the medical link

September — October 2020

THE INDEPENDENT VOICE OF MEDICINE
GCMA
THE GOLD COAST MEDICAL ASSOCIATION INC.

THE OFFICIAL PUBLICATION
OF THE GOLD COAST MEDICAL ASSOCIATION INC.
PUBLISHED BY SWAN MANAGEMENT

Cardiac Imaging Services Update

New Medicare Benefits Schedule
1 August 2020

SOUTH COAST RADIOLOGY

Echocardiogram

Overview of Item 55126

Initial real time echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows:

For the investigation of any of the following:
(i) symptoms or signs of cardiac failure; *or*
(ii) suspected or known ventricular hypertrophy or dysfunction; *or*
(iii) pulmonary hypertension; *or*
(iv) valvular, aortic, pericardial, thrombotic, or embolic disease; *or*
(v) heart tumour; *or*
(vi) symptoms or signs of congenital heart disease; *or*
(vii) other rare indications*

Overview of Item 55133

Frequent repetition serial real time echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows:

For the investigation of a patient:
(i) with isolated pericardial effusion or pericarditis; *or*
(ii) who has commenced medication for non-cardiac purposes that have cardiotoxic side effects, and if the patient has a normal baseline study which requires echocardiograms to comply with the requirements of the Pharmaceutical Benefits Scheme*
If clinical criteria is met, there are no restrictions on referral.

Item 55126 only applicable once in a 24 month period. Any GP referred follow up studies within 24 months will incur an out of pocket fee.

Myocardial Perfusion Studies

Overview of Item 61329 *(medical practitioner other than a specialist or consultant physician)* and Item 61345 *(specialist or consultant physician)*

Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study:

The patient has symptoms of cardiac ischaemia where at least one of the following applies:
(i) the patient has body habitus or other physical condition/s (including heart rhythm disturbance) to the extent where a stress echocardiography would not provide adequate information; *or*
(ii) the patient is unable to exercise to the extent where a stress echocardiography would not provide adequate information; *or*
(iii) the patient has had a failed stress echocardiography provided under a service to which item 55141, 55143, 55145 or 55146 applies

For specialist or consultant referrals only
(iv) the patient has had an assessment of undue exertional dyspnoea of uncertain aetiology*

Items 61329 and 61345 can be referred once in a 24 month period. Item 61349 can be referred once in a 12 month period.

Overview of Item 61349

(Specialist or Consultant Physician)

Repeat combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study:

(a) in the previous 24 months, the patient has had a single stress or combined rest and stress myocardial perfusion study performed under item 61324, 61329, 61345 or 61357 and has undergone a revascularisation procedure; and
(b) the patient has one or more of the following symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy, where at least one of the following applies;
(i) the patient has body habitus or other physical condition/s (including heart rhythm disturbance) to the extent where a stress echocardiography would not provide adequate information; *or*
(ii) the patient is unable to exercise to the extent where a stress echocardiography would not provide adequate information; *or*
(iii) the patient has had a failed stress echocardiography provided under service to which item 55141, 55143, 55145 or 55146 applies; *or*
(iv) the patient has had an assessment of undue exertional dyspnoea of uncertain aetiology*

**For full list of clinical criteria please refer to the MBS website: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-CardiacServices1Aug20.*

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A message from the
GCMA President

Dear Doctor Colleagues,

The Covid-19 pandemic continues to affect our lives and change our perspectives and challenge our beliefs. So far Queensland has done well controlling the spread of the virus. We can be thankful for the good advice our government has received (and adopted) from our public health colleagues, and the excellent work our doctors and nurses are doing both in hospital and in primary care settings. I also acknowledge the good work the vast majority of the Queensland public has done in complying with Covid health regulations and restrictions. But ongoing vigilance is required and if we lose focus the virus can surge in a 'second wave' of infection like that which happened to our Victorian cousins.

The GCMA has continued its monthly clinical meetings through the pandemic. During the months of April, May, June, July and August we ran these meetings by Zoom webinar. At our last meeting Dr Peter McLaren spoke about the way the Covid-19 virus was affecting anaesthetic practice on the Gold Coast and around Australia.

I am pleased to announce that our next meeting on Thursday evening September 17 will be our first face-to-face dinner meeting back at the Southport Golf Club. Our speaker is Dr Mark Stickley, an infectious diseases and respiratory diseases specialist from Brisbane. Dr Stickley runs the TB clinics at RPAH and the Gold Coast University Hospital. This meeting is sponsored by the QIAGEN Company.

A message from the

GCMA President

The topics covered in his presentation include: the comparison of blood tests versus skin tests for TB, interpretation of blood test results, the problem of latent TB infection and who to test, the status of TB infections in Australia and overseas, and a number of illustrative case studies.

I believe this presentation will be very valuable for all of our medical colleagues, general practitioners and specialists alike.

In October we have invited Prof Nicholas Zwar, Executive Dean, Bond University Medical School to speak. In October, Prof Allan Cripps and Dr Nic West, of Griffith University, will speak on the development of Covid-19 vaccines. One of these Thursday evening clinical meetings will be accompanied by our AGM. This business meeting was postponed earlier this year due to the pandemic.

I would like to thank our executive committee for their hard work and support throughout this period. And special thanks to our administrative secretary, Serena Mills too.

Please encourage your medical colleagues to join the GCMA. It is very easy – go to the GCMA website membership form section at https://www.gcma.org.au/becoming-a-member.

I look forward to seeing you at our next meeting.

Yours sincerely,

Prof Philip Morris AM
President GCMA

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Keeping the medical community informed

The Medical Link enriches the Gold Coast medical community by uniting the voice of its doctors.

Here you will find insightful stories and the latest trends in field research conducted abroad, and of course, right here on the Gold Coast. Keep informed of new health services, developments in the medical profession, and general interest items.

We invite you to submit your company updates, new recruits and promotions to **info@themedicallink.com.au**

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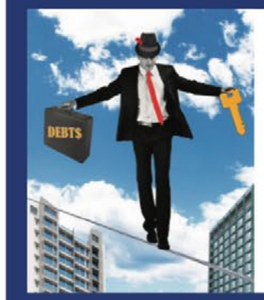

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Dr Robert Bourke **Retinal & Cataract Surgeon** Macula, Vitreous, Retina **& General Ophthalmology**

Dr Bourke is one of very few ophthalmologists who manage all complexities of cataract, macular and vitreoretinal eye surgery. After completing his Bachelor of Medicine and Bachelor of Surgery in 1984, Dr Bourke furthered his experience by completing two Vitreoretinal-Macular-Cataract Fellowships at Moorfields Eye Hospital (London) and St Paul's (Liverpool UK) between 1991-95.

