

GPNews

Strathfield Private Hospital
3-5 Everton Road
Strathfield NSW 2135

T: 02 9745 7444

strathfieldprivate.com.au

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WHAT'S INSIDE

- 4 Peripheral Artery Disease, Dr Robert Tang
- 5 Ankle Arthritis, Dr Mark Kao
- 6 Bunions, Dr Alice Chang
- 7 Obstructive Sleep Apnoea, Dr Lyndon Chan
- 8 Scaphoid Fractures, Dr Jai Sungaran
- 9 Chronic Rhinosinusitis, Dr Catherine Banks

WINTER 2020 EDITION



**Strathfield
Private Hospital**

Part of Ramsay Health Care

A word from the CEO

Welcome to the Winter 2020 edition of our GP Newsletter.

As we move through COVID-19, the wellbeing of our people – patients, staff and doctors – remains our highest priority. Thanks to the preparedness of Ramsay Health Care, Strathfield Private Hospital has been well equipped to provide a safe environment and continue to deliver a high standard of care during this unprecedented time.

We understand the rapidly evolving effects of the pandemic may result in high levels of concern for your patients. I would like to assure you that our strict infection control protocols remain in place to protect patients, staff and visitors. These include a single entry point, appropriate screening (including temperature checks) of all visitors upon entry and strict social distancing measures. These are reviewed and updated in line with NSW Health and government guidelines.

In regards to elective surgery, I am pleased to announce that as of July 1st all elective surgery restrictions have been lifted across Ramsay facilities and we are working towards 100% capacity. The reintroduction of elective procedures will be made with the safety of our people remaining the top priority.

We understand this has been a challenging time for you and your patients, and we appreciate your patience and support as we move forward together.



Rowann O'Mullane

CEO/Director of Clinical Services
Strathfield Private Hospital



About Strathfield Private Hospital

Strathfield Private Hospital has been servicing the community of Sydney's inner west for over 25 years and is owned by global hospital group Ramsay Health Care. We cater for a broad range of health care needs from day surgery procedures to highly complex surgery.

Our facilities encompass 84 beds, 7 operating theatres, 1 endoscopy suite, 1 cardiac catheterisation lab, a 10 bed Intensive Care and Coronary Care Unit and a Day Surgery Unit. We also have onsite radiology and pathology.

Our specialties include:

- Bariatric Surgery
- Breast Surgery
- Cardiology/Cardiothoracic Surgery
- Colorectal Surgery
- Dental Surgery
- Ear, Nose and Throat Surgery, including paediatrics
- Gastroenterology
- General Surgery
- Gynaecology
- Head and Neck Surgery
- Oral Maxillo-facial Surgery
- Orthopaedic Surgery
- Plastic & Reconstructive Surgery
- Upper Gastro Intestinal Surgery
- Urology
- Vascular Surgery



GP Hotline | 02 9745 7899

Strathfield Private Hospital has implemented a GP Hotline to assist in improving referral pathways for GPs and their patients. Please call us if you would like information on hospital services or If you are looking for a specialist who, for example:

- Consults in a specific location
- Speaks a particular language
- Specialises in a specific subspecialty area
- Conducts telehealth consultations

The hotline will connect you with a hospital representative who can assist where needed.



New technology a game changer for Inner West heart patients

Inner West Sydney heart patients now have access to new state-of-the-art technology that provides faster procedures and cuts radiation exposure in half. The recently built cardiac catheter lab at Strathfield Private Hospital is home to a new \$1 million diagnostic image-guided therapy system that visualises arteries and chambers of the heart.

Cardiologist, Professor Mark Adams, said the new Phillips Azurion system is used for both diagnostic and therapeutic procedures in heart patients. "Apart from being more efficient, the system reduces radiation exposure by about half for patients and staff," he said. "It is believed to be the most up-to-date equipment in the Inner West region and will really help with high risk cases and

complex coronary procedures where very high-resolution images are required."

Prof Adams said the system produced high quality images and allowed specialists who worked at Strathfield Private Hospital to perform complex procedures that previously had to be treated elsewhere. "We have an ageing population in this region and it's important that they feel confident they will receive top quality care and have access to the most up-to-date medical equipment within their own community," he said.

Strathfield Private has had a long history of providing high quality cardiac services and the new Cardiac Catheter Lab would ensure its reputation as an exceptional centre for heart disease would continue.

The lab offers a full range of both mainstream and complex cardiac interventions including diagnostic procedures and treatment for conditions including heart disease and cardiac arrhythmias. Doctors who have used the new system are extremely satisfied with the quality and capability of the equipment.

Strathfield Private Hospital has been providing cardiac services for 25 years and cares for cardiac patients throughout New South Wales. The hospital performed Australia's first private heart surgeries and treated more than 730 cases in its previous Cardiac Catheter Lab in 2019.

Cardiology and Cardiothoracic Surgery at Strathfield Private

Specialists

Cardiologists

Professor Ian Wilcox
Ph: 02 9516 3456

Professor Mark Adams
Ph: 02 9516 3456

Dr Michele McGrady
Ph: 02 9516 3456

Dr Mark Herman
Ph: 02 9747 4133

Dr Kevin Fung
Ph: 9398 6666

Dr Sean Lal
Ph: 02 9516 3456

Dr Pavan Chandrala
Ph: 02 9747 4133

Cardiothoracic Surgeons

Dr Matthew Bayfield
Ph: 02 9550 1933

Professor Paul Bannon
Ph: 02 9188 4044

Professor Brian McCaughan
Ph: 02 9550 1933

Dr Benjamin Robinson
Ph: 02 9550 1933

Interventional Cardiologists

Professor David Brieger
Ph: 02 9767 7282

Dr Kim Chan
Ph: 02 9515 8063

Dr Sanjay Patel
Ph: 02 959 6875

Dr Hatish Jangwal
Ph: 02 9519 6875

Dr Kaleab Asress
Ph: 02 9722 7060

Dr Young Yu
Ph: 02 8917 3322

Facilities

Our 10 bed Intensive Care and Coronary Care Unit provides specialised care for patients who require intensive nursing care and advanced respiratory, cardiac and renal support. Our Intensive Care Consultants and specialised nurses provide 24 hour care.

