the medical link

ISSUE 140 | JULY – AUGUST 2022

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

THE OFFICIAL PUBLICATION
OF THE GOLD COAST MEDICAL ASSOCIATION INC.
PUBLISHED BY RYRISS SERVICES

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RADIOLOGY

SAVE THE DATE:
Samoa Medical Conference

- Cochlear Implants on the Gold Coast
- A Story of a Breast Cancer Survivor
- Improving Screening & Management of Lymphoedema
- Approach to Iron Deficiency in Pregnancy
- Managing Gender Dysphoria in Young People
- Cystic Fibrosis in This Day & Age

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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,

We are now getting to half way through this year. Time moves on so fast! The GCMA continues to provide independent commentary on current medical and health matters and is sought out as a reliable source of public and professional information. Our monthly dinner meeting speakers program has been a great success so far this year. Earlier in the year we had addresses from Dr Michael Slancar and Dr Brent McMonagle. In April Prof David Ellwood, Griffith Medical Dean gave us an update on the Griffith University Health Program and in May we had Prof Simon Broadley speak on new developments in Multiple Sclerosis. Did you know that a vaccine against Epstein-Barr virus is likely to prevent most cases of MS? I did not, but Simon gave a convincing case that this is the next step in preventing this debilitating condition. This month (June) we have Prof Peter Silburn give us an update on the treatment of Parkinson' disease.

From July onwards we hope to have interesting presentations from Dr David Green (Emergency Medicine), Dr Rhea Laing (breast surgery and encouraging diversity in the RACS), Dr Hanlon Sia (new hematology and oncology clinical trials), Dr Hal Ric (radiology), and we hope our new Governor, Dr Jeannette Young AC PSM, will accept our invitation to join us later this year. We are nearing the final stages of planning a GCMA Gala Social Event for November for members and partners. Keep a lookout for more about this later in The Medical Link and in email distributions.

Planning for our Pacific Island joint conference with the local Samoan Medical Association and medical schools continues. The meeting will be held in Apia, Samoa in late September 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 local 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 (stephenweinstein@bigpond.com) or me for details.

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 am so pleased we have had two junior colleagues join our GCMA executive team – Dr Cassie Joyce (now our treasurer) and Dr Amy Doumany. These two excellent doctors will give the GCMA a connection to our junior colleagues and a path to the future.

I look forward to seeing you at our next GCMA meeting
Yours sincerely,

Prof Philip Morris AM
President GCMA

> "Planning for our Pacific Island joint conference with the local Samoan Medical Association and medical schools continues.

Dr. Paul Frank
Pain Medicine Specialist & Anaesthetist,
M.B.B.S. FANZCA FFPMANZCA

Pain Rehab
Dr. Peter Georgius
Pain Medicine Specialist, FFPMANZCA
Rehabilitation Physician, FAFRM, MBBS, BMedSc

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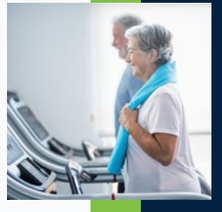

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Ryriss Services Pty Ltd
admin@themedicallink.com.au

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

GCMA MEMBERS
gcma.org.au

KEEPING THE MEDICAL COMMUNITY *INFORMED*

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

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 on new health services, developments in the medical profession and general interest items.

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Medical Conference in Samoa 28 – 30 September 2023

Prof Stephen Weinstein
MHA, FRCPA, FRACMA, FACHSE
stephenweinstein@bigpond.com

As we finally seem to be emerging from a difficult two years (notice I avoid the expression back to normal), your GCMA is in the early planning stages of a joint medical conference in Samoa, building on the popularity of the previous joint conferences in Fiji and Vanuatu

Last week Prof Philip Morris and myself had a zoom meeting with Prof Viali Laumeko, the Dean of the Oceania University of Medicine, in Apia, Samoa, and agreed on preliminary dates for this event, Thursday 28 to Saturday 30 September, 2023.

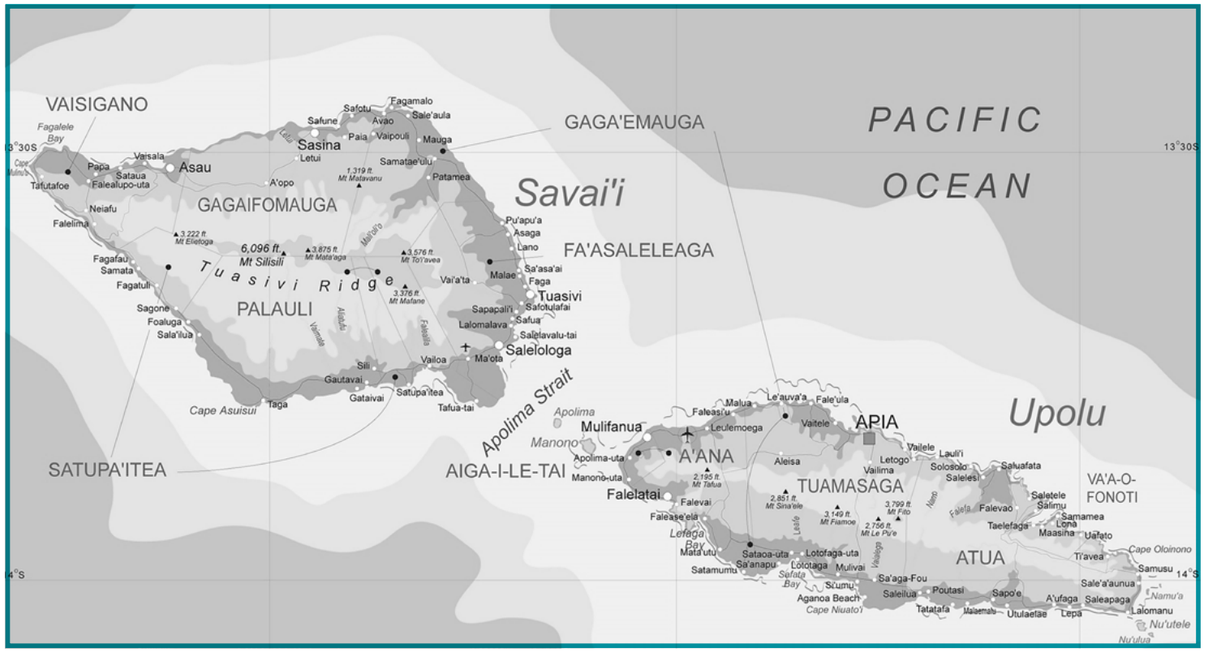
To briefly recapitulate the GCMA's history of Pacific partnerships, Dr Vijay Kapadia was a driving influence for our first joint conference in Fiji in 2009, when our partner organisations were the Fiji College of General Practitioners, and the Fiji Medical Association. This was followed up by a further well attended joint conference in Fiji in 2015, this time opened by the Fiji Minister of Health. In 2017 we held a meeting in Vila, Vanuatu, with the Vanuatu Medical and Dental Association. Dr Sale Vurobaravu, an enthusiastic young Ni-Van doctor, was our counterpart on the steering committee, emphasising how essential it is to have helpful, local support to make such an event a success.

Samoa has an interesting history, becoming the first independent nation in the South Pacific in 1962 (apart from Tonga, which always retained its independent monarchy). Back in 1889, Samoa was engaged in a three-way civil war between rival chiefs, with each side supported by Britain, Germany and the US. A great hurricane that year wrecked most of the foreign warships in Apia harbour, putting a damper on military activities. At the same time the author Robert Louis Stevenson (Tusitala – teller of stories in Samoan) was living in Apia, and was much loved by the local people. (His house Vailima is a major attraction in Samoa, and his mountaintop grave can also be visited). The conflict was resolved by partition in 1899, with the larger Western islands of Upolu and Savaii going to Germany, and Tutuila, with its natural harbour of Pago Pago, becoming American Samoa, which it still is today. German Samoa was taken by a New Zealand expeditionary force in 1914, and ruled by Wellington until 1962.

Our partner organisations this time will be primarily the Oceania University of Medicine (OUM, see their website), headed by the Brisbane based Vice Chancellor Prof Hugh Bartholomeusz. Dr Laumeko is the Dean for Samoa, and there are also Deans for Australia and the USA, where many of the students come from. The OUM is a private fee-paying medical school, and my wife Lis and I spent some very rewarding time teaching there in 2008. We taught mostly the Samoan medical students, because the Australian and US students spend the majority of the course on attachments in their home countries. The Samoa Medical Association, the National University of Samoa, and the Ministry of Health are likely to be the other partners.

When we discussed what contribution our speakers could make, Dr Laumeko outlined a very wide range of topics corresponding to the health problems currently affecting Samoa, including non-communicable diseases (diabetes, cardiovascular, cancer and obesity), mental health, and infectious diseases. The other major contribution that the GCMA could make to the OUM would be to assist with the placement of medical students in hospitals and private practices, which we expect to hear more about later.

As part of the conference planning process, as we did in Fiji and Vanuatu, a site visit to meet our Samoan counterparts is expected to occur in the second half on this year 2022. In summary, please mark your calendars, talk to your families and colleagues (the dates deliberately coincide with the Queensland school holidays), and think about how you can contribute to making our joint Samoa conference a success.



