the medical link

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

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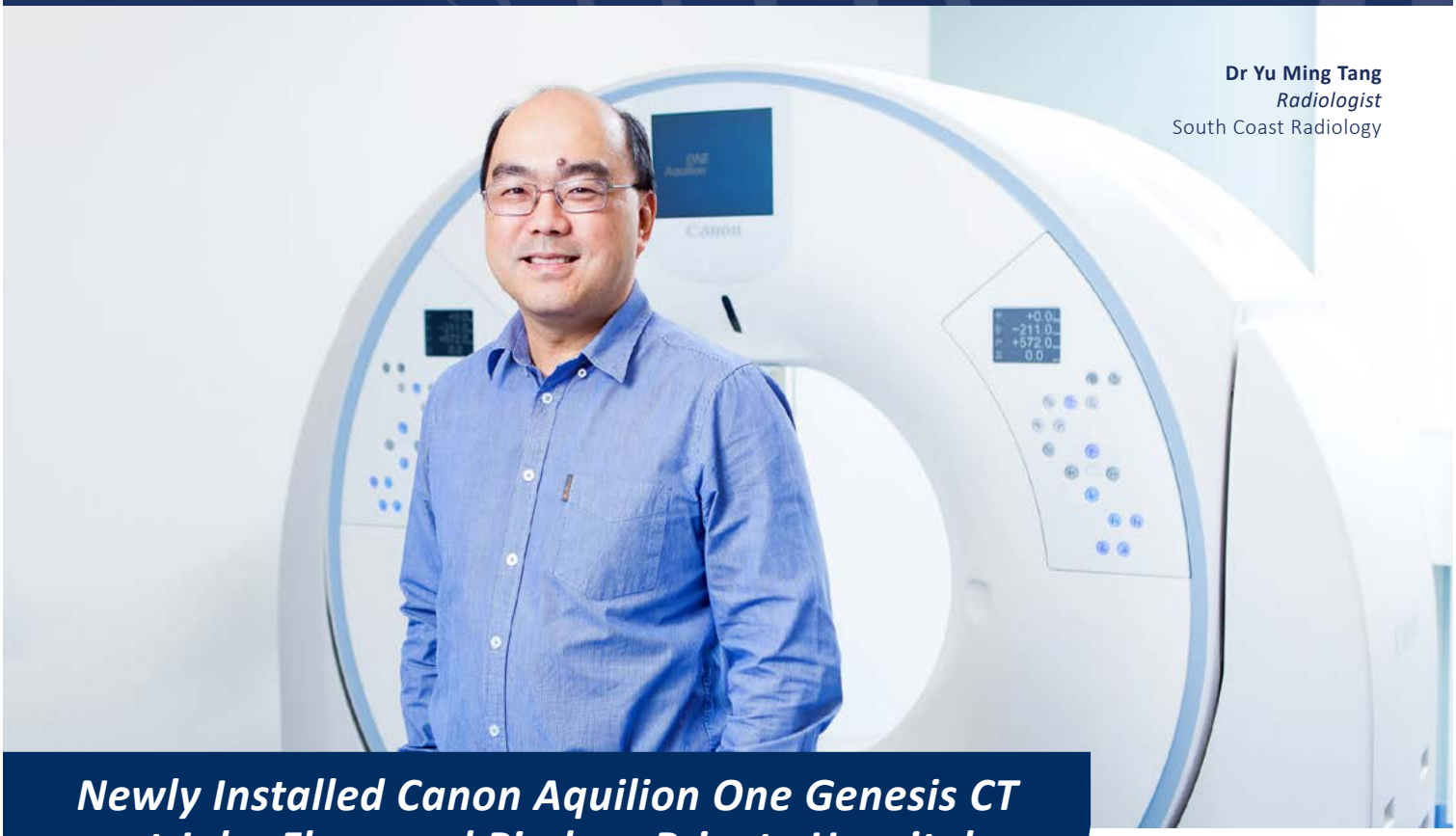
SOUTH COAST RADIOLOGY



Dr Yu Ming Tang
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A message from the

GCMA President

Dear Doctor Coleagues,

We are now coming towards the end of 2020. This year has been one of a kind! I hope we do not have a repeat any time soon. In Queensland at least the fear of a pandemic sweeping all before it has been replaced by a quiet determination to keep the Covid-19 virus in check and to remain vigilant until an effective vaccine becomes available. I am sure we are all thankful the Victorian second outbreak is now back under control and the prospect of all state and territory borders being open before Christmas will be eagerly anticipated.

Our GCMA monthly Thursday evening meetings have continued. Prof Nicholas Zwar from Bond University Medical School talked to our members at the October meeting. Our final meeting for the year on Thursday 19 November will be with Prof Allan Cripps and Dr Nic West from Griffith University on vaccine development for Covid-19. This is a timely presentation as Pfizer have just announced a 90% effective vaccine for Covid-19.

Our first monthly evening meeting in 20121 will be on 18 February at Southport Golf Club. The topic will be on a

A message from the

GCMA President

matter close to many doctor's hearts – when and how can overseas travel begin?

We plan to have our AGM and dinner speaker meeting in March next year. Until then our executive team will continue to serve the association and its members. I would like to thank our management committee of Dr Katrina Mclean, Dr Maria Coliat, Dr John Kearney, Dr Geoff Adsett, Prof Gordon Wright and Dr Daisy Swindon for their contributions this year. Dr Stephen Weinstein provided wise counsel to the president. Serena Mills has provided valuable assistance as our administrative officer. Please encourage your medical colleagues to join the GCMA. It is very easy – go to the GCMA website membership form section at www.gcma.org.au/becoming-a-member.

