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THE INDEPENDENT VOICE OF MEDICINE

GCMA

THE GOLD COAST MEDICAL ASSOCIATION INC.

THE OFFICIAL PUBLICATION
OF THE GOLD COAST MEDICAL ASSOCIATION INC.
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Celebrating 40 Years of Dr John Kearney

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- Danii Foundation: Advocacy for Type 1 Diabetes
- Doctors in Training Society (DiTS)
- Swollen Legs – The Often-Difficult Quandary
- COVID-19 Webinar Fact Sheet
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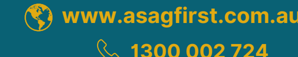

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A Message from the GCMA President

Prof Philip Morris AM, President GCMA
MB BS BSc PhD FAChAM (RACP) FRANZCP FPOA FFP ABPN
info@drphilipmorris.com | 0422 545 753 | www.drphilipmorris.com

Dear GCMA colleagues,

How different a world we are in since my last report to you just two months ago. From a relatively benign environment with the Covid-19 virus well-contained and largely absent within Queensland, we now have unfettered community spread of the Omicron variant, thousands of infected people isolating at home or in home quarantine because they are close contacts, workforce shortages in health and essential services, panic buying in supermarkets, cancelled elective surgery, increasing hospitalisations and ICU admissions, and rising deaths from Covid-19. All seemingly as a result of an injudicious throwing open of the state borders, an underestimation of the infectiousness of the omicron variant, and an overestimation of the power of the vaccines to limit transmission of the virus. The 'horse has now bolted' and we are now playing catch-up to try and limit the effect of the virus on vulnerable individuals and groups (including indigenous communities) and protect the hospital and health system from being overwhelmed.

We all have a role to play – getting fully vaccinated (including the booster shot), maintaining physical distancing, avoiding large groups, wearing masks indoors and outdoors where people are gathered (shops, malls, sporting events, family gatherings etc.), not going to work when unwell, getting tested (either rapid antigen tests or PCR tests) when symptomatic, maintaining personal hygiene practices, and following the isolation and quarantine regulations if testing positive or a close contact of a positive person. Patients can play their part by phone contacting their doctors before appointments and being prepared to answer questions about their Covid-19 status, and if unwell with this infection, obtaining a telehealth consultation if appropriate.

While back in November I hoped 2022 would see the end of the pandemic, I am not so sure now. But I am still optimistic that we will be 'breathing a lot easier' and less constrained by the pandemic by the second half of 2022.

The GCMA was planning a gala dinner in early February at Tiger Island Dreamworld for our members and partners. Because of the Omicron Covid-19 extensive spread of infection we have postponed this event to May. Please keep a look out for notices of this important event. The regular monthly clinical dinner meetings will begin again on Thursday 17 February at the Southport Golf Club. A meeting notice will be emailed soon. We have an exciting monthly program planned for 2022 with informative speakers lined up to educate our members and guests. We plan to hold our GCMA AGM in March. Nominations for executive positions are welcome.

Later in 2022 we plan to start preparations for our next Pacific Island joint conference with a local medical association. Our next collaboration will be with the Samoan Medical Association and the Oceania University of Medicine, based in Apia, Samoa. We are hoping to have a medical conference with these two partners in Samoa in 2023. I hope many GCMA members will offer their services as speakers for this meeting. A 'fact finding' tour of Samoa is being planned for later in 2022 to begin planning for this conference. Any GCMA member who is interested in participating in this preparation visit is welcome to be involved. Please contact A/Prof Stephen Weinstein or me for details.

The GCMA has a new administrative officer, Marnie Masor (gcmasecretariat@gmail.com). Please contact Marnie for GCMA information. We are always looking to expand our membership. I encourage you to invite your doctor colleagues to join the GCMA. It is very easy to do. Just go to the GCMA website (www.gcma.org.au) and click through to the 'Become a Member' page to join. The registration page can take credit card payments. The $150 annual membership is extremely good value. It covers 10 monthly evening meetings where salient updates on clinical and professional matters are presented as well as a two-course meal and complimentary beverage, and the opportunity to interact with colleagues from all professional disciplines.

I look forward to seeing you at our next GCMA meeting.

Yours sincerely,

Prof Philip Morris AM
President GCMA

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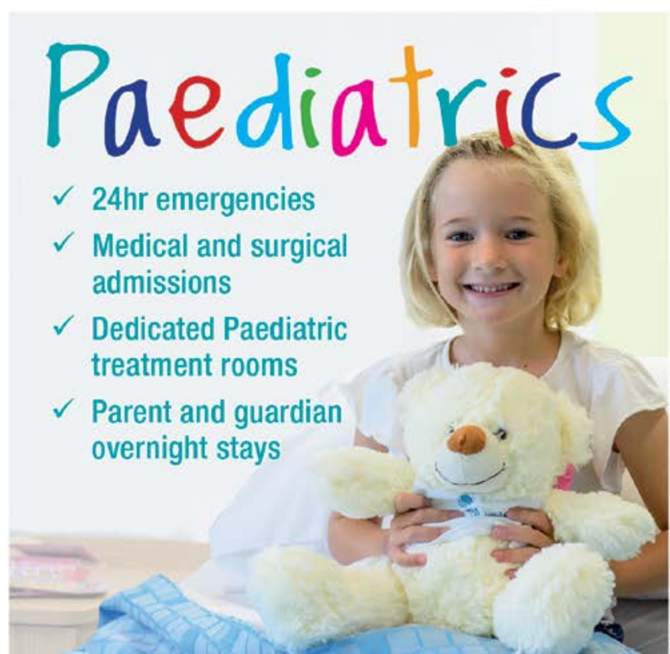

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Emma Daley
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PUBLISHER
Ryriss Services Pty Ltd
admin@themedicallink.com.au

MEDICAL EDITORIAL COMMITTEE
Philip Morris, Geoff Adsett, Stephen Withers, John Kearney, Maria Coliat

GCMA MEMBERS
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GCMA EXECUTIVE COMMITTEE
President Prof Philip Morris 5531 4838
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The Medical Link enriches the Gold Coast medical community by uniting the voice of its doctors.

