellow of the National Heart Foundation of Australia and the Australian Society of Cardiac Imaging. He has recently been awarded the Fellowship in Clinical Epidemiology and Clinical Cardiac and Imaging Research. He has presented in the Journal of the American College of Cardiology and presented at the American Heart Association. His interests are echocardiography and stress echocardiography. (www.cardiology.unsw.edu.au). Contact 8621 8400

Further references available on request.

FIGURE 1


A/PROF NIGEL HOPE

MB BBS, MS (SAZ), FRACS

Orthopaedic Surgeon

Associate Professor Hope completed a BM at the University of Sydney and presented at the American Heart Association, the American College of Cardiology and received the American Heart Association Presidential Award for Research in 2004. He recently presented his research on the prognostic value of exercise echocardiography at the 3rd World Congress of Cardiac Imaging. He has received the National Heart Foundation of Australia Research Award and presented at the American Heart Association.}

The editors and Sydney Adventist Hospital do not accept responsibility for any errors or omissions in any article in this publication.
Minimally invasive! Min incision! Less invasive! Keyhole! What is happening? It is possible but let’s half believe! “Min incision” is a standard surgical approach performed through the smallest possible incision. “Laser surgery” uses a small incision combined with laser control for fracture fixation. “Keyhole” surgery refers to the arthroscopic which requires a 5mm incision. These terms refer that the length of the incision is not very long. Nothing could be further from the truth.

The most important issue in a surgical approach is the amount of dissection and the degree of tissue exposure required. Surprisingly, a “mini incision” technique (because of lack of clear visualization) may require more splitting, detaching or cutting of muscle than the standard approach using a longer incision.

To aim at a phras or two: “It’s not the deep down but the small incision that may be only skin deep but the surgical approach extends all the way to the bones.”

So what is “minimally invasive”? This is a surgical approach which uses an intermuscular and an internervous plane. These planes lie between muscles which are supplied by different nerves. There is no dissection, splitting, detachment or denervation of muscle.

Total hip arthroplasty (THA) traditionally used two approaches. The anterior approach has a lower dissection rate but the hip abductor muscles are detached causing some patients to limp. The posterior approach leaves the abductors intact (no limp) but has a higher dissection rate.

50 years on two French men began using these minimal incision approaches which are supplied by different nerves. There is no dissection, splitting, detachment or denervation of muscle.

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Uterine fibroids (myomatosus) are the most common benign tumour of the female reproductive organs and have been found in up to 70% of women on ultrasound. Many fibroids are asymptomatic and diagnosed incidentally. Although a causal relationship has not been proven, fibroids are associated with menorrhagia, pelvic pain and pregnancy symptoms, infertility, miscarriage and rarely pregnancy complications.

Transvaginal ultrasound, sonohysterography and magnetic resonance imaging (MRI) can be used to evaluate the number, size and position of fibroids. Asymptomatic fibroids are generally managed expectantly. Treatment depends on the patient’s symptoms, fertility desires and personal preference. Treatment options include hormonal therapies, hysteroscopic, laparoscopic or open myomectomy, uterine artery embolisation and hysterectomy. The risk of fibroids undergoing malignant transformation is extremely remote.

AETIOLOGY
Fibroid growth is stimulated by oestrogen and growth hormone and inhibited by progesterone. Fibroids arise more in women in their 30’s and 40’s and regress after menopause. Obesity and nulliparity increase the risk of fibroids after menopause. A family history, obesity and reproductive organs and have been found in up to 70% of women on ultrasound.

Many fibroids are asymptomatic and diagnosed incidentally. Although a causal relationship has not been proven, fibroids are associated with menorrhagia, pelvic pain and pregnancy symptoms, infertility, miscarriage and rarely pregnancy complications.

CLINICAL EFFECTS
Menorrhagia and intermenstrual bleeding are the most commonly reported symptoms associated with fibroids. However, less commonly, obesity and nulliparity increase the risk of fibroids developing. Prolonged oral contraceptive use (OCP) use is associated with a decrease in risk of fibroids.