Our cardiac catheter suite features sophisticated automated digital medical imaging equipment and can perform the latest tests and procedures in the diagnosis and treatment of heart disease and cardiac arrhythmias.

Our 29 bed cardiovascular unit is staffed by specialist nurses who care for patients pre and post cath lab and surgical procedures. Medical management is provided for conditions including chest pain, heart failure, respiratory conditions and arrhythmias.

Peripheral arterial disease: who needs urgent assessment?

Dr Robert Tang

Peripheral arterial disease (PAD) is divided into acute limb ischaemia and chronic limb ischaemia. The former is the most feared arterial compromise and requires immediate treatment. The majority of the PAD are chronic leg ischaemia, which includes intermittent claudication(IC) and critical limb ischaemia(CLI).

Critical limb ischaemia:

- Rest pain
- Tissue loss
- The European Consensus defines CLI as rest pain for more than 2 weeks, or ulceration/gangrene, and an ankle pressure of <50 mmHg or a toe pressure of <30 mmHg

IC and CLI are very different prognostically; IC patients have amputation rates of 1%-7% at 5 years compared to CLI patients who has approximately 40% chance of losing their legs and 20% chance of death within 6 months of onset. Hence, patients with CLI should be seen urgently.

The Rutherford's classification system is commonly used for PAD. Diabetic foot can also present as neuro-ischaemic ulceration as diabetics usually have a propensity for tibial arteries disease and they should be reviewed promptly.

Rutherford Classification

Stage 0 – Asymptomatic

Stage 1 – Mild claudication

Stage 2 – Moderate claudication

Stage 3 – Severe claudication

Stage 4 – Rest pain

Stage 5 – Ischaemic ulceration not exceeding the digits of the foot

Stage 6 – Severe ischemic ulcers or frank gangrene

History and physical examination should be focused on excluding acute limb ischaemia and neurogenic claudication. Buerger's test involves lying the patient supine and raising their legs until they go pale and then lowering them. It is positive if the foot becomes hyperaemic. The angle at which limb goes pale is termed Buerger's angle; an angle of less than 20 degrees indicates severe ischaemia.

Investigations

Duplex ultrasound – in experienced hands, it is accurate at identifying disease from the common femoral to the distal popliteal artery, with a sensitivity of 84–87% and specificity of 92–98% compared to catheter angiography. This usually suffice as the initial test prior seeing a vascular surgeon.

Computed tomography angiography - has limitations with severely calcified vessels e.g. in tibial arteries seen in diabetics.

Magnetic resonance angiography - not commonly used.

Ankle-brachial index is a useful and non-invasive test:

- >1.30 incompressible
- 1-1.30 Normal
- 0.90-1.0 Equivocal
- <0.90 PAD
- Limitations- calcified vessels in diabetics or patient with end stage renal failure

Management

PAD medical treatment - risk factors management, smoking cessation, antiplatelets and a statin.

CLI-Revascularisation (open surgery or endovascular interventions) to prevent limb loss or primary amputation.

IC-Exercise therapy has been shown to be the initial treatment of intermittent claudication. It involves exercise training, in the form of walking, should be performed for a minimum of 30 to 45

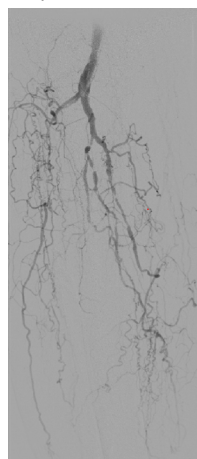


Figure 1.

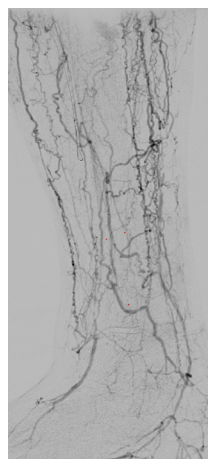


Figure 2.

minutes per session, three to four times per week, for a period not less than 12 weeks. It improves symptoms and reduces cardiovascular risk by lowering cholesterol and blood pressure and by improving glycaemic control. If that fails and affects quality of life, then revascularisation can be contemplated.

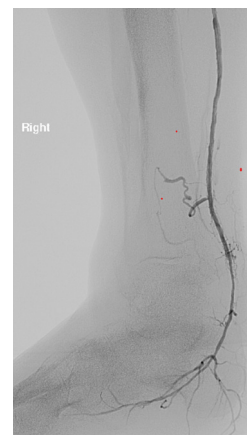


Figure 3.

Figure 1 and 2-a diabetic with significant ulceration with all 3 tibial arteries occluded.