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Celebrating 40 Years of John Kearney

Barbara Taylor-Anderson RN OAM

Dr John Kearney was a prominent Gold Coast Ophthalmologist, from the early 1980s, until hisvrecent retirement. I will give an overview of his long and successful career, focusing on his tireless and great work as an international volunteer.

I first worked with John, as his scrub nurse, when he came to operate at Pindara Private Hospital in the early 80s. During the following 30 years I worked with John at Pindara Private, Gold Coast University Hospital, Wesley Private Gold Coast, Surgicentre, Pacific Private, and in his private consulting rooms. As well as consulting in his very busy practice, and operating in theatre several times each week, John gave his time, energy and expertise as a volunteer. I was privileged to share in this work.

In 1996 John asked if I would take time off from theatre at Gold Coast Hospital, and go with him to work on the M/V Island Mercy ship for an outreach to PNG. The Mercy Ship was an old, 60-berth cargo vessel, and was part of the YWAM (Youth With A Mission) family of Christian Ministries before becoming a stand-alone organisation in 2003.

Before we sailed, the cargo hold of the ship was modified, and two small rooms were built, one for eye surgery, and one for dental work. We flew to Cairns, then sailed to Alatau, PNG. We were docked, and patients, most of them blind, queued for hours on the wharf in the hot sun. Working conditions were difficult, but we 'got the job done'. Patients were led down the stairs by a crew member, and then had to lay on the floor outside the 'theatre' door. After I crawled around putting drops in the patient's eye, John then knelt down and administered the anaesthetic injection into the eye. This was in the area where all our boxes of surgical supplies were stored, and there was no room for a bed/bunk for the patient.

It was very often a comedy/frustration/juggle to get a blind person, who did not speak English, to lie down on the floor. They could not see our actions, or understand the instruction. The 'theatre' was so small that the operating bed/bench took up all the length of the room, so I had to climb over the bed first, then encourage the patient to get onto the bed and lay down. We did the first ever eye operation on the M/V Island Mercy, and restored the sight of many people.

We worked long hours in the cargo hold, with no air conditioning. There was a curfew in PNG, and we had to be finished by 8pm. Sometimes patients had to stay on the ship overnight because they were not allowed on the streets to get home. John told me that because these people waited for many hours, and often walked for days to get to the ship, that if anything happened to his hands, then I would have to operate. Although I had assisted in thousands of cataract operations, I was not trained to 'use the knife'. To avoid this situation, I cut up all John's food for the next few weeks, and would not let him have a hot drink. On board we were all volunteers, and paid $50/week to be there. We lived on food donations, and so ate lots of bananas!

The M/V Island Mercy Ship sailed to a different place in the Pacific each year. In 1997 we worked in the islands of Vanuatu. John and I flew into Port Vila and joined the ship there. We sailed around, and anchored at several different islands, and then worked our magic, restoring the sight of many people. The ship had to anchor outside the coral reefs that surround the many islands. All the eye testing was done ashore, and each day eye testing equipment, microscopes and generators were taken ashore. Patients for surgery then came by lifeboat to the ship. Lamen Bay was the last remote island that we worked in Vanuatu, and John and I flew out to Port Vila in a small plane that landed on the beach to pick us up. There were pigs and chooks on the flight with us.

In 1998 we flew to Nukualofa in Tonga to join the M/V Island Mercy Ship for a few weeks. The Tongan people are happy, but not healthy, as most are overweight. There is a lot of diabetes, and eye disease. We sailed to several places to work in the Vava'u and Ha'apai Island groups. Each morning after breakfast (toast and peanut butter), we made lunch (peanut butter sandwich), and went ashore in the lifeboat. We then walked 1km to the hospital at Niu'ui, and worked in the hospital operating theatre. The hospital staff lock up the theatres at lunchtime, so we sat outside in the heat and gave the pigs, who were wandering around, our crusts. Local staff all go home for lunch.

The staff gave us a wonderful thank you and farewell feast of baby pig cooked on the spit, and fresh fish. Banana leaves were used for cooking many dishes, but thankfully not a banana in sight! The East Timor Eye Program was commenced in July 2000 in response to a request by WHO, who established eye health services in Timor Leste soon after it gained independence from Indonesia. ETEP was founded by Australian Ophthalmologist Dr Nitin Verma, and Dr John Kearney helped set-up the program with Nitin. RACS administered the program on behalf of the Australian Government.

Initially John and I worked many times in Dili, and later, when regions were set up, John became the team leader for Baucau, which was a 4–5-hour drive from Dili. In early days we carried all our equipment and supplies to do 100 cataract operations. This included microscope, steriliser, disposable sterile pack for 100 operations, water and antiseptics, instruments, lenses, and even cleaning cloths. It was always a stress/challenge to get all this gear on board our flights. Brisbane to Darwin was okay as I always had a Qantas excess baggage waiver for up to 100kg. The flight

from Darwin to Dili was on a small aircraft, and despite all my pleading, lots of our goods did not arrive until the next day.