As we come up toward Christmas and other religious celebrations, as well as the holiday and festive season, let me wish all our GCMA members and their families and friends a Merry Christmas and Happy New Year!

Yours sincerely,

Prof Philip Morris AM

President GCMA

Dr Greg Seeley

has been practicing Clinical Haematology at the Gold Coast/Tweed Heads for more than 24 years.

His particular areas of interest are:

- Leukaemia
- Lymphoma
- Myeloma
- Venous Thrombosis
- Pregnancy Associated Haematology

He is the Senior Visiting Medical Officer - Haematologist at the Gold Coast University Hospital thereby providing clinical inpatient/ outpatient treatment at both public and private hospitals.

Greg has a dedicated history of providing an efficient, comprehensive and patient focused Clinical Haematology service for Gold Coast and Tweed/Northern Rivers patients & their families.

Please contact Greg by either phone on 0419 667943 or via Medical Objects for any haematology advice.

DR GREG SEELEY

MBBS Hons. (1st Class) (QLD), FRACP, FRCPA

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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**

Contents

The official publication of the Gold Coast Medical Association

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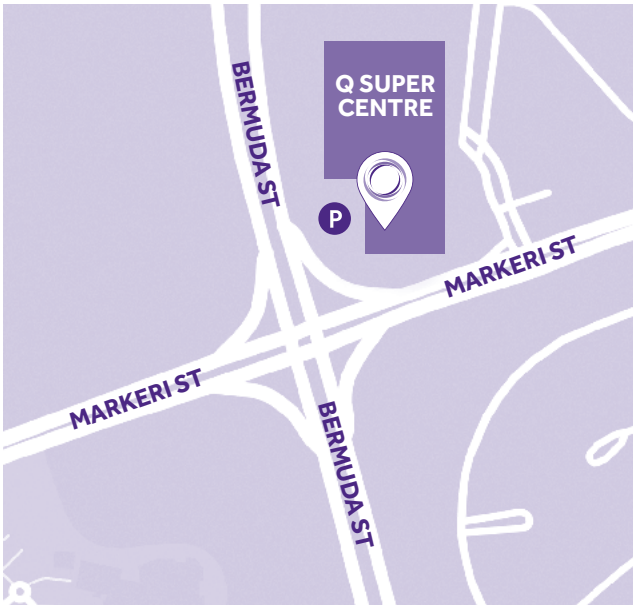

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Dr Robert Bourke **Retinal & Cataract Surgeon** Macula, Vitreous, Retina **& General Ophthalmology**

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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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.

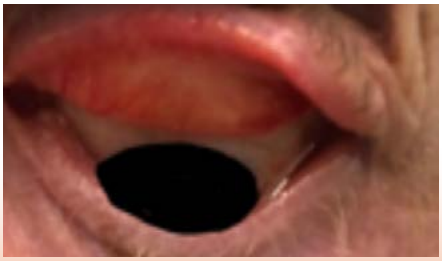
Mechanically, if the eyelids are loose on the horizontal vector then the natural blink tone of the lid is altered and this causes roughness or irritation to the eye surface. I liken it to a "raggedy wind-screen wiper on the car windscreen".

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!

ACL Reconstruction in 2020

No other letters strike fear into a sportsman following a knee injury like 'ACL', but an innovative technique by a Gold Coast Private lower limb surgeon is helping change that. Dr Price Gallie offers an "all-inside" arthroscopic ACL reconstruction using a shorter graft with a wider diameter that allows an accelerated recovery and may reduce the risk of re-rupture.

Dr Price Gallie
M.B., B.S., F.R.A.C.S. (Ortho.), C.I.M.E., G.E.P.I.
(07) 5591 3454

Dr Gallie also uses a variety of grafts including the patella tendon, quadriceps tendon and allograft (donor tendon), alongside the traditionally-used hamstring – matching the graft to the patient, rather than the other way around.

He said with advanced surgical techniques and training programs to help prevent ACL tears, the injury need-not be feared like it once was.

"Historically, rupture of the anterior cruciate ligament (ACL) was a devastating, career-ending injury for athletes and sportsmen with poor diagnosis, limited surgical options and a painful and lengthy recovery process," said Dr Gallie.

"Preventative measures of developing appropriate muscle strength and encouraging safe movement patterns means we can significantly reduce the number of ligament tears – which has been particularly relevant in the vulnerable teenage group.

"We have also seen a significant improvement in the detection of ACL tears which has come about through better knowledge and education, as well as easy access to MRI scans in the setting of acute knee injuries."

Dr Gallie said while preventative programs could lessen the severity of the injury, surgical technique played the most important role in the success or failure of ACL reconstructive surgery.

"With ACL reconstruction, we aim to restore normal movement and function, which is why I pioneered the introduction of the 'all-inside' technique using the TLS® system," he said.

"The system facilitates precise placement of the graft, and with robust fixation, it also allows us to implant a thicker, stronger, and more rigid graft."

Traditional ACL reconstructions use two hamstring tendons; while the short graft TLS® technique uses only one hamstring and wraps it four times to create a shorter, larger diameter graft.

It is then fixed in place inside the bone with a screw-tape interface which is up to three-times stronger than traditional fixation methods.

"The larger graft diameter has been shown in studies to reduce the chance of re-rupturing the graft in the future," said Dr Gallie.

"The robust fixation also allows us to have an accelerated early rehabilitation recovery, so patients can now walk independently within hours of the surgery, avoiding splints and crutches."

More recently Dr Gallie has focussed on other graft choices and is currently studying the use of the peroneus longus tendon with very promising outcomes.

"We need to treat each patient on an individual basis rather than doing the same generic operation for everyone," he said.