Cochlear Implants on the Gold Coast

Ben Hoddinott & Dr Brent McMonagle

Hearing loss in 2022

Hearing loss is very common, affecting 1 in 6 Australians overall. If we exclude those with mild to moderate hearing loss, there are more than 300,000 Australians with severe to profound hearing loss. The hearing loss may be congenital (identified at birth) or acquired during life from a variety of causes, such as excessive noise exposure, ototoxic medications, inner ear disease, tumours, or advancing age.

The effects of hearing loss are widespread. Initially people with hearing impairment become frustrated by missing out on conversations, which can strain personal and work relationships. With time, irritability, anger, anxiety, and depression may develop. Eventually people tend to withdraw from social situations, leading to isolation and loneliness. From a cognitive perspective, studies have shown reduced alertness, impaired memory, inability to learn new tasks, and reduced work performance and earning power. The estimated costs of hearing loss are a staggering $16B per annum in Australia.

While some of the causes of hearing loss are amenable to surgery, most are not, and hearing aids are the only option. Hearing aids amplify sound, preferentially speech rather than noise, but have their limits. Ironically, hearing aids tend to work least effectively in noisy environments where patients need them most! They can also be irritating to wear, easy to lose, and expensive (up to $10K for a pair of top of the range aids). Once the hearing loss reaches a severe level, they become less effective, and cochlear implants are the next step.

Cochlear implants

A cochlear implant (CI) is an electronic, implanted hearing device for people with severe hearing loss where hearing aids are no longer effective. There is an external component which is worn like a hearing aid on or near the ear (and can be removed), and an internal component which is surgically implanted under the skin behind the ear.

There are 3 main criteria for suitability for a CI: hearing thresholds worse than 60 decibels (dB), speech discrimination less than 60%, and major difficulties communicating (with hearing aids) at work and/or home. Age is not a major factor- newborn babies can be implanted from 6 months of age, and elderly patients can undergo surgery provided they are fit for a 2 hour general anaesthetic (can even be done under local anaesthetic). There is minimal pain from the operation, and patients usually go home the following day (some even as day surgery). Suitable patients are assessed medically and audiologically with extensive audiovestibular tests, CT scans and sometimes MRI scans. All CI candidates meet with a CI recipient pre-operatively to ask them “real-life” questions about living with a CI.

The operation entails several steps:

1. Pre-operative setting up
2. Skin incision and creation of a soft tissue 'pocket' for the implant to sit under the skin
3. Mastoidectomy (drilling away the bone behind the ear)
4. Identifying the round window of the cochlea & creating a cochleostomy (opening into the cochlea)
5. Insertion of the implant electrode
6. Closure of the wound & dressing

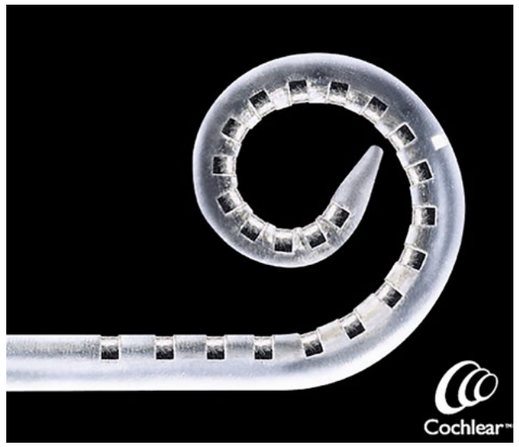
Patients are placed on antibiotics (to reduce the risk of infection) and steroids (to reduce the inflammatory reaction of the cochlea) for 5 days post-operatively. The wound is checked 7 – 10 days post-operatively.

The CI is usually switched on 2 weeks later. The audiologist “maps” the 22 electrodes to determine the optimum levels of electrical stimulation to give the patient the best level of sound without excessive sensitivity. There are several mapping sessions in the first few months as the patient becomes used to the CI. Once this has stabilised (usually 6 -12 months), these audiology sessions are done on annual basis, like a hearing aid adjustment. It is important that the patient (and their family/friends) undergo regular rehabilitation by listening to audio recordings while reading text to help them adjust to the CI.

Over 14,000 Australians have a CI, with 1,700 cases per annum. Because of the effective neonatal hearing screening program, virtually all babies are identified before 6 months of age, and over 90% receive a CI. However, the opposite is true of adults. 10% of eligible adults have a CI. Once aware that this is an option, >90% of these adults undergo cochlear implantation within a year. 12 years is the average time span between developing severe hearing loss and receiving a CI- for all of this time, the patients and their family/friends are struggling with hearing aids when a more effective option is available.

There are some common misconceptions about CIs:

- They are not for only for the ”stone” deaf- they are suitable for anyone with severe hearing loss in one or both ears
- It is not an experimental operation - CIs are the gold standard treatment for severe hearing loss, even in third world countries.
- They are too expensive- they compare favorably to pacemakers and artificial joints, and are covered by most private health insurance policies and DVA.



Curved tip of the cochlear implant electrode (CochlearTM)

CI632 cochlear implant (CochlearTM)

Kanso external speech processor

N7 behind the ear speech processor (CochlearTM)

The Gold Coast

The Gold Coast is Australia’s 6th largest city, and growing rapidly- it is projected to overtake Adelaide in the next 10-20 years. It has a similar population to Amsterdam and is a true “global” city, having hosted major international events such as the Commonwealth Games in 2018. Gold Coast University Hospital (GCUH) was the first University-Hospital in the Southern Hemisphere, and is co-located with Griffith University and its impressive School of Health Sciences. It has the busiest Emergency Department in Australia. GCUH services virtually all facets of medicine and surgery, except cochlear implants.

Cochlear implants on the Gold Coast:

I performed the first cochlear implant operation on the Gold Coast in 2010 in Pindara Private Hospital. The Neurosensory Unit (private audiology company) have provided audiological services for all of the CIs over this time. For 14 years, I have been trying to establish a public CI program on the Gold Coast. I see no sensible reason for this situation to remain any longer. The new hospital is well established. The operating theatres have all of the appropriate equipment already. I am willing to avail myself for these extra cases (only 5-10 per year). After lobbying and a formal submission to the Queensland Government in 2020, funding was granted for an additional 28 adult public CIs per year- GCUH could potentially claim some of these. There is now an audiology department on site at GCUH which could be provided with additional resources to manage these patients, or they could be out-sourced to the Neurosensory Unit.

At present, any CI eligible public patients from the Gold Coast and catchment area are offered referral to Mater Hospital or Royal Brisbane and Women’s Hospital. In my experience, most decline this option due to the degree of difficulty in transporting to/from Brisbane for the many appointments before/during/after the CI surgery. This is even more frustrating considering much smaller hospitals such as Townesville, Newcastle, and even Lismore provide this service for their patients and do not have the otherwise vast range of services available at GCUH. It is my hope that this great discrepancy and injustice to severely hearing-impaired patients and their family/friends on the Gold Coast will be rectified in the near future.

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

A Story of a Breast Cancer Survivor

E.K. Daley
The Medical Link
admin@themedicallink.com.au

The year was 2015, it was December, coming up on Christmas. Caroline, aged 35, a non-smoker, 60kg in weight, exclusively a social drinker and living on a pescatarian diet was in bed, happy and healthy. Caroline turned on her side and scratched the side of her right breast, she felt a lump.

Breast cancer is one of the most commonly diagnosed forms of cancer in Australia, and in the world, with approximately 55 Australians, both men and women, diagnosed every day. This equates to over 20,000 people a year. Breast Cancer affects both men and women, though it is more commonly found in women. In 2021; 19,866 women 164 men we were diagnosed with Breast Cancer.

Caroline had an ultrasound, mammogram and then a core biopsy which confirmed her diagnosis of triple negative Breast cancer in early January 2016.

Breast Cancer, being such a common form of cancer worldwide, has been thoroughly investigated and there are many resources available to the general public, to raise awareness of symptoms to look out for if someone suspects there may be something wrong.

Notable symptoms may include a new lump in the breast or underarm (armpit). Thickening or swelling of part of the breast. Irritation or dimpling of breast skin. Redness or flaky skin in the nipple area or the breast. Pulling in of the nipple or pain in the nipple area. Nipple discharge other than breast milk, including blood. Any change in the size or the shape of the breast. Pain in any area of the breast. Keep in mind that these symptoms can happen with other conditions that are not cancer.

The day Caroline met her surgeon was her first shock moment, when both chemo and fertility preservation were put on the table. This was real. This was actually happening. Her oncologist suggested she take part in a trial, which would mean chemo before surgery.
Caroline did 1 round of fertility treatment and started chemo late February. Chemo was 5 months, weekly Taxol for 12 weeks, plus trial drug or placebo every 3rd week, followed by 4 x fortnightly "AC" treatments, and tablets twice daily as well and then all the other medication that come along with having chemo.

Carolines final period was in March 2015, and it never returned.

Studies have found that about half of young women with breast cancer would like to experience pregnancy after completing treatment. However certain types of chemotherapy can cause infertility. Fertility preservation can be quite complicated. Collecting eggs from a woman and potentially creating fertilized embryos for storage via cryopreservation requires delaying some parts of cancer treatment for weeks or months, which can be detrimental depending on the severity of the cancer's malignancy.