Dr Bourke is a fellow of RANZCO and has authored several peer-reviewed journal articles and has been a guest lecturer at both national and international conferences. Dr Bourke has served the Gold Coast community since 1996 specialising in complex cataract, macular and vitreoretinal diseases.

Dr Lewis Lam **Retinal & Cataract Surgeon** Macula, Vitreous, Retina **& General Ophthalmology**

Dr Lam is a vitreoretinal specialist with a special interest in cataract surgery. While he underwent his vitreoretinal fellowship in NZ, he also undertook a diploma in laser refractive and cataract surgery with the University of Sydney. In addition to managing routine cataracts, he is adept at managing complex surgeries of the globe. In terms of general ophthalmology, he deals with macular degeneration, retinal vascular diseases, diabetes, uveitis, glaucoma, pterygium, trauma, and lid surgeries. Dr Lam also offers **evening clinics on Thursdays** till 8 pm and emergency weekend clinics. He is fluent in English and Mandarin and is happy to consult in either language as needed.

Dr Sharon Morris **Cataract, Oculoplastics & General Ophthalmology**

Dr Morris is an accomplished and friendly Eye Specialist and Oculoplastic Surgeon. After completing her training in the United Kingdom, she worked as a consultant at Moorfields Eye Hospital, a world leading eye hospital in London before relocating with her family to Australia. She is a Fellow of RANZCO and ANZSOPS and is actively involved in training future ophthalmic surgeons in her part time position at the Gold Coast University Hospital. She has published a number of medical articles, presented internationally and written a book chapter on orbital conditions.

Dr Morris provides comprehensive eye care in General, Cataract, and Oculoplastic eye conditions.

Dr Heather Russell **Cataract, Strabismus, General & Paediatric Ophthalmology**

Dr Heather Russell is a general ophthalmologist specialising in cataract, minimally invasive glaucoma surgery, double vision and strabismus, and paediatric ophthalmology. She also uses muscle-relaxing injections for blepharospasm, hemifacial spasm, and for non-surgical management of strabismus.

Heather trained in the UK and New Zealand before relocating to Australia to take up a position at GCUH where she continues as Senior Staff Specialist. She is a fellow of both RANZCO and RCOphth(UK). Heather has published widely, is actively involved in training doctors and medical students, and regularly presents both locally and nationally.

Dr Alan Hilton **General Ophthalmology, Paediatric Ophthalmology & Strabismus**

Dr Hilton has worked in private practice since 1970. He has a worked in a number of Hospitals in Queensland and has also been the chairman of Ophthalmology Assessment Tribunal for Q Comp. In conjunction, Alan has been a lecturer and examiner at a number of Universities and Medical Institutions in Australia. As well as General Ophthalmology, Alan has a special interest in paediatric ophthalmology and strabismus.

Dr Hilton is a Fellow of the RANZCO and member of a number of colleges and associations, including the Royal College of Surgeons Edinburgh and Royal Society of Medicine London.

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Eye Specialist Institute

Dr Sharon Morris

BM MRCSEd FRCOphth FRANZCO ANZSOPS

Consultant Ophthalmologist & Oculoplastic Surgeon

Floppy Eyelid Syndrome

Do you snore or have congestive airway disease and are your eyes gritty, dry and irritable? Do your eyes water? Have you tried a number of drops and treatments but your eyes still feel the same? **Chances are, you have Floppy Eyelid Syndrome.** This condition is very under-recognised, yet is often the cause for eye discomfort, watery eyes, gritty eyes, droopy eyelids, puffy lower eyelids and lid malposition.

Pathophysiology

Floppy eyelid syndrome (FES) is a horizontal loosening of the eyelids, both upper and lower. This usually occurs in people with obstructive sleep apnoea (OSA), but can occur in obesity, other congestive airway diseases, chronic sinus disease, allergic disease, keratoconus and Down's syndrome.

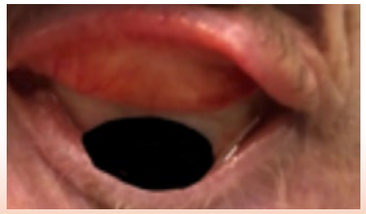
Mechanically, if the eyelids are loose on the horizontal vector then the natural blink tone of the lid is altered and this causes roughness or irritation to the eye surface. I liken it to a "raggedy wind-screen wiper on the car windscreen".

The inside linings of the eyelids become irritated and inflamed and the quality of the eye tear film is reduced. There may be a mild mucous production.

When the eyes are irritated on the surface they often present with sudden bursts of tearing spilling down the cheeks. Sometimes the eyelids are so stretchy that they easily evert/turn inside out! Sometimes they lift open by themselves during the night and the eye gets exposed or rubs on the pillow!

Potential consequences

The eyelids are the first defence to the eye – compromise of this protection and the eye is exposed to abrasions, infections and blindness of the eye. This patient has marked looseness of the upper eyelid tone such that a simple sideways distraction of the lid will reveal the inside lining tarsal conjunctiva. The conjunctiva is reddened and inflamed.



Potential consequences

Patients with floppy eyelid syndrome have loss of elastin in the eyelid but the pathophysiological processes behind this are not fully understood. Over time, chronic obstruction of the airways causes 'back-pressure' around the orbit, orbital fat and eyelid skin. This also causes the lids to puff out or become full and sometimes the lids will have festoons – pockets of fluid that fluctuate with position.

The lid skin stretches and they become heavy. Commonly the change in the tone leads to ptosis (droopy lids), excess skin and lower lid ectropion (lids displaced downwards or outwards).

Treatment

Treatment is multifactorial. Unfortunately, there is not one quick fix to solve the symptoms. Firstly, the underlying cause needs to be assessed for otherwise the disease process will perpetuate. OSA is associated with increased risk of stroke and death, as well as glaucoma. Driving ability can be severely compromised during the day due to daytime somnolence from poor sleep patterns. Treatment depends on the level of severity of the airway obstruction and may simply need weight loss or a change in sleeping position. Sleep studies assess the disease and, if severe, usually a C-PAP or BiPAP breathing device is recommended. The masks and fit around these are very important as a poorly fitting mask will often escape air onto the eye surface damaging the eye further and the pressure of a tight large mask can increase the fluid fill of the eyelid. However, treatment of OSA is crucial to reduce the life-threatening risks.

Secondly, the ocular inflammation and poor tear film needs to be addressed. I usually start patients on a preservative free lubricant 4 times daily with a night-time gel tear substitute as a baseline treatment. This will improve the quality of the base tear film and reduce the sudden reflex hyper-tearing responses. It will also start to reduce the inflammation from the mechanical abrasion effect. If a patient presents with a marked papillary inflammation of the tarsal conjunctiva, I will add in a low dose steroid drop twice daily eg. FML. Some patients with notable eversion of the eyelid at night may wish to tape their right and then left eyelids closed on alternate nights to prevent exposure or use a gel foam dressing to occlude the eye. Switching sleeping positions to the opposite side from the worst eyelid features is beneficial.