Figure C-The posterior artery was recanalised using subintimal arterial flossing with antegrade-retrograde intervention (SAFARI) with a puncture in the common femoral artery and a puncture in the distal posterior tibial artery and advancing and advancing wires and catheters to cross the lesion. Subsequently, the lesion was treated with angioplasty balloons. ■

Dr Robert Tang

MBBS, MS, FRACS(Vasc)

Dr Robert Tang is a vascular, endovascular and vascular access surgeon with interests in peripheral vascular disease, extracranial carotid disease, aortic stenting, vascular access, varicose veins and diabetic foot disease. Dr Tang also consults in Eastwood and Penrith.

74 Burwood Road
Burwood NSW 2134

T: 02 9161 1668

F: 02 9475 1328

W: vascularsydney.com.au

L: Cantonese, Mandarin

PA: Concord, Nepean



Managing ankle arthritis

Dr Mark Kao

Incidence and aetiology

The ankle joint is far less commonly affected by arthritis than other major joints. The reasons for this include differences in articular cartilage, joint motion, and the susceptibility of cartilage to inflammatory mediators. The most common cause of end-stage arthritis of the ankle is trauma. Additional causative factors include arthropathies, chronic ankle instability, malalignment, and certain medical conditions, such as haemophilia.

Diagnosis

A patient who presents with end-stage ankle arthritis often reports considerable limiting pain. It is important to obtain a thorough history to differentiate between the most common causes of ankle arthritis. The examiner should ask about a history of trauma to the extremity, including fracture or recurrent sprains. Other less common aetiologies to inquire about include a history of inflammatory or infectious arthropathies, gout, haemophilia, or neuropathy.

The examination should begin with simple observations in standing. This assessment include looking for any residual signs of trauma, such as previous surgical incisions or skin graft sites. The overall alignment of the lower extremity should be evaluated. On standing, the heel should fall into slight valgus of 5-7 degrees. It is also important to evaluate the alignment of the knees. Next, the gait pattern should be assessed to look for abnormal loading of the foot as it contacts the ground. A neurovascular examination should be performed to exclude neuropathy. Motion of ankle and subtalar joints should be assessed, as well as areas of point tenderness. Although it's uncommon to have instability in the setting of arthritis, the ligamentous integrity of all joints should be assessed and documented.

A complete weight-bearing radiographic series of the ankle is the first investigation required to further evaluate the extent of the arthrosis. In addition, the weight bearing radiographs of the foot may

be necessary to assess for adjacent joint arthritis. On occasion, CT may be obtained when deformity is present, large subchondral cystic change is suspected, talar topography is altered (as in osteonecrosis), or further characterization of the joint is desired.

Treatment

Nonsurgical

The mainstay of initial treatment of ankle arthritis is managing the patient's symptoms non-surgically. Options include NSAIDs, bracing, shoe modifications, mechanical unloading, and selective joint injection.

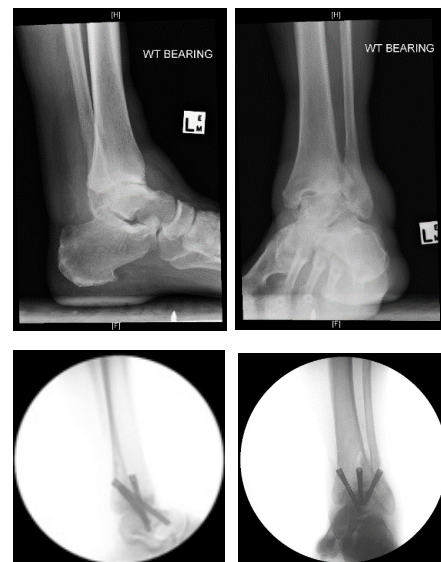
Surgical

When nonsurgical measures do not provide adequate symptom relief, two primary treatment options exist for global end-stage ankle arthritis: ankle arthrodesis and total ankle arthroplasty (TAA). Both have reported similar good or excellent outcomes. Clinicians who favour arthroplasty point to the risk of non-union with arthrodesis, as well as adjacent joint disease, and loss of normal ankle motion which affect the patient's functional status. TAA has the advantage of earlier weight bearing after the operation, and maintained ankle range of motion hence closer to normal biomechanics of the lower limb. However, it should be approached with caution, as patient selection is of utmost importance in TAA. Not every patient with end-stage arthritis is a candidate for TAA. Patients with acute or chronic joint infections, an insensate foot, severe multiplanar deformity, severe joint laxity with non-reconstructible ankle ligaments, Charcot arthropathy, osteonecrosis of the talus, severe osteopenia or osteoporosis, obesity, and young heavy labourers are often poor candidates for this procedure, with increased risk of failure and revision.

Summary

In some patients, global end-stage ankle arthritis can be effectively managed non-surgically. In patients who have

persistent symptoms despite having undergone nonsurgical care, the treating surgeon often faces the difficult decision whether to fuse or replace the ankle joint. The literature supports both arthrodesis and arthroplasty. Patient-specific factors, such as medical comorbidities, amount of deformity of the joint, age, and activity level, influence this decision. The key to a successful outcome is to engage the patient in the decision-making process. ■



Dr Mark Kao

MD, FRACS
(Orth), FAORTHA,
BAAPPSC(PHTY)



Dr Mark Kao is an orthopaedic foot, ankle, hip and knee surgeon. He specialises in bunions and arthritis of the foot, hip and knee replacements, knee reconstruction, sports injuries and general trauma.