"Our goal is not only to return to previous level of sporting activity and performance, but also prevent reinjury in the longer term."

For more information, please contact:

Dr Price Gallie
Coast Orthopaedics
Pacific Private Clinic: 123 Nerang Street, Southport, QLD 4215
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Relocation assistance to the Gold Coast will be considered for suitable applicants.

For a confidential discussion contact Kenny Craig, Chief Executive Officer, Robina Private Hospital on 07 3254 9100 or email kenny.craig@healthecare.com.au

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Eating disorders specialist

Robina Private's 10-bed eating disorders unit has a well-deserved reputation for excellence. Our specialist multi-disciplinary team of practitioners deliver contemporary and evidence-based treatment options for people suffering from a range of eating disorders.

Two eight-week outpatient day programs offer an intensive program for Anorexia Nervosa and Bulimia Nervosa; and for Binge Eating Disorder.

Robina Private's eating disorders service was established by psychiatrist and director of the service, Dr Vinay Garbharran, and psychologist and clinical lead of the day programs, Dr Kim Hurst, who both have their private practices at the hospital.

We are currently the only private hospital in Queensland offering such a comprehensive eating disorders program.

Acute adult mental health

With 80 dedicated acute mental health beds, Robina Private Hospital provides expert care to manage and treat a wide range of mental health disorders.

We offer a holistic approach with treatment provided in a safe, supportive environment for inpatients, day patients, outpatients and new hospital-in-the-home services. Our specialist services include:

- A 10-bed eating disorders unit providing the highest standard of treatment by a specialist multi-disciplinary team of practitioners; and
- A 10-bed older persons specialised care unit delivering specialist care by psycho-geriatricians and a specialist multi-disciplinary team of practitioners for patients experiencing mental health problems co-morbid to their neurocognitive disorder.

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‘Business as usual’ at Currumbin Clinic these holidays, with **private mental health support for your patients**

The holiday season is often a time for celebration, socialisation and relaxation.

But for others, the added pressure of family gatherings; social commitments; over spending, or alcohol in excess can be troubling. These holidays, many Gold Coasters will struggle with loneliness, sadness, anxiety or depression.

To help your patients manage during the Christmas and New Year period, Currumbin Clinic is open for ‘business as usual’ with private mental health beds, day programs and outpatient appointments available to help your patients throughout the festive season, and to continue their recovery into 2021.

Addictive disorders

Currumbin Clinic provides specialised treatment for addiction and mental health concerns that often go hand-in-hand, and adopts an abstinence-based approach to treatment. Its inpatient services for the treatment of alcohol and addiction include complete detoxification, whilst ensuring any side effects and risks associated with withdrawal are treated within a controlled and supervised environment.

Through group participation, patients learn about relapse prevention and lifestyle management strategies, and the skills needed to understand and manage their dependency. Treatment extends beyond drug and alcohol addiction, including medication, opioids and behavioural addiction.

Acute adult admissions

Treatment and support is available for patients presenting with mental health disorders and the exacerbation of pre-existing disorders including depression, anxiety, bipolar disorder, PTSD and borderline personality disorder. Inpatient treatment, day programs and outpatient appointments are available, to minimise relapse during the holidays.

If your patients are in need of mental health support these holidays, call Currumbin Clinic’s admissions and assessment team on 1800 119 118.

To find out more about Currumbin Clinic’s extended range of mental health day programs, call 07 5525 9682.

NEW YEAR, **NEW VIEW**

Currumbin Clinic is committed to helping Gold Coasters with the skills and strategies to lessen relapse and continue their recovery journey into 2021 and beyond.

- **Safe trauma recovery** – a 12 week program for people who have experienced trauma or are living with PTSD; to gain a deeper understanding and find skills and strategies to cope better in life
- **Building strength and resilience** – an 8 week program for depression, anxiety, addiction and adjustment issues; learning skills to ‘bounce back’ and meet the demands of day-to-day living.

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Is Cannabis a Treatment for Glaucoma?

Medicinal cannabis is often presented as an alternative treatment for glaucoma. Although cannabis lowers intraocular pressure, its role as a viable glaucoma therapy is limited by a short duration of action, psychotropic effects, and possible tachyphylaxis. This article summarises the evidence regarding cannabis and glaucoma.

Dr Nick Andrew
MBBS, FRANZCO
admin@eyeandlasercentre.com.au | (07) 5555 0800 | www.eyeandlasercentre.com.au

Cannabis is a genus of plant that is best known for producing a family of molecules known as "cannabinoids". Of these, tetrahydrocannabinol ("THC") is the main psychoactive agent. Other commonly known cannabinoids include CBD and CBN. The cannabinoid profile varies according to the species of cannabis plant, the way it is grown, and which part of the plant is harvested.

In 1971 it was discovered that smoking cannabis can lower intraocular pressure. Eleven healthy subjects each smoked 2 grams of cannabis and were found to have a change in intraocular pressure ranging from +4% to -45%. Subsequent studies demonstrate that approximately 65% of glaucomatous eyes will experience a 30% pressure reduction after cannabis inhalation. This is comparable to some existing glaucoma medications. The pressure-lowering effect lasts 3 to 4 hours and is dose-dependent.

THC is the main cannabinoid that lowers intraocular pressure. It binds to cannabinoid receptors on the eye to reduce aqueous production and increase aqueous outflow. THC is also claimed to have a neuroprotectant effect on the optic nerve, however evidence for this role is weak.