Finally, if the simple conservative and supportive methods of the tear film do not improve the overall symptoms, then surgery should be considered. Surgery is usually staged as all four eyelids usually need to be addressed. The lower and upper lids need horizontal tightening, usually with lateral canthal tendon plication or wedge resections. Often the upper lid will override the lower lid margin due to the laxity until the upper lids get fully corrected too. Once healed, the secondary ptosis or excess skin can be addressed. These surgical techniques usually dramatically improve the comfort and blink of the eye and reduce the ongoing need for eye drops. However, most patients will require some form of ongoing lubrication to the eyes and if the underlying cause goes unchecked the features will reappear with time.

Research is currently exploring whether cross-linking techniques (riboflavin tissue soaks irradiated with UV light) will stiffen the elastin deficient tarsal plates of the eyelid, thereby reversing some of the features of floppy eyelid syndrome and improving the long-term stability of the eyelid.

Restoration of the eyelid function is critical to protect the eye. Treatment of the underlying cause can be life-saving. Look out for the floppy eyelid!

Correct Diagnosis Key to a Quick Return to the Sports Field

Prompt and correct diagnosis is critical when it comes to recovering from a significant sports injury, says Gold Coast Private orthopaedic surgeon, Lochlin Brown.

Dr Lochlin Brown
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Dr Brown, who specialises in sports knee, general knee, hip replacement and trauma surgery, said time was critical when it came to management of an injury, with misdiagnosis the biggest risk to an athlete's recovery.

He said semi-professional and 'weekend' sportsmen and women were at the greatest risk.

"One of the first things a professional sportsman or woman wants to know is when can they return to sport after an injury," said Dr Brown.

"Most elite athletes have an entire specialist team working with them, so misdiagnosis is rare. It is the semi-professional or amateur sports person that this is more likely to happen to.

"Often they won't get a specialist to look at their injury, like a knee joint for example, so they either undergo inappropriate investigations which won't find what they need to, or they won't undergo any investigation at all thinking it's just a 'strain'.

"In this instance, players can go weeks in pain and the injury will become increasingly difficult to treat, making full recovery far less likely."

Dr Brown said it was important not to play through an injury.

"If something is causing pain while on the field, it's vital to stop playing and get it looked at immediately.

"A delay in treatment can be detrimental to recovery and this can then have an impact on other things, like return to work."

Dr Brown said knee and ankle injuries were extremely complex in nature, and it was best to leave treatment to the specialists.

"Every person and injury is different, so there's no one-size-fits all approach," he said.

"A specialist will be able to address the injury and tailor a treatment to individual needs.

"Getting the right treatment will give the best chance of a full recovery."

For more information, please contact:

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F: (07) 5532 4341
E: reception@drlbrown.com.au

Currumbin Clinic's targeted mental health support for **veterans and emergency service workers**

Currumbin Clinic continues to build on its reputation for specialised programs supporting veteran and emergency services communities with an inpatient group program that provides skills, techniques and group therapy addressing the specific mental health issues they often face as a consequence of their service.

The new inpatient program uses cognitive behaviour therapy (CBT), cognitive processing techniques, relaxation training and mindfulness, with completion of a relapse prevention plan by all patients an essential part of the program. The program is specifically designed for veterans and emergency services personnel who have post-traumatic stress disorder, depression and anxiety; as well as a dual diagnosis of substance misuse.

Hospital CEO, Kate Cross explained the group work encourages patients to explore issues and learn skills to manage their mental health more effectively in a safe and supportive environment where skilled therapists guide them through their inpatient admission.

"Psycho-education helps them to understand their mental health diagnosis and equip them with skills and techniques to reduce distress; manage substance use; regulate emotions and responses; and improve interpersonal effectiveness."

"Whilst process oriented therapy enables patients to discuss and explore their mental health needs", says Kate.

Currumbin Clinic is the only licensed private provider of inpatient treatment specifically designed to help manage the mental health concerns of veterans and emergency service personnel on the Gold Coast and Northern NSW. Providing specialist treatment for veterans and emergency services for over 20 years Currumbin Clinic has been recognised as expert treatment providers by the Australian Centre for Post-traumatic Mental Health, now Phoenix Australia.

For further information or to arrange a referral, please contact Currumbin Clinic on 1800 119 118.

MENTAL HEALTH DAY PROGRAMS FOR VETERANS AND EMERGENCY SERVICES WORKERS

Veterans and Emergency Services

Providing resources, education and clinical support this program is for currently serving military and veteran personnel, and current or ex-serving emergency services personnel with post-traumatic stress disorder. This 12 week program uses cognitive behavioural therapy, interpersonal therapy, relaxation techniques and mindfulness in a safe, confidential and supportive environment to complement individual treatment pathways with participants encouraged to undergo individual therapy or specific trauma processing where appropriate.

CBT for Veterans and Emergency Services

This eight week day provides a very specific focus on exposure therapy to decrease the impact that anxiety can have on the life of serving military and veteran personnel, and current or ex-serving emergency services personnel . Cognitive behavioural therapy (CBT) is used to identify unhelpful thoughts that maintain anxiety, and relaxation techniques are utilised to better manage the physical symptoms of anxiety.

Referral to a psychiatrist with admission rights to Currumbin Clinic is required to access these programs. Participants are admitted as day patients and can claim attendance via their health fund or through funding from the Department of Veterans' Affairs or WorkCover if approved.

For further information or to arrange a referral, please contact Currumbin Clinic on 07 5534 4944.

Binge eating disorder more common than anorexia or bulimia; new outpatient day program for Gold Coasters

A new outpatient day program at Robina Private Hospital is helping people with binge eating disorder (BED) manage and recover from the condition.

A psychological illness characterised by frequently eating excessive amounts of food, often when not hungry, BED is different to overeating being recurrent, more serious and compulsive; distinct from obesity in that most larger-bodied people do not meet the criteria for BED (American Psychiatric Association, 2013); and different to bulimia as there is no accompanying compensatory behaviours such as vomiting.

A 2012 Butterfly Foundation study found 4% of Australians have an eating disorder at any given time, of these 47% have binge eating disorder making it more common than anorexia or bulimia.

General practitioners are well positioned to link patients with BED dually to a dietitian, psychologist or psychiatrist who specialises in eating disorders, or to an inpatient or day program. Robina Private Hospital has a comprehensive eating disorder service and has now added a BED specific outpatient day program.