Work was hard in difficult conditions, and in 2007 the political situation made our trip to Baucau a challenging experience. We were a team of three instead of the usual eight because of the heightened security.

Report in RANZCO NEWS, Overseas Aid

"There was a lot of activity around the place because we were there when Major Alfredo Reinado led the mass walk out from the Dili prison. There were mobs in the street pelting cars with stones, but the biggest problem we faced was that in the last week that we were there, the operating theatres were full of people with bullet wounds which took precedence and limited the ophthalmic work we could do," Dr Kearney says.

When our medical teams had trained local staff in Timor Leste in eye care and surgery, John and I volunteered to go to Micronesia. In December 2009 we flew from Brisbane to Cairns to Guam overnight. Then we flew on Continental Micronesia to Koro for another overnight. At 12:30am the next day we flew to Yap, arriving at 2am. This airline goes to many islands, and stops and starts like a bus route. The service is continuous for 24 hours – on/off. We were working in Yap on the 31st of December, and were called into theatre after hours for an emergency. While partying on New Year's Eve, a 19-year-old lit a wick sitting in a bottle of petrol, and the bottle exploded. We worked for many hours to get glass from one eye. The other eye was blown out.

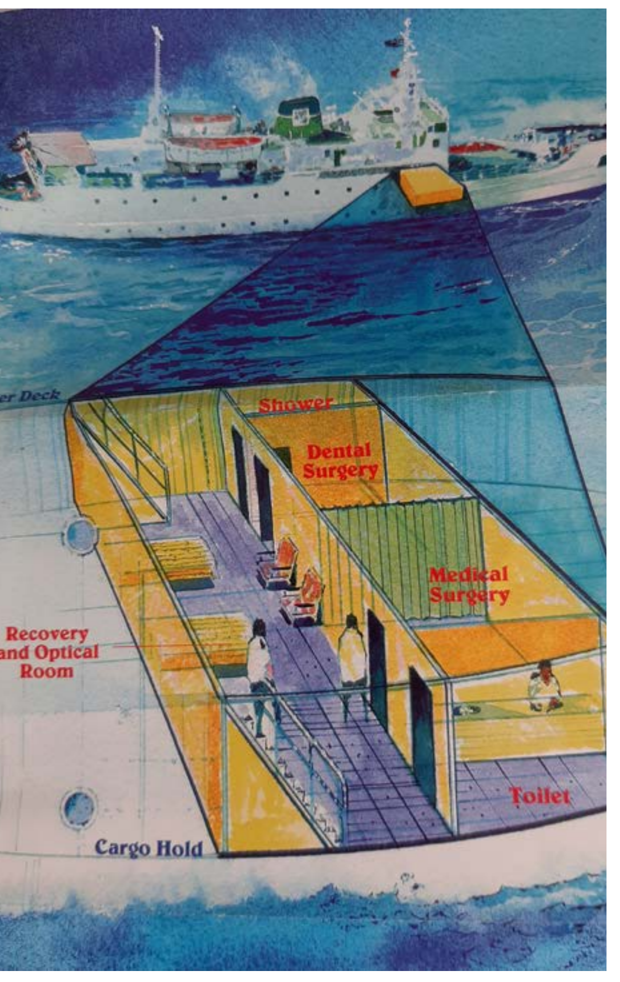
The next Micronesia trip was to work in Pohnpei and Chuuk. Same crazy flights in the middle of the night, and in very heavy monsoon rain. All of our gear waiting out on the tarmac was soaked.

John has worked tirelessly as a volunteer over many years. He is a great teacher. His enthusiasm for helping others less fortunate was an inspiration for me.

The personal reward is special, and you could not buy the feeling with all the money in the world. The gentle, poor but happy patients come to us blind and frightened. Lack of common language is no barrier because gentle guiding, and a soothing voice is all that is needed. On the morning after the operation, when the eye pad is removed, the smile, hug or hand squeeze is the greatest of all rewards. And often the patient would look at me and laugh. Probably because they had never seen a tall blonde white woman before!

John will be missed by many of his colleagues and patients on the Gold Coast.

I hope he will continue teaching, which he loves to do.



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Key messages from webinar 1, 1 December 2021

COVID is coming to Queensland – are you "storm-ready"?

HCQ's webinar series is to help consumers feel empowered and clear on what they can do to prepare themselves and the people they care for in case of a surge in COVID cases.

Guest presenter: Dr Alex Markwell *(pictured),* Senior Staff Specialist at the Royal Brisbane and Women's Hospital Emergency and Trauma Centre and Senior Lecturer with the University of Queensland. She is the Chair of the Qld Clinical Senate and a past president of AMA Queensland.

What's ahead?

Modeling gives an idea of what may happen but cannot accurately predict the future. It also can't give details of what might happen for certain groups of people or communities. It's only a general picture.

In NSW and Victoria, high vaccination rates have kept transmission and hospital admissions lower than expected. The vast majority of their hospitalisations are in unvaccinated people.

In Queensland, our vaccination rates are much higher than when cases began to spread in the southern states.

It is important to realise that COVID-19 will come into Queensland once the border opens.

There are some people in Queensland that are likely to face different challenges and the way these people are supported and protected needs to be tailored to their particular needs for example, First Nations communities, some remote locations and schools, residential and correctional facilities.

What can you do now to prepare for community spread of COVID once the borders open?

Stop the spread

The things we have been doing are still important to stop COVID spreading. Continuing these will be particularly important if you are at higher risk of COVID complications:

- Masks
- Handwashing
- Physical distancing
- Vaccination (see below)
- Isolation
- Quarantine

These measures will help protect you from getting COVID and also "flatten the curve", which will slow the spread and help stop the health system being overwhelmed.