Caroline was treated in Tweed Hospital by Dr Abdi and had a wonderful experience with the doctors and nurses. Her surgeon at John Flynn Hospital was Dr Su-Lin Leong whose work was so excellent, Caroline stated that her scar was hardly visible. Though she doesn't remember their name, the doctor Caroline initially saw for her lump looked past the seemingly healthy woman with no family history of cancer and referred her immediately to an oncologist. Caroline says that doctor saved her life.

It is important that patient concern be taken with absolute seriousness and care, especially in female health, due to fertility being a sensitive topic for many women worldwide.

Caroline stated that she had no prior knowledge or education on breast cancer prior to her diagnosis. Only that she knew her own body, and the lump she felt she knew was not meant to be there. She had never had any previous breast screenings, nor was she informed it was something she would have to consider. It is important that young women in 2022 are equipped with the tools and knowledge to identify potential health risks like breast cancer early on, and as doctors it falls under a duty of care to remind the general public to keep on top of their checks and teach them tactics and exercises to identify the smallest abnormality at its earliest stage.

Caroline has been cancer free since 2016 and has stated that she had a wonderful experience going through the public health care system as a cancer patient. That she felt like she was treated like a human, rather than just any other fragile patient. She elaborated on the many friendly faces that she saw day to day while fighting of this disease, and shows gratitude every step of the way for the life she is living now that she has come out of the other side.

Initial biopsy results:

- Invasive carcinoma which appears fully necrotic, infiltrating as nests, chords and single cells.
- Nuceli appears high grade. Numerous mitotic figures
- Tubule formation minimal
- Associated high grade DCIS is seen predominantly as cancerised lobules

Further results:

- e-cadherin immunostain positive
- Triple negative
- Positive staining for EGFR & focal positive staining for CKI4
- CK5 negative
- SISH negative
- Mean copy per cell I.4
- HER2/ChrI7: I.I
- Non amplified - diploid (ratio <2)

> **Breast cancer is one of the most commonly diagnosed forms of cancer in Australia, and in the world, with approximately 55 Australians, both men and women, diagnosed every day.**

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- World-class radiation therapy technology
- Private 24-chair day oncology hospital
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- Lymphoedema screening and early intervention service
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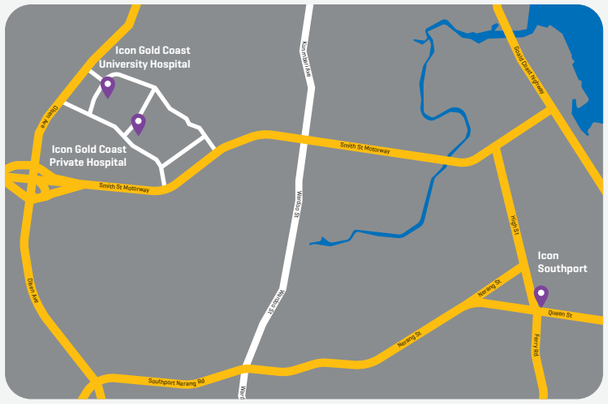
- Clinical research and trials

Commitment to affordable care

Radiation oncology is largely funded by Medicare with up to 90% of the fee covered; no private health insurance required. Day hospital treatments require private health insurance and out-of-pocket costs, if any, are health fund dependent.



Icon Cancer Centre Gold Coast Private
Lower Ground 3, 14 Hill Street
Southport QLD 4215
P 07 5634 2400
F 07 5634 2401
E admin.goldcoastprivate@icon.team

Icon Cancer Centre Southport
Level 9, 39 White Street
Southport QLD 4215
P 07 5657 6400
F 07 5657 6401
E admin.southport@icon.team

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Based at Icon Gold Coast Private

Dr Pretti Bagga
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A/Prof Jim Jackson
Brain, head and neck, gynaecological, genitourinary, lung, breast and skin cancers

Dr Eric Khoo
Head and neck, colorectal, prostate and skin cancers

Dr Dominic Lunn
Brain, central nervous system, breast, gynaecological, lung cancers and palliative care

Dr Andrew Oar
Central nervous system, gastrointestinal, lung, skin and genitourinary cancers

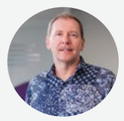
Medical Oncologists

Based at Icon Southport

Dr Keith Horwood
Breast, lung, ovarian and upper gastrointestinal cancers

Dr Mohammed Islam
Colorectal, head and neck, lung and prostate cancers

Prof Matthew Links
Geriatric, breast, lung and prostate cancers



A/Prof Michael Slancar
Breast, prostate, lung, colorectal cancers and gynaecological malignancies

Haematologists

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Dr Shane Bleakley
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Dr Renee Squires
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Dr Katherine Martinez

Dr Momin Sid

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Improving Screening & Management of Lymphoedema

Icon Cancer Centre
Gold Coast Private Hospital
Lower Ground 3, 14 Hill Street Southport
(07) 5634 2400 | admin.goldcoastprivate@icon.team

While lymphoedema can't be prevented, there is a lot that can be done to reduce the risk of developing it.

During Lymphoedema Awareness Month in March, Icon Cancer Centre teams were busy spreading the word about the importance of early detection and management of lymphoedema.

Icon Cancer Centre Gold Coast Private Hospital now proudly offers a lymphoedema screening and early intervention service for local breast cancer patients. The service provides:

- Complimentary screening conducted by trained healthcare professionals, including baseline screening to identify risk of developing lymphoedema
- Measurement using the SOZO device® - the latest technology for breast cancer-related lymphoedema
- Follow-up screening to monitor any changes
- No out-of-pocket costs for the first 12 months of screening
- A referral is not required for the screening service

One in five breast cancer patients who undergo axillary lymph node dissection (ALND) will develop secondary lymphoedema. 1

This risk is significantly increased when surgery is combined with radiation therapy and may also be increased by chemotherapy drugs, either alone or in combination with radiation. 2,3

The primary healthcare practitioner plays an important role in the management of breast cancer patients, as lymphoedema can develop weeks, months and years following treatment.

Clinical lymphoedema is preceded by a subclinical or latent stage, where the lymphatic system is impaired, but swelling is not yet obvious.

As there is no cure for established clinical lymphoedema, the earlier lymphoedema is detected in a sub-clinical stage, the better it can be managed to prevent progression to clinical signs and symptoms.

International research has shown that regular screening, education, early detection and intervention of lymphoedema can assist in reducing the long-term impacts caused by the progression of the condition and improve a patient's commitment to self-care. .4, 5

When detected early, the implementation of education, short-term compression therapy and exercise can reduce progression of lymphoedema by 95%.6

This demonstrates the importance of increasing access to lymphoedema screening and management for the local communities.

Bioimpedance spectroscopy (BIS) is a recent advancement in lymphoedema screening and offers a non-invasive approach.

BIS uses resistance to electrical currents to measure a patient's total body water, extracellular fluid volumes – informing a baseline L-Dex score and allowing clinicals to monitor lymphoedema progression.

The introduction of a SOZO device, which uses BIS technology means local patients can access baseline screening to identify their risk of developing lymphoedema and follow-up monitoring.

The optimal management of patients with breast cancer requires the expertise of multidisciplinary specialists, including general practitioners.

General practitioners can have a significant impact on the incidence and progression of breast cancer-related lymphoedema through patient education on the importance of early detection and support in accessing lymphoedema screening and early intervention services.

> Icon Cancer Centre Gold Coast Private Hospital now proudly offers a lymphoedema screening and early intervention service for local breast cancer patients.

Lymphoedema screening at Icon Gold Coast Private with Registered Nurses Tanya & Erica.

For further information, please contact Icon Cancer Centre Gold Coast Private Hospital, Gold Coast Private Hospital Lower Ground 3, 14 Hill Street Southport on 07 5634 2400 or admin.goldcoastprivate@icon.team

A referral to a therapist may be subject to additional costs.

References

1. DiSipio T, Rye S, Newman B, Hayes S. Incidence of unilateral arm lymphoedema after breast cancer: a systematic review and meta-analysis. Lancet Oncol. 2013;14(6):500-515. doi:10.1016/S1470-2045(13)70076-7
Warren AG, Janz BA, Slavin SA, Borud LJ. The use of bioimpedance analysis to evaluate lymphedema. Ann Plast Surg. 2007 May;58(5):541-3. doi: 10.1097/01.sap.0000244977.84130.cf. PMID: 17452840.

2. Boyages, John & Vicini, Frank & Shah, Chirag & Koelmeyer, Louise & Nelms, Jerrod & Ridner, Sheila. (2020). The Risk of Subclinical Breast Cancer–Related Lymphedema by the Extent of Axillary Surgery and Regional Node Irradiation: A Randomized Controlled Trial. International Journal of Radiation Oncology*Biology*Physics. 109. 10.1016/j.ijrobp.2020.10.024.