Dr Kim Hurst, clinical lead eating disorders, believes recovery from an eating disorder is possible, but recognises an individual's journey is not linear, and at times the intensity for treatment needs increase to match the strength of the illness.

"The purpose of this BED day program is to provide intensive treatment over a short period of time to help improve health and functioning, and support the patient's journey towards total recovery", says Kim.

Dr Vinay Garbharran, director of eating disorders, adds binge eating is a difficult problem to overcome as it may serve to reduce unpleasant feelings and thoughts... despite the guilt and shame associated with these behaviours which can also exacerbate low self-esteem issues.

"It can be challenging to identify as binge eating is usually done in secret when the patient is alone, meaning often close friends and family don't know the patient is engaging in this behaviour", says Vinay.

The BED program is delivered by a multidisciplinary team using efficacious and evidence based treatment including: supported meals; medical monitoring; dietetic input; psychiatric reviews and input; therapeutic groups; and art therapy. Patients need a referral from a medical practitioner, ie a GP, paediatrician or psychiatrist to access the program.

Robina Private Hospital is also in the process of finalising a two-week inpatient program for BED which could be used as an adjunct to the outpatient program.

For further information or to arrange a referral, contact Robina Private Hospital on 07 5665 5100 or 1800 707 581.

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Robina Private Hospital is a purpose-built, state-of-the-art 90-bed private hospital with three specialist wards along with consultancy, outpatient, psychiatric day programs, day surgery, general medical and rehabilitation services. Opportunities currently exist for consultant psychiatrists to develop their private practice in the specialist consulting suites at the hospital.

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For a confidential discussion, contact:
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P: 07 5665 5100
E: kenny.craig@healthecare.com.au

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The Red Painful Eye That Needs Referral

Approximately 5% of primary care presentations are eye related. Some of these can be sight threatening. This can be difficult for a busy General Practitioner to ascertain, particularly without Ophthalmic equipment.

Dr Louise Robinson
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RED FLAG HISTORY

- Eye trauma, inc. chemical injury
- Recent ocular surgery
- Contact lens wearer
- Previous eye infections e.g. cold sore virus
- Shingles involving the eye
- Unresponsive to treatment from previous GP presentation

RED FLAG SYMPTOM

- Unilateral
- Pain: moderate to severe
- Photophobia
- Decreased vision
- Associated nausea & vomiting

When in doubt including the above red flags will help the Ophthalmologist triage the referral appropriately.

The above "Red flags" in the patient's history or symptoms can aid in making an urgent referral to an Ophthalmologist.

The most sight threatening presentation is one of a penetrating eye injury. This is commonly ascertained from history. This patient should be urgently referred to an Ophthalmologist. A hard shield should be placed over their eye, please note, no pressure should be placed on the affected eye.

Any patient who presents with the red flag symptoms who has had a recent Ophthalmic surgery, is assumed until proven otherwise, to have endophthalmitis, a serious infection in the eye. This patient needs to be urgently referred back to their surgeon for assessment and treatment.

Viral and bacterial infections of the cornea, including any herpes virus and contact lens related pseudomonas infections need early treatment in order to decrease the long term visual scarring effects of such. The likelihood of these can be ascertained from the history. Photophobia is a common symptom of many red eyes, but can be indicative of uveitis, or inflammation of the front of the eye. This can be related to an underlying auto-immune disease, which requires urgent treatment.

CHLORSIG

An very effective antibiotic for scratches and bacterial infections. If symptoms or vision doesn't improve within 2 days, a referral to an Ophthalmologist should be made.

TOPICAL STEROID DROPS

If you are considering using these, the patient should be reviewed and treated by an Ophthalmologist.

The above does not aim to be a comprehensive list of presentations of painful red eyes.

Below is a useful link to the Sydney Eye Hospital Eye Emergency Manual which provides more detail of such presentations:
https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0013/155011/eye_manual.pdf

Gastrointestinal Disorder: The Role of the Mast Cells

Mast cells have been identified as a major player in gastrointestinal disorders [2]. Mast cells are a multifunction immune cell, and have a crucial role in both innate and adaptive immunity, participating in host defence, tissue repair, wound healing and angiogenesis [2]. They play an important immuno-regulatory function, particularly at the mucosal barrier between the body and the environment [1].

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The gastrointestinal tract and its intestinal mucosa, have a large interface with the inner and outer environments, constantly exposed to luminal contents [1, 4]. The function of this intestinal barrier is to protect the body from harmful luminal content and control mucosal permeability, only allowing small amounts of antigens and bacteria to cross the epithelium, while preventing the passage of potentially harmful substances [4].

The maintenance of the intestinal barrier is fundamental for homeostasis and disturbance of this barrier by an uncontrolled mechanism may lead to enhanced mucosal permeability and passage of luminal antigens and or microorganisms across the intestinal epithelium, potentially inducing disturbances in the epithelial – neuro-hormone interactions that facilitate the development of inflammation in the gut [4]. Impaired epithelial barrier function has been largely implicated in the origin and development of many digestive and non-digestive diseases [4].

A variety of research methodologies have identified an increased number of MC in the intestinal mucosa of patients with altered barrier function, in inflammatory intestinal diseases and functional gastrointestinal disorders [4].

MC are long-lived granulated immune cells, that reside in all vascularised tissue in the body, and preferably reside in mucosal interfaces, including the skin, respiratory, genito-urinary and gut mucosa, hence are in close contact with the environment, with the potential to react against infectious organisms, harmful substances and other environmental challenges [4].

Mast cells (MC) have a great variety of receptors and respond to different stimuli including microbial, neural, immune, hormonal, metabolic and chemical triggers, thereby exerting antimicrobial, neurological, immune and metabolic functions [4]. In the intestinal mucosa, mediators released by MC affect epithelial integrity and viability, blood flow, coagulation, and vascular permeability, wound healing and fibrosis and facilitate neuro-immune, which promote peristalsis and pain perception [4].

MC have the ability to react to a great variety of stimuli and secrete biologically active products with pro-inflammatory, anti-inflammatory and or immunosuppressive properties [4]. They play a prominent role in IgE mediated allergic inflammation and in a variety of intestinal and non-intestinal disease including gastrointestinal inflammation, functional gut disorders, infections, auto-immune disease, atherosclerosis and carcinogenesis [4].

MC play a fundamental role in the regulation of mucosal integrity and epithelial barrier activity and the maintenance of neuro-immuno interaction which support the gut brain axis [4].

MC can be activated by a variety of different mechanisms, including IgE and non-Ig E mediated and Ig G triggers, microbial agents and endogenous factors from cell damage and endogenous stimuli, including neurotransmitters, neuropeptides, neurotrophins and gaseous neurotransmitters [3,4].