COVID Update

Vaccination

People who are vaccinated are much less likely to become infected with COVID-19 and show fewer symptoms and are likely to have a lower viral load if they are infected with COVID. This means they are less likely to infect others.

People with lower immunity should especially consider vaccination, as well as ensuring the people around them are vaccinated.

Getting your **booster shot** done as soon as you are eligible is important. This can be from 6 months after your last COVID vaccination. Read more about booster shots on the Australian Department of Health website: https://tinyurl.com/VaxBoosterInfo

Cyclone season is here, so we are thinking about how we manage COVID risk plus evacuation. Vaccination will help if people need to shelter together in a small space.

Plan ahead

Think about what you and anyone you care for will need if you test positive for COVID and/or your community needs to go into lockdown. These could include:

- Are there any health screenings or procedures overdue or coming up that you could do now? This could be the dentist, skin check, breast screen, etc
- Medications and scripts – do you need to go to your GP to get another script if yours is nearly finished? Can you ask for a two week back up supply?
- If you currently receive regular care or treatment, talk to your healthcare provider about what care you are likely to get during increased community spread of COVID-19.
- Do you have enough basic groceries for 2 weeks? Can you slowly build a supply of groceries now?
- Have a plan in place for if you become sick with COVID. Who can you call on to look after children, pets or others you have responsibility for?
- If your income is reduced, what will you do?
- Queenslanders will be living with COVID for years to come. If vaccination rates remain low in some communities, localised lockdowns may continue. So it is important to find a way to cope well with being isolated. Have a conversation about it with someone you trust to help you make a plan to adjust as well as you can.

What will care look like if I get COVID?

We expect that people who have COVID-19 but are not very unwell will be cared for at home using telehealth.

People who are unwell at time of their diagnosis or who are at higher risk of COVID complications, such as low immunity, will go to hospital (which may be several hours from your home town).

These webinars are recorded and shared for 1 week on Health Consumers Queensland's YouTube channel. Visit this channel at https://tinyurl.com/HCQYouTube

Doctors in Training Society (DiTS)

Dr Cassandra Joyce
Outgoing DiTS President
gcuhdits@gmail.com | www.ditsgoldcoast.com.au

In December 2021, the GCMA hosted a meeting that provided a platform for a handful of young doctors to speak their minds on topics that they dedicated their profession to, and were passionate about. Out of the handful of young doctors was Dr Cassandra Joyce, who has provided this excerpt.

Greetings from the Doctors in Training Society (DiTS) at the Gold Coast Hospital and Health Service. I trust that the New Year finds you happy and healthy (somewhat, despite this crazy pandemic we are living and working in). We were really honoured to be invited to the last meeting of 2021 to share our experiences working as a junior doctor/DiT in these trying times. I shared the floor with several of my motivated and dedicated colleagues and we talked about some of the key issues facing our medical workforce in 2011/22. The members who were present would have heard the first-hand experiences of doctors with disabilities and the plight of those who return to work after illness (Dr Dinesh Palipana), doctors who are balancing training with a young family (Dr Lee Forman), doctors who are on the edge of starting training whilst undertaking advocacy work (myself) and doctors who are pushing for change at a federal level and are passionate about responsible clinical governance (Dr Hashim Abdeen).

It's with a heavy heart that we shared some of the dark moments that we have either experienced or witnessed:

- Heavy burnout with massive resident shortages resulting in many juniors working long hours across multiple departments (made particularly worse by the pandemic and less doctors coming to GCUH from overseas).
- Ongoing unpaid overtime in certain departments and fear of repercussions when trying to advocate for one's rights.
- The invisible or 'forgotten' expectations of those trying to get onto training programs (a 40-hour working week may become a 70-hour working week when factoring in research, volunteering, exam study and teaching).
- The impact of the COVID-19 pandemic (redeployment from important clinical rotations, reduced education, course cancellation, exam cancellations or technological failures, senior registrars/fellows not progressing through and causing a bottleneck for junior trainees, health implications with frontline staff exposed to the virus).

However, I must say, our health service has always welcomed our feedback (the good, the bad and the ugly) with open arms. In 2021 we made headway on several key topics, with DiTS advocacy proving to have some success.

We have pushed for practical occupational violence training to become mandatory (and be facilitated through training days and time off work) for doctors a number of doctors were physically assaulted by patients.

The DiTS pushed for facilitated focus sessions with juniors to redesign the "lines" that dictate what clinical rotations our junior doctors can preference (this influences which doctors can get experience to niche/popular/mandatory rotations needed for applications to training programs).

- Some residents interested in critical care can now get exposure to both ICU/anaesthetics
- Other residents wanting to pursue paediatrics can now get exposure through a number of different settings (general paeds, NICU, child + youth mental health, paeds ED).
- Many lines will detail the exact medical (e.g – CCU) and exact surgical (e.g – ENT) rotation the doctor will be allocated to (in place of broad descriptions "MEDICAL") to allow for better career planning.
- "Float" rotations were introduced to allow staff to be freed up to fill in service delivery gaps (to avoid residents being redeployed from highly valued rotations).

We have advocated for more opportunities for GCHHS residents to "step up" into PHO roles when these become available (and have the flexibility to be able to backfill those roles). Our resident interview process was overhauled to ensure greater transparency and more notification. (Some doctors used to be advised of an interview the night before!)

DiTS now has a direct line of contact with the GCHHS Hospital Board.