3. Zhu W, Li D, Li X, et al. Association between adjuvant docetaxel-based chemotherapy and breast cancer-related lymphedema. Anticancer Drugs. 2017;28(3):350-355. doi:10.1097/CAD.0000000000000468

4. Koelmeyer LA, Borotkanics RJ, Alcorso J, Prah P, Winch CJ, Nakhel K, et al. (2019) Early surveillance is associated with less incidence and severity of breast cancer–related lymphedema compared with a traditional referral model of care. Cancer. 125(6):854–62.

5. National Comprehensive Cancer Network. (2020). NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer and Survivorship. Retrieved 20 August 2021 https://www.impedimed.com/wp-content/uploads/2021/01/PM-104-Rev-G-NCCN_flashcard_DIGITAL.pdf

6. Ridner, Sheila H., Mary S. Dietrich, Koelmeyer, L, John Boyages et al. (2019). A randomized trial evaluating bioimpedance spectroscopy versus tape measurement for the prevention of lymphedema following treatment for breast cancer: interim analysis. Annals of surgical oncology 26, no. 10: 3250-3259.

New satellite practice now open at **The Brickworks, Ferry Rd, Southport**

At Grace Private, we believe every woman deserves to live her best life.

And now we've expanded our services to empower even more women on their health journey, opening an additional satellite practice at The Brickworks, 107 Ferry Road, Southport.

Designed by women for women, Grace Private provides specialist multidisciplinary healthcare to the women of the Gold Coast and surrounding areas.

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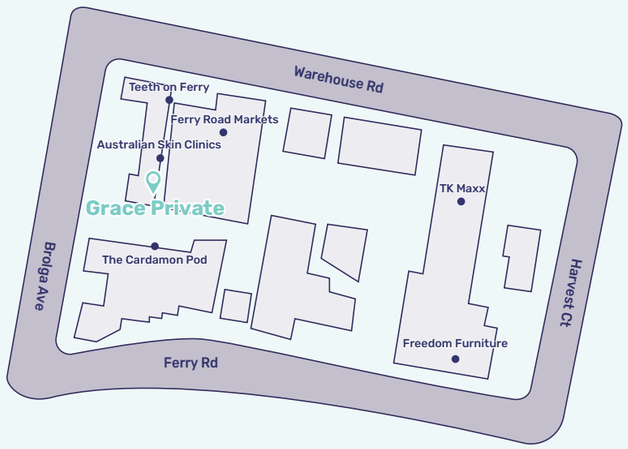

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Maternal Fetal Medicine Specialist, Obstetrician

Dr Tania Widmer
Fertility Specialist Obstetrician & Gynaecologist

Dr Tina Fleming
Fertility Specialist
Obstetrician & Gynaecologist

Dr Helen Green
Gynaecological Oncologist

Dr Yasmin Pilgrim
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Dr Bridget Gilsenan
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Dr Aakansha Zala
Endocrinologist

Debra Miller
Women's Health Physiotherapist

Karen White
Clinical Psychologist

Sharnie Dwyer
Dietitian

Kerryn Blunt
Clinical Psychologist

Anna Alderton
Specialist Women's Health General Practitioner

Elise Turner
Specialist Women's Health General Practitioner

Frances Knight
Specialist Women's Health General Practitioner

CHO Charity Calendar Raises Funds for Refugee Organisations

PRESS RELEASE by Sense & Centsability Pty Ltd
0419 592 942 | www.senseandcentsability.com

For the second year in a row, Victorians have shown their admiration for their Chief Health Officer while raising funds for two worthy charities.

The 2022 Chief Health Officer Brett Sutton Charity Calendar raised $23,953 for The Asylum Seeker Resource Centre and the Victorian Foundation for Survivors of Torture (Foundation House), two organisations selected by Prof Sutton. The calendar featured climate change messaging from Nobel Laureate Prof Peter Doherty and Prof Sutton.

Quote attributable to CEO of Foundation House, Paris Aristotle AO

"Your gesture selecting Foundation House and the Asylum Seeker Resource Centre, sees and acknowledges our collective clients and their communities and the struggles they face in their daily lives. Those struggles have been accentuated throughout this pandemic. The funds we have received as a result of your generosity will be used to provide practical support to refugee families and young people."

Quote attributable to ASRC Community Fundraising Coordinator, Jo Gumley

"Your support enables the ASRC to provide essential services to thousands of people in need. This includes providing legal support and meeting vital needs like food, housing and basic material goods. It also enables us to provide an ear to listen when people are feeling overwhelmed and training and education to help them on the path to employment and a brighter future. Together, we are part of the movement that will shape Australia into a fairer, more compassionate, and welcoming place for people who seek safety on our shores."

Melbourne film producer, Leanne Tonkes created the initiative which also raised over $17,500 in 2021 for Médecins Sans Frontières and The Smith Family.

Asylum Seeker Resource Centre

Founded in 2001, the Asylum Seeker Resource Centre (ASRC) is Australia's largest human rights organisation providing support to people seeking asylum.

The ASRC is an independent not-for-profit organisation whose programs support and empower people seeking asylum to maximise their own physical, mental and social wellbeing.

They champion the rights of people seeking asylum and mobilise a community of compassion to create lasting social and policy change.

The ASRC movement is proudly supported by a community of committed volunteers and supporters.

Profits from the sale of this calendar will support where help is most urgently needed - this could be anything from foodbank, housing, casework, legal or health programs.

Twitter: @ASRC1
Facebook: @asylumseekerresourcecentreASRC
Instagram: asrc1
Website: asrc.org.au

Foundation House

Foundation House provides services to advance the health, wellbeing and human rights of people from refugee backgrounds who have xperienced torture or other traumatic events.

Established in Melbourne in 1987, Foundation House is a state-wide agency offering services in metropolitan, regional and rural areas. Offices are in Brunswick (head office), Dallas, Dandenong, Ringwood and Sunshine. Services are also provided in partnership with other agencies in rural areas throughout Victoria.

Working with thousands of clients a year, an integrated trauma recovery service model guides the organisation to:

- Provide services to clients in the form of counselling, advocacy, family support, group work and complementary therapies
- Work in partnership with client communities and the sectors they interact with
- Offer professional and organisational development
- Advocate to governments for improvements to policies and programs.

Twitter: @FHouseAustralia
Facebook: @FoundationHouseAustralia
Instagram: foundationhouseaustralia/
Website: foundationhouse.org.au

Expanded eligibility for self-collection under the National **Cervical Screening Program**

Information for health professionals

What are the changes?

From 1 July 2022, the National Cervical Screening Program (NCSP) will expand screening test options by offering self-collection as a choice to all people participating in cervical screening. The change means from 1 July 2022 all NCSP participants will have the choice to screen using either a self-collected vaginal sample or a clinician collected sample from the cervix.
Participants are eligible for self-collection if:

- they have a cervix
- they are between 25* and 74 years of age
- they have ever been sexually active
- they are asymptomatic.**

Why is self-collection being introduced?

Self-collection allows all cervical screening participants to have the option to take their own vaginal sample for HPV testing, removing a known and significant barrier to participation in screening.

There are also some groups that are less likely to screen, including Aboriginal and/or Torres Strait Islanders, people from culturally and linguistically diverse communities, people who identify as LGBTIQ+, people with disabilities, people who have experienced sexual violence, post-menopausal women and people who have had previous negative cervical screening experiences. Self-collection may be more acceptable to these groups and may also improve general screening participation.

Importantly, a recent pilot demonstrated that 85.7 per cent of never or under-screened women who declined a speculum examination agreed to HPV self-collection when the test was offered to them in a sensitive and culturally appropriate manner and with appropriate follow-up advice. In addition, more than 70 per cent of women diagnosed with invasive cervical cancer are under-screened or have never screened, so it is important more opportunities to participate in screening are made available.

Queensland Government

Approach to Iron Deficiency in Pregnancy

Dr Renee Squires

General practitioners and obstetricians often face the challenge of managing anaemia in pregnancy. There are numerous causes for anaemia, with iron deficiency being the most common.