Suite 209, Level 2 Strathfield Plaza
11 The Boulevard
Strathfield NSW 2135

T: 02 9053 8888

F: 02 9053 8867

L: Mandarin

Bunions: Examination, Investigations and Treatment

Dr Alice Chang

Presentation and risk factors

Hallux valgus, or bunion, is a common orthopaedic forefoot presentation. Patients usually present with pain over the 1st metatarsophalangeal joint (MTPJ) medial prominence preventing them from wearing shoes and/or paresthesia in the dorsomedial great toe due to nerve compression. Patients are often female with a positive family history. Other risk factors include ligamentous laxity, pes planus, inflammatory arthritis.

Examination

Examination starts with patient standing for assessment of lower limb alignment looking for hindfoot valgus and pes planus. Deformities at the 1st MTPJ and at the 1st interphalangeal joint are assessed. Associated hallux pronation and its resultant medial callosity are noted. 1st MTPJ irritability and correctability as well as 1st tarsometatarsal joint hypermobility are assessed. Lesser toes are examined for deformities such as crossover toes and hammers toes as these can be secondary to the hallux valgus. Plantar callosity and pain under the lesser metatarsal heads, especially the 2nd and 3rd, are assessed for transfer metatarsalgia. Neurovascular supply of all toes shall also be examined with particular attention to the dorsomedial hallux as the dorsomedial cutaneous nerve is commonly compressed in shoes or stretched.



Figure 1. Photo of weight bearing right foot – note the clinical hallux valgus, erythematous medial eminence.

Figure 2. AP weight bearing X-ray right foot. 1: intermetatarsal angle; 2: hallux valgus angle; 3: hallux valgus interphalangeus angle; incongruency between the articular surfaces of proximal phalanx and metatarsus (green and yellow lines)

Investigations

Weight bearing AP, oblique and lateral foot x-rays are the first line imaging investigation. It is important to obtain weight bearing x-rays as weightbearing maximizes most deformities and reflects the true foot alignment during standing and gait. Intermetatarsal, hallux valgus, hallux valgus interphalangeus and distal metatarsal-articular angles are assessed (Figure 2). 1st MTPJ is assessed for

congruency (Figure 2) and degenerative changes. The lesser toes are also reviewed.

Treatment Options

Non operative

Non-operative treatment includes accommodating shoe, pads and spacers, and for patients with flatfeet, orthosis with medial arch support. However, these are for symptom control rather than definitive treatment of the underlying altered anatomy.

Surgical options

Surgery is indicated when patients are still symptomatic despite appropriate shoes and other non-operative measures. It needs to be emphasized that cosmesis is not an indication for surgical correction as surgical goal is a painless and shoeable foot. Operative treatments are either joint sparing (realignment osteotomies) or joint sacrificing (1st MTPJ arthrodesis). Realignment osteotomies usually consist of proximal phalanx Akin osteotomy and 1st metatarsal SCARF or Chevron osteotomies. This can be performed percutaneously through multiple 5mm incisions rather than the traditional 8cm medial incision. 1st MTPJ arthrodesis (Figure 3) is indicated when there is significant degenerative change. It is a very reliable realignment and pain-relieving operation when arthritis is present.



Figure 3. 1st MTPJ arthrodesis.

Post-Operative Recommendations

The short term (0-42 days) post-operative pain is significantly lower with the percutaneous technique but there is no difference between the two techniques long term except scar cosmesis. Patients are allowed to weight bear as tolerated immediately post-op in a stiff-sole post-op shoe and can transition into accommodating off-the-shelf shoes at 6 weeks post-op. Specific risks associated with these surgical measures are persistent hallux dorsomedial numbness, non-union, and over or under correction. Patients are advised to wear sensible shoes lifelong as hallux valgus can recur, particularly in younger patients. ■

Dr Alice Chang

BASc, MBBS, FRACS(Ortho)

Dr Alice Chang is an orthopaedic surgeon who specialises in foot and ankle surgery.

Burwood Medical Specialists
Suite 107, 3 Burwood Parade
Burwood NSW 2134

T: 02 9160 6296

F: 02 9166 9948

W: dralicechang.com.au

L: Mandarin, Hokkien

Dr Chang also consults in Leichhardt, Bankstown, Chatswood and Hurstville.

PA: Bankstown



What to do when your patients fail conservative device therapy for obstructive sleep apnoea (OSA).

Dr Lyndon Chan

Why is it important?

- OSA is prevalent - estimated 14% of males and 5% of females have moderate to severe OSA
- High rate of untreated/partially treated disease in the community, at best only 2/3 have long term compliance with conservative devices such as continuous positive airways pressure (CPAP)², mandibular advancement splint (MAS)³ and positional devices
- Significant health effects for patients
 - Increased incidence of cardiovascular disease and mortality
 - Decreased neurocognitive function, increased motor vehicle accidents⁶
 - Reduced quality of life, social embarrassment, disruption of partner's sleep, relationship strain

Common causes of persistent symptoms

- Non-compliance or ineffective use of conservative device
- Concomitant sleep disorders contributing to symptoms (poor sleep hygiene, insomnia, anxiety)
- Anatomical obstruction

What can be done for the patient failing conservative devices?

1. Identify underlying cause of non-compliance/ineffective use and consider return to it's original provider to resolve device related issues
2. Review other conservative treatment options including other devices, weight-loss and address non-OA causes of patient symptoms
3. Refer to a Sleep/respiratory physician for review
4. Refer to an ENT surgeon with training in OSA/snoring

What is the role of ENT in OSA?

- Medical and surgical management of nasal obstruction: nasal patency improves OSA/snoring and device compliance.
- Dynamic assessment of the upper airways to identify levels and pattern of obstruction.
- Surgery to appropriately selected cases
 - Modern techniques involve reconstruction, rather than resection of tissue
 - Different procedures are utilised to address specific levels of obstruction; this usually involves multilevel or staged surgery
 - The primary goal of surgery is to improve disease burden and potentially facilitate return to conservative devices

When should I refer to ENT Surgery?