MC, when activated release biologically active products including proteases, biogenic amines, proteoglycans, lysosomal enzymes, certain cytokines, growth factors and granule membrane associated proteins [4].

Piecemeal and anaphylactic degradation are the two main mechanisms of secretion of mast cell mediators [4]. Digestive diseases involving piecemeal degradation, including inflammatory bowel disease, irritable bowel syndrome and functional dyspepsia, have been the most studied [4].

The intestinal barrier functions as an effective defensive system involving intra –and extracellular elements which closely interact to promote the correct functioning of the epithelium, immune response and acquisition of tolerance against food antigens and the intestinal microbiota [4]. The loss of epithelial integrity facilitates penetration into the mucosa, triggering immunological responses, increasing epithelial permeability and promoting inflammation (4).

Abnormality of the intestinal barrier has been identified in the origins and development of many digestive (coeliac disease, IBD, IBS and food allergy) and non-digestive diseases (schizophrenia, diabetes, sepsis and others) [4].

A network of interactions among the microbiota, epithelial cells and immune and nervous system control the intestinal barrier [4]. The bilateral communication between the central and enteric nervous systems, regulates ion secretion, epithelial tightness, immune function and peristalsis and hence regulation of the intestinal barrier [4].

MC, contribute to barrier function through a neuro-immune mechanism which has been evidenced in different experimental settings [4]. Stressors, both physical and psychological, acute and chronic have been shown to increase ion secretion and epithelial permeability, resulting in a disturbance of barrier homeostasis, with these effects being avoided in "mast cell knock out" rats and in humans treated with a mast cell stabilizing agent [4].

Epithelial function and integrity is regulated by a variety of molecules released by the MC, including tryptase, chymase, histamine and cytokines [4]. Tryptase is an enzyme contained in the mast cell and has been largely implicated in epithelial permeability, promoting tight junction disruption, increasing intestinal permeability and cell damage [4]. Chymase is mainly implicated in extracellular degradation impacting epithelial integrity [4]. Histamine is a mast cell mediator in the gastrointestinal tract, mediating immunological responses, visceral nociception, modulation of intestinal motility, gastric acid secretion through activation of it receptor H1-H4 [4]. Histamine's role in epithelial dysfunction is mediated by H1 receptors, directly stimulating chloride secretion [4]. A large variety of cytokines are produced by MC, many of which have a direct impact on the intestinal epithelial barrier, which can result in the disruption of the tight junction, modulation of epithelial paracellular permeability, regulation of intestinal function and increasing intestinal permeability associated with genetic profile identified in intestinal anaphylaxis leading to tight junction disruption [4]. Cytokine IL20 has been shown to have anti-inflammatory effects developing a protective role in the intestinal barrier function [4].

MC, are involved in gastrointestinal and systemic manifestation of food allergy [4]. MC are the main effector participant in allergic response involving the gastrointestinal tract, where the immune response can be IgE mediated, non IgE mediated or mixed [4]. MC activation increases intestinal permeability, along with contribution to the initiation of food allergic inflammation [4]. MC have a pro-inflammatory role and modulate the allergic sensitization and downregulation of allergic inflammation [4].

Human and experimental studies have identified the role of MC in IBD, where increased numbers of MC were identified in tissue specimens in Ulcerative Colitis and Crohn's Disease patients [4]. Altered gut-brain axis and a potential role in neural inflammation have also been identified in IBD patients [4].

A chronic inflammatory disorder of the small intestine, Coeliac disease, caused by an intolerance to gluten, has an identifiable increased number of MC and the mediator histamine in the small intestine [4].

In the functional gut disorder, IBS, research to date, has not been able to identify a biomarker. However, low grade inflammatory infiltrate, with an increased number of MC and T –lymphocytes have been identified in the mucosa of the small and large intestine [4]. Studies have identified common findings including altered intestinal barrier with increased epithelial permeability and disruption of tight junction [4]. The associated loss of functional integrity may facilitate the flux of antigens, including from food, microorganisms and toxins, resulting in stimulation of immunological responses, further increasing the paracellular epithelial permeability and promoting low – grade inflammation [4]. In the small intestine of IBS – diarrhoea patients, tryptase has been implicated in intestinal barrier deregulation, gastrointestinal motor abnormalities and visceral pain [4]. In the IBS patient, there is a correlation between the severity of pain and the number of colonic mast cells in proximity to nerves [4]. MC support a local neuro-immune interaction between the brain and the gut, mediating the response to psychological stress, with recent research identifying the relationship between stress episodes and the initiation / exacerbation of functional gut disorders [4]. This relationship has been support by studies identifying an improvement in gastrointestinal symptoms after the administration of the mast cell stabilizer disodium chromoglycate or ketotifen, H1 receptor antagonist, leading to a reduced visceral perception, particularly in hypersensitive IBS patients [4].

Functional dyspepsia, is one of the most common functional gut disorders, with a prevalence of 10 - 20%, characterised by symptoms including epigastric pain, sensation of fullness, nausea, early subjective satiety and abdominal bloating (4). Studies have identified and increased number of MC and eosinophils in the duodenum, though no biomarker has been identified (4). The identified higher number of mast cells with an activated phenotype does not appear to correlate with the impaired mucosal barrier integrity observed in the duodenal mucosa, though evidence still suggest MC activation may play a role (4).

Mast Cell Activation Syndrome (MCAS) is a chronic multisystem disease of abnormal MC activation, leading to inflammatory and allergic symptoms [2]. The most common symptoms include abdominal pain, nausea both, cyclical and chronic, vomiting, heart burn, alternating diarrhoea and constipation [2, 4]. Other symptoms may include, tingling and burning, apthous ulcers, globus, abdominal bloating, and dysphagia [2]. In these individual symptoms are often refractory to targeted medications [2].

MCAS involves a constitutive and reactive abnormal activation and release of mediators which have harmful effects locally and distantly [2]. CD-117 immuno-histochemical staining is used to detect MC within the GI tract mucosa obtained via endoscopic biopsy, with the general protocol to obtain 8 specimens from the second part of the duodenum [2]. In most MCAS patients, researchers have identified ≥20 MC per hpf from the duodenum and ileum [2].

Mast cells play a major role in the maintenance of intestinal barrier and the neuro-immune interaction which supports the gut –brain axis. Studies have identified the role of MC in IBD, IBS and functional dyspepsia and MCAS.

Emerging research has identified treatment which encompasses the identification and avoidance of MC triggers and the control of mast cell mediator production and action. First line management encompasses the avoidance of potential triggers which may include stress, heat and alcohol [2]. Researched clinical experience also identified dietary interventions, encompassing the avoidance of gluten, dairy protein, histamines and moderating FODMAP load as part of first line management [2].