PARAMETER	IRON DEFICIENT ERYTHROPOIESIS	IRON DEFICIENCY ANAEMIA
Hb	Low normal	Decreased
HCT	Low normal	Decreased
MCV	Low-normal to decreased	Decreased
MCHC	Low-normal to decreased	Decreased
Serum iron concentration	Decreased	Decreased
Serum transferrin concentration	Increased	Increased
Serum TIBC	Increased	Increased
Serum transferrin or TIBC saturation	<20%	<15%

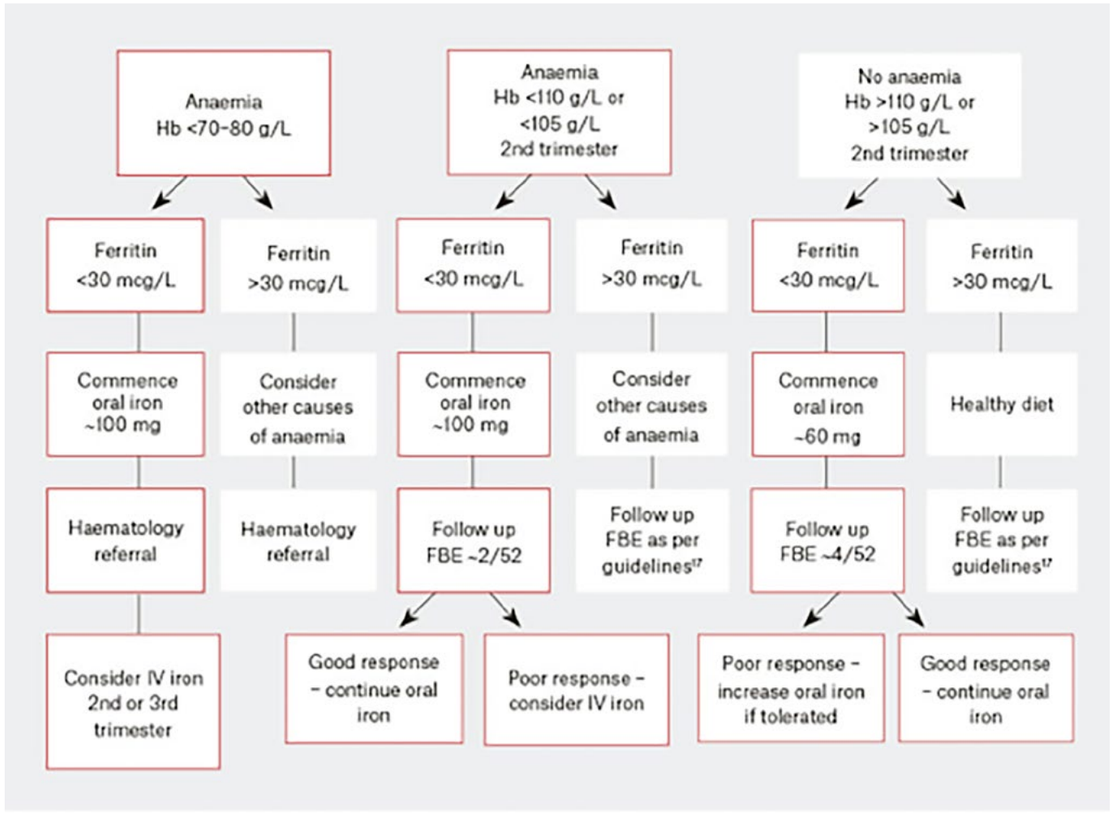
[2]

General practitioners and obstetricians often face the challenge of managing anaemia in pregnancy. There are numerous causes for anaemia, with iron deficiency being the most common. Other causes include micronutrients deficiencies such as B12 or folate, haemoglobinopathies, thalassemia, gastrointestinal conditions and malabsorption issues such as coeliacs or inflammatory bowel disease, chronic disease, infection and rarely may indicate a more sinister cause such as underlying bone marrow issues or malignancy1,2. Normal pregnancy is associated with a physiological anaemia related to a plasma volume expansion of approximately 50%, while red cell expansion only increases by about 25%3.

There is no current definition within Australian guidelines that define anaemia in pregnancy. WHO guidelines suggest a haemoglobin below 110g/L or a haematocrit below 33% defines anaemia and requires further investigation4,5. Currently, approximately 50% of anaemia in pregnancy is caused by iron deficiency. The need to identify iron deficiency and other micronutrient deficiencies, particularly in high-risk groups such as Indigenous and Torres Strait Islander and immigrant communities, is important to avoid morbidity and mortality within the mother and the fetus1,2,4. Other at-risk groups to consider are vegetarians, vegans and pescatarians, low socio-economic groups and those who for religious reasons my refuse blood transfusion support in the event of a post-partum haemorrhage.

Early identification and treatment of iron deficiency anaemia can reduce adverse effects such as maternal fatigue, shortness of breath, lightheadedness or difficulty concentrating and the need

Early identification and treatment of iron deficiency anaemia can reduce adverse effects such as maternal fatigue, shortness of breath, lightheadedness ...



for post-partum transfusion support. The average blood loss during delivery was 300ml in vaginal deliveries and 800ml for caesarean delivery, further impacting a woman's iron storage6. Fetal implications include intrauterine growth retardation, prematurity, neurodevelopmental impact and infant death2.

Physiological demand for iron during pregnancy is three times greater, equating to 27mg/day 1,4. Prenatal vitamins can vary in their iron content, ranging from 0 to 60mg1. Over the counter iron supplements such as Ferro-Grad C and Maltofer increase the elemental iron content to around 100mg, however these tend to be poorly tolerated in the later stages of pregnancy with side effects such as constipation, nausea and reflux depending on the dose7.

Interpretation of iron studies can sometimes be difficult and serum ferritin concentration is often used to identify those women who are iron deficient. However, this can be impacted by a variety of factors with infection or underlying inflammation causing a falsely elevated result. A full iron status is a more accurate way of identifying women who are truly iron deficient.

Replacing iron for women who are deficient should include a trial of per oral supplementation. Careful consideration of which pre-natal supplementations women are taking and compliance should be a part of the history taking. Switching to a pre-natal vitamin with supplemental iron or the addition of a per-oral iron supplement such as Ferro-Grad C or Maltofer should be trialled. For patients who tolerate per oral supplementation, continuation on supplements for the remainder of the pregnancy and for 6 weeks post normalisation of iron studies in conjunction with a healthy diet should be adhered to7. Women who are in their second to third trimester, or those who are intolerant to per oral supplementation, intravenous replacement should be considered. The algorithm above from the Australian Journal of General Practice shows a logical approach to tackling iron deficiency in women. 1

Icon Cancer Centre can offer same day consultations for investigations of other potential causes of anaemia, and iron infusion if appropriate. A phone review with repeat blood tests is conducted 6 weeks post-partum to reduce the impact of an in-person consultation on new mothers and to assess if further intervention is required.

Biography

Dr Renee Squires is a clinical haematologist at Icon Cancer Centre Southport. In 2008, she completed her Bachelor of Medicine and Bachelor of Surgery (MBBS) at James Cook University and then commenced specialist training in haematology, bone marrow transplantation and haematology pathology at Townsville Hospital, Royal Brisbane and Women's Hospital and Sullivan and Nicolaides Pathology. She is a fellow of the Royal Australasian College of Physicians (FRACP) and Royal College of Pathologists of Australasia (FRCPA).

Dr Squires is experienced in caring for a wide range of malignant and non-malignant blood disorders including leukaemia, lymphoma, myelodysplasia, myeloproliferative disorders, myeloma, haemoglobinopathies and thrombosis. She also has experience in managing women's health, obstetric haematology, clotting and bleeding disorders in addition to autologous and allogenic stem cell transplantation and apheresis procedures. Dr Squires is accredited at Gold Coast Private Hospital, Pindara

> **There is no current definition within Australian guidelines that define anaemia in pregnancy. WHO guidelines suggest a haemoglobin below 110g/L or a haematocrit below 33% defines anaemia and requires further investigation[4,5].**

References

1. AJGP-03-2019-Clinical-Frayne-Anaemia-Pregnancy-WEB.pdf.
2. T, M., Robert. Iron Deficiency and Iron Deficiency Anemia: Implications and Impact in Pregnancy, Fetal Development, and Early Childhood Parameters. Nutrients 12, 447.
3. Auerbach, M. & Landy, H. Anaemia in Pregnancy. (2022).
4. Organization, W. H. Anaemia in Women and children. http://www.who.int/data/gho/data/themes/topics/anaemia_in_women_and_children.
5. Breymann, C. Iron Deficiency Anemia in Pregnancy. Seminars in Hematology 52, 339–347 (2015).
6. N, C., Shayna et al. Accuracy of Estimated Blood Loss in Predicting Need for Transfusion after Delivery. Am J Perinatol 32, 1225–1230.
7. Wu, T.-W. & Tsai, F.-P. Comparison of the Therapeutic Effects and Side Effects of Oral Iron Supplments in Iron Deficiency Anaemia. Drug Res (2016).

Garden and Graves

Our Museum is situated on one of the last remnant inland sand dunes in the area. This "sandy ridge" was used as a burial ground for local family members connected with the Bundall Sugar Plantation & Mill, dating as far back as 1873. Some of the larger trees are heritage listed with the City of Gold Coast such as the Quinine trees (Petalostigma pubescens), and are remnants of the littoral rainforest found amongst the dunes and mangroves that once stretched along the coast. Volunteer gardeners maintain the various sections including; the cottage garden, Wallum garden (heath plants that thrive on nutrient poor, sandy soil), littoral rainforest, banksia woodland, an Aboriginal plant trail as well as feature and screen gardens. We also have abundant bird life that visit and live in the grounds including rainbow lorikeets, scaly breasted lorikeets, magpies, butcher birds, corellas, rosellas and woodland ducks.

Visit and support your local Museum!
Instagram: @goldcoasthistory www.gcmuseum.com.au
Facebook: Gold Coast Historical Society & Museum

94.1 FM · Griffith University · Gold Coast Private Hospital

Visit Your Local Museum

The Gold Coast Historical Museum is situated on 1.7 acres off Bundall Road. The museum site was originally part of an Aboriginal gathering place with evidence of middens (prehistoric refuse piles containing shells and bones) in the grounds. Artefacts from that time period have also been found nearby and are on display. In later years, when the Bundall sugar plantation & mill was in operation (1872 - 1888), "the hill" as it was known, was a cemetery for these pioneers.