- Patients with nasal obstruction
- Patients with moderate/severe OSA proven on sleep study that fail conservative measures despite review by sleep physician.
- Patients with simple snoring or mild OSA on sleep study wishing to seek a surgical opinion

Other commonly asked questions:

1. How do I know if my ENT surgeon is trained in sleep surgery? Most sleep surgeons will have undergone fellowship training in sleep surgery and a list of sleep surgeons can be found here: <https://surgicalsleeper.org/full-members/>
2. Is surgery for OSA Medicare rebatable and available in the public system? Yes, for both
3. What is the recovery time following sleep surgery? Most will require an overnight admission and 2 weeks convalescence

4. Do ENT surgeons perform sleep studies? Rarely, they are usually done through a sleep physician or an external company and can be requested by a GP. A good summary and further information can be found here: <https://www1.racgp.org.au/ajgp/2019/april/adult-obstructive-sleep-apnoea>
5. What are my responsibilities with OSA and driving? A doctor's obligation is to inform the patient of their legal responsibility to self-report. While there is no mandatory reporting for OSA, a doctor may advise the driver licensing authority at their own discretion. More information can be found at <https://austroads.com.au/publications/assessing-fitness-to-drive/ap-g56/sleep-disorders/medical-standards-for-licensing-9>
6. What surgical treatments are on the horizon for OSA? The implantable hypoglossal nerve stimulator has shown very promising results and will soon be available in Australia. ■

Dr Lyndon Chan

MBBS (HONS), FRACS

Dr Lyndon Chan is an adult and paediatric ear, nose and throat surgeon with interests in OSA and snoring, nasal obstruction/allergic rhinitis/sinus disease, palate reconstruction/tongue reduction and lesions of the sinuses, head and neck.

My-ENT

Level 3, Suite 303
135 Macquarie Street
Sydney NSW 2000

T: 02 9247 1762

F: 02 9247 2141

W: my-ent.com.au

PA: Northern Beaches

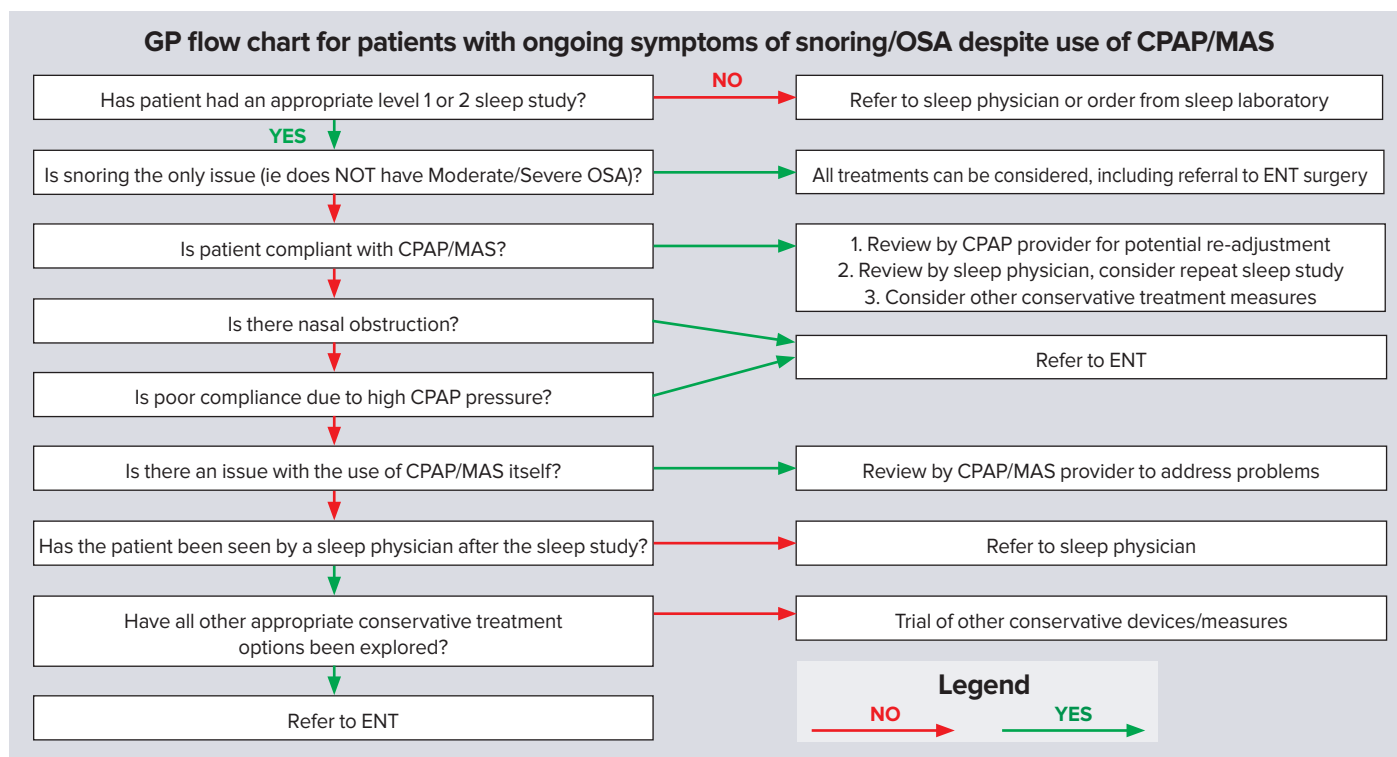
L: Cantonese (Chinese)

Dr Chan also consults in Lindfield.



continued overleaf...