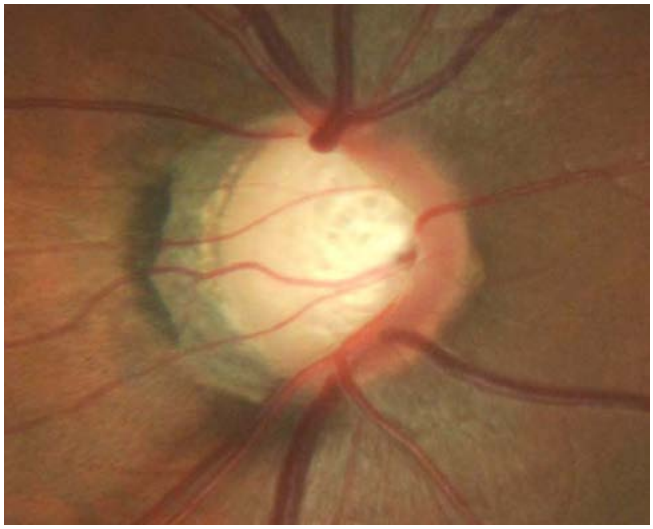
It has been shown that CBD partially blocks the pressure-lowering effect of THC. This is important, as cannabis plants contain a mixture of cannabinoids including both THC and CBD.

There are numerous problems with using cannabis to treat glaucoma. Firstly, the pressure-lowering effect is brief (3 to 4 hours), which necessitates frequent dosing. This is impractical for a chronic disease that requires continuous, lifelong control. It is estimated that 24hr IOP control would require 8 to 10 marijuana cigarettes. This dose would have significant psychoactive and cardio-pulmonary effects and would be more expensive than conventional glaucoma treatments.

Tachyphylaxis is another limiting factor. One study treated 9 end-stage glaucoma patients with inhaled TCH capsules ever 4 hours. All had a reduction in IOP but 7 of 9 patients lost the beneficial effect due to tolerance. All patients elected to discontinue treatment by 1-9 months due to loss of benefit or systemic side effects.

Systemic side effects of cannabis could be reduced by administering cannabinoids as an eye drop or manufacturing synthetic cannabinoids without psychoactive properties. Both possibilities are being pursued. A synthetic analogue of THC known as HU211 has minimal psychoactive effects but still achieves IOP-lowering.

The cannabinoids hold promise as a relatively potent glaucoma pharmacotherapy. Since they act via a different family of receptors, they could work synergistically with existing treatments. However, inhaling or ingesting cannabis as a glaucoma treatment makes little sense due to systemic side effects, short duration of action, tachyphylaxis, and expense. Future studies need to focus on individual chemicals rather than non-standardised plant material. In my opinion, if cannabinoids have a future role in glaucoma it will be a synthetic analogue of THC delivered topically to the eye.



Glaucoma is a intraocular pressure-dependent optic neuropathy characterised by disc "cupping"

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Iron – Its Importance in Early Brain Development & Function

Iron is an essential component for almost all biological systems and in humans is required for a multitude of biological processes, including energy production, oxygen transport and utilization, cellular proliferation and pathogen destruction [1].

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The human body has a complex regulatory system than controls the rate of iron absorption, the maintenance of a readily available supply and recycling of iron from cells that are at the end of their lifecycle [1]. Iron requirements change dramatically during cell growth and maturation [1].

In food, the two major forms of iron are heme iron in meat products and non- heme iron in both plants and animal food sources [1]. Heme iron is well absorbed, where the absorption of non –heme sources is influenced by the iron status of the individual and the composition of the meal. Ascorbic acid and along with other organic acids and animal tissue, are the most effective enhancer of non-heme iron absorption with phytates and polyphenols as well as some plant and milk proteins being the most noted inhibitors [1].

Deficiencies in iron, iodine and vitamin A are the most common micronutrient deficiencies in infants, women and children and often occur concurrently [1]. Vitamin A deficiency results in impaired erythropoiesis, poor red blood cell differentiation, impaired incorporation of iron into haemoglobin, increased breakdown of malformed red blood cell and impaired mobilization of iron from reticuloendothelial macrophages and liver iron stores [1]. In animal studies, where the dietary is iron sufficient and vitamin A is deficient, anaemia can be corrected through vitamin A supplementation [1].

In animal studies, iron deficiency, with or without anaemia impairs thyroid metabolism, suggestive that iron deficiency can lead to alterations in the thyroid hormone feedback system. This reduces deiodinase activity and lowers the transformation of thyroxine to triiodothyronine in the peripheral tissue, reducing hormone synthesis [1].

The absorption of iron, in the absence of infection or inflammation, is stimulated when iron stores are low or erythropoiesis is increased and is increased in response to a hormone, erythroferrone, by suppressing hepcidin [1].

In the early stages of pregnancy, iron is required to maintain growth and differentiation of the foetus, where deficiency can result in significant changes and a potential increase for malformation [1]. During this time the foetus is entirely reliant on maternal supplies to its iron requirements, with prioritization to the foetus at the expense of the mother [1].

There is preclinical evidence that iron deficiency effects brain electro-physiology, structure, metabolism, neurotransmitter concentration, myelination and gene expression [1].

Iron is essential for normal brain development and function, playing a key role in the brain of energy metabolism, neuronal and oligodendroglial cell migration, myelination, monamineregic and glutamatergic neurotransmitters metabolism and the regulation of genes related to myelin, synaptic plasticity and growth factors [1]. Disruption of these processes by the presence of iron deficiency leads to predictable and consistent structural, electrophysiological and behavioural abnormalities both during the period of iron deficiency and long after iron repletion [1].

There are three periods of paediatric development that are at risk for iron deficiency, including foetus/newborn, children between the age of 6 months to 2.5 years and female adolescents, with the most vulnerable to iron deficiency being the foetus/newborn and from 6 months to 2.5 years [1].

In humans, iron is prioritised to the red blood cells over other organs, including the brain, during foetal and early post natal life.