GOLD COAST HISTORICAL MUSEUM INC.
8 Elliott Street, Surfers Paradise
(off Bundall Road) Gold Coast, Australia

Open - TUESDAY 9am to 1pm
WEDNESDAY 9am to 1pm & SUNDAY 10am to 3pm
Entry: $5 donation adults, children free.
Email: histsocbun@bigpond.com

Managing Gender Dysphoria in Young People – A Practical Guide

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

Gender dysphoria/incongruence in young people is a contested area of medical practice. This guide describes a practical approach that avoids political, social, religious and ideological positions.

This approach to developing guidelines for managing gender dysphoria [1] or gender incongruence [2] in children and adolescents aims to protect and safeguard the health, safety and welfare of the child. This guide prioritises the best interests of the child in accordance with human rights obligations under the International Convention of the Rights of the Child [3].

Specifically, this guide:

- While respecting young people's views about their gender identity, it does so as part of the totality of their developmental and holistic clinical picture, and incorporates these into the clinical formulation. This approach requires that a comprehensive bio-psycho-social assessment of the young individual and their family be conducted before recommending specific treatment.

- Acknowledges that childhood and adolescence is a time of rapid physical and psycho-social growth and profound personal development, during which young people may question their identity, sexual orientation and gender. As the child matures and progresses through puberty this questioning usually transforms and resolves, and the young person, in the majority of cases, accepts his/her biological sex and adult body [4, 5].

- Understands that gender dysphoria/incongruence can be both a symptom and a syndrome. For a young person to have the syndrome of gender dysphoria/incongruence there must be a significant, established and prolonged pattern [2] of desire and behaviour that indicates the person insists they are a gender different to their biological sex and natal (birth assigned) gender.

- Recognises that gender dysphoria/incongruence can often be a manifestation of complex pre-existing family, social, psychological, or psychiatric conditions or predisposing factors [6]. A holistic approach to assessment includes a comprehensive exploration for these potential conditions in order to more fully understand a child presenting with gender dysphoria/incongruence [7,8]. Where these conditions are presenting as gender dysphoria/incongruence, the treatment of the underlying condition is a priority.

Individualised psychosocial interventions (e.g., psychoeducation, individual therapy, school-home liaison, family therapy) should be first-line treatments for young people with gender dysphoria/incongruence. Exploratory psychotherapy should be offered to all gender-questioning young people to identify the many potential sources of distress in their lives in addition to their gender concerns. Clinicians can apply a range of psychological interventions (e.g., supportive psychotherapy, CBT, dynamic psychotherapy, and family therapy) to assist the young person clarify and resolve these contributory factors. Such approaches are consistent with established principles of comprehensive, systemic youth health care [7]. They should be undertaken before experimental puberty-blocking drugs [9] and other medical interventions (e.g., cross-sex hormones, sex reassignment surgery) are considered.

Psychotherapy for gender dysphoria in children and adolescents is a respectful, supportive and exploratory process that does not seek any particular outcome in relation to gender identity or sexual orientation. It seeks to understand the nature and meaning of the young person's gender distress and the context in which it has arisen. Psychotherapy addresses the multiple factors that contribute to the young person's difficulties, helping to address issues that resolve distress and support ongoing development and maturation. Conversion therapies, on the other hand, aim to

achieve a pre-determined outcome, such as gender normativity or heterosexual orientation. Psychotherapy for gender dysphoria must NOT be conflated with conversion therapies.

Medical interventions to block puberty and cross-hormone treatment to achieve feminization and masculinization according to the young person's perceived gender are not fully reversible and can cause significant adverse effects on physical, cognitive, reproductive and psychosexual development [9,10,11,12,13,14,15,16].

Currently, while some individuals report a successful transition, we are not aware of published long-term outcome studies that have followed up adults who have undergone childhood or adolescent transition that show substantial benefit. As a consequence, there is no consensus that medical treatments such as the use of puberty-blocking drugs, cross-sex hormones or sexual reassignment surgery lead to better future psychosocial adjustment [17,18,19,20].

Increasing numbers of individuals who have undergone hormonal treatment and surgical interventions subsequently report experiencing regret and a wish to de-transition [21]. They describe significant psychological and physical suffering, including loss of fertility and sexual function as a consequence of decisions made when younger [22,23,24,25,26,27].

Medico legal considerations must be fully appreciated in this area of clinical practice. Health professionals are exposed to significant legal risk:

- If a child or adolescent is found not to have been competent to give an informed consent,
- If in children under age 16 years both parents have not agreed to puberty suppression and cross-hormone treatment,
- If gender affirming treatment is not preceded by a comprehensive psycho-social assessment, that considers and excludes alternate diagnoses, or
- If the patient was not informed of all the risks of puberty blockers and cross-hormone treatment including their experimental nature [9].

Clinicians should therefore reflect carefully before recommending treatments for gender dysphoria/incongruence.

The still unproven risks and benefits of gender reassignment interventions make it imperative that parents and children under 18 years and young people over 18 years are made aware of the current evidence of potential harm regarding gender transition and provide fully informed consent before potentially damaging and irreversible treatment is commenced.

This cautious approach is also mirrored in clinical guidance by national treatment advisory bodies in Finland, Sweden, France and the United Kingdom that recommend treatment methods for gender dysphoria in minors [28, 29, 30, 31]. In Finland, the clinical guidance recommends that among young people with gender dysphoria and significant psychiatric comorbidity, no conclusions can be drawn on the stability of the gender identity of the child at that stage [28].

In preparing this guide, advice was obtained from a number of senior medical colleagues in child and adolescent psychiatry, adult psychiatry, and forensic psychiatry, as well as from physicians and psychologists who have cared for young people experiencing gender dysphoria/incongruence, and legal practitioners who have experience in this field.

References

1. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.

2. World Health Organization. (2018). International classification of diseases for mortality and morbidity statistics (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en

3. UN Commission on Human Rights, Convention on the Rights of the Child., 7 March 1990, E/CN.4/RES/1990/74, available at: https://www.refworld.org/docid/3b00f03d30.html [accessed 3 November 2020]

4. Entwistle K. Debate: Reality check – Detransitioner's testimonies require us to rethink gender dysphoria. Child Adolesc Ment Health. 2020. doi:10.1111/camh.12380

5. Ristori J, Steensma T. Gender dysphoria in childhood. International Review of Psychiatry. 2016;28(1):13-20. doi:10.3109/09540261.2015.1115754

6. Kozlowska K, et al. Attachment patterns in children and adolescents with gender dyshoria. Frontiers in Psychology, 12 January 2021.

7. Kozlowska K, et al. Australian Children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems: Therapy, Culture and Attachments, 22 April 2021.

8. Kosky R. Gender-disordered children: does inpatient treatment help? Medical Journal of Australia 1987;146:565-69 (June 1, 1987). doi: 10.5694/j.1326-5377.1987.tb120415.x

9. https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf

10. Vlot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. Bone. 2017;95:11-19. doi: S8756-3282(16)30333-7 [pii].

11. Vlot MC, Wiepjes CM, de Jongh RT, T'Sjoen G, Heijboer AC, den Heijer M. Gender-affirming hormone treatment decreases bone turnover in transwomen and older transmen. J Bone Miner Res. 2019;34(10):1862-1872. doi: 10.1002/jbmr.3762 [doi].

12. Schneider M, Spritzer P, Soll B et al. Brain Maturation, Cognition and Voice Pattern in a Gender Dysphoria Case under Pubertal Suppression. Front Hum Neurosci. 2017;11. doi:10.3389/fnhum.2017.00528

13. Auer MK, Ebert T, Pietzner M, et al. Effects of sex hormone treatment on the metabolic syndrome in transgender individuals: Focus on metabolic cytokines. J Clin Endocrinol Metab. 2018;103(2):790-802. doi: 10.1210/jc.2017- 01559 [doi].

14. Alzahrani T, Nguyen T, Ryan A, et al. Cardiovascular disease risk factors and myocardial infarction in the transgender population. Circ Cardiovasc Qual Outcomes. 2019;12(4):e005597. doi: 10.1161/CIRCOUTCOMES.119.005597 [doi].

15. Nota NM, Wiepjes CM, de Blok, C. J. M., Gooren LJG, Kreukels BPC, den Heijer M. Occurrence of acute cardiovascular events in transgender individuals receiving hormone therapy. Circulation. 2019;139(11):1461-1462. doi: 10.1161/CIRCULATIONAHA.118.038584 [doi].

16. Goodman M, Nash R. Examining health outcomes for people who are transgender. https://www.pcori.org/research-results/2013/examining-health-outcomes-people-who-are-transgender. Updated 2014. Accessed Nov 7, 2019.

17. 22 Dhejne C, Lichtenstein P, Boman M, Johansson AL, Langstrom N, Landen M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. PLoS One. 2011;6(2):e16885. doi: 10.1371/journal.pone.0016885 [doi].