What to do when your patients fail conservative device therapy for obstructive sleep apnoea (OSA) cont...



Diagnosing a scaphoid fracture with normal X-rays

When a patient presents with a wrist injury and clinical signs of a scaphoid fracture, normal initial radiographs do not exclude a fracture. Approximately 20% do have a true scaphoid fracture and need further imaging to establish a definitive diagnosis. The fear of under-treatment can result in a large amount of over-treated wrist injuries. CT, MRI and Bone scan are all secondary imaging modalities that can be used to help diagnose a suspected scaphoid fracture with normal radiographs. The question is though, which one is best?

A systematic Cochrane review was undertaken by Mallee et al which aimed to establish which technique was best and hence to prevent unnecessary treatment. Bone scan had the highest sensitivity, but lower specificity compared to CT and MRI. Bone scans are also invasive and may be inappropriate in certain populations such as in children where the radiation dose is unacceptable. CT and MRI were found to be comparable in diagnostic accuracy.

Bearing in mind the cost of each test, as well as the availability issues, it may be a good algorithm to perform a CT scan with reformats in the plane of the scaphoid if one suspects a fracture with normal X-rays. CT's nowadays are of excellent resolution and lower dose. With newer "Cone-beam" CT scans, the field can be narrowed to a very specific area to help improve resolution and diagnostic value.

MRI scans may be best reserved for patients with suspected ligament damage or in those cases where clinical suspicion is high but with normal CT scans as well. In those cases, bone oedema is a telling factor in diagnosis. It must be remembered however that an early MRI may miss a fracture if the bone oedema has not yet occurred.

Once a diagnosis is made, then treatment can be instituted. This should be tailored to the specific patient and can include short arm cast immobilisation or percutaneous screw fixation if indicated. ■

Dr Jai Sungaran

Dr Jai Sungaran

BSc(Med) MBBS
FRACS(Orth) MASurg(Orth)
FAOA



Dr Jai Sungaran is an Orthopaedic hand and wrist specialist, with particular interests in wrist arthroscopy for acute and chronic conditions, endoscopic carpal tunnel surgery, scaphoid and scapholunate ligament injuries, nerve and tendon injuries of the hand and wrist, as well as trigger fingers, ganglions and tumours of the hand.

Burwood Medical Specialists
Suite 107, 3 Burwood Parade
Burwood NSW 2134

T: 02 9525 2055

W: handandwrist.com.au

PA: Concord, Canterbury

Dr Sungaran also consults in North Strathfield and Caringbar.

Acute Exacerbation of Chronic Rhinosinusitis in Adults

Dr Catherine Banks and Justine Oates

As we move through the winter season, many of our patients with chronic rhinosinusitis (CRS) become more susceptible to acute exacerbation of their CRS. (AECRS) This article highlights the key features of AECRS and the latest evidence to support our patients during this time.

What is an Acute Exacerbation of Chronic Rhinosinusitis in Adults?

It is an extension of the definition CRS:

- CRS: (with or without nasal polyps) in adults is defined as:
Presence of 2 of more symptoms for \geq 12 weeks

One of which should be:

1. Nasal blockage/obstruction/congestion or nasal discharge (posterior or anterior nasal drip)
 2. +/- facial pain or pressure
 3. +/- reduction or loss of smell
- Acute Exacerbation of Chronic Rhinosinusitis (AECRS) is defined as:
A sudden worsening of any of the CRS criteria, including nasal congestion, or obstruction, or increasing facial pain or pressure with return to baseline CRS symptom intensity, often after intervention with corticosteroids and/or antibiotics
 - Aetiology:
 - Unclear and multifactorial
 - Lack of bacterial airway pathogens identified
 - Many patients have had previous sinus surgery thus create a new microbial environment and other pathogens possibly elicit a host inflammatory response
 - Viral infections: more likely the cause especially with increasing evidence that rhinovirus infection can drive eosinophilic inflammation
 - A focus on prevention and management of viral infections may be more effective than treating secondary infections with antibiotics and oesophilic flare ups with corticosteroids. 2

Management

- No evidence-based treatment recommendations for AECRS currently exist.
- Consensus guidelines and expert opinion recommend short-term antibiotics for AECRS, in the setting of a positive culture to provide symptomatic relief.^{1,2}
- The pre-existing inflammatory component of CRS, and the role it plays in the acute exacerbation is not well understood.
- The treatment for ARS with the implementation of antibiotics has been extrapolated and applied to AECRS, despite AECRS being recognized as a distinct entity of CRS.^{3,4}
- Antibiotics and treatment of the pre-existing CRS are often implemented.
- Non-randomized studies have been reported in the literature. However, it is difficult to draw meaningful conclusions due to the heterogeneous nature of the studies, the adoption of diverse definition criteria of AECRS, the different clinical endpoints documented, and the small sample size.

What can we offer our patients when they have an Acute exacerbation of Chronic Rhinosinusitis?

Systemic corticosteroids: do play a role in the treatment of facial pain – with a small but significant effect versus placebo on facial pain at days 4-7

Nasal corticosteroids: are has a small effect in reducing total symptom score for patients There is no effect on quality of life scores.

Nasal decongestant: may be effective in improving mucociliary clearance throughout the acute phase of the disease however care must be taken to educate the patient to not use for more than 3-5 days to prevent rhinitis medicamentosa.