CLINICAL EFFECTS
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Fibroid Pain
The pressure of large fibroids can cause pelvic discomfort and urinary and bowel symptoms.

Miscarriage and Infertility
Submucosal fibroids which significantly distort the uterine cavity can affect implantation and be associated with recurrent miscarriage, infertility and failed IVF attempts. The impact of intramural and subserosal fibroids on fertility is much less certain. A study revealed myomectomy for intramural fibroids greater than 5 cm in diameter did not improve live birth rates in patients undergoing IVF. Surgery to remove intramural fibroids can cause adhesions, impairing fertility and necessitating cesarean delivery.

Pregnancy
During pregnancy fibroids may increase in size and cause soft labour. They rarely undergo degeneration causing acute self-inflicted bleeding. They rarely cause obstruct labour or are associated with an abnormal foetal heart rate presentation necessitating cesarean delivery. Fibroids can be associated with post-partum haemorrhages by interfering with uterine involution.

MANAGEMENT OPTIONS
Expectant
For asymptomatic fibroids observation is all that is necessary. Patients can be reassured regarding their benign nature. Ultrasound can be used to monitor their growth. The risk of a leiomyosarcoma developing is extremely rare and is almost invariably associated with symptoms. Post-menopausal women not on HRT with an enlarging fibroid would be of high concern.

The Oral Contraceptive Pill
Studies have found no evidence that low dose contraceptive pills cause fibroids to grow. The OCP can be used to control menorrhagia and provide cycle control for women with fibroids.

Progestogens
Menstrual suppression using a progestogen (eg. Primolut-N 15 mg daily) either continuously or cyclically may control menstrual disturbances in women with fibroids and have a beneficial effect. Depot Provera can be used to induce amenorrhea in women with asymptomatic fibroids although side effects of breakthrough bleeding, headaches, mood changes and weight gain can be troublesome.

The Mirena IUCD
The Mirena, levonorgestrel releasing intrauterine device, results in suppression of endometrial proliferation, marked endometrial decidualisation and markedly reduced uterine bleeding. A study has shown use of Mirena for 12 months resulted in significantly reduced menstrual bleeding and fibroid size, and improved iron stores among women with fibroids. GnRH Agonists
GnRH agonists such as Synarel and Zoladex have been shown to shrink fibroids by up to 35%, however, fibroids regrow after ceasing treatment. Treatment duration is limited to only 6 months due to menopausal side effects and osteoporosis. They are sometimes used to shrink large fibroids prior to surgery.

Hysterectomy
Menorrhagia is a day only procedure suitable for submucosal fibroids up to 4 cm in size and, depending on the presence of other factors, is highly effective in treating menorrhagia, dysmenorrhoea, recurrent miscarriage and infertility associated with submucosal fibroids. Patients are able to return to normal activities soon after surgery.

Laparoscopic Myomectomy
Laparoscopic removal of subserosal and intramural fibroids may be indicated in a woman with menorrhagia or pressure symptoms wishing to retain her fertility.

There is evidence that laparoscopic myomectomy is associated with less morbidity, including adhesions, than open myomectomy. The main concern with laparoscopic surgery is the potential for uterine rupture in a subsequent pregnancy.

Uterine Artery Embolisation
Several large prospective randomised trials have confirmed that UAE is an effective treatment for fibroids in the US and UK. The procedure is performed under IV sedation following which the patient remains in hospital for 48 hours for observation. Over the next few weeks the fibroids may feel tender and experience a low-grade temperature and vaginal discharge. Major complications such as infection, haemorrhage, distal embolus and premature menopause are rare. The procedure is contraindicated in women wishing to retain their fertility, and those with pulsulated subserosal or submucosal fibroids.

Quality improvement at the San has been recognized by a San Quality Awards evening 10 hospital projects to improve quality were judged on evidence of the quality cycle, customer focus, leadership, continuous improvement and measurable outcomes in clinical care and service delivery. Winners included a Haemostasis Blood Stress Injection initiative and an interhospital transfer form for the CLINIC Nursing Service. For information contact Quality Management on 9687 9740.