First line pharmacotherapy is offered in a stepwise fashion, introducing one medication at a time to determine the benefit [2]. This initial intervention could encompass the use of histamine receptor antagonists, which block receptors on MC and other cells throughout the body which are responsible for symptoms [2]. These medications could include non- sedating H1 – receptor antagonists, Ceterizine and Fexofenadine, and H-2 receptor antagonist, Famotidine, Nizatidine [2].

Other, over the counter agents for consideration, could include vitamin C, vitamin D and Quercetin. Vitamin C - 500mg as sustained release, can assist in stabilising mast cell and reduce histamine formation and chemical degradation of released histamine [2]. Quercetin, a plant based flavonoid, assists in decreasing the production of anti-inflammatory mediators such as prostaglandins [2]. Vitamin D, may play a role in the down regulation of MC receptors and dose is dependent on patient serum level [2].

Second line intervention may encompass the introduction of a disodium chromoglycate, acting as a mast cell stabilizer [2]. Third line pharmacotherapy may include a second generation H 1 receptor antagonist with an anti-inflammatory effect, Ketotifen and the fourth line, therapy Omalizumab [2], with the latter two pharmacotherapy interventions having application in the patient with refractory gastrointestinal and systemic symptoms [2].

Disorders of the gastrointestinal tract are often complex in their symptom presentation, with stabilising mast cells constituting a promising tool in their management. Frist line therapy encompasses the identification of triggers and dietary modification, to optimise patient outcomes.

The skills and expertise of a dietitian with extensive experience are paramount to achieving the best outcome for our patients.

References

1. Mast Cells in Gastrointestinal Disease. David B. Ramsay, MC, Sindu Stephen, MC, Marie Brown, MC, EdD, MPH, Lysandra Voltaggio, MC, and David B, Doman, MC, FACP, FACG. Gastroenterology & Hepatology Volume 6, Issue 12, December 2010.

2. Mast Cell Activation Syndrome: A Primer for the Gastroenterologist. Leonard B. Weinstock, Laura A Pace, Ali Rezaie, Lawrence B. Afrin, Gerhard J. Molderings. Digestive Diseases an Sciences. https://doi.org/10.1007/s10620-020-06264-9.

3. Mast Cell Activation Syndromes. Cem Akin, MD, PhD, Ann Arbor, Mich. 2017 American Academy of Allergy, Asthma & Immunology. http://dx.doi.org/10.1016/j.jaci.2017.06.007.

4. Intestinal Mucosal Mast Cells: Key Modulators of Barrier Function and Homeostasis. Merce Albert-Bayo, Irene Paracullellos, Ana M. Gonzalez-Castro, Amanda Rodriguez-Urrutia, Maria J. Rodriguez-Lagunas, Carmen Alonso-Cotonor, Javier Santos and Maria Vicario. Cells 2019. 8., 135;doi:10.3390/cells8020135.

Defining a Deficit: The Key to Accurate Neurological Examination & Differential Diagnoses

The clinical assessment of sensory and motor function may appear simple, and examining these two systems form the basis for most physical examinations. However, clinicians can easily be fooled when assessing sensation and power in such a physical examination.

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At Corbett Neurophysiology Services, we perform focused physical examinations on every patient before conducting electrodiagnostic (EDX) studies (most authoritative EDX texts recommend this). This allows us to customise our neurophysiological studies in light of the patient's presenting complaints and differential diagnosis for the most appropriate investigation. It also allows us to compare and contrast our clinical findings with those described by the referring practitioner. Upon analysing tens of thousands of patient's data, we find that over 50% of referral diagnoses are altered by our physical examination prior to performing the neurophysiological investigation.

The key to accurate neurological examination relies on one simple thing – the identification of true neurological deficits. Peripheral nerves are original conduits that move information around the body. In the case of most peripheral nerves, the relevant information is sensory or motor. When nerves are malfunctioning, the only result can be localised sensory or motor function deficits. This allows correlation of the deficits to match with the nerve supply, leading to a differential diagnosis. Therefore, the identification and localisation of sensory or motor deficits are critical in neurological differential diagnoses. Conversely, an inaccurate sensory or motor examination will often lead the diagnostician to an incorrect diagnosis.

Neurologically, the precise details of the deficit make the clinical examination more or less difficult. This is where the examiner's skill is put to the test.

From our observations, our referrers' most common misinterpretation of clinical examination is one thing – the presence of pain. Pain is not usually associated with a sensory or motor deficit. While pain is highly motivating for the patient and can be the dominant symptom in their presentation, it can be a major distraction in identifying neurological deficits.

Pain without sensory or motor deficit is generally not indicative of neuropathy. Instead, it typically confirms the preserved function of a nerve. However, this does not mean that sensory impairment is not often painful. For example, acquired generalised peripheral neuropathy of small-fibre axonal types tend to be accompanied by painful paraesthesia, often with a burning quality. Oddly, it is not uncommon in our experience for patients with deep pains such as aching, bony, or joint pains to describe numbness or weakness. However, sensory and motor testing may be normal. Therefore, such symptoms cannot correctly be described as sensory deficits and can usually be excluded as clearly neurological in origin.

Pain with, triggered by, or exacerbated by movement is typically mechanical in type. It is common in cases such as this for patients to describe weakness in association with pain. Power can become compromised as a result of protective inhibition. However, weakness is often incorrectly "confirmed" by using tools such as grip-strength dynamometers, which might reveal measurable reductions in force of grip strength but fail to expose painful arthritis that led to the poor volition and presented as "weakness". Pain-related weakness is not considered a motor deficit. Again, the examiner's clinical skills can be tested in situations such as these and can lead to spurious motor examination results and incorrect differential diagnoses.

In summary, the key to accurate neurological examination and differential diagnoses lies in differentiating true neurological sensory and motor deficits from the white noise which often surrounds them.

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Housing Trends for Living in a Contagious World

The Covid 19 pandemic has significantly impacted most of our lives over the past few months, and even if a successful vaccine is developed, life will probably never return to the way it was before this crisis began. We will be forced to adjust to a new “normal”.

We present 5 predictions as to how this contagion is likely to change our lifestyles and the way we design our homes in the future.

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Lower Density Housing

In recent times there has been a discernible trend towards inner city living in high rise apartments. This has been led by population growth and a desire to live closer to work, or within easy walking distance of dining precincts supporting a wide range of lifestyle venues such as cafes, restaurants, and bars.

From Baby Boomer empty nesters to Gen Y professionals, the ideal of owning a house on a quarter acre lot with a large backyard garden was becoming an outdated living model.

However extended periods of confinement within our homes has clearly identified that having ready access to private space, whether inside or outside our homes, is vital for our mental and physical wellbeing.