Culture directed antibiotics: to date remains an unknown entity and until

further high-quality studies are available, I would recommend treating patients with culture directed antibiotics despite there being a lack of evidence in quality of life and endoscopy scores.

In summary:

The pre-existing inflammatory component of CRS, and the role it plays in the acute exacerbation is not well understood. Further high-quality studies are needed in this area. ■



Photo of an Endoscopic view demonstrating AECRS

Dr Catherine Banks

MBCHB FRACS

Dr Catherine Banks is an adult and paediatric ear, nose and throat surgeon with fellowships in rhinology and skull base surgery. Dr Banks has interests in nasal disorders, sinusitis, allergic rhinitis, nasal obstruction, cystic fibrosis, anterior skull base lesions and endoscopic orbital surgery. Justine Oates is Dr Banks' Nurse Practitioner.

My-ENT

Level 3, Suite 303
135 Macquarie Street
Sydney NSW 2000
T: 02 9247 1762
F: 02 9247 2141
W: my-ent.com.au
PA: Prince of Wales Hospital, Sydney Hospital and Sydney Children's Hospital at Randwick
Dr Banks also consults in Concord.



New Specialists



Contact Details

Sydney Specialist Suite
670b Darling Street
Rozelle NSW 2039

T (02) 8868 9601
F (02) 9818 5317

DR PENELOPE DE LACAVALERIE

MBBS, FRACS, CSSANZ

General and Colorectal Surgeon

Dr. De Lacavalerie is a specialist Colorectal and General Surgeon. She has a particular interest in advanced surgical techniques such as laparoscopic (keyhole) transanal and robotic surgery for conditions of the bowel including colorectal cancer, inflammatory bowel disease, endometriosis and diverticular disease.

Dr De Lacavalerie also manages other benign anorectal and pelvic floor conditions such as rectal prolapse, anal fissure/fistula, haemorrhoids and functional conditions such as obstructive defecation and faecal incontinence. Her clinical practice includes

general and acute surgical conditions such as hernia operations, gallstones and endoscopic procedures (gastroscopy and colonoscopies).



Contact Details

Level 2, Suite 201
St. George Sports Medicine
131 Princes Highway
Kogarah, NSW, 2217

T 1300 563 344
F: 02 8458 0772

DR BEN SCHWARZ

MBBS (Hons), FRACS (Ortho), FAOrthA

Orthopaedic Surgery - Hip and Knee

Dr. Ben Schwarz is an Orthopaedic surgeon who specialises in managing conditions of the hip and knee as well as general orthopaedic trauma. Dr. Schwarz studied Medicine at the University of New South Wales and graduated with honours in 2008. He undertook specialist training in Orthopaedic surgery by the Australian Orthopaedic Association in 2013 and was awarded Fellowship by the Royal Australasian College of Surgeons in 2018. After obtaining his fellowship, Dr. Schwarz spent 6 months working as a consultant surgeon at a major trauma service hospital in NSW, then went

overseas to Canada to undertake a sub-specialty fellowship with a focus on primary and revision hip and knee replacement. On his return to Australia, he completed a further sub-specialty knee fellowship focusing on knee arthroplasty and arthroscopic reconstruction.

Special Interests

- Hip and knee primary and revision arthroplasty
- Arthroscopic knee surgery (including ACL reconstructions and meniscal repair)
- Orthopaedic trauma



Contact Details

74/76 Burwood Road
Burwood NSW 2134

T (02) 9747 4133
F (02) 9747 4166
PA: Blue Mountains

DR PAVAN CHANDRALA

MBBS DipEcho FRACP CTCANZ

Cardiology

Dr Pavan Chandrala trained in general cardiology at Nepean Hospital in Sydney and then undertook fellowship in advanced cardiac imaging, heart failure management and structural intervention at Barts Heart Centre in London, which is the largest cardiac hospital in Europe.

He is an expert in echocardiography, cardiac CT and cardiac MRI. He is also proficient in transcatheter aortic valve replacements and other structural interventions.

During his career he has held academic teaching positions, published in peer reviewed journals and brought efficiency to his workplaces. He is passionate

about innovation in Cardiology and providing the best outcomes for his patients through understanding their individual needs and health goals.

Special Interests

- Cardiac imaging (echocardiogram, CT coronary angiogram and cardiac MRI)
- Valvular heart disease
- Heart failure



Contact Details

Ryde Medical Centre

Suite 15, 247 Ryedale Road
Eastwood NSW 2122
PA: Auburn

T (02) 9874 7749

F (02) 9874 5543

Dr Woo also consults in Auburn

DR JONG WOO

MD FRACS

General Surgeon

Dr Jong Woo is a specialist general surgeon at Auburn Hospital, Strathfield Private Hospital and Westmead Private Hospital. He completed his surgical training at Westmead Hospital and acquired a Fellowship of Royal Australasian College of Surgeons in general surgery in 2018. He subsequently undertook a year of fellowship in Trauma and Acute care surgery at Westmead Hospital. Dr Woo has recently returned to Sydney after one year of successful public and private practice in Bathurst.