The San’s annual free Carols by Candlelight is on Sunday 13th December. Activities start from 9pm and the Children’s Concert starts at 7pm with the hit movie “Ice Age” characters. Main Carols at 9pm feature singer and presenter Jay Jagaitra and Gorgie Coght. Food and beverages available for sale. Ponc rugs welcome. A free Carols program is available on the night.

See www.sah.org.au for more details.

Delivering more than 2000 babies each year San Maternity now offers fathers sleep recognition up to 4 hours for the baby. If breasfeeding during labour, a birthing partner can stay. Lasers and parents are able to provide support and enjoy this important time. Enquiries to SAH Maternity on 9687 9111.

The San Ultrasound for Women is celebrating its expansion with an official opening in December. With 5 machines, including 4 state-of-the-art 4D ultrasound machines the unit is the largest private specialised obstetric and gynaecological ultrasound practice in Australia. To tour the facility please contact www.ultrasoundcare.com.au or ring 9687 9802.

The San’s Children’s Sleep Disorders Unit celebrates 10 years in 2010. The unit cares to patients from birth until school leaing age. Patients and their families have an initial consultation and a sleep investigation (sleep polysomnography) is arranged if indicated. All paediatric sleep disorders are comprehensively covered by this service. Contact 9687 9348.

The San has reduced its waste emissions by half and increased diversion from landfill by implementing new waste management procedures throughout the last 16 months. The new practices include composting at point of use, a large compactor and bale system, separating cardboard, paper and commingled recyclables out of the waste.

The San’s recently launched NEW Website
The new website is located at the same address www.sah.org.au and with over 650 pages provides a wealth of information to patients, visitors and doctors. There is also a special section for doctors and a ‘Find a Specialist’ search function.

Click here on the website for ‘Find a Specialist’

www.sah.org.au

Detaileds about 2010 SAH OP Conferences will be released in early 2010. Each Conference includes registration and free buffet dinner from 6 -7pm with presentations from 7 -9pm. The program is approved by the RACGP QA & CDP Program. Ring 9487 9871 to register.
Uterine fibroids (leiomyomas) are the most common benign tumour of the female reproductive organs and have been found in up to 70% of women on ultrasound.

Many fibroids are asymptomatic and diagnosed incidentally. Although a causal relationship has not been proven, fibroids are associated with menorrhagia, pelvic pain and problems with symptoms, infertility, miscarriage and rarely pregnancy complications.

Transvaginal ultrasound, sonohysterography and magnetic resonance image (MRI) can evaluate the number, size and position of fibroids.

Asymptomatic fibroids are generally managed expectantly. Treatment depends on the patient’s symptoms, fertility desires and personal preference. Treatment options include hormone therapies, hysterectomy, laparoscopic or open myomectomy, uterine artery embolisation and hysteroscopy. The risk of fibroids undergoing malignant transformation is extremely remote.

AETIOLOGY

Fibroid growth is stimulated by oestrogen and growth hormone and inhibited by progestogens. Fibroids arise mainly in women in their 30’s and 40’s and regress after menopause. Obesity, smoking and nulliparity increase the risk of fibroids developing. Prolonged oral contraceptive use (OCU) use is associated with a decrease in risk of fibroids.

CLINICAL EFFECTS

Menorrhagia/Abnormalities

Menorrhagia and intermenstrual bleeding are the most commonly reported symptoms associated with fibroids. Menorrhagia, obesity, smoking and nulliparity increase the risk of fibroids developing. Prolonged oral contraceptive use (OCU) use is associated with a decrease in risk of fibroids.

Pain

Pain

The pressure of large fibroids can cause pelvic discomfort and urinary and bowel symptoms.

Miscarriage and Infertility

Subinvasive submucosal fibroids which significantly distort the uterine cavity can affect implantation and be associated with recurrent miscarriage, infertility and failed IVF attempts. The impact of intramural and subserosal fibroids on fertility is much less certain. A study revealed infertility for intramural fibroids greater than 5 cm in diameter did not improve live birth rates in patients undergoing IVF. Surgery to remove intramural fibroids can cause adhesions, impairing fertility and necessitating cesarean delivery.