As residential lot sizes have been shrinking, house sizes have grown. Consequently large suburban backyards have gradually been replaced by smaller courtyards, outdoor terraces or balconies, unsuitable for many outdoor recreation or sporting activities.

The inability for families to play or exercise in these confined spaces is one of the major factors influencing the trend back to low density living.

A large backyard will once again be aspired to.

In addition, high density living now exposes us to potential risks of infection as numerous residents share the same communal spaces.

Even accessing homes within a medium or high density multi-residential building often requires travelling in a confined lift space, touching buttons, and other surfaces potentially harbouring infectious bacteria.

Urban Farming

Paradoxically this global pandemic which is believed to have originated in a marketplace in China has exposed our total reliance on the complex supply chain that stocks our fridges and pantries.

Whilst consumers in many Asian countries purchase their daily food needs from fresh produce markets once or twice a day, in western cultures we tend to only shop on a weekly basis.

The sudden irrational fear that our regular food supply chain would collapse, leaving us starving and locked in our homes with empty pantries and no toilet paper, resulted in a rush to shop every day, and to stockpile as much as we could to survive!

Nurseries were selling out of seeds and seedlings for fruit, vegetables, and herbs as those fortunate enough to have a garden, or somewhere to place a pot embraced self-sufficiency through “urban farming”.

Whilst this has been practiced for many years by European immigrants, carefully manicured gardens across the country are likely to be uprooted to make way for vegetable patches and orchards.

Expect to see a glut of chutney and other preserves in the years ahead.

More Flexible Living Spaces

This was an emerging trend before Covid 19 but will now become far more significant in the design of new homes.

Open plan living was evolving with the introduction of moveable walls or doors allowing spaces to be subdivided or enclosed for specific uses or functions.

The sudden need for whole families to share these common areas for work, exercise, dining, and relaxation has identified the need for additional dedicated spaces within the home.

This starts with the entry space. Entry lobbies or mudrooms will become sanitisation zones where street or work attire, shoes, coats etc can be removed and stored.

Powder-rooms or wash areas will be located adjacent to the entry allowing for visitors to wash their hands before entering the inner sanctum of the home.

The transition for many to working from home has also highlighted the importance of dedicated work zones. It quickly became apparent that the dining table or lounge were not practical for this purpose.

Study nooks or rooms that can be permanently set up for ergonomic work use, offering acoustic privacy and access to work equipment including desktop computers, screens and printers will become sought after as more of society embraces working from home on a full or part time basis.

The forced closure of restaurants and other public dining facilities has also seen a resurgence in home cooking - for those used to dining out on a regular basis it suddenly became a necessity for survival.

The kitchen will regain its status within the home, banishing the little used "show kitchen" to a historical fad from a different time.

The resurgence in popularity of baking will also ensure the oven in all its iterations will be retained as an essential appliance.

The Butler's pantry has been in ascendance for a while now, but the importance of allowing more space for additional refrigerators or chest freezers, and incorporating large storage cupboards to stockpile food, will become more of a priority.

Another casualty of the forced shutdown of public gathering spaces were commercial Gymnasiums and exercise equipment in public parks. Gym equipment sold out of stock almost as quickly as toilet paper.

Demonstrating our strong desire to exercise to maintain our fitness, or simply as a means of breaking the tedium of home isolation, dumbells and yoga mats took over our living spaces.

This has exposed another shortfall in many home designs with indoor or outdoor spaces too small or unsuitable for intensive workouts.

Flexible spaces that can easily be cleared of furniture to create an exercise area, or dedicated home gyms with suitable hard-wearing finishes, air conditioning, and equipment storage areas will become popular ensuring households can workout at their leisure within the home., in any weather conditions.

Families cooped up together in the same household for extended periods has also highlighted the importance of multiple separate living zones.

The master bedroom retreat, once the preserve of the very wealthy, will increasingly be incorporated into the parent's private area within the home. Taking the form of a small lounge area within a larger bedroom, it will allow parents to "retreat" to their own sanctuary as the children take over the balance of the house. And let us not forget the most important lesson we have learnt from this crisis. We cannot survive without toilet paper! Expect bathrooms to increase in size as bidet sales skyrocket.

Hygiene

The ability for community transmission of the corona virus through contact with contaminated surfaces will see an increase in the use of anti-microbial finishes within our homes.

Unlike other metallic surfaces such as stainless steel which has been shown to harbour the Covid 19 bacteria for several days after contamination, bacteria, yeasts and viruses are rapidly killed on metallic Copper. Expect to see copper products used increasingly for benchtops, tapware and other applications.

Krion is another product suited for use in benchtops with antibacterial properties. It is a composite solid surface material comprised of natural minerals and binding resins similar to reconstituted stone.

Whilst not currently available in Australia, demand for the antibacterial properties of this product will undoubtedly see it imported in the future.

Richlite, an antimicrobial panel board manufactured using recycled paper sourced from environmentally sustainable forests (FSC) has a wide range of uses from external cladding to furniture design. It is easy to clean and can be used for benches and tabletops.

Since most materials we regularly touch in our work and home environments do not possess antibacterial properties (unless applied with special coatings), touchless technology will become more prevalent, especially in public spaces.

Facial recognition, motion sensors and audio controls will reduce the need to touch buttons, handles keypads etc to access controlled or closed spaces.

Self-Sufficiency

In the not so distant past the Cold War threat of nuclear war induced many people to install bunkers in their homes as protection against the fallout from a possible nuclear attack.

The recent response to the Covid 19 threat has highlighted our considerable dependence on others for survival and will see a resurgence in people's desire for self-sufficiency and isolation from the world in an attempt to "ride out the storm".

Whilst unlikely to result in homes being built with bunkers in the basement and a large proportion of the population moving off grid, our reliance on reliable external sources for daily essentials such as power, fuel, food and water is certainly being questioned.

Solar power has already been adopted by many, and as battery storage technology improves, our reliance on external power generation will diminish. Solar harvesting technology is being incorporated into ever more building materials, and as the size of storage batteries continues to decrease, dedicated battery rooms or external storage space is being replaced by compact wall mounted cells.

Rainwater harvesting is also common and will continue to increase as the effects of climate change and recent droughts has clearly demonstrated the precarious situation we could face in the future if our dams dry up.

With 86% of Australians living in an urban environment, we are highly unlikely to ever be self-sufficient in our individual food production. This crisis has demonstrated however that many of us will give it a good hot go!

Expectations of a successful vaccine being developed by the end of the year are increasing, however even if we can defeat this virus, our freedoms and lifestyle choices may never be the same.

The unfortunate reality is that other pathogens are likely to emerge in the future, so we must adjust our way of living accordingly.

"They Could Have Stereo" What is That?