Iron deficiency in these instances results in neurodevelopmental alterations that persist despite iron repletion [1].

The multiple centres of the brain have different developmental trajectories, where the timing of the nutritional insult will influence the impact to different regions of the brain or nutrient dependent processes [1].

In humans, the monoamine neurotransmitter system begins its development in mid gestation and continues to have a rapid development until 3 years of age. Iron's most direct impact is on the synthesis of these neurotransmitters, through the alteration of the iron containing enzymes [1]. A deficiency during gestational and lactational periods acutely alters aspects of dopamine and serotonin metabolism during the iron deficiency and in the long term after iron repletion [1].

Brain energy status is also affected by iron deficiency via reduced cyctochrome C concentrations and reduced cyctochrome C oxidase activity, which are markers of neuronal activity [1]. Iron deficiency effects neuronal energy metabolic balance, resulting in abnormal dendritic arborisation, synapse formation and expression of synaptic plasticity and growth factor genes [1]. Abnormal dendritic arbors have reduced electro-physiologic function and in animals they display altered learning and memory behaviour [1].

Myelination in humans begins in the late foetal period and extends at a rapid pace through the first 2-3 years [1]. In rats, iron deficiency anaemia results in hypomyelination with significant alterations in the fatty acid profile of the myelin and reductions in myelin basic protein expression [1].

Infants with low cord ferritin were almost 5 fold more likely to score

poorly on fine motor skills and almost 3-fold more likely to have poorer tractability, poorer language ability, and score worse on every subtest than children with normal ferritin concentration at age 5 years [1].

In humans, deficits map directly onto the abnormal brain processes elucidated from animal models [1]. Notably, reductions in intelligence, motor abnormalities, including activity levels and coordination, disrupted sleep patterns, slower speed of processing, altered affect and social interaction and reduced learning and memory capacity, with the long term persistence of some of these abnormalities continuing into adulthood [1].

There are a number of gestational conditions that lead to a disruption of iron balance and can lead to foetal iron brain deficiency, including severe maternal iron deficiency, placental insufficiency (usually due to maternal hypertension), maternal diabetes mellitus and maternal smoking [1]. Studies have shown that iron brain concentrations are reduced by 40% in new born iron deficient infants of diabetic mothers and by 33% in newborn intrauterine growth restricted infants [1].

There are a number of systematic reviews on the effect of post-natal iron deficiency on early childhood development, which revealed poorer functioning on general tests of cognition, motor and social and emotional capacity in children with iron deficiency anaemia [1].

Researchers have also identified that the developing brain can suffer the consequence of iron deficiency, in the absence of anaemia, and brain iron deficiency independent of anaemia is responsible for long term neurological deficits [1].

Achieving optimal iron status, prior to conception, through the consumption of an adequate dietary intake / supplementation, is paramount to support the optimal growth and development of the foetus, new born, infant and toddler.

In pregnancy, the measurement of serum ferritin level has the highest sensitivity and specificity for detecting iron deficiency [2]. Ferritin levels of <20ng/ml are diagnostic of iron deficiency regardless of the haemoglobin concentration [2]. Ferritin levels between 20 – 50 ng/mL are regarded in the grey area [2]. However, the diagnosis of anaemia in pregnancy is based on the differentiation between the relative or physiologic anaemia of pregnancy , with the pathogenesis being multifactorial [2].

The above highlights a critical period in which iron is necessary for normal brain development [1]. It highlights the importance of appropriate screening to facilitate early detection of iron deficiency with or without anaemia. Implementation of treatment should be prompt and based on the individual presentation and tolerance of oral supplements. Often women taking oral supplements report gastrointestinal disorders [2]. If oral supplementation is not tolerated or is not effective in correcting the deficiency then intravenous treatment with Ferric carboxymaltose (FCM) should be utilised. Prompt and appropriate supplementation is also recommended for the infant / toddler, initially trialling oral supplementation, and if not tolerated or effective intravenous measure should be introduced.

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Foot Drop

"Foot drop" is a neurological symptom presenting as a unilateral "floppy foot" resulting in an abnormal gait. Unless associated with an acute injury, most patients cannot accurately describe the onset of a foot drop, often attributing their symptoms to a fall. However, this can mislead Practitioners as the fall is usually the result of the foot drop, not the cause.

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Clinical diagnosis of foot drop is made through history and examination of sensory and motor deficits. Neurophysiological studies are then essential to confirm and quantify the extent of pathology.

There are several differential diagnoses to consider in a case of foot drop, the most common being peroneal mononeuropathy. This neuropathy can present with weakness of toes, ankle dorsiflexion, foot inversion, plantar flexion and knee flexion. Sensory impairment can vary but is expected in the dorsal foot and anterolateral leg. A Tinel's sign is not uncommon in the fibular head region. Except in obvious cases like knee trauma, the patient generally denies knee injury. However, on further questioning, less obvious knee traumas can be established. These include localised pressure from leg-crossing and frequent kneeling or squatting. These are common amongst painters, tilers and other tradespeople commonly in such postures. The patient rarely describes knee or leg pain.

The next most common differential diagnosis is L5 nerve root dysfunction. Such dysfunction often initially differs from a peroneal mononeuropathy in the presence of lower-back or radicular leg pain, most typically extending to the great toe. Sensory impairment may also be present on the dorsal and ventral foot. Motor dysfunction may include weakness of toes extension; ankle dorsiflexion, eversion and inversion and knee flexion. It is the weakness of foot inversion that is often the critical feature in differentiating a peroneal neuropathy from L5 radiculopathy. This is due to the innervation of the tibialis posterior muscle, which is supplied peripherally by the tibial nerve.