We have made our health service aware of departments with poor rosters, heavy workloads and/or those who do not pay overtime to our juniors and they are taking steps to rectify these issues (e.g. – there was an increase in the number of FTE staff allocated to orthopaedics.

The DiTS are advocating for more work to be done with rostering, staffing levels in busy departments and a centralised AVAC system for recording work hours. We can't truly know the impact of fatigue in our DiTS cohort and safely plan for it, if we don't know how many hours they work!

Notifying the executive of a few rotations that were not safe for junior staff to be allocated early in the work year.

In addition, large percentages of our registrar cohorts have experienced high exam pass rates across a number of specialties (ED/ICU/physicians exams).

In 2022, I will step down into the DiTS Vice Presidency role and I look forward to my colleague Dr Matthew Fairnington continuing the advocacy work.

Learn more about us at **www.ditsgoldcoast.com.au**
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Ballina, NSW 2478

Ph: (07) 5610 4945
Fax: (07) 5610 4963
Email: gtadmin@goldcoastheartclinic.com.au

Swollen Legs – The Often-Difficult Quandary

Dr Christopher Lekich
Phlebologist, FACP, MBBS
JD Barrister at Law (QLD), MBA
Medical Director Vein Doctors Group

Dr Gilles Laur
Phlebologist, FACP, FRACGP, FASLMS
MBBS, Dr of Medicine (France)
DipSCCA, AAICD

Dr Stuart McMaster
Phlebologist, FACP
MBCHB, FRACGP

Dr Jane Cross
BA, MA, MBBS, MRCS
FRCS, MD, FRACS

Many patients suffer with swollen and often painful legs, the management often challenging and fragmented and patients can be mismanaged by GPs and specialists. A streamlined management pathway is required.

Common causes of swollen legs can include obesity, lymphoedema, lipoedema or venous diseases, each with their own unique characteristics. All of these conditions can co-exist making the diagnosis complex.

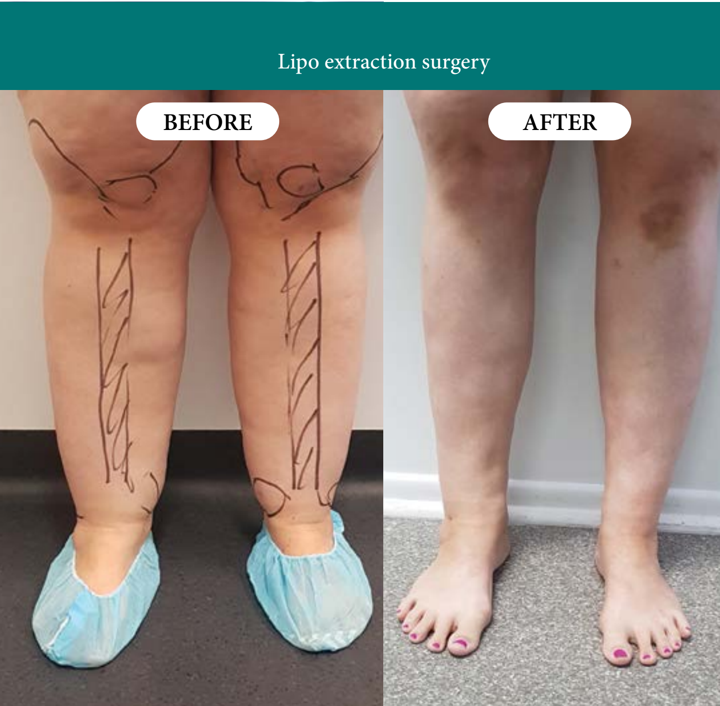
Expert clinical experience and ultrasound is fundamental to diagnose and manage the swollen leg or legs in the very young right through to the elderly to avoid misdiagnosis, as well as ineffective and potentially damaging treatment. For instance, it is important to know that lipoedema, which is a real disease and not known by most GPs and specialists, is bilateral and doesn't involve the feet or hands, whereas lymphoedema is usually unilateral and results in swollen hands or feet. This is even more complex when there is venous reflux in the lower limb leading to progressive accelerated swelling and pain called lipo-lymph-phleboedema.

Vein Doctors Group phlebologists are experts and multidisciplinary and are well positioned to provide clarity in diagnosis of swollen legs alongside onsite specialist sonographers. There is extensive experience in managing venous disease using ultrasound guided modern endovenous ablation techniques, managing lymphoedema, as well as expert management of Lipoedema resulting from training and collaboration from world experts in Lipoedema in Germany. The Vein Doctors Group phlebologist on a daily basis manages pregnancy veins, lymphoedema, Dercums disease, Klippel Trenaunay syndrome, pelvic vein congestion syndrome, phlebitis, venous ulcers and DVTs.

If GPs are unsure of the best pathway for their patients' swollen legs, a diagnosis from highly experienced, globally trained, and expert phlebologists is a good place to start. Register to attend our GP education evening to learn more.