Stereotactic radiosurgery, stereotactic radiotherapy and stereotactic ablative body radiotherapy are changing the landscape in the management of patients with limited metastases from cancer.

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Patients with brain metastases and metastases to the lung, liver, lymph nodes and bone including vertebrae, can be treated with focussed high dose radiation therapy to ablate cancer cells, while minimising the radiation dose to normal healthy tissue.

What is Stereotactic Radiosurgery and When is it Used?

Stereotactic radiosurgery (SRS) is the non-invasive, precise delivery of a high dose of radiotherapy in a single treatment session to the brain, while stereotactic radiotherapy (SRT) is delivered in a small number (up to 5) treatments. With the precise delivery of radiotherapy, the radiation dose is focussed on the tumour, so less radiation dose is delivered to the normal brain, with less neurocognitive effects. Protection of normal brain tissue is achieved through a steep decline in radiation dose outside of target metastasis.

Brain metastases are common, occurring in up to 30% of patients with cancer. Stereotactic radiosurgery is an alternative treatment option to surgery in patients with metastases in eloquent or inaccessible areas of the brain, in patients not fit for surgery and in some patients with multiple brain metastases.

Patients with a with small number (up to 4) cerebral metastases can be treated with stereotactic radiosurgery, which is associated with lower neurocognitive decline than whole brain radiotherapy [1]. There is also evidence to show that patients with 5 to 10 brain metastases have a similar overall survival and low comparable toxicity to those with 2-4 metastases, when treated with stereotactic radiosurgery [2].

Patients with limited cerebral metastasis(es) may be suitable for neurosurgical resection. These patients have a 30-40% risk of local recurrence at the surgery site. This is can be reduced with stereotactic radiosurgery [3]. In a phase 3 trial, patients who have postoperative stereotactic radiosurgery had significantly better cognitive-deterioration-free survival, improved quality of life and functional independence compared with those who had whole brain radiotherapy [1].

How is Stereotactic Radiosurgery Delivered?

Patients usually have radiotherapy as an outpatient, with the patient awake and the radiation beam on for only a few minutes. The state of art Varian Hyperarc radiotherapy system can treat patients in a streamlined manner with automation between steps in the delivery of radiotherapy targets, minimising the overall treatment time for the patient.

Radiotherapy is accurately delivered using real time CT scanning and surface guidance. Align RT is a surface guided patient radiotherapy system which utilises a complex light pattern shone on the patient, tracks the patient position in real time and detects sub-millimetre deviations in position, which can be corrected immediately.

Stereotactic Radiotherapy in Other Parts of the Body

In the body, outside of the brain, stereotactic ablative body radiotherapy (SABR), also known as stereotactic body radiation therapy (SBRT) can improve local control and survival in patients with limited metastases. Common sites of metastases treated with SABR include lung, liver, bone including vertebrae and adrenal glands. The recently published long term results of SABR-COMET trial showed that patients with a controlled primary and 1 to 5 metastatic lesions treated with SABR had improved overall survival (42%) compared with standard palliative radiotherapy (18%) [4]. SABR is well tolerated and the quality of life between the treatment groups were similar.

Stereotactic treatment to the brain and body can improve the control of metastases to these locations, improve quality of life and has less side effects compared with traditional radiotherapy.

References

1. Brown PD, Ballman KV, Cerhan JH et al. Postoperative stereotactic radiosurgery compared with whole brain radiotherapy for resected metastatic brain disease (NCCTG N107C/CEC3): a multi-centre, randomised, controlled, phase 3 trial, The Lancet Oncology, 2017, 18(8), 1049-1060.
2. Yamamoto M, Serizawa T, Shuto T, et al. Stereotactic radiosurgery for patients with multiple brain metastase (JLGK0901): a multi institutional prospective observational study, Lancet Oncology, 2014; 15 (4), 387-395.
3. Mahajan A, Ahmed S, McAleer MF et al. Post-operative stereotactic radiosurgery versus observation for completely resected metastatic brain metastases: a single centred, randomised, controlled, phase 3 trial, Lancet Oncology, 2017, 18(8), 1040-1048.
4. Palma DA, Olson R, Harrow S, et al. Stereotactic Ablative Radiotherapy for the Comprehensive Treatment of Oligometastatic Cancers: Long-Term Results of the SABR-COMET Phase II Randomized Trial [published online ahead of print, 2020 Jun 2]. J Clin Oncol. 2020; JCO2000818. doi:10.1200/JCO.20.00818

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Welcome to Grace Private: Meet Our Specialists

Committed to women's health, Grace Private's team of doctors and allied health practitioners are driven and passionate in delivering optimal outcomes for every patient, empowering and supporting women on their health journey for life. Please take a moment to meet our specialists:

Dr Adriana Olog MBBS, FRANZCOG, CMFM
Maternal Fetal Medicine Specialist, Obstetrician & Gynaecologist

Dr Olog specialises in managing high risk and complex pregnancy, tertiary level pregnancy ultrasound, diagnosis, intervention and management of complex fetal conditions as well as pre pregnancy counselling and perinatal loss care. She offers genetic counselling as well as invasive procedures and management of abnormal genetic results, management of risk of preterm birth as well as performs cervical cerclage.

Dr Tania Widmer MBChB, MMED, FCOG, FRANZCOG
Obstetrician & Gynaecologist

Dr Tania Widmer's special interests include normal and high-risk pregnancy, fertility, treatment of abnormal uterine bleeding, endometriosis and Polycystic Ovarian Syndrome. She performs a full range of gynaecological procedures including colposcopy, laparoscopic and vaginal surgery, investigations for infertility and assisted reproduction including IVF if required.

Dr Tina Fleming MBBS (Hons), FRANZCOG, MReprodMed
Obstetrician & Gynaecologist

Dr Tina Fleming is an experienced clinician, with additional subspecialty training in minimally invasive gynaecology and a Masters in Reproductive Medicine. She specialises in the management of endometriosis and pelvic pain, fertility and conception issues and complex gynaecological surgeries.

Dr Helen Green FRANZCOG, CGO
Gynaecological Oncologist

Dr Helen Green specialises in the diagnosis and treatment of women with cancerous or precancerous gynaecological conditions with a particular interest in the use of minimally invasive surgery to treat a range of benign gynaecological conditions. Her focus is on providing excellence in care, with compassion and advocacy for women's medical, psychological, social, cultural and sexual needs.

Dr Bridget Gilsenan MBBS, BExSci, FRANZCOG
Obstetrician & Gynaecologist

Dr Bridget Gilsenan provides a high standard of compassionate care in all aspects or pregnancy and gynaecology. She has a special interest in colposcopy, minimally invasive surgery and paediatric and adolescent gynaecology.

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