A less common differential diagnosis is sciatic mononeuropathy. Such mononeuropathy commonly results in diffuse weakness of dorsiflexion, inversion, eversion and plantar flexion, which in severe cases results in a "flail" foot (complete loss of mobility); L4 nerve root dysfunction, which may result in minor weakness of dorsiflexion but is associated with knee extension weakness and impairment of knee-deep tendon reflex; or severe generalised peripheral neuropathy, or a variant of such, which generally causes bilateral symptoms. Mechanical ankle pathologies can also result in impairment of dorsiflexion via a reduced range of joint movement, though are commonly identified as passive ankle movements are abnormal in this case.

As with all neurological disorders, the location of the pathology is essential to establishing a precise diagnosis. With foot drop, thorough clinical examination, history taking, and knowledge of peripheral neuroanatomy make for accurate differential diagnoses. Neurophysiological studies are then essential to confirm the location and aetiology of the pathology.

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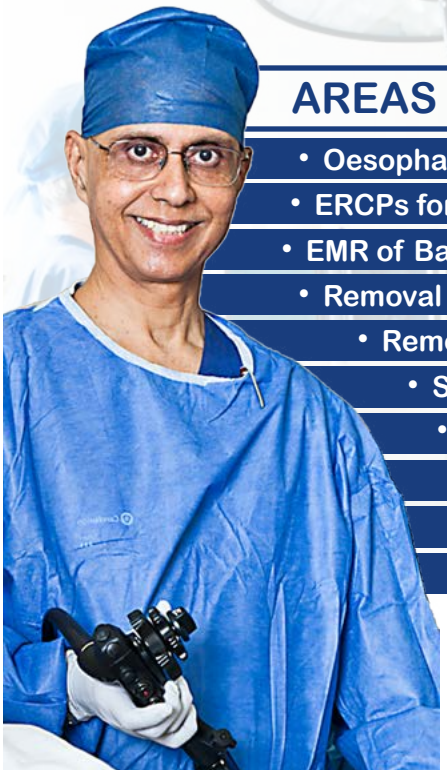

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- It is a very short treatment course: 5 sessions over 2 weeks, compared to 30+ with conventional treatment[1]
- The cancer control rates of SBRT are equivalent to those of brachytherapy, conventional external beam radiotherapy, or surgery[2]
- Reduced radiation dose to surrounding healthy tissues resulting in less side-effects[1,3]

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Stereotactic Body Radiotherapy for Prostate Cancer – Harnessing Innovation, Delivering Positive Patient Outcomes

An estimated 16,741 Australian men will be newly-diagnosed with prostate cancer this year [2].

Dr Debra Furniss
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Most will be diagnosed with clinically localised prostate cancer and low- or intermediate-risk disease, as defined by the National Comprehensive Cancer Network (NCCN) [3,4]. Fortunately, there are multiple management options available from active surveillance and radical prostatectomy to brachytherapy and external beam radiotherapy (EBRT). Indeed, EBRT continues to be a standard of care for localised prostate cancer but technological advances over time have changed the way it is delivered [5]. Today, thanks to high-tech precision innovation, patients have the option of receiving highly targeted stereotactic body radiotherapy (SBRT) to treat their prostate cancer that minimises the risk of damaging surrounding healthy tissues and organs but offers a shorter treatment course than conventional RT approaches.

How does SBRT compare to conventional RT in prostate cancer?

SBRT differs from conventional RT as it involves the delivery of higher doses of radiation to the cancer over a fewer number of treatments or fractions. How this is possible requires an understanding of the proliferative (or cell death) capacity of cancer cells, mathematically determined by what is called the α:β ratio'. This ratio is often used to describe the response of cells to radiation exposure, noting that different tissues exhibit different sensitivities to radiation therapy. Prostate cancer cells are thought to have a low α:β ratio meaning that they require relatively higher doses of radiation for complete cell death compared to normal surrounding tissues [6,7].

What does SBRT mean for the patient?

Combined with improvements in onboard and online imaging, SBRT offers a shorter, targeted course of radiation therapy that is non-invasive, has potential for smaller safety margins and greater patient convenience as a result of the reduced number of fractions than conventional radiation approaches: commonly five high-dose treatments over two weeks vs. 20–40 treatments over 4–8 weeks for conventional treatment [1,6-13].

There are a number of studies that provide detailed outcomes for patients with localised prostate cancer treated with SBRT. Recently, two phase III trials: HYPO-RT-PC and PACE-B compared SBRT approaches with conventional RT in patients with localised prostate cancer [14,15]. In HYPO-RT-PC, 1200 Swedish men were randomised to receive RT either in seven fractions, 3 days per week for 2.5 weeks or conventional fractionated radiotherapy in 39 fractions, 5 days per week for 8 weeks. This study showed that efficacy and long-term side effects were equivalent with both approaches, although there was higher patient-reported toxicity [14]. PACE-B that provided a direct comparison of modern, longer course radiation (20 to 39 treatments) versus modern SBRT (five fractions over 1–2 weeks) in men in the UK, found no differences in short term genitourinary or gastrointestinal side effects [15].

Indeed, in the largest pooled analysis to date that included low, intermediate, and high-risk patients (n=6,116), the Overall, 5- and 7-year biochemical relapse-free survival were 95.3% and 93.7%, respectively. Estimated late grade ≥3 genitourinary and gastrointestinal toxicity rates were 2.0% and 1.1%, respectively. By two years post-SBRT, urinary and bowel scores had returned to baseline [16].