Pregnancy

During pregnancy fibroids may increase or decrease in size and soften. They rarely undergo degeneration causing acute severe pelvic pain or present as a life-threatening entity. Rarely they obstruct labour or are associated with an abnormal fetal lie or presentation necessitating cesarean delivery. Fibroids can be associated with post-partum haemorrhage by interfering with uterine involution.

MANAGEMENT OPTIONS

Asymptomatic fibroids are observed in all that is necessary. Patients can be reassured regarding their benign nature. Ultrasound can be used to monitor their growth. The risk of a leiomyoma experiencing a spontaneous hemorrhage is extremely rare and is almost invariably associated with symptoms. Post-menopausal women not on HRT with an enlarging fibroid would be of high concern.

The Oral Contraceptive Pill

Studies have found no evidence that low dose oral contraceptive pills cause fibroids to grow. The OCP can be used to control menorrhagia and provide cycle control for women with fibroids.

Prostaglandins

Menstrual suppression using a progestagen (eg. Formestane 1-3 mg daily) either continuously or cyclically may control menorrhagia in women with fibroids and amenorrhoea in the early phase of pregnancy. Depo-Provera can be used to induce amenorrhoea in women with symptomatic fibroids although side effects of breakthrough bleeding, headaches, mood changes and weight gain can be troublesome.

The Mirena IUCD

The Mirena, levonorgestrel releasing intrauterine device, results in suppression of endometrial proliferation, marked endometrial decidualisation and markedly reduced uterine bleeding. A study has showed use of Mirena for 12 months resulted in significantly reduced menstrual bleeding and fibroid size, and improved iron stores among women with uterine fibroids.

 GnRH Agonists

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Hysteroscopic Myomectomy

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Laparoscopic Myomectomy

Laparoscopic removal of subserosal and intramural fibroids may be indicated in a woman with menorrhagia or pressure symptoms wishing to retain her fertility. There is evidence that laparoscopic myomectomy is associated with less morbidity, including adhesions, than open myomectomy. The main concern with laparoscopic surgery is the potential for uterine rupture in a subsequent pregnancy.

Uterine Artery Embolisation

Several large prospective randomised trials have confirmed that uterine artery embolisation is effective in the UAE. The procedure has a lower morbidity and mortality than hysterectomy. Subsequent hysterectomy for failure of UAE to alleviate symptoms occurs in between 2-25% of patients.

The procedure is performed under IV sedation following which the patient remains in hospital for 48hrs for observation and observation. Over the next few weeks the patient may feel tired and experience a low grade temperature and vaginal discharge. Major complications such as infection, haemorrhage, distal embolus and premature menopause are rare. The procedure is recommended in women wishing to retain their fertility, and those with pedunculated subserosal or submucosal fibroids.

Hysterecomy

Hysterecomy is performed as definitive treatment for uterine fibroids. It can be performed vaginally, laparoscopically or as an open procedure, depending on the size and position of the fibroids. Although hysterectomy is an absolute cure for menorrhagia, the procedure is associated with a small incidence of long term sequelae including urinary incontinence, vaginal vault prolapse and early menopause.

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See www.sah.org.au for more details.

Delivering more than 2000 babies each year San Maternity now offers fathers sleep in with their baby from 4 to 6 hours with bonding during hospital stay. Hospital. The San has extensive clinical experience in obstetrics, gynaecological surgery and endoscopically and minimally invasive treatment of menstrual disorders. Dr Kirsop consults at the San. Contact 9687 6693.

NEWLY ACCREDITED DOCTORS

Dr Glen Scholpph

Radiology, Interventional Radiology

Dr Ramesh Cugnon

Radiology

Dr Neveen Gupta

Perfusion, Cardiac Anaeosthesia

Dr Pietro Fiorentino

Perfusion, Cardiac Anaeosthesia

Hysterectomy

News from the San

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The San’s Children’s Sleep Disorders Unit celebrates 10 years in 2010. The unit caters to patients from birth until school-leaving age. Patients and their families have an initial consultation and a sleep investigation ( overnight polysomnography) is arranged if indicated. All paediatric sleep disorders are comprehensively covered by this service. Contact 9687 5538.

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