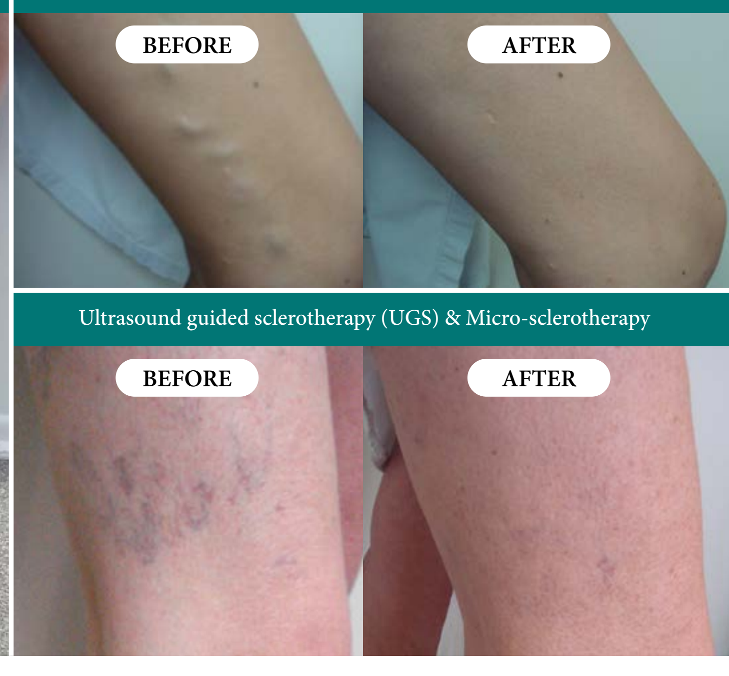
Contact Vein Doctors for more information on 1800 483 467 or at info@veindoctorsgroup.com.au.

Lipo extraction surgery



Endovenous laser ablation & Ultrasound guided sclerotherapy

Ultrasound guided sclerotherapy (UGS) & Micro-sclerotherapy



GP EDUCATION INVITATION

walk with freedom

The Vein Doctors Group in partnership with Coastal Medical Services invites you to an evening of education on Phlebology & swollen legs including venous, lymphatic & lipoedema diseases.

Phlebologist, FACP, MBBS, MBA, JD Barrister at Law (Qld), Medical Director Vein Doctors Group, CEO Miami Private Hospital

Dr. Chris Lekich, Medical Director of the Vein Doctors Group will present the latest advancements on Swollen Legs:

- The role of the phlebologist in scanning, diagnosing & managing causes of swollen legs including venous, lymphatic & lipoedema diseases
- The impact of varicose veins on swollen legs
- Common comorbidities for consideration & exclusion
- Managing swollen legs with conservative management & surgery.

Phlebologist, FACP, MBBS, FRACGP, FASLMS, Dr. of Medicine (France), DipSCCA, AAICD

Dr. Gilles Laur of the Vein Doctors Group will present on Modern Management of Venous Disease:

- The spectrum of venous & lymphatic disease
- Impacts of venous disease
- Modern treatment modalities & the role of ultrasound
- Chronic & interesting presentation.

EVENT DETAILS

Cost: FREE

BRISBANE

Date: Thurs, 24 February 2022
Time: **6:00pm - 6:30pm** Registration & Dinner
6:30pm - 8:30pm Presentation
Venue: Quartz Room, Victoria Park, 309 Herston Rd, Herston QLD
RSVP: Mon, 14 February 2022

GOLD COAST

Date: Thurs, 10 March 2022
Time: **6:00pm - 6:30pm** Registration & Dinner
6:30pm - 8:30pm Presentation
Venue: Panorama Room, HOTA, 135 Bundall Rd, Surfers Paradise QLD
RSVP: Mon, 28 February 2022

LISMORE

Date: Thurs, 28 April 2022
Time: **6:00pm - 6:30pm** Registration & Dinner
6:30pm - 8:30pm Presentation & Dinner
Venue: Invercauld House, 163 Invercauld Rd, Goonellabah NSW
RSVP: Mon, 18 April 2022

Ph: 1800 483 467 | Miami Private Hospital & Specialist Centre, 24 Hillcrest Parade, Miami QLD 4220

To register your attendance visit: **www.veinclinic.com.au/rsvp**
phone: **1800 483 467** *or email:* **info@walkwithfreedom.com.au**

Donna Meads-Barlow
(Volunteer CEO & Co-Founder)
DANII Foundation

OUR MISSION: To support people with type 1 diabetes, lobby government and industry toensure latest technologies are available and affordable and alert carers to life-threatening hypo and hyperglycaemia. To Educate & Advocate for a Voice for type 1 diabetes. www.danii.org.au

The DANII Foundation was established by Donna and Brian Meads-Barlow in early 2012 after the death oft heir 17-year-old Daniella as a result of nocturnal hypoglycaemia, or dead-in-bed syndrome. Shortly after Daniella's death, their trusted Endocrinologist, Dr Neville Howard, informed them of the early use of Continuous Glucose Monitor's (CGM) elsewhere in the world and how this technology was indeed life-saving.

From here they began a labour of love to prevent unnecessary deaths and to improve the quality of life for Australians living with type 1 diabetes. They are proud to say DANII has achieved much despite being such a young organisation. The DANII Foundation led the campaign for Government funded CGM's; our advocacy was rewarded with a $54M funding commitment for T1D's under 21. It was fantastic to hear Minister Hunt refer to the announcement as, 'Danii's Gift'.

In November 2018, a second announcement was made by Minister Hunt, granting a further $100M for government funded access to CGMs towards pregnant, planning and nursing mothers, concession cardholders and those insulin dependent under 21 however not necessarily diagnosed T1.

This very generous funding strengthened our resolve. DANII believes that every Australian with type 1 diabetes should be supported in affordable life-saving and life-changing technology, such as CGM's. Since 2013 the foundation has provided over 1200 x 12-month CGM scholarships and over 900 free 14-day CGM trials.