18. Bränström, R., & Pachankis, Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. American Journal of Psychiatry. 2019;177(8), 727- 734. https://doi.org/10.1176/appi.ajp.2019.19010080

19. Correction to Bränström and Pachankis. American Journal Of Psychiatry. 2020;177(8), 734-734. https://doi.org/10.1176/appi.ajp.2020.1778correction

20. Kalin, N. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender Affirming Surgeries: A Comment by the Editor on the Process. American Journal Of Psychiatry. 2020;177(8), 764- 764. https://doi.org/10.1176/appi.ajp.2020.200608

21. Vandenbussche E. Detransition-related needs and support: a cross-sectional online survey. Journal of homosexuality. 2021 Apr 30; 1-19. Doi: 10.1080/00918369.2021.1919479.

22. Lesbian Strength 2019 – Charlie Evans. YouTube. https://www.youtube.com/watch?v=-JazgA3AdUE. Published 2019. Accessed November 1, 2019.

23. Female detransition and reidentification: Survey results and interpretation. archive Web site. https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey. Accessed Nov 7, 2019.

24. Pique resilience project. PIQUE RESILIENCE PROJECT Web site. https://www.piqueresproject.com/. Accessed Nov 7, 2019.

25. Subreddit survey update! : detrans. Reddit.com. https://www.reddit.com/r/detrans/comments/azj8xd/subreddit_survey_update/. Published 2019. Accessed November 1, 2019.

26. Reddit.com. Has anyone been to gender therapy? What was your experience?: detrans. [online]:https://www.reddit.com/r/detrans/comments/aeo5zd/has_anyone_been_to_gender_therapy_what_was_your/ Published 2019. Accessed November 1, 2019.

27. Tumblr: Guide on raging stars. Female detransition and reidentification survey. Available: https://tinyurl.com/female-detrans-survey. Published 2016. Accessed November 1, 2019.

28. Recommendation of the Council for Choices in Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors. Health Care in Finland (PALKO / COHERE Finland), 11 June 2020.

29. Linden T, MD PhD Director/Government Chief Medical Officer. The National Board of Health and Welfare, Sweden 2022.

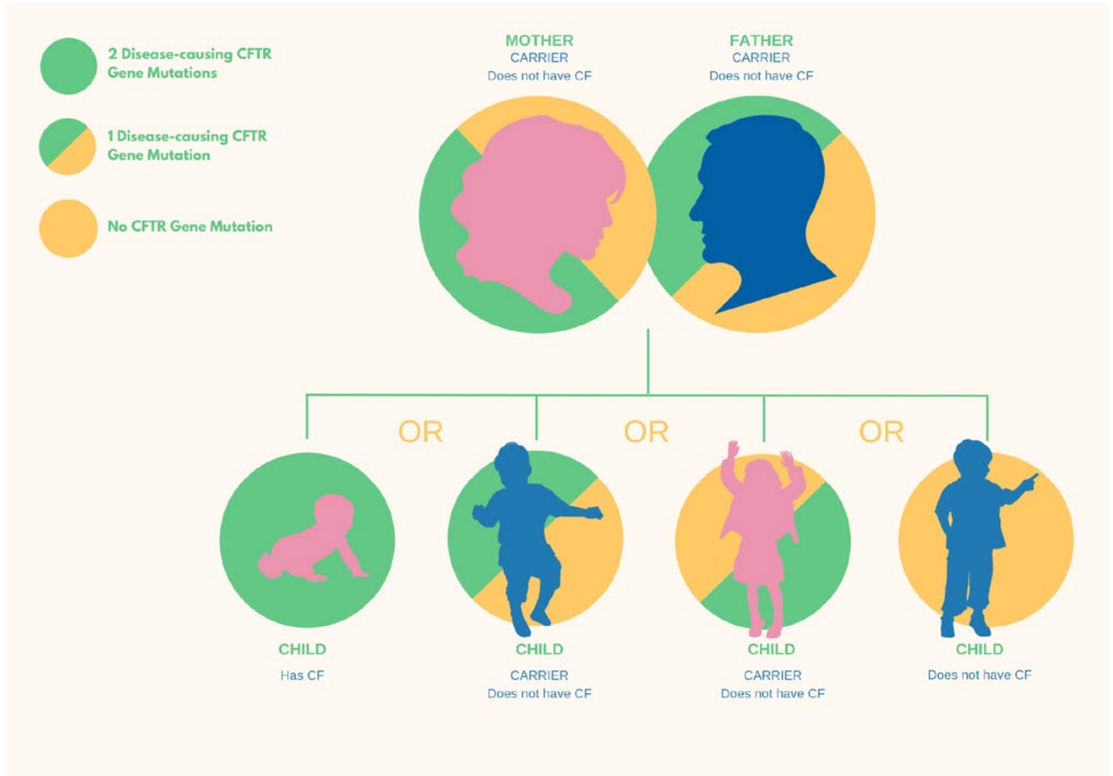
30. https://segm.org/sites/default/files/English%20Translation_22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf

31. https://cass.independent-review.uk/publications/interim-report/

Cystic Fibrosis in This Day & Age

E.K. Daley
The Medical Link
admin@themedicallink.com.au

Cystic Fibrosis is a progressive genetic disease that more than 70,000 people worldwide currently live with. Being a genetic disease, it is inherited from your parents. While the parent may not have CF, they may be a carrier.



The disease is caused by a mutation in the genes. One of the genes in our bodies is called the **Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) gene**. Everyone inherits two copies of this gene, which contains the instructions for making the CFTR protein. If one of the CFTR genes you inherit has a mutation (change) that causes CF, this means you are a "carrier" of the mutated gene, but you do not have the condition. If both CFTR genes you inherit have a mutation that causes CF, you are born with CF. There are around 3,235 people in Australia living with CF. (CF Source by Vertex Pharmaceuticals).

CF causes long lasting lung infections and limits the ability to breathe over time. CF is not discriminatory and affects people of every racial and ethnic group. In people with Cystic Fibrosis, the CFTR gene causes the CFTR protein to become dysfunctional. When this protein does not work as it should, it is unable to help move chloride to the cell surface. Without chloride to attract water to the cell surface, the mucus in various organs become thick and sticky. In the lungs, this mucus clogs the airways and traps germs, leading to infections, inflammation, respiratory failure, among other complications. Because of this, individuals with CF must avoid germs as a high priority.

In other organs like the pancreas, the build-up of mucus prevents the release of important digestive enzymes that help the body absorb food and key nutrients, resulting in malnutrition and poor growth. People living with CF are also prone to liver disease due to the mucus blocking the bile duct. In men CF can also cause fertility complications.

Symptoms of CF include salty tasting skin, persistent coughing, frequent lung infections, shortness of breath, poor growth or weight gain, nasal polyps, chronic sinus infections, frequent greasy, bulky stools, difficulty with bowel movements, clubbing, rectal prolapse, and male infertility.

Today because of improved medical treatments and more attention to care, more than half the people with CF are living healthy fulfilling lives into their 30s, 40s and beyond.

Saxon's Story – Told by his mother, Donna.

Saxon was diagnosed with cystic fibrosis from the heel prick test at birth, we found out that he had CF when he was four weeks old. We had no indication anything was wrong he was putting on weight and seemed to be thriving, so his diagnosis was a complete shock to us but once we learned more and looking back on those first four weeks Saxon did have a lot of digestive issues and I did notice after I kissed him I tasted salt on my lips which is an indication of cystic fibrosis as they lose a lot of salt through their sweat.

Living with CF has impacted Saxon greatly and of course as well as us. His daily life is full of medication and 20 plus tablets a day. He also does twice daily treatments one of them is called a PEP therapy combined with inhaling hypertonic saline (salty water) and the other nebulised medication he does this every day never a day off and if he should pick up even the slightest cold or cough, he must do these treatments twice daily which is usually a minimum of two weeks or until he recovers from it.

Not only does he have to be cautious of colds and coughs but also environmental factors as well stagnant water, dirt and mud are just a few examples of things we are very wary of as it harbours bacteria that is very harmful and dangerous to those with CF. Saxon has not been on any trials, his daily treatments are hypertonic saline combined with PEP which helps him bring up any mucus that is sitting on his lungs and he nebulisers Pulmozyme which thins out the mucus. these treatments are very effective in helping keep his lungs clear but sometimes he picks up a nasty bacteria which will put him in hospital for 2 weeks on strong iv antibiotics & intensive therapy & we come home he continues for a month on extra nebulised medication plus doubling his normal daily treatments. We are lucky that this medication is on the PBS which means the government subsidise it therefore each prescription cost us around $6.30 there are some incredible new medications that have come out and Saxon is very fortunate enough to be on one called Symdeko. He has been in this which for 18 months this drug thankfully is subsidised by the government at a cost to us $6.30 per month instead of the price tag of $25,000 per month and has changed his life, his lung function is now stable and slowly increasing, he has much more energy and his is keeping healthier this new medication came about from fundraiser dollars into research for better therapies.

We fought for years for better drugs for the CF community & soon Saxon will be on the latest one called Trikafta which is supposed to be 5x better than the one he is on now Symdeko. Our experience with doctors dealing with Saxons health has been interesting a lot of GPs don't know much about cystic fibrosis so it's always been hit and miss with getting the medical attention he needs. we found over time it's best if we can get down to Brisbane so he can be seen by the specialised CF clinic staff (which is a 2 hour drive from us) as the local hospitals and GPs are not very well informed with how to treat someone that has CF for example I had to take him to the ER at our local hospital many years ago after the EE doctor ran the standard tests she sent us home with a prescription for antibiotics for a chest infection he had no indication of anything happening with his chest it was actually severe tummy pain m. so I didn't agree with her diagnosis so I took him down to Brisbane and he had a bowel blockage so that's what we're dealing with up here.

