GPNews

Westmead Private Hospital Cnr Mons & Darcy Road Westmead NSW 2145

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Westmead Private Hospital Celebrating 20 years of caring for the community



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A word from the CEO Mike Flatley

In October, we celebrated 20 years of providing excellent health care services to the people of Western Sydney. From our opening on 9th October 2000, Westmead Private has gone from strength to strength; now admitting more than 20 thousand patients a year.

We have established a strong reputation for providing the best standard of medical care to our patients. Our team is very proud of the health care services we provide, in fact it's one of the reasons why so many people want to work for Ramsay Health Care – our core value is 'people caring for people'.

We have a dedicated team of professions who excel in their fields and I'm thrilled that a staggering 94 of them have been here since day one. It says a lot about our culture and the dedication we have to our patients. From anaesthetists, specialist surgeons, nurses, midwives, physiotherapists, staff and volunteers – for two decades they've been providing outstanding care right here at Westmead Private.

We also have a proud tradition of investing in the latest technology and resources. From our beginnings as a 136-bed hospital in 2000, our hospital now boasts 192-beds, 13 operating theatres, two cardiac catheterisation labs, a 16-bed ICU, seven birthing suite s and a 14 cost SCU, plus oncology and neurosurgery services.

We are currently undertaking a multimillion dollar expansion, which will see an extra 28 beds, 13 consulting suits and two operating theatres added by 2022.

As 2020 comes to an end, I would like to extend my sincere gratitude to our GP community for your hard work in caring for the patients of Western Sydney through what has been a tumultuous year.

As a hospital, we recognise the important role that GPs play in the continuum of patient care and endeavour to remain closely connected to best meet the needs of the community. We value your support and if there's anything more that we can do to improve our services for you as GPs or for your patients, please don't hesitate to contact us.

We wish you health and happiness this festive season and hope that you get to take some well-deserved time to relax with loved ones.

Mike Flatley Chief Executive Officer



GP Ezi Access

Westmead Private Hospital's communication line solely for GP's to assist with improving clinical pathways for you and your patient

02 8837 8999

The GP hotline will ensure we are easily accessible 24/7. We welcome you to call us on the hotline if:

- · You are looking for a specialist to refer to in your area
- · You need to find a specialist with a specific sub-specialty interest
- You would like information on services available at Westmead Private
- You require information on one of your patients that has been admitted to our facility

Please call our direct GP hotline to speak with a hospital representative who can assist you.



westmeadprivate.com.au

New Surgical Robot a first for Western Sydney



Pictured: Professor Howard Lau and Professor Felix Chan

Westmead Private Hospital has made a quantum leap in surgical technology - investing in the latest robotic system to provide the very best in patient care. Surgeons say the da Vinci Xi robot is 'like an extension of their hands', giving them an advanced set of instruments to perform many different types of complex surgery.

Leading gynaecologist at Westmead Private Hospital, Associate Professor Felix Chan, said it has never been so exciting to practice as a surgeon. "This machine is a fantastic surgical tool, it improves the accuracy of gynaecological surgery and reduces complications," Prof. Chan said. "It's like an extension of your arm or hands and it's exciting for surgeons to be able to use this technology and look at higher definition, 3D camera imaging while we are operating."

Reviews of published studies suggest patients operated on with the da Vinci technology experienced fewer overall complications, a shorter stay in hospital and less pain than those who had open surgery.

Professor Chan said since using the da Vinci Xi robot for complex gynaecological procedures, 90% of his patients were able to go home within 24 hours and 15% were able to go home the same day. "Westmead Private is really leading the way because no other hospital in the Western Sydney region has this," Prof. Chan said. "The population is growing rapidly and by having the latest technology to work with, surgeons can work more efficiently and that opens up the potential to serve more of our community."

Leading urologist Professor Howard Lau said the da Vinci Xi robot can be used for a range of complex procedures including urology, kidney, prostate, gynaecological, bowel, cardiothoracic, head & neck, bariatric, pancreatic and upper gastrointestinal tract surgeries. "Our surgeons are very experienced in robotic surgery and we've been able to adapt to this upgraded equipment very, very quickly," Professor Lau said. "This latest generation of robot really takes surgery to the next level, because it is a safer option than open surgery and allows patients to recover more quickly."

Westmead Private Hospital has led the way with robotic surgeries in Western Sydney, with earlier models including the da Vinci Si surgical system and the ROSA robot. The hospital was the first in Australia to offer single site incision capabilities and performed Australia's first partial nephrectomy using firefly imaging.

"The da Vinci Xi robot is cutting edge technology and Westmead Private, and Ramsay Health Care, really need to be congratulated for keeping in touch with the latest medical facilities so that surgeons can use them to produce the best outcome for patients," Prof. Chan said.

500th Robotic Case for Professor Felix Chan

Highly respected gynaecologist Associate Professor Felix Chan has reached an incredible milestone, performing his 500th robotic surgery at Westmead Private Hospital. The procedure marks yet another achievement in Professor Chan's long and distinguished career.

Professor Chan is a renowned expert in his field across Australia, performing the most robotic procedures per year across any specialty. "Numbers are just numbers to me but really it's such an exciting time and it is a milestone, so I'm ready for the next 500," Professor Chan said. "It's important to push the boundaries, be innovative and use the best equipment because you get better at what you do and robotics is one of the technologies that produce the better outcomes for the patient," he said.

Associate Professor Chan says while he is proud of reaching the milestone he also relishes the opportunity to share his skills by mentoring colleagues at Westmead Private Hospital. "I really enjoy working at Westmead Private. The staff are amazing, they look after surgeons and Ramsay is always aware and observant of the latest innovation and technology."



Pictured: CEO Mike Flately and Professor Felix Chan

Cervical Spinal Stenosis and Myelopathy

Dr Andrew Kanawati

Cervical spinal stenosis is defined as a reduction in the volume of the spinal canal. This is most commonly caused by degenerative changes in the cervical spine, which may result in chronic compression and dysfunction of the spinal cord in a subset of patients (cervical myelopathy).

Disk bulging and osteophytes may result in anterior compression. Hypertrophied or infolded ligamentum flavum and degenerated facet joints may cause dorsal compression.

The degenerated spinal motion segment may result in direct compression of the neural elements, and also ischemia due to compression of the arterial blood supply to the spinal cord. Even daily range of motion can change the cross-section of the spinal canal and can result in dynamic compression of the cord.

Clinical symptoms and signs

Cervical myelopathy is the most common cause of spinal cord dysfunction in adults.

It can manifest with a range of signs and symptoms. The natural history may involve symptom-free periods with step-wise deterioration, however it may also follow a relatively progressive course of neurological decline.

Patients with degenerative cervical spondylosis may experience neck pain and limited motion.

Early symptoms include gait instability and diminished hand dexterity. Late symptoms include bladder and bowel dysfunction.

Clinical signs include wide-based gait and a positive Romberg test. Examination of the reflexes is a crucial part of the diagnosis, with upgoing Babinski signs and hyperreflexia being classic of cervical myelopathy. The presence of four beats of clonus also suggest upper motor neuron pathology.

Myeloradiculopathy, where myelopathy and radiculopathy (due to nerve root compression) co-occur, is quite common. In these cases, hyperreflexia may not be present secondary to nerve root compression.

Medical imaging

Plain x-ray evaluation includes an AP and lateral view of the cervical spine. Pertinent findings include loss of cervical lordosis, reduced disc height, end-plate sclerosis, osteophytes and translational deformity.

MRI is the gold-standard advanced imaging modality for assessing cord status. However cervical stenosis is a common age-related finding, and degree of neural compression is often not well correlated to symptom severity. One study found anterior compression of the dura and spinal cord occurred in 61% of health volunteers. Nevertheless, poor prognosis is related to high-signal intensity changes with the cord of T2-weighted images, and low intensity on T1-weighted images.

Management

20-60% of patients with mild cervical myelopathy will suffer neurologic decline if non-operative management is decided. Therefore, once diagnosed, surgical referral and operative treatment is considered to be the mainstay of treatment.

Surgical treatment aims to stabilise neurological function at a minimum, with some mild improvement often anticipated.

Spinal alignment and location of spinal cord compression will dictate surgical approach, which can be via an anterior, posterior or a combined approach.

Conclusion

Cervical myelopathy is the most common disease of the spinal cord and early diagnosis is important to prevent functional decline.



Figure 1: A T2-weighted sagittal MRI of the cervical spine in a 67-year-old female with cervical myelopathy. The cervical lordosis is well maintained, however there is severe stenosis at C3-4 and C4-5, and moderate stenosis at C5-6. The stenosis is due to disc bulging anteriorly and ligamentum flavum infolding posterior.

References

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Lebl DR, Bono CM. Update on the Diagnosis and Management of Cervical Spondylotic Myelopathy. J Am Acad Orthop Surg. 2015;23(11):648-660. doi:10.5435/JAAOS-D-14-00250



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W: harbourspine.com.au PA: Westmead Hospital Dr Kanawati is an orthopaedic spine surgeon with interests in adult degenerative spinal disorders, adult deformity surgery, minimally invasive spine surgery and 3D printing in spine surgery including patient specific surgery.

Managing Ankle Sprains and Instability

Dr Rajat Mittal

Overview

Ankle sprains are common. There are two types of sprains; high ankle sprains (syndesmosis injuries) are less common, while low ankle sprains are more common. The low ankle sprains include injury to ligaments such as the anterior talo-fibular ligament (ATFL), calcaneofibular ligament (CFL) and the posterior talo-fibular ligament (PTFL). More than 90% of all ankle sprains are the low ankle sprains.

Ankle sprains occur more commonly as a result of sporting or dancing injuries. They are also more common in patients with ligament laxity. While most ankle sprains are ligament injuries, rarely, they can be associated with osteochondral injuries, fractures of the 5th metatarsal, calcaneus and talus and peroneal tendon injuries. Ankle sprains can rarely also be associated with complex regional pain syndrome that can be more difficult to treat and requires a multi-disciplinary team approach involving allied health and pain physicians. Ankle sprains may be reduced with preventative training programs that include strengthening and balance (proprioception) exercises.



The anatomy of the lateral ankle ligaments is described in Figure 1 above.

In an ankle sprain, the ATFL is the first ligament to rupture and is very commonly injured. With increasing severity, the CFL is next affected and the PTFL is the least commonly ruptured.

Assessment

The patient often presents with a twisting ankle history often with an inversion injury. They often present with a limp and are likely to have swelling especially around the lateral aspect of the ankle. While significant bruising may increase suspicion of a fracture or other injuries, it is not always the case. On palpation, tenderness at specific locations around the ankle joint may be helpful to discern lateral ankle sprains from other oncomitant injuries, although this can be very difficult in the acute setting. The ATFL is best tested with an anterior draw with the ankle in plantarflexion. The CFL competency can be tested with talar tilt or a draw test with the ankle in the neutral position.

Imaging

Xrays should be performed following the Ottawa Ankle rules, but if in doubt an xray is recommended. Ideally it should be a weight bearing xray and include the foot as required. The ankle xrays should include an AP, lateral and mortise views while the foot xrays should include an AP, oblique and lateral. This allows assessment of the joint along with the presence of fractures.

A CT or MRI is not commonly required in the acute situation unless there is concern about an osteochondral injury, tendon injuries or suspicion of a high ankle sprain. It is commonly performed in a chronic ankle sprain to identify the pathology.

Treatment

The vast majority of ankle sprains are treated with non-operative management. This involves rest, ice, compression and elevation. Some patients may require a short period of immobilisation while weight bearing in a walking boot for example, but early mobilisation and physiotherapy facilitates a better recovery. The mainstay of physiotherapy includes range of motion exercises followed by strengthening and balance (proprioception) exercises.

Operative management is reserved for patients with chronic ankle instability or other concomitant pathology requiring surgery. The surgery is often individualised and may include an ankle arthroscopy, lateral ligament reconstruction and address other pathology that may be present.



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Dr Mittal is an

orthopaedic surgeon with interests in knee and ankle replacements (including robotic surgery), joint fusions, sporting and traumatic injuries, bunions and forefoot surgeries.

Extrauterine Pregnancies

Dr Adeline Chan

Also known as ectopic pregnancies, this occurs in about 1-2% of all pregnancies. There can be 3 different types of extrauterine pregnancy :

- Ectopic pregnancy
- Heterotropic pregnancy
- Pregnancy of Unknown Location (PUL)

The main risk factors for ectopic pregnancies include :

- Previous abdominal surgery
- History of STI
- Previous ectopic pregnancy (increases the risk to 10%)
- Previous fallopian tube surgery
- Presence of IUCD
- Assisted reproduction (ovulation induction, IVF)

Features suspecting ectopic pregnancy:

- Abdominal pain, especially to one side
- Slow rising BHCG general rule of BHCG to be doubling every 48 hours in the first 8 weeks of pregnancy
- BHCG >1800 without an intrauterine pregnancy (IUP) seen
- Persistent pain with IUP seen (for heterotropic pregnancy)
- Pelvic ultrasound demonstrating an adnexal mass without an IUP with positive BHCG

A transvaginal ultrasound should be able to see an IUP at BHCG levels of >1,500 IU/L and transabdominal at levels of >1,800 IU/L. An ectopic pregnancy can be seen as an adnexal mass with a BHCG as low as <100 IU/L. Therefore, if there is a slow rise in the BHCG even at levels <100 IU/L, consideration for pelvic ultrasound to be done especially in presence of abdominal pain.

Types of ectopic

Ectopic pregnancy is a visualised pregnancy out of the uterus, with the commonest site being the fallopian tube (~90%). Other possible locations are ovarian (1-2%), interstitial (~2%), cervical (1%), abdominal (1%). Caesarean scar ectopic pregnancies were quite uncommon but since the rise of caesarean rates worldwide, it is not uncommon to see it more frequently now (~3-4%)

A heterotropic pregnancy remains quite rare, with the occurrence of 1:10,000 – 40,000 in spontaneous conception but as common as 1:100 – 400 in assisted reproduction. Often this diagnosis is missed as most are falsely reassured by the presence of an IUP. It should be strongly suspected in patients with persistent pain despite confirmation of IUP or persistently elevated BHCG after a miscarriage or termination. Occasionally, an ultrasound may demonstrate the two pregnancies.

A pregnancy of unknown location (PUL) is where there is positive BHCG but there is persistently no imaging that correlates to this, especially in BHCG levels of >2,000 IU/L. The commonest scenarios where this occurs is :

- A failed intrauterine pregnancy (IUP) where the BHCG eventually normalises without a confirmation of the location of pregnancy made
- An ectopic pregnancy which has not been identified sonographically

The dilemma with managing a (PUL) is the management options. While the main concern is of an ectopic pregnancy, about 30% of these patients have had an intrauterine pregnancy and methotrexate or surgery is not needed.

Treatment options for extra-uterine pregnancies:

- 1. Conservative (requires very strict criteria)
- Medical (Methotrexate) criteria : BHCG <3,000 IU/L with a small mass (<3cm) or PUL, no pain. Success with single dose is up to 85%. About 15-20% of patients may need a second dose.
- 3. Surgical ruptured ectopic, haemodynamically unstable, severe pain, high BHCG, large mass, patient preference.

For women who elects for conservative or medical management, there is still a risk of ectopic rupture and these women should be educated on red flags, and present to a hospital as soon as possible. They would also need to attend a weekly blood test until BHCG is negative.

All women with a suspicion for extra-uterine pregnancy should be referred and followed up with an early pregnancy assessment unit or O&G specialist.

More information can be obtained at:

https://www.rcog.org.uk/en/guidelines-research-services/ guidelines/gtg21/





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Meniscal Root Tears: An Increasingly Recognised Cause of Osteoarthritis in the Knee

Dr Matt Jones

What is a meniscal root tear?

Meniscal root tears are defined as radial tears located within 1cm of the meniscal attachment to bone (Figure 1). Biomechanically they are comparable to a total menisectomy, with a medial root tear resulting in a 25% increase in contact pressures in the medial compartment of the knee. The consequence of this may be rapid development of OA requiring joint replacement surgery.



Figure 1: Sites of meniscal root tears

If recognised early root tears can be repaired arthroscopically, restoring normal joint contact pressures and slowing the development of OA.

Characteristics of meniscal root tears

Most root tears do not have a history of trauma. They are more common in middle aged, overweight women with varus alignment. Typical meniscal symptoms such as locking and giving way are not frequently reported. Joint line tenderness and pain with deep flexion are common signs, although not specific for root tears.

Gender	Female>Male
Age	Middle aged
Trauma	Not typical
Signs	Joint line tenderness, pain deep flexion
MRI findings	Meniscal extrusion, signal at meniscal root

Diagnosing a meniscal root tear

Diagnosis is made on MRI scan. I find it easiest to detect them on coronal T2-weighted sequence, where extrusion of the meniscus can be seen at the midpoint of the joint and increased signal is seen posteriorly at the root insertion (Figure 2).



Figure 2: Coronal T2-weighted MRI scan demonstrating medial meniscal extrusion (left) and signal at the posterior root insertion (right)

Treatment

Given the natural history of root tears I tend to offer most patients arthroscopic repair. Exceptions would be those that already have advanced degenerative arthritis in their knees, or those that are unable to comply with postoperative rehabilitation. The surgery is performed arthroscopically as a day case. The injured root is sutured and drawn into a prepared bony tunnel at the anatomic origin of the root, thereby restoring meniscal anatomy and function (Figure 3). I use a range of motion brace for six weeks after surgery to prevent deep flexion.

There is good evidence to support meniscal root repair, with 84% of patients in one study having no radiographical progression of OA. In another study progression of arthritis was seen in only 10% at a mean

of 30.3 months.

Figure 3: The root is repaired with sutures passed through a bony tunnel



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T: 02 9051 2424 F: 02 9055 1724 E: admin@mattjonesortho.com.au W: mattjonesortho.com.au PA: Westmead Hospital Dr Matt Jones is an orthopaedic surgeon specialising in hip and knee arthroplasty, revision arthroplasty, sports knee reconstruction and general orthopaedic trauma.

Renal Cysts When should I be concerned?

Dr Kieran Beattie

Renal cysts are a common incidental finding on imaging, as they are widely prevalent within the adult population and in the vast majority of cases asymptomatic. They are found in around 10% of young adults, increasing to roughly 50% in those over 70. The majority of these will be sporadic in origin, although genetic disorders such as autosomal dominant polycystic kidney disease and medullary sponge kidney may cause many cysts in a single patient.

When detected on imaging, renal cysts should be classified by the radiologist as either simple or complex, based on certain imaging features. Simple cysts do not require urological referral and follow up, except in rare circumstances, such as being symptomatic or containing haemorrhage, or if there is a new suggestion of an underlying genetic disorder.

In addition to this basic classification, you may find radiologists referring to the 'Bosniak' classification when a complex cyst is encountered, named for Dr Morton Bosniak, a New York-based professor of radiology who developed the eponymous system back in 1986. Essentially, the Bosniak classification provides a guide to the characteristics of cysts which allow the risk of malignancy to be stratified. It requires a contrast CT or MRI, as ultrasound and non-contrast imaging do not adequately characterise the cystic features, although they are sufficient for determining simple cysts.

Much like Douglas Adams's famous trilogy of four, the Bosniak 4-part classification has 5 categories, described below:

I - A benign simple renal cyst or multiple renal cysts, with the density of water, each with a thin wall without septa, calcifications, or solid components.

Risk of malignancy - <1%, no follow up required.

II - Benign cystic lesions in which there may be a few thin septa and the wall or septa may contain fine calcifications. This category also includes hyperdense cysts, proteinaceous cysts with a density higher than water, if they are under 3cm.

Risk of malignancy - <1%, no follow up required.

IIF - The F stands for follow up. This category was added after the original system was developed, allowing radiologists to classify cysts more complicated than category II cysts but without the criteria of category III cysts. They may have multiple thin septa or minimal smooth thickening of the septa or wall, which may contain calcification that may also be thick and nodular. This category also includes hyperdense cysts that are >3 cm in diameter.

Risk of malignancy - 10%, referral and follow up required

The primary differentiating characteristic of both category III and IV cysts is contrast enhancement on multiphase CT or MRI imaging.

III - Indeterminate cystic masses that have thickened, irregular or smooth walls or septa. Measurable enhancement is present.

Risk of malignancy - 50%, referral and follow up required

IV – These cystic masses have all the characteristics of category III cysts, plus they contain enhancing soft-tissue components that are adjacent to and independent of the wall or septum.

Risk of malignancy - 90%, referral and follow up required

Given the difficulty in obtaining a safe and accurate biopsy from a cystic renal lesion, most management decisions are made based on imaging. Surgery remains the mainstay of treatment where malignancy is suspected. Thankfully, urologists have become more proficient at minimally invasive partial nephrectomy over the last decade, reducing the number of nephrons sacrificed for potentially benign disease.

Take home message:

Simple cysts require no follow up or additional imaging. Complex cysts require a multiphase contrast CT or MRI, and if they are Bosniak classification IIF, III or IV, subsequent referral to a urologist.





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Dr Kieran Beattie is a locally trained urologist with interests in many facets of urology, from lower urinary tract symptoms to stone disease and cancer. His primary interest lies in minimally invasive management of both benign and oncological diseases of the kidney and ureter.

Westmead Private donations to help developing nations

Some of the world's poorest countries are set to receive muchneeded hospital equipment from Westmead Private Hospital thanks to Ramsay Health Care Australia's ongoing partnership with the Rotary Club of Berrima District. Under the partnership, which first started in 2010, Ramsay donates medical equipment and goods which are no longer needed in its hospitals to disadvantaged countries around the globe.

Ramsay Health Care Australia's CEO, Carmel Monaghan, said she was proud to announce the donation of 70 electrocardiogram (ECG) machines to Rotary's Medical Aid for Oceania and Worldwide (MAFO) project.

"ECG Machines are an important piece of equipment to monitor heart health and this initiative ensures the responsible and ethical donation of equipment and supplies to other communities around the world," Ms Monaghan said.

"Our hospitals which have donated the machines are North Shore Private, Strathfield Private, St George Private, Kareena Private, Westmead Private, Wollongong Private, Port Macquarie Private and Sunshine Coast University Private."

Berrima Rotary's International Director Barry Barford said the equipment would be put to good use in several developing nations.

"These ECG machines will be going to Pacific Island nations like the Solomon Islands, Papua New Guinea, as well as East Timor in South East Asia. There's also a consignment going to the Democratic Republic of Congo, Nepal and we've just had a request from a new customer in Afghanistan so it will be great to assist that nation as well because that's a new area for us," Mr Barford said.

"In developing countries, they really do rely on donated equipment like this. They have very poor infrastructure and

very limited budgets. We can always rely on Ramsay Health Care to supply equipment that is first class and in good working order which is so important."

Ramsay Health Care's partnership with the Rotary Club of Berrima District started in December 2010 with the donation of hospital beds, consumables and other essential items to hospitals in Fiji. Since then, Ramsay donations have included wheelchairs, theatre lights and tables, hospital furniture, anaesthetic machines, ultrasound & x-ray machines, blood pressure monitors, sterilisers and consumables. Ramsay also provides \$10,000 each year to supplement funds raised by Rotary Berrima to meet overseas transport costs.

Westmead Private donates hospital supplies to Papua New Guinea

Westmead Private Hospital has donated a shipping container of blue storage containers to a hospital in Papua New Guinea, as part of an ongoing initiative to provide medical equipment and supplies to disadvantaged communities. The new storage solutions will make a difference to the working environment for staff at Sopas District Hospital, which had previously been using cardboard boxes. Sopas District Hospital is located in one of the highest provinces in the highlands of PNG.

The hospital's Medical Superintendent and surgeon, Dr Elvis Biofa Japhleth, said: "Donation of various medical equipments and supplies by Westmead Private Hospital to Sopas District Hospital has indeed assisted the hospital in a huge scale. Through these donations, the standard of care and the quality of services we provided have exceptionally improved and attracted more patients than ever before."

Westmead Private Hospital will also be donating some endoscopy processing units at the end of 2020.



Pictured: Westmead Private hospital supplies being delivered to Sopas District Hospital, Papua New Guinea

New Specialists at Westmead Private Hospital



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DR RAJAT MITTAL

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Orthopaedics – Knee, Foot and Ankle

Dr Mittal is an Australian trained Orthopaedic Surgeon with extensive experience in trauma and sub-specialty interests in foot & ankle and knee surgery. During his training he completed a Master of Surgery, a Master of Medicine and a PhD in orthopaedics. After completing his fellowship training with the Royal Australian College of Surgeons and the Australian Orthopaedic Association, Dr Mittal went on to complete fellowships in ankle arthroplasty (replacement); arthroscopy; hindfoot, midfoot and forefoot fusion surgery; and complex foot and ankle surgery. He is an adjunct senior lecturer at the University of New South Wales and a faculty member of the CLEAR course with the Royal Australasian College of Surgeons (RACS).

Special Interests

- Knee and ankle replacements (including robotic surgery)
- Joint fusions
- Sporting and traumatic injuries



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DR KAVITA MARAVAR

MBBS, MRepMed, FRANZCOG Obstetrics and Gynaecology

Dr Kavita Maravar is an Obstetrician and Gynaecologist who completed her Bachelors in Medicine (MBBS) degree from the University of Mumbai, India and followed this by undertaking a Master'sDegree in Medicine & Human Reproduction from the University of Sydney. Dr Maravar underwent specialist training at the Western Sydney Local Health district to obtain the prestigious Fellowship in Royal Australia & NZ College of Obstetricians & Gynaecologists (FRANZCOG). Dr Maravar has a special interest in treating women with gestational diabetes and thyroid issues during pregnancy. She has also undertaken intense training in Gynaecology surgery including laparoscopic surgery.

Special Interests

- Obstetrics
- Gynaecology including laparoscopic surgery, hysterectomy, menstrual issues, contraception and menopause
- Colposcopy for management of abnormal cervical screening and pap smears
- Fertility



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DR MOHAMMED BABA

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Orthopaedic Shoulder, Elbow and Hand Surgeon

Dr Baba is an Australian trained orthopaedic surgeon with a subspecialty interest in disorders of the shoulder, elbow, wrist and hand. Raised in Sydney, Dr Baba completed his medical degree at UNSW. He was accepted into the Australian Orthopaedic Association training programme in 2009, where he worked in some of the largest trauma and specialist hand and upper limb centres in the state. After gaining his fellowship from Royal Australasian College of Surgeons, he spent a further 18 months of subspecialty training in shoulder, elbow, wrist and hand surgery in Sydney, France and North America. He has authored numerous papers and presented at national and international meetings.

Special Interests

- Arthroscopic surgery of the shoulder elbow and wrist
- Shoulder rotator cuff and instability surgery
- Arthritis and joint replacement therapy for shoulder, elbow, wrist and hand
- Traumatic and sports injuries of the hand and upper limb including fractures



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DR SEBASTIAN RODRIGUES

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General and Breast Surgeon

Dr Sebastian Rodrigues has been trained both in Australia and internationally. He has 25 years of clinical experience. He has been practising general surgery since 1995 in Mumbai, India at one of the largest tertiary referral centres. After immigrating to Australia in 2005, Dr Rodrigues retrained with Royal Australasian College of Surgeons at the Prince of Wales Hospital network, Sydney. He undertook post fellowship training in breast and endocrine surgery at Nepean Hospital and Concord Repatriation Hospital.

Special Interests

- General surgery including haemorrhoid, vasectomy, hernia, gall bladder
- Endoscopy and colonoscopy (GESA accredited)
- Breast surgery
- · Endocrine surgery
- Excision of skin lesions and cancer



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DR KRIS MA BSc(Med) MBBS PhD FRCP FRCPA

Haematology

Dr Ma is an Australian trained Consultant Haematologist who completed his Medical degree at the University of Sydney in 2002. After completing training at Royal North Shore and Westmead Hospital he went on to complete his PhD on Adoptive Cellular Immunotherapy at the University of Sydney in 2016. He then undertook a clinical fellowship in Blood and Marrow Transplantation at St Vincent's Hospital in 2017. Dr Ma has presented at a number of National and International Haematology conferences and has published multiple first-author articles in peer reviewed Medical journals. He is also a Clinical Senior Lecturer at the University of Sydney.

Special Interests

- Malignant haematology
- Blood and marrow transplantation
- Adoptive cellular immunotherapy



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DR KIERAN BEATTIE

FRACS (Urol), MBBS (Hons), MS, BVSc (Hons I)

Urological Surgeon

Dr Kieran Beattie is a locally trained urological surgeon with interests in many facets of urology, from lower urinary tract symptoms to stone disease and cancer. His primary interest lies in minimally invasive management of both benign and oncological diseases of the kidney and ureter.

Dr Beattie studied medicine at the University of Sydney Medical School, graduating with honours. He then completed a Master of Surgery degree and commenced his training with the Urological Society of Australia and New Zealand (USANZ) in 2013. Kieran travelled to Manchester, United Kingdom for international fellowship training in robotic and minimally invasive surgery of the kidney and upper urinary tract. He has presented research both nationally and internationally on multiple occasions and is an author on numerous publications.

Special Interests

- Minimally invasive management of benign and oncological diseases of the kidney and ureter
- Lower urinary tract symptoms
- Stone disease and cancer

VIRTUAL GP EDUCATION

Westmead Private Hospital Part of Ramsay Health Care

Westmead Private Hospital is committed to the ongoing education of general practitioners. Our recorded education sessions below are available online to undertake at any time.

Back off: Managing lower back pain

Dr Yingda Li, Neurosurgeon

Learning outcomes:

- Assess someone with lower back pain
- Identify and complete initial work up
- Implement a care pathway for chronic lower back pain

Heart Beat

Dr David Tanous and Dr Gopal Sivagangabalan, Cardiologists Learning outcomes:

- · Identify the cardiac causes of stroke
- Implement a care path for someone at risk of stroke
- Describe the new technologies in pacing

Nodules in the Lungs

Dr Peter Wu, Respiratory Physician

Dr Graham Meredith, Cardiothoracic Surgeon

Learning outcomes:

- Complete initial investigations for someone with pulmonary nodules
- Confer with specialist colleagues and refer in a timely manner
- Manage postoperative complications

Heavy Menstrual Bleeding and CST Post Hysterectomy

Dr Adeline Chan, Obstetrician and Gynaecologist

Learning outcomes:

- Assess and manage someone with HMB
- Investigate and diagnose cause of HMB and any postmenopausal bleeding
- Implement rules for CST post hysterectomy

Oral Contraceptive Pill: Prescribing for adolescents

Dr Jinny Foo, Obstetrician and Gynaecologist

Learning outcomes:

- Discuss best practices in prescribing contraception in adolescents
- Implement a care path for managing adolescents on the pill
- Discuss other options for menstrual management in adolescents

These sessions are Quick Log activities; RACGP CPD points can be logged through the RACGP portal.

Managing Radiculopathy during the COVID-19 Pandemic

Dr Vinay Kulkarni, Orthopaedic Spine Surgeon

Learning outcomes:

- Discuss ways of managing radiculopathy symptoms during the current isolation period
- Explain the nonsurgical and surgical treatment options available
- Implement a care path for someone with acute radiculopathy

New Developments in Prostate Cancer

Professor Manish Patel, Urological Cancer Surgeon

Learning outcomes:

- Understand PSA testing guidelines, the role of MRI and biopsy options
- Assess and manage patients with prostate cancer
- Implement a care path for someone with prostate cancer

Treatment Options for Knee Arthritis

Dr Matt Jones, Orthopaedic Hip and Knee Surgeon Learning outcomes:

- Assess and manage patients with knee osteoarthritis
- Review treatment options for knee osteoarthritis
- Identify the care pathway for people with knee osteoarthritis

Renal and Adrenal Incidentalomas: When to worry

Professor Howard Lau, Urologist

Learning outcomes:

- Complete initial work up of an 'incidental' renal/adrenal mass
- Identify diagnostic and treatment options
- Explain the importance of complex renal cysts

How to Manage Common Shoulder & Elbow Conditions

Dr Manish Gupta, Orthopaedic Surgeon

Learning outcomes:

- Assess and manage common elbow and shoulder conditions
- Perform a quick and thorough examination of the shoulder and elbow and order relevant investigations
- Identify the care pathway for shoulder/elbow conditions

For more information or to register

People caring for people.

Visit the GP tab at westmeadprivate.com.au or email Sandra Southwell at southwells@ramsayhealth.com.au