You can find out more about their CGM scholarships and trials on their website at **www.danii.org.au/diabetes**

In addition to advocacy the Foundation hosts an annual Jelly Bean Educational programme. This event brings together a team of Diabetes Health professionals and provides intensive support and education alongside often very necessary rest and respite for both the T1D and their family. The 2022 Educational Camp for both adults and children is scheduled to be held in NSW Lake Macquarie area from the 18th to 23rd of April. More information on this support programme can be found at www.danii.org.au/events. DANII also offers Jelly Bean Educational Scholarships for T1Ds struggling financially, and their carer.

T1D Education and Advocacy material: developed by the foundation includes the see and feel symptoms of hypoglycaemia and how to treat it, and DKA awareness and information for teachers, including school care plans. The DANII Foundation encourages you to utilise these resources and promote amongst your patients. Available on their website www.danii.org.au/downloadables/

Printed posters are also available for your rooms. Please contact our Advocacy & Support Representative Blerina on 0455 905 904 or email team@danii.org.au if you would like hard copies posted.

The DANII Foundation aims to create a safe, caring and supportive community for T1Ds of all ages to speak up about their day-to-day encounters with this chronic disease. Their Facebook, Instagram and Twitter profiles allow for light-hearted conversations, but also a range of emotional support from fellow T1Ds experiencing the same or similar situations. It encourages normalisation of this disease which can often make people feel isolated and alone.

Without funding from the government, the DANII Foundation relies on sponsorship and fundraising to support the T1D community. The Jelly Bean Fundraising Ball is held in June each year with hope you can support it in some way. More information is available on the website at www.danii.org.au/events

The DANII Foundation looks forward to working together with you to support your patients and all Australians living with type 1 diabetes. Please reach out to our team if they can support you or any of your valued patients.

Helix Health is excited to announce that we are now accepting referrals for TMS.

Our rTMS service (repetitive Transcranial Magnetic Stimulation) will be up and running from early February. Please forward your referrals to Dr Sandeep Chand, Helix Health Specialist Clinic – reception@hhsc.net.au or via Medical Objects.

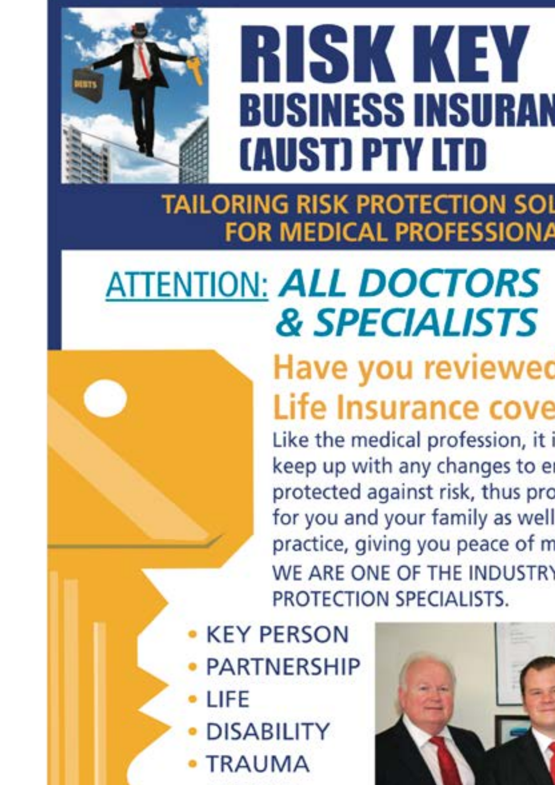
In addition to our new rTMS Service, Helix Health has a team of experienced Clinical Psychologists that are available to conduct the following testing:

- Cognitive Testing for Adults & Children (6+ years)
- Diagnostic Assessment for Autism – Adults
- Diagnostic Assessment for ADHD – Adults & Children (6+ years)
- NDIS Assessments

CONTACT US TODAY (07) 5527 0190 reception@hhsc.net.au www.hhsc.net.au

Helix Health has availability for a full-time or part-time Psychiatrist or Psychologist to join our team. For more information please contact our Practice Manager at manager@hhsc.net.au.

07 5537 9282
WWW.RUNAWAYBAYPODIATRY.COM.AU



Contact Martin and his team on
07 5532 8867 or 0418 787 506
Email: riskkeybusiness@bigpond.com

The GCMA November Meeting

Dr Alfred Lam, Dr Liz Weinstein, Dr Margaret Kilmartin

Dr Dinesh Palipana

Dr Lee Forman

Dr Dinesh Palipana, Dr Hashim Abdeen, Dr Lee Forman, Prof Philip Morris, Dr Cassandra Joyce, Prof Shane Brun

Dr Roger Wilson, Dr Mark Doudle

Prof Shane Brun

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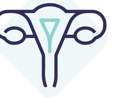


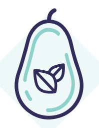
Gynaecology

Fertility

Ultrasound

Physiotherapy

Psychology



Dietetics

Endocrinology

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Our Team

Dr Adriana Olog
Maternal Fetal Medicine Specialist, Obstetrician

Dr Tania Widmer
Fertility Specialist
Obstetrician & Gynaecologist

Dr Tina Fleming
Fertility Specialist
Obstetrician & Gynaecologist

Dr Helen Green
Gynaecological Oncologist

Dr Yasmin Pilgrim
Obstetrician & Gynaecologist

Dr Bridget Gilsenan
Obstetrician & Gynaecologist

Dr Aakansha Zala
Endocrinologist

Rebecca Lackie
APA Titled Continence & Women's Health Physiotherapist

Karen White
Clinical Psychologist

Debra Miller
Women's Health Physiotherapist

Kerryn Blunt
Clinical Psychologist

Sharnie Dwyer
Dietitian

DCISionRT® – Biological Profiling for Personalised Treatment

Dr Tulasi Ramanarasiah
MBBS, MD, FRANZCR
Radiation Oncologist

Dr Sagar Ramani
MBBS, FRANZCR, MRCP (UK), FRCR (UK)
Radiation Oncologist

Dr Selena Young
MBBS, MPallC, FRANZCR
Radiation Oncologist

Supporting women to make informed decisions

DCISionRT® is a risk assessment test which looks at the likelihood of ductal carcinoma in situ (DCIS) recurring after surgery, the risk of the disease spreading, and the impact of radiation therapy in reducing that risk. DCISionRT assists you and your patients to select treatment based on the biology of the tumour, not just clinical pathology.