So Saxon is now 17. 10 years ago, after I could wrap my head around his diagnosis, I started a fundraiser called 65Km's for Cystic Fibrosis which in the first year was 4 mums all with child with cystic fibrosis. we all ran a non-stop running relay of 65 Km's on a treadmill at our local Jetts Gym, since then the event has become an annual event. We always run in May because May is cystic fibrosis awareness month. this is our 10th year, and our event will be held this month 07th May. to date we have raised over $150,000 which has gone into research for better therapies and ultimately our cure and funds raised to cystic fibrosis Australia and Queensland to assist families where needed. my hopes naturally are that one day soon CF will stand for 'Cure Found' and I hope that will happen in my son's lifetime.

Ayden's Story – Told by his mother, Rachel.

In the June of 2010 our beautiful son Ayden was brought into our lives, along with a disease we weren't at all familiar with...Cystic Fibrosis. He was diagnosed via the heel prick test, but we didn't receive his results until he was 6 weeks old and already failing to thrive in a big way. Our Cystic Fibrosis journey began the very next day, going to the hospital to meet the multiple people that would teach us how to care for our son, and all the medications he was going to need just to grow and breathe.

The day we found out I had taken him to our GP as I had endured 6 weeks of feeding around the clock and he would just scream in pain any time he wasn't feeding and he had lost so much weight, he was only 2.7 kgs born and had lost over 10% of his body weight by this time. The midwives that visited the house thought I wasn't feeding him, or there was something wrong with my milk, so they would come to the house every day to weigh him, clothes on, then clothes off, with him screaming the whole time. Watching me feed him, then watching me express and feed him with a bottle. They then said he was tongue tied. My mum had started staying over during the night so I could get some rest, but he would just scream around the clock, he was slowly starving to death, everything would go straight through him, or he would do big mucus vomits, he needed digestive enzymes to help absorb any of the nutrients I was giving him.

CF has impacted our lives immensely, from the beginning, not being able to take Ayden to places for fear of him picking up viruses, leaving birthday parties and family functions as someone there was unwell. Teaching family and close friends how to administer his medications and follow strict hygiene practices. From this we have lost relationships with family and friends, we have also moved states from NSW to QLD for his health and struggled financially due to me not being able to return to work for 10 years due to being a primary carer and his regular hospital admissions.

Ayden had a rough start, up until the age of 6. He cultured pseudomonas at 8 months old and this affected him greatly. He was in and out of hospital many times trying to eradicate this bug, he was considered colonised by the Drs with this bug from the age of 2. He also cultures Staphylococcus aureus all the time in his sinuses.

At present Ayden is 11 years old. During this time, he has had:

- Tune Ups: x 7 2/3 weeks each time of intensive IV & physio treatment in hospital
- Admissions for bowel issues: 3 (due to compactions and suffered with rectal prolapses for 1 year)
- Doses of Laxatives or stool softeners: Twice a day for 8 years
- Chest Xray's: 13
- Sinus surgeries: 3 due to polyps
- CT Scans: 4
- Sputum's samples: 125
- Salt tablets: 18,980
- Days on antibiotics: 1211 (half that time spent on combination of 2 + antis)
- Physio: 4,200 hours
- Enzyme tablets: 44,945
- Vitamins: 7,400 vitamin tablets
- Nebulisers: 1,635 Tobi nebs
- Hypertonic Saline nebs: 1,460
- Pulmozyme nebs: 4,020
- Orkambi tablets: 1825

He has been part of a few trials, one for measuring physio and growth of bones and muscles which involved a lot of extra special scans and tests. Watching liver disease progression in children that are identified as having CF related liver disease early, which involves some extra liver scans and blood tests every year. One with the Multiple Breath Washout test, which detects early lung changes better than traditional lung function tests and how well they are clearing out specific gasses from their lung tissue.

We are extremely lucky in Australia to have PBS and Medicare. Ayden was issued a health care card when he was born, regardless of our financial situation, due to him having a 'life limiting' illness. I am extremely worried about this when he turns 16 as he will automatically lose his health care card. To put in perspective why this worries me, as an example of two of his medications; a script for 1 month supply of Pulmozyme at full cost is over $1000. His enzyme tablets at full price cost $120 per bottle for 100 tablets, he must have 1 tablet per 8 grams of fat that eats daily…You can do the calculations on that one!

Cystic Fibrosis Aus has been lobbying the government for years to change this ruling, to date there has been no success, so in the government's eyes when he turns 16 CF automatically goes away!?

The costliest part of Ayden's healthcare has been the car parking and meals when in hospital. I've also had multiple fines for parking for over 2 hours on the street when the car park has been full, I can't exactly move my car when Ayden is in the middle of a procedure that we have had to wait an extended time to perform.

We have been in many challenging situations with medical professionals over the years. His specialist CF doctors have always been super supportive and understanding, acknowledging the emotional and psychological burden that CF can have, not only on Ayden but the whole family.
However, nursing staff on wards, dieticians, non-specialist CF doctors, in ED for e.g., and GPs, have put us through extra emotional stress that isn't needed. I have had regular medications that he has to take, like his enzymes since he was 6 weeks old, every time he eats, taken away from us and must call a nurse to administer them, and must wait until said nurse is not busy to bring them to us when he has been delivered breakfast, lunch and dinner. The OTs (Occupational Therapists) have been essential to Ayden's wellbeing and overcoming big feelings and his acute procedure anxiety with finger pricks and blood tests.

I do wish that we didn't have to repeat his entire medical history and list of medications when we transfer hospitals or wards or when a shift changes, or have groups of Drs walk into your room first thing in the morning when you haven't slept all night and ask a bunch of questions, which I know they use as a learning opportunity, which is great, I'm all for learning, but not at the expense of us when we are extremely anxious & exhausted when our child is unwell. CF never has a day off, treatment, cleaning and medication regimes are endless. If doctors had more understanding of this and understanding that there is a human side of this disease instead of just what it says in the textbooks.

"Non-CF doctors could have more knowledge about CF so that they can help and be more cautious about what they say so that I don't stress about anything that is going to happen." Ayden says

There has never been a more exciting time in relation to being the 'closest' we've been to a cure for CF with the new gene altering therapies from Vertex Pharmaceuticals.

The PBS has recently (1st April 2022) approved the latest gene therapy called Trikafta, used to treat cystic fibrosis (CF) in patients aged 12 years and older who have at least one F508del mutation in the CFTR gene, we are waiting to get access to this one, so this will be an upgrade (were hoping) from Aydens existing mediation Orkambi, Trikafta is a combination of ivacaftor, tezacaftor and elexacaftor. While Orkambi is a combo of ivacaftor with lumacaftor.

"If there was a cure, I could stop taking tablets and doing treatments, I wouldn't have to rely on doing those things every day to keep me well and so I could just be normal. A treatment that does everything you would usually do in a shorter time span would mean that I have more time to do the things I enjoy doing." Ayden inputs.

* * *

Both mothers are powerhouse's behind NFP's and other organisations that are searching for a cure to CF every day. Donna started 65Km's for Cystic Fibrosis, an annual event to raise money for CF research. 65km's for Cystic Fibrosis was founded by Donna alongside parents of children with CF and in partnership with Jett's Gym to bring awareness and raise money for disease research. They recently participated in this annual event on the 7th of May. Funds donated to the My Cause Gift Fund will be split 50/50 between Cystic Fibrosis Queensland and Cure4CF Foundation. The Trustees will always disburse funds to the nominated cause, however in the case that is not possible, the funds will be disbursed to a DGR charity at the trustee's discretion.

In Donna's words "As Mums to young children suffering with this disease, we wanted to inspire them to keep as active as possible & also push ourselves in breathlessness as a symbolic way to raise awareness & also much needed funds to help families suffering with CF & into research for better therapies & ultimately our Cure Found".

To donate to the cause, visit www.65kms.com

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Rachel works for Air Liquide – the second largest supplier of industrial gases by revenues and has operations in over 80 countries – as Manager Sleep Solutions ALH Gold Coast & Northern NSW.

Rachel and her family have been a part of many charity fundraising events for Cystic Fibrosis since 2010. Their first event was the CF walkathon when Ayden was 5 months old, in which we raised $11k for CF NSW. We coined the term 'Team Chriso 4 CF' which is their fundraising name.

They went on to host charity golf days and raised over $56,000 in NSW before moving to QLD which they were lucky to have a very supportive community that got involved and were very successful. They managed to raise money for CF NSW and purchased medical equipment for the CF clinic at the Children's Hospital Westmead, specialist sinus nebulisers, iPads for every clinic room for kids to play for the day while waiting for their various appointments and a special vest that we got to assist with Ayden's physio treatments. Rachel's husband has participated in a charity boxing event for CF QLD which they raised $8k.

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