"Prostate SBRT marks another milestone in the treatment of men with localised prostate cancer. Modern precision technology allows us to deliver high dose of radiotherapy to the cancer and low dose to the other organs, over a shorter period of time (2 weeks) compared to 4 or 8 weeks of conventional radiotherapy. In select patients, prostate SBRT is as effective and tolerable as conventional radiotherapy with a more convenient schedule and less disruption to everyday life."

— Sagar Ramani, Radiation Oncologist, QLD

"For carefully selected patients with low to intermediate risk, localised prostate cancer, studies with long term follow up have proven the safety and effectiveness of this shortened treatment program, now available at GenesisCare Gold Coast and Brisbane."

— James MacKean, Radiation Oncologist, QLD.

GenesisCare have been treating patients with stereotactic radiation therapy in Brisbane for over 20 years.

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QIAGEN Sponsor GCMA Meeting

QIAGEN, the manufacturer of the QuantiFERON-TB Gold Plus test, was the proud of sponsor the Gold Coast Medical Association dinner meeting on the 17th September 2020.

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The speakers for the evening were Dr. Mark Stickley, Senior Medical Officer from the Metro South Tuberculosis Control Centre of Princess Alexandra Hospital and Dr. Ruth Hopgood, GP from the Hinterland Medical Centre. The speakers addressed the topic of tuberculosis in primary care through an informative and educational session that was followed by an open discussion with members of the association.

Below are some highlights from the evening and a summary of the important information that was presented and discussed. More information can be found in the referenced links below.

The National Tuberculosis Advisory Committee (NTAC) released their position statement for the management of LTBI [1], recommending testing of the following groups determined to have a high probability of infection:

• Migrants from countries with a high incidence of TB, including both permanent residents and temporary residents, e.g. international students:
  a) aged 35 or under
  b) aged over 35 with at least one risk factor for reactivation
• Migrants from any country with a history of TB contact within the last two years
• Healthcare workers from high TB incidence settings
• Close (household) contacts of pulmonary TB
• Those identified by contact tracing within Australia

Amongst the identified risk factors of progression to active disease are:

• Evidence of recent infection
• Human Immunodeficiency Virus (HIV) infection
• Solid organ transplant recipient
• Treatment with anti-tumor necrosis factor inhibitors
• Other immunosuppressive therapy, including long-term oral corticosteroids (prednisolone ≥ 15mg/day or equivalent)
• Other co-morbidities, including silicosis, renal failure and poorly controlled diabetes mellitus

In 2019 there were 1512 [2] active TB notifications in Australia, in QLD 194 [2].

In 2013, there were 1322 [3] notifications of active TB in Australia. 88% [3] of cases were in the overseas-born population, with this proportion rising over the last decade.

Primary care practitioners play an important role in the identification of asymptomatic patients with Latent TB Infection (LTBI) in the community who are at increased risk of progression to Active TB.

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What Have We Learnt From the WFH Experiment?

Architecture affects our daily lives in many ways that we take for granted. It defines the environments in which we work rest and play. So, when a life changing event like COVID causes dramatic disruption to our lifestyles, it will ultimately require an architectural response.

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What have we learnt from the WFH experiment?

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So, when a life changing event like COVID causes dramatic disruption to our lifestyles, it will ultimately require an architectural response.

The necessity for a large proportion of the workforce to abandon their offices and transition rapidly to working from home (WFH) has resulted in many challenges, and surprising results.

Many are now embracing it as a permanent ideological shift that will change the structure of our urban environment, and the future design of the houses in which we live.

We've touched on the design implications of this in our recent article in the September / October issue of this magazine. With the knowledge garnered after experiencing WFH in various forms for much of this year, we can now analyse some of the pros and cons of this lifestyle shift.

The results will ultimately determine whether the WFH model becomes a permanent change and whether consequently we will need to adapt our future home designs to suit.

Lifestyle

The flexibility to work when and where we want without the restriction of set office hours is a definite benefit of the WFH change that many of us have enjoyed.

The time previously needed for personal grooming before presenting ourselves to weekday public exposure has decreased considerably, especially for those used to wearing makeup or working on their coiffure daily.

Combined with the time saving gained from no longer having to commute to and from an office, this can add hours of extra time to every working day, allowing more time for leisure, exercise or other personal pursuits.

For most of us, the extra time spent in the home with family is also a bonus. For others, this may not be perceived as a benefit at all!

The choice of work attire in a WFH environment becomes much simpler when dress codes are not mandatory and dressing comfortably in casual attire every day is possible. Consequently, the need to wash and iron work clothes diminishes considerably, adding more credits to the leisure time bank.

Financial

Establishing a dedicated office(s) in homes that do not already incorporate suitable workspace may incur unexpected capital expenditure, and in some cases could trigger the need to purchase or design and build a new home.

We are also witnessing a trend of families migrating out of the dense city environments to regional areas. This is a direct consequence of the WFH experience as employers and their staff realise that working remotely from home is actually a viable option for many businesses.

This is resulting in a dramatic slowing of the capital growth of housing in the major cities, and an increase in housing values in regional areas. Often this results in a cash positive outcome reducing mortgage stress and improving quality of life.

WFH also reduces day to day work related expenses associated with transport costs such as fuel, fares, and carparking. The number of household vehicles could also potentially be reduced as cars now sit idle in the home garage throughout most of the week.

Further work-related expenses associated with purchasing takeaway coffee, snacks or lunch are no longer incurred, and the cost of maintaining a wardrobe of specific work attire is redundant.

Depending on your individual circumstance, there are also potential tax advantages to WFH.

Without the daily commute to an office, the percentage of business use of your vehicle is likely to increase with the

potential for higher tax deductions. You may also be able to claim a percentage of your house running costs as a tax-deductible business expense.

Health

The pace of life in the 21st Century has steadily increased over the years, with the work / life balance often out of kilter, resulting in increased stress and associated health issues.