GenesisCare Radiation Oncologist Dr Tulasi Ramanarasiah, said: "DCISionRT is a data driven, precision medicine tool that helps determine the necessity for radiation in Ductal Carcinoma in Situ after initial surgery. We are indeed fortunate to have access to this test on the Gold Coast."

A personalised treatment approach

DCIS itself is not considered life threatening, however, a recent study suggested that women with DCIS have a 3-fold increased risk of death from breast cancer compared with women without DCIS because of the variations in treatment practice, due to geographical access and differing clinical protocols.1,2

DCISionRT looks at women diagnosed with DCIS and assesses their 10-year risk of recurrence or of developing invasive disease with or without radiation therapy. It is the only test developed specifically for this purpose.

The outcomes of the test show whether your patient's risk is 'low' or 'elevated' and assesses the potential benefits of radiation therapy. The test results are then used as a decision tool for you and your patients when considering treatment options.

"Historically, most women who had breast conserving surgery for DCIS were offered radiation therapy to reduce the risk of recurrence. By using DCISionRT testing, we are now able to predict the risk of recurrence more accurately. This allows us to treat patients who are likely to benefit from radiation and avoid treating patients with low risk disease," said Dr Sagar Ramani.

"In addition to using traditional clinico-pathological factors, DCISionRT uses biomarkers to assess a patient's risk of recurrence and benefit from radiotherapy - true personalised medicine" said Dr Selena Young.

The DCISionRT test

The test can be applied to the breast tissue sample taken as part of your patient's biopsy or breast surgery; no additional procedure is required.

The results will be shared with the referring doctor and a radiation oncologist at GenesisCare within approximately one week from the lab receiving the tissue sample. The lead clinician will then discuss the treatment options directly with the patient.

GenesisCare is offering the DCISionRT test along with radiation therapy as a bundled financial package. If no radiation therapy is needed at the time of results, there will be no cost to your patient for the test. The cost of the test is not covered by private health insurance or Medicare.

Clinical Evidence

DCISionRT has been developed and validated on over 3,500 patients across 6 distinct patient cohorts. Studies on 5 of these cohorts have produced consistent results study to study in published research from 2010 to 2018.1,4-6

The 6th cohort currently consists of >1,400 patients who are part of the ongoing PREDICT Registry in the US. Results to date from this study are also consistent with prior studies but not yet published.

GenesisCare have also partnered with PreludeDx on a research program to further the clinical development of precision medicine tests, including breast and other cancers, with global real-world evidence.

For more information please contact:
1300 086 870 or oncologyQld@genesiscare.com

References: [1] Weinmann S, et al. Clin Cancer Res 2020; (26)(15):4054-4063. [2] Australian Government, Australian Institute of Health and Welfare 2020.Available at: https://www.aihw.gov.au/getmedia/e414a344-ab3d-4a35-a79b-a29723f22939/aihw-can-135.pdf.aspx?inline=true. [Accessed on:18/01/21]. [3] van Seijen M, et al. Br J Cancer 2019; 13;121(4):285–292. [4] Bremer TM, et al. Clin Cancer Res 2018; 1;24(23):5895-5901. [5] Warnberg F, et al. Cancer Res 2018; 78 (4 Suppl);GS5-08. [6] PreludeDX 2016-2017. Data on file.

We test your DCIS with **7** biomarkers, their interactions, and their relationship to **4** factors about you.

Your age at diagnosis

How the lesion was discovered (by mammography or physical exam)

The extent of the lesion (size)

Whether the rim of tissue surrounding the lesion was free of DCIS (margin)

Your personalised DCISionRT® report

DCISionRT® – biological profiling for personalised treatment

Supporting women to make informed decisions

GenesisCare are proud to be the first in Australia to provide access to DCISionRT® – a **new** test improving the treatment choices of thousands of breast cancer patients as they work with you, their doctors, to make informed decisions about their treatment options.

Based on studies carried out in over 3,500 DCIS patients,[1-4] DCISionRT is a risk assessment tool looking at the likelihood of:

- DCIS recurrence after surgery
- Invasive disease development after surgery
- DCIS recurrence after surgery and radiation therapy
- Invasive disease development, after surgery and radiation therapy

At GenesisCare, we focus our care on the individual, not just the condition, and support you to bring a personalised approach to your patient's treatment. Our care is based on the unique needs of every individual, backed by innovative technology, a global network of over 5,000 specialists, and advanced diagnostic and multidisciplinary treatment options.

Evidence-based, precision testing – improving patient outcomes.

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References:
Weinmann S, *et al. Clin Cancer Res* 2020; (26)(15):4054–4063.
Bremer TM, *et al. Clin Cancer Res* 2018; 1;24(23):5895–5901.
Warnberg F, *et al. Cancer Res* 2018; 78 (4 Suppl);GS5–08.
PreludeDX 2016–2017. Data on file.

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