Languages

Korean

Special Interests

- Endoscopy/Colonoscopy – GESA accredited
- Laparoscopic/open hernia surgery (Inguinal, incisional, umbilical hernias)
- Laparoscopic cholecystectomy
- Laparoscopic bowel resection (benign, malignant)
- Thyroid/ Parathyroid surgery
- Skin cancers – Local flaps or Skin graft (under local anaesthesia)
- Carpal tunnel syndrome, Ganglion cyst, Dupuytren's contracture
- Varicose veins (Open surgery/ RFA Endovenous ablation)
- Pilonidal disease, lipomas, epidermoid cyst excision



Contact Details

Digestive Pelvic Floor Centre
Suite 107, 3 Railway Parade
Burwood NSW 2134

T (02) 8084 3831

F (02) 8084 3881

PA: dipelvic.com.au

DR PAMELA HOWSON

BMedSc (Hons) MBBS FRACS

Breast, Endocrine and General Surgeon

Dr Howson is a Breast, Endocrine and General Surgeon at Strathfield Private Hospital, Concord Hospital and Auburn Hospital. Having completed her surgical training in Sydney Australia, she undertook further local and overseas breast Fellowships, gaining extensive experience in the surgical management of both benign and malignant breast disease with a particular focus on reconstructive approaches including implant and flap based reconstruction. Dr Howson also has a subspecialty interest in Endocrine surgery, specifically benign and malignant diseases of the thyroid and parathyroid glands.

Special Interests

- Breast cancer
- Benign breast disease
- Oncoplastic breast reconstruction including implants and lipofilling
- Thyroid cancer
- Hyperparathyroidism
- General surgery including hernias, gallbladders, endoscopies



Contact Details

Eastwood Specialist Centre
Suite 30, 1 Lakeside Road
Eastwood NSW 2122

T (02) 9460 8711

F (02) 9463 2103

DR MAY WONG

MBBS, FRACP, MMed (Cli Epi), MRCP(UK), PhD

Gastroenterologist

Dr Wong is a gastroenterologist with a broad range of interests, including functional gut disorders, bowel cancer screening, liver disease and inflammatory bowel disease.

Dr Wong was born and raised in Sydney. She studied medicine at the University of New South Wales. Following this she completed physician training at Royal Prince Alfred Hospital where she continued her specialist gastroenterology training. She completed her fellowship in Melbourne at Royal Melbourne Hospital and The Alfred.

Special Interests

- Functional gut disorders
 - Irritable Bowel Syndrome

- Chronic constipation
- Chronic diarrhea
- Nausea and vomiting
- Chronic abdominal pain
- Motility conditions
 - Suspected achalasia
 - Dysphagia
 - Rumination Syndrome
- Bowel cancer surveillance
- Inflammatory bowel disease
 - Intestinal ultrasound
- Liver disease

Languages

Cantonese, Mandarin

ezifind

Orthopaedic Surgeons

3 Everton Rd, Strathfield NSW 2135

strathfieldprivate.com.au

General Enquiries: 02 9745 7444

Strathfield Private Hospital performs a wide range of orthopaedic procedures including foot, ankle, hip, knee, shoulder, elbow and hand surgery. With on-site imaging, a 6 bed intensive care unit and personalised physiotherapy, Strathfield Private Hospital is equipped to provide the highest level of orthopaedic care for your patients.



Dr Alice Chang

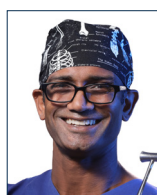
Foot, Ankle, Hand

Ph: 02 9160 6296

L: Hokkien, Mandarin

PA: Bankstown-Lidcombe

R: Burwood, Bankstown



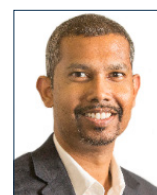
Dr Jonathan Herald

Shoulder, Elbow, Knee

Ph: 02 9233 3956

PA: Bankstown-Lidcombe

R: Strathfield, Bankstown



Dr Jai Sungaran

Hand, Wrist

Ph: 02 9525 2055

R: Burwood, North Strathfield



Dr Calvin Chien

Shoulder, Elbow, Knee

Ph: 02 9159 9180

L: Mandarin, Bahasa Malaysian

PA: Bankstown-Lidcombe

R: Strathfield, Bankstown



Dr Mark Kao

Hip, Knee, Foot, Ankle

Ph: 02 9053 8888

L: Mandarin

R: Strathfield



Dr Arnold Suzuki

Paediatrics, Hip, Knee

Ph: 02 9744 2666

PA: Randwick Children's

R: Strathfield, Randwick



Dr Alan Dao

Shoulder, Elbow, Hand

Ph: 02 8078 0633

L: Cantonese

PA: Bankstown-Lidcombe

R: Strathfield, Bankstown



Dr George Konidaris

Hip, Knee, Foot, Ankle

Ph: 02 9399 5333

L: Greek

PA: Bankstown-Lidcombe

R: Randwick



Dr John Trantalidis

Shoulder, Elbow

Ph: 02 9525 2055

PA: Concord

R: North Strathfield



Dr Paul Della Torre

Hip, Knee

Ph: 1300 887 718

L: Italian

PA: Concord Hospital

R: Five Dock



Dr Leonard Kuo

Shoulder, Hip, Knee

Ph: 02 9789 5414

PA: Canterbury

R: Campsie



Dr Alexander Woo

Hip, Knee

Ph: 02 9763 7822

L: Cantonese, Mandarin

R: Strathfield



Dr David Dilley

Hand, Wrist

Ph: 02 9745 257

R: Harris Park



Dr Daniel Rahme

Hip, Knee, Shoulder

Ph: 02 9709 8833

L: Arabic

PA: Canterbury

R: Leichhardt, Bankstown



Dr Kwan Yeoh

Hand, Wrist

Ph: 02 9233 3956

PA: Canterbury

R: Concord, Hurstville

Legend

R: Room location

PA: Public hospital appointment

L: Language



Strathfield Private Hospital

Part of Ramsay Health Care