Many of us have found that this enforced pause in our hectic schedules has come as a welcome relief, a time to reflect on what we truly value and consider most important in life.

Whilst working from home should allow for more lifestyle time, the lines between private and business life can easily become blurred when your home is also your office.

When work pressures arise, the temptation to slip straight from bed to desk, or to return to your computer after dinner can result in increased working hours. Weekdays and weekends can also become indistinguishable without the strictures of formal office working hours determining when to start and stop work.
Without the distractions and social interactions of an office environment, it is also easy to lose track of time and spend long periods of time sitting in front of your computer without standing and moving around. This extended sedentary behaviour is a well-known cause of health conditions including high blood pressure, high blood sugar and increased cholesterol levels.

This can be averted by taking regular breaks, assisted by devices such as smart watches that provide you with regular reminders to stand up and move around, or take time out to focus on some deep breathing.

It is also vital that the home office provides an ergonomic work environment.

Most commercial workspaces incorporate desks, chairs and computer monitor stands that promote good posture and a

comfortable working environment. The home dining table or TV lounge are not designed specifically for work use, so will ultimately result in muscular ailments or cause other health issues if used over extended periods of time.

Diet can also be impacted positively or negatively in a WFH environment.

Having your own kitchen readily at hand allows you to prepare your own meals. For those with a disciplined diet, this can be a definite benefit. For others, the temptation to indulge in leftovers from last night's roast dinner with a glass of wine at lunch may prove too great a temptation to resist!

The lack of social interaction with work colleagues in an office environment can also be detrimental mentally.

Whilst introverts generally thrive in a WFH environment and enjoy reduced contact with the office loudmouth or psychopathic boss, extroverts need daily contact with others to ensure their mental wellbeing. We are ultimately social beings, and the enforced isolation and need to WFH has seen a definite spike in reported cases of depression and suicide.

Conversely, the driver for this entire WFH scenario relates to the risk of catching COVID, a highly contagious disease from others in the workplace and public domain.

As a result of this enforced isolation from our work colleagues, the prevalence of flu cases over the winter period has dropped dramatically, as have other community spread conditions like the common cold.

Where to from here?

One certainty we can all accept is that life will not be returning to any kind of normal unless we find a successful vaccine to combat this disease.

Even if we do, the WFH genie has already escaped the bottle and is unlikely to be recaptured. Globally many companies are debating the merits of both work options in a post COVID world, and it is likely that a third hybrid option will develop in response involving some days of working in an office, and the balance of the week to WFH.

As Architects we will be watching closely how this plays out, and be ready to respond with innovative design solutions that enhance our ability to continue to work rest and play in fit for purpose buildings, whatever that might entail.

Happy Holidays

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Wishing you and your families a safe and healthy holiday season. With best wishes from the team at Grace Private

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More services for women's health at Grace Private

With growing demand for women's healthcare, Grace Private has expanded its services to include Gynaecological Oncology and Endocrinology, welcoming doctors Helen Green and Jane Tellam (respectively) to its team of specialists.

Designed by women for women, Grace Private is a dedicated specialist practice offering integrated women's healthcare in one location at the Gold Coast Private Hospital, Southport. The team offers a full range of obstetrics, gynaecology, fertility and tertiary ultrasound services supported by physiotherapy, psychology and dietetics.

"We believe every woman deserves to live her best life," said Grace Private Director and Specialist Dr Tina Fleming.

"Our multidisciplinary approach involving our doctors, midwives, nurses and allied health team, enables us to focus on the whole woman, ensuring we deliver the best possible outcomes for our patients.

"We are delighted to welcome Dr Green and Dr Tellam to Grace, further rounding out our team as a full-service specialist practice for women's health."

Meet Grace Private's new specialists

Dr Helen Green

Gynaecological Oncologist
FRANZCOG, CGO

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 Jane Tellam

Obstetric Physician and Endocrinologist
MBBS FRACP

Dr Tellam is passionate about managing women with medical conditions in pregnancy. An experienced specialist, she has a particular interest in preconception care, diabetes in pregnancy and adult endocrine conditions. She is a published author in Medical journals and co-authored a chapter in the internationally acclaimed textbook Global Library of Women's Medicine.

Meet Grace Private's allied health team

Karen White

Clinical Psychologist

With 20 years experience, Karen is a clinical psychologist who is passionate about supporting women to live their best lives. Warm and nurturing, Karen has extensive experience working with women in the areas of emotional and general well-being, fertility, trauma, parenting, adjustment, relationship difficulties, sexuality and sexual function.

Rebecca Lackie

APA Titled Continence
& Women's Health Physiotherapist

With almost 20 years experience in women's health physiotherapy, Rebecca's interests include incontinence, pelvic floor dysfunction, pregnancy and post-natal physiotherapy. She was awarded the APA Title of Continence and Women's Health Physiotherapist by the Australian Physiotherapy Association in 2020.

Debra Miller

Women's Health Physiotherapist

Debra graduated from Griffith University in 2007 with a Masters Degree in Physiotherapy and a Bachelor of Exercise Science. She has a special interest in women's health and has completed extra studies in the areas of chronic pelvic pain, management of pelvic organ prolapse, incontinence and perinatal physiotherapy.

Sharnie Dwyer

Dietician

With her holistic approach, Sharnie is one of the leading Gold Coast dietitians with a special interest in gastrointestinal and women's health. Focussing on diet and lifestyle, Sharnie is a vital member of the Grace team for treating endometriosis, Polycystic Ovarian Syndrome (PCOS), fertility, gastrointestinal issues, diabetes during pregnancy, prenatal and post-natal nutrition, weight management and hormone balancing.

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