

Spring 2022

San Doctor

collaborating with our GPs
to provide coordinated
community care



Message from Brett Goods, Chief Executive Officer

We are excited to share the knowledge and expertise from a range of our specialists in this new edition of San Doctor with you.

I am delighted to share the news that Sydney Adventist Hospital has once again been ranked in the Newsweek World's Best Specialized Hospitals 2023 survey for Oncology, while also being ranked for the first time for Cardiology.

Following from this we are also elated to share that in the 2021 Bureau of Health Information (BHI) Outpatient Cancer Clinics Survey the San leads NSW in providing an excellent cancer outpatient experience. This is the fifth year in a row we have achieved these outstanding results.

We are enormously proud of all the teams involved in these achievements and the fantastic support and care they consistently give our community.

In this issue you will also read about some great achievements from some of our doctors, including the finalists at the 2022 Eureka Awards and the Rosalin Franklin Society Awards.

I hope this edition of San Doctor provides some insight into the amazing successes coming from the San.

Brett Goods, CEO
Chief Executive Officer
Adventist HealthCare Limited

CONGRATULATIONS!

For the fifth year in a row, the San leads NSW in providing an excellent cancer outpatient experience.

Sydney Adventist Hospital's Integrated Cancer Centre, which operates in partnership with Icon Cancer Centre Wahroonga, once again leads the way in providing an outstanding patient experience for cancer patients.

In the 2021 Bureau of Health Information (BHI) Outpatient Cancer Clinics Survey, the San's Integrated Cancer Service is the only cancer clinic in New South Wales to achieve eight measures significantly higher than the NSW result.

Patients were asked to evaluate their experience of access to services, care planning and coordination, complications, follow-up and support.

The report also compares patients' experiences in rural and urban facilities, examines patients' experiences of virtual care, and provides insights into differences in experiences between patients who speak a language other than English at home and those who speak English, on selected measures.

While the San performed strongly in all categories, the highest results were in the areas of 'timely and coordinated care' and in a 'safe, comfortable environment'.

The results reflect the experiences of more than 8,000 people who attended one of 42 facilities housing outpatient cancer clinics in November 2021. The survey included 310 San Integrated Cancer Centre patients.

The survey is the result of a partnership by BHI and the Cancer Institute NSW with the aim to improve understanding and quality of the patient experience.

Clinical Director of the Integrated Cancer Service Professor Gavin Marx says that achieving the highest ranking in the state for five consecutive years shows the great success of the San's model of care.

"The integrated nature of our care, which we have worked very carefully to achieve, is fundamental to a comfortable and positive experience," he said. "In addition to excellent clinical and surgical work, we pay attention to a patient's emotional wellbeing.

"A cancer patient's experience can be broad, stressful and traumatic simply because of the complex nature of the disease. This is why the way in which patients experience the non-medical aspects of a cancer service can influence how they and their carers cope, how they respond and what their ultimate outcomes are.

"This year's BHI survey results once again shows that the San takes this seriously and continues to treat patients with respect and empathy during a difficult time. Areas in which we'd like to perform better will be looked at and addressed as part of the San's core commitment to continuous improvement."

CEO Brett Goods expressed his pride in the Hospital's performance and congratulated the team.

"The San's solid strategy around whole-person health, along with our Christianity in Action mission, are clearly having a positive impact on patient experience," he said. "We are proud to offer a personalised approach to care that ensures our patients are supported every step of the way with empathy and commitment to a high-quality experience."





The San Integrated Cancer Centre offers a comprehensive approach to cancer care for the local community, including medical oncology and radiation oncology services under the one roof. Radiation oncology services are provided by Icon Cancer Centre Wahroonga, which is part of Icon Group – Australia's largest dedicated cancer care provider.

Icon Cancer Centre Wahroonga Clinical Director of Radiation Oncology Dr Andrew Fong says the outstanding results are a testament to the strength of the multidisciplinary service provided for the local Sydney North Shore community.

“We are very proud to partner with the Sydney Adventist Hospital to deliver the full remit of exceptional cancer care, closer to home. To be recognised for the fifth year in a row as the leading outpatient cancer clinic in NSW reflects our shared commitment to offering the best possible care and supporting our patients from diagnosis through to treatment and beyond,” Dr Fong said.

The San also offers extensive cancer support services, providing a wide range of services to the community including support groups, education, counselling, bereavement support, and other resources.

The Hospital provides more than 12,500 admissions for cancer treatment per year and complements an excellent standard of public sector cancer care services widely available across NSW.

About Sydney Adventist Hospital

Sydney Adventist Hospital (SAH) – fondly known as ‘the San’, is operated by Adventist HealthCare Limited. Adventist HealthCare is a Christian health care provider owned by the Seventh-day Adventist Church. As a not-for-profit organisation our purpose is to benefit our community – not shareholders, with all proceeds reinvested back into services & facilities ensuring we provide the best possible care. For almost 120 years, the San has been a leading healthcare provider. We started leading health & wellbeing when we first opened our doors back in 1903 as the ‘Sydney Sanitarium’ - a small 70 bed facility. The San is now

NSW’s largest private hospital with over 700 beds. It is also the largest single employer in the Ku-ring-gai Council area. Over 2,300 staff, 400 volunteers and 1,000 accredited medical practitioners care for approximately 60,000 inpatients and 120,000 outpatients annually with more than 2,000 babies delivered each year. The hospital’s reputation for exceptional care is built on the continuous provision of leading medical & surgical care, underpinned by the expertise, commitment and compassion of our people, and our faith-based approach to caring for the whole person - body, mind and spirit.

About Icon Cancer Centre Wahroonga

Icon Cancer Centre Wahroonga has delivered exceptional cancer care within the Sydney Adventist Hospital for more than 45 years, and is dedicated to providing the local Sydney North Shore community with access to world-class cancer care at the exact time

they need it. The centre offers cutting-edge radiation therapy treatment for all cancer types, with no private health insurance required for radiation therapy and up to 80% of costs covered by Medicare.

AN ARTICLE
BY**Dr Alan
Nazha**

BMed FANZCA FIPP FPPMANZCA

Meralgia paraesthetica: Entrapment of the Lateral Femoral Cutaneous Nerve

Figure 1

Meralgia paraesthetica is a painful condition affecting the antero-lateral thigh usually due to compression of the Lateral Femoral Cutaneous Nerve (LFCN) by the inguinal ligament (or potential stretching of the nerve).

Anatomy & Aetiology

The LFCN is solely a sensory nerve and originates from the L2 and L3 nerve roots. To reach the anterolateral thigh, the nerve passes through fibrous tunnels consisting of the inguinal ligament and the fascia lata. The nerve is vulnerable to compression and stretching from its origin under the psoas muscle until it exits through the inguinal ligament and the fascia lata. Since the LFCN is fixed at both its origin and at the fascial tunnels, leg length changes, scoliosis, increased tension of the abdominal musculature and fascia lata, trunk or leg hyperextension and surgery can damage the nerve. Amongst the triggering factors, wearing clothes that are too tight is notable, along with the stresses applied on the abdominal wall such as in pregnancy and obesity.

Clinical symptoms and signs

The pain often appears suddenly and is bilateral in 10% of cases and can be located anywhere from the anterior-lateral hip, thigh, and distally to the anterior knee. It is typically neuropathic with symptoms of paraesthesia, burning, and dysaesthesias. Patients may also describe coldness, deep muscle ache, numbness in a discrete area, or hair loss in the anterolateral thigh, usually from the patient repeatedly stroking the area.

Neurologic symptoms are restricted to sensory changes since the LFCN does not contain motor fibres. These symptoms can be aggravated by even the touch of clothing, or leg extension while sleeping. The pain be worse at night or during prolonged standing and can be relieved by flexion of the thigh on the body.

Clinical examination will reveal hyperaesthesia, however progressively a hypoaesthesia settles in the painful territory. No motor deficit should be present. The pain is increased by extension of the leg; local pressure of the inguinal ligament, especially close to the anterior superior iliac spine may produce pain or local irritation of the nerve distribution, similar to a Tinel's sign.

Investigations

Diagnosis is clinically based on history and examination. Investigations are helpful to rule out differential diagnosis which include intra or extra spinal radiculopathies of the L2 and L3 nerve roots and lumbar plexus pathology. Imaging studies can be utilised to rule out compressive pathologies. Utilising nerve conduction studies can be attempted to confirm LFCN involvement however these are not always conclusive. Nerve blockade with local anaesthetic can be useful to diagnose meralgia paraesthetica in some cases.

Treatment

Conservative management includes lifestyle changes such as weight loss, removal of compressive garments and wearing loose clothing combined with simple analgesics. Anti-neuropathic agents may be helpful however their side effect profile tends to preclude long term treatment whilst basic interventional therapies provide greater benefit with less side effects.

If pain is refractory to medical management, then consideration can be given for referral to an Interventional Pain Specialist to perform LFCN blockade which can be helpful in terms of confirmation of diagnosis or nature of the entrapment pathology. Although relief may be short lived, this would help prognosticate response to percutaneous pulsed Radiofrequency (pRF) therapy to the LFCN, which is a minimally invasive and relatively non-traumatic procedure.

The performance of pRF has been used successfully for the treatment of many other neuropathic pain syndromes, including mono-radiculopathies and trigeminal neuralgia. The performance of pRF does not destroy the nerve or impair function but rather modulates the way the nerve fires.

Open surgical neural lysis or resection should only be utilised in patients where the symptoms are of significant severity refractory to less invasive measures. These procedures have the disadvantage of potential surgical complications such as permanent anaesthesia. There are non-destructible surgical techniques such as peripheral nerve stimulation which can be trialled first with a temporary device to predict success. They are unlikely to worsen the pain and can be removed without significant permanent adverse effects in most cases.

Summary

Meralgia paraesthetica can present in a classic fashion; however, a high index of suspicion is required to diagnose and treat it appropriately. Interventional pain management therapies consisting initially of nerve blockade, followed by pulsed radiofrequency ablation and potentially peripheral nerve stimulation are appropriate measures. Surgical management is only for severe cases refractory to medical management and interventional pain therapies.

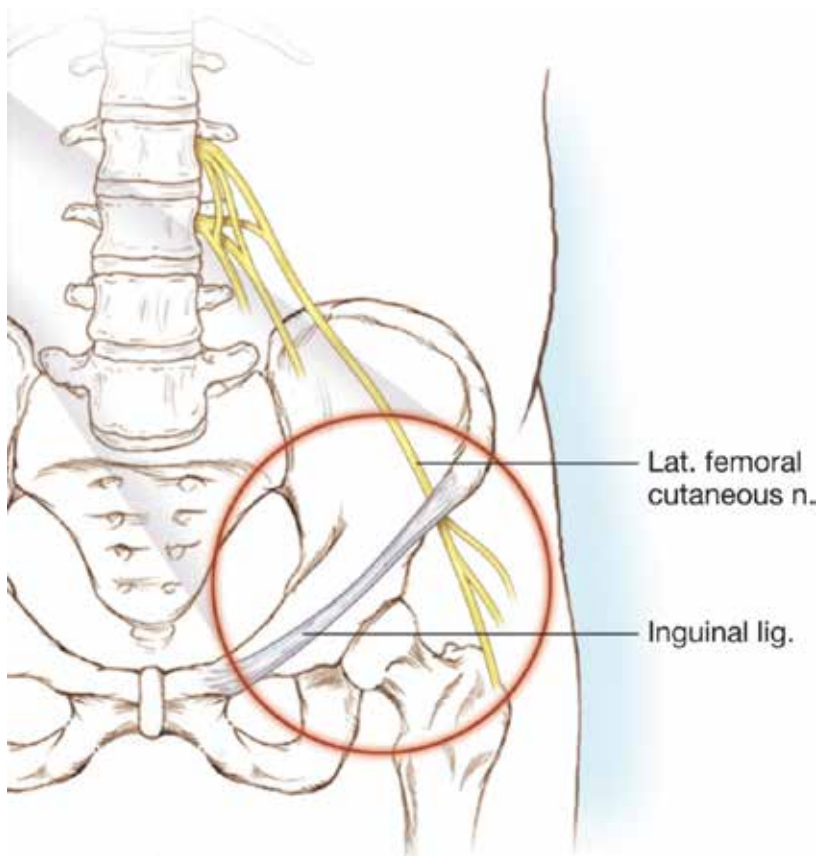


Figure 2

Figure 1: Clinical examination will reveal hyperaesthesia, however progressively a hypoaesthesia settles in the painful territory. No motor deficit should be present.

Figure 2: The nerve is vulnerable to compression and stretching from its origin under the psoas muscle until it exists through the inguinal ligament and the fascia lata.



Dr Alan Nazha

BMed FANZCA FIPP FFPMANZCA

Dr Alan Nazha is a qualified Interventional Pain Physician and currently consults at Sydney Adventist Hospital amongst other locations.

Dr Nazha has expertise in minimally invasive pain therapies and is qualified with a Fellowship in Interventional Pain Practice (FIPP). Dr Nazha has a special interest in the utilisation of Peripheral Nerve Stimulation in the treatment of persistent post-surgical pain, neuropathic pain, and CRPS.

Dr Alan Nazha is co-founder and director of Sydney Pain Specialists.

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San researcher wins prestigious international Rosalind Franklin Award



Dr Ann Liebert has won one of the Rosalind Franklin Society Awards in Science for her paper demonstrating that light therapy is effective in reducing clinical signs of Parkinson's Disease (PD). The prestigious award recognises a published scientific paper by a female researcher.

Dr Liebert's paper – 'Remote Photobiomodulation Treatment for the Clinical Signs of Parkinson's Disease: A Case Series Conducted During COVID-19' – was published in the journal *Photobiomodulation, Photomedicine, and Laser Surgery* in 2021. It is the first such paper to demonstrate the mechanism of remote photobiomodulation (PBM) to help with the symptoms of Parkinson's Disease.

PD is a progressive neurodegenerative disease for which there is no cure and few treatment options. There is a strong link between the microbiome–gut–brain axis and PD.

PBM in animal models can reduce the signs of PD and protect the neurons from damage when applied directly to the head or remote parts of the body.

Dr Liebert's Sydney-based trial, conducted at the Photobiomodulation Therapy Clinic at Sydney Adventist Hospital (SAH), enrolled seven participants who were treated with PBM to the abdomen and neck three times per week for 12 weeks.

Participants were assessed for mobility, balance, cognition, fine motor skill and sense of smell on enrolment, after 12 weeks of treatment in a clinic and after 33 weeks of home treatment.

A number of clinical signs of PD were shown to be improved by remote PBM treatment, including mobility, cognition, dynamic balance, spiral test and sense of smell.

"Our study shows PBM was shown to be a safe and potentially effective treatment for a range of clinical signs and symptoms of PD," said Dr Liebert. "Improvements were maintained for as long as treatment continued, for up to one year in a neurodegenerative disease where decline is typically expected. No other treatment has achieved this.

"Several studies have observed that the gut microbiome in Parkinson's patients is radically altered, with certain proteins traveling from the gut to the brain. Dysbiosis in the intestine indicates

inflammatory disease. Applying light to the stomach stimulates the body to produce anti-inflammatory chemicals. Once inflammation is reduced, the body goes into homeostasis and can produce positive clinical effects."

In winning the award, Dr Liebert said she is humbled to be standing on the shoulders of many people – including many courageous women – who have been working on understanding the mechanisms of light therapy since 1994.

"I am grateful also to Sydney Adventist Hospital, especially my mentor, co-researcher and head of Research at SAH, Professor Geoffrey Herkes, for the support of my work and enabling this clinical innovation to change the treatment of many people around the world," she said.

"From our current research, we have developed a home-device that is TGA and CE marked (in Europe) for the treatment of symptoms of Parkinson's disease."

As a result of the research, Dr Liebert has cofounded an Australian company with the goal of using PBM to treat the symptoms of PD and other intractable neurodegenerative diseases.

SAH has used light therapy since 1903 across different areas such as wound care, arthritis and lymphedema, and is now adopting it in new areas such as neurological and chronic pain.

Dr Liebert's award-winning paper has informed on a new triple-blind randomised controlled trial involving 40 participants who remotely attend the Photobiomodulation Therapy Clinic at SAH.

Dr Liebert and her team at the SAH – including cardiologist Professor Hosen Kiat – were the first to articulate the complex mechanistic actions by which low-level photon energy might confer myocardial protection. They have also been successful in using light therapy to treat oral mucositis in cancer patients. The San Foundation is also supporting Dr Liebert's team at SAH in collaboration with Professor Carol Pollock in the study of PBM to treat diabetic renal disease in a pre-clinical study.

Dr Liebert's full paper can be accessed here:

[liebertpub.com/doi/abs/10.1089/PHOTOB.2021.0056](https://doi.org/10.1089/PHOTOB.2021.0056)



AN ARTICLE
FEATURING

**Dr Geetha
Sivapirabu**

Topical treatments for skin cancers

Non-surgical treatments for some skin cancers and pre-cancerous conditions are a good first-line option, with surgery available should it be needed at a later stage.

While advanced malignancies and melanoma skin cancers need immediate surgical review, lesions like superficial basal cell carcinomas and thin squamous cell carcinomas can be treated with topical agents as a first-line option.

“Not all skin cancers need to be surgically excised,” said Dr Geetha Sivapirabu, medical and surgical dermatologist at the San.

“Certain early skin cancers can be treated non-surgically, and might be preferred by a patient for a variety of reasons.

“Creams are especially desirable if lesions are located on cosmetically sensitive areas like the face or on areas that are difficult to operate on, like the lower legs. Sometimes patients also prefer topicals if they have a history of multiple skin cancers and have needed frequent surgical interventions. It can also be a cheaper option for patients.

“Topical treatments are not perfect, and they do carry a higher recurrence rate compared to standard surgical excision. However, we monitor a patient’s progress very closely and, should the cream not prove effective, surgery is still available to them.”

The other scenario where these treatments are extremely useful is in the management of pre-cancerous cells such as with actinic or solar keratoses. These treatments can be used to ‘mop up’ sun spots over a large area, where liquid nitrogen could be painful due to the sheer number of lesions. Cosmetically, there is less chances of permanent hypopigmentation – or ‘white marks’ that can occur with liquid nitrogen treatment – making it more attractive in significantly photodamaged patients.

“These topical treatments are patient led,” explained Dr Sivapirabu, who completed a Master of Medicine at the University of Sydney where she researched the benefits of vitamin B3 (or nicotinamide) on ultraviolet light-induced immunosuppression.

“The downside is that a patient has to commit to complying with the treatment schedule for a few weeks – so it’s not for everyone. But there are ways we can shorten the treatment regime in a motivated patient.”

Two main creams are used. Aldara (imiquimod) stimulates the patient’s immune system to respond to a lesion. The other option, 5-fluorouracil, known as Efudix, is a well-established chemotherapy agent.

“The beauty of these treatments is that they can attack even the microscopic damage,” explained Dr Sivapirabu. “By ‘mopping’ large areas, such as the whole face, patients avoid the need to have sun spots frozen off one-by-one with liquid nitrogen. The treatments are safe and effective and can even be done annually in some badly sun-damaged patients.”

Dr Sivapirabu also offers patients Daylight Photodynamic Therapy (PDT), which can be used to treat large areas of sun damage. The light-sensitive cream is applied, with the patient then spending a couple of hours outside. The photochemical reaction destroys the tumour cells. This treatment is completed in one office-based session and there is no need for the patient to continue treatments at home. Some patients like the convenience of this approach, despite its higher cost compared with topicals.

Patients using topical treatments are monitored to see how they respond, with regular follow-ups over a number of years. Dr Sivapirabu completed her undergraduate medical degree at the University of NSW and obtained her FACD in 2012. She sees patients at the Parkway San Clinic.



Dr Geetha Sivapirabu

BSc (Med) MBBS (UNSW)
MPhil (Med) FACD

Dr Geetha Sivapirabu is a medical and surgical dermatologist at Sydney Adventist Hospital.

Dr Sivapirabu completed her MBBS at the University of NSW in 2002. Having worked as a junior doctor, she went on to complete a Master of Medicine at the University of Sydney where she researched the effects of nicotinamide on ultraviolet light-induced immune suppression and its effects on skin cancer development. She trained as a dermatologist at various hospitals including Royal Prince Alfred, Prince of Wales, Westmead and St Vincents Hospitals. Dr Sivapirabu became a Fellow of the Australasian College of Dermatologists in 2012.

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AN ARTICLE
BYDr Christos & Dr Carla & Dr Andrew
Apostolou Gillespie Pearson

Diabetes & Bariatric Surgery



Obesity is a global epidemic, and one that is only increasing. Figures from the World Health Organisation show that when compared to three decades ago, the prevalence of obesity has already doubled¹. This is an issue due to the massive health and economic burden it places on society, in an already aging population.

Type II Diabetes Mellitus (T2DM) is one of the most common obesity related diseases, affecting up to 23% of those with morbid obesity². And national prospective trials from both the United States³ and Sweden⁴ show an exponentially increased risk of T2DM as weight increases.

Conventional treatment for T2DM aims at glycaemic control and lowering cardiovascular risk. But the majority of oral hypoglycaemic agents and insulin therapy can lead to weight gain, which can further risk good glycaemic control. There have been some early promising results with diabetic medications used to treat obesity, for example the GLP-1 agonist semaglutide (Ozempic). However longer trials proving the durability of the weight loss have not yet been performed, and weight regain on cessation of the medication appears to be a problem. The STEP 4 trial⁵ looked at the use of Semaglutide after 20 weeks, where patients were randomly assigned either a further 48 weeks of use or placebo. It found that those who stopped the medication at 20 weeks experienced weight regain and had associated increased weight circumference and blood pressure. This was again confirmed with an extension to the STEP¹⁶ trial, which showed after withdrawal of the medication patients regained two-thirds of their previous weight lost with similar increase in their cardiovascular parameters.

Obese patients require 10-15% total body weight loss for diabetes remission, and improvements in hyperglycaemia still continue at >15% weight loss. Semaglutide is one of the only medications currently available in Australia that has a chance of achieving this, however it still doesn't compare to the results that can be obtained by bariatric surgery (Figure 1). Hence bariatric surgery remains the mainstay of long-term weight loss and glycaemic control in those with obesity due to the paucity of other durable options.

A randomised trial published in the New England Journal⁷ looked at bariatric surgery versus standard medical therapy in the treatment of T2DM in those with a BMI >35. It found that at two years, no patients in the medical arm had achieved diabetes remission. This was compared to 75% of patients in the gastric bypass group. This was further reiterated in a cohort study published in 2017 in the Journal of the American Medical Association⁸. Over 1800 morbidly obese patients were included in the study and they either underwent bariatric surgery or standard medical diabetic treatment. With a median of 6.5 years follow up, the relative risk of diabetes remission in the surgical group was 3.9 (2.8 – 5.4) and relative risk of hypertension remission was 2.1 (2.0 – 2.2).

Bariatric surgery is certainly not without its risks and the modifications require lifelong change. But considering the long-term outcomes that can be achieved- including resolution of medical comorbidities, improvements in mental health and general quality of life- it should be considered for obese patients who suffer from T2DM (Table 1).

When visiting our practice, each patient is reviewed by the surgeon and then subsequently a multidisciplinary team. The team includes a physician, dietician, exercise physiologist and mental health professional. This is not only for medical optimisation prior to surgery but also to ensure the patient is adequately educated and supported for the journey ahead.

If your patient has a BMI>35 and suffers from T2DM, then bariatric surgery may be worth a conversation.



Dr Christos Apostolou

MBChB (UCT), FCS (SA), MMed (Surg), FRACS

Dr Christos Apostolou is a specialist General Surgeon in the fields of upper gastrointestinal, liver, biliary, pancreatic and bariatric surgery. Dr Apostolou has special expertise in upper gastrointestinal oncology, antireflux, hernia & laparoscopic surgery, endoscopy and ERCP. He holds full accreditation in robotic surgery.

They have formed Northern Bariatrics promoting collaboration and a surgical team approach towards optimal care and best patient outcomes.

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Dr Andrew Pearson

B.Ap.Sci (Physio) MBBS (Hons) FRACS

Dr Andrew Pearson is a specialist General Surgeon with interests in acute, emergency and trauma surgery as well as surgery of the liver, pancreas and gallbladder. He also has an interest in abdominal wall hernia repair and robotic surgery.

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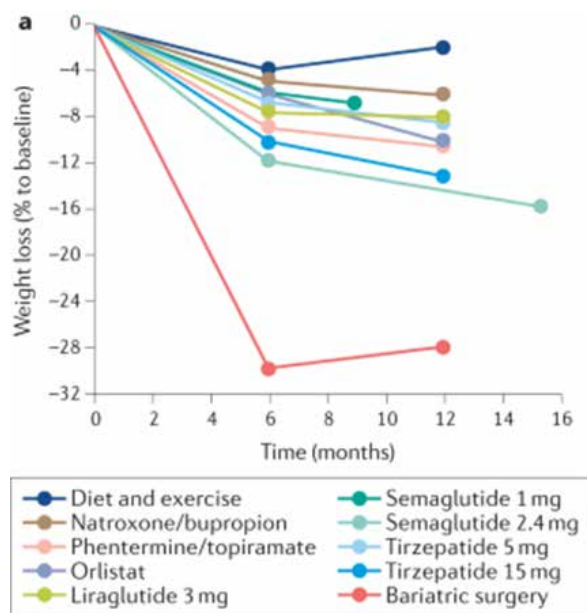


Figure 1

body weight loss changes using diet & exercise, antiobesity medications and bariatric surgery.

Bariatric Surgery	BMI >40 or BMI > 35 with obesity related comorbidity
Antiobesity medications	BMI > 30 or BMI 27-30 with weight related comorbidities

Table 1

Candidates for surgery and medical therapy for obesity.

Dr Carla Gillespie

BMed MS FRACS

Dr Carla Gillespie is an Upper Gastrointestinal and Bariatric Surgeon with a special interest in the treatment of stomach and oesophageal cancer, reflux surgery, hiatus hernia repair and bariatric surgery (including sleeve gastrectomy, gastric bypass and revision procedures).

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AN ARTICLE
BY

Dr James
Newcombe

Self-collected Respiratory Virus/COVID-19 PCR Swabs now available

THROUGH DOUGLASS
HANLY MOIR PATHOLOGY



Dougllass Hanly Moir Pathology (DHM) is now offering patient self-collected swabs for the diagnosis of COVID-19 and other respiratory viruses. Self-collect swabs (including patient instructions) are available for doctors to distribute to patients who would benefit from fast and accurate diagnosis (for example, pre-operative screens, high-risk patients who would benefit from oral antiviral therapy).

With the availability of safe, effective oral antivirals, and a new wave of COVID-19 predicted before the end of the year, timely and accurate diagnosis of COVID-19 remains as important as ever.

In April 2020, DHM published the first paper in the world, validating patient self-collected swabs as equivalent to clinician-collected swabs for the diagnosis of COVID-19. Self-collected swabs can also be reliably tested for other respiratory viruses, including influenza and RSV, if respiratory virus PCR is requested.

While rapid antigen tests (RATs) have made patients accustomed to self-collected swabs, RATs have poor sensitivity for the diagnosis of COVID-19 and cannot diagnose other respiratory viruses. A 2022 study at ICPMR and the Doherty Institute found the analytical sensitivity of all RATs marketed in

Australia to be low. Extrapolating this low sensitivity to samples at DHM, over 35% of all positive COVID-19 PCR results would be falsely negative on RAT testing.

The consequences of false-negative RATs to patients and doctors are high. Firstly, RATs may offer false reassurance that a patient does not have COVID-19, for example, pre-operatively, with associated infection risks to healthcare workers and other patients. Secondly, a false-negative RAT prevents high-risk patients from accessing highly effective oral antivirals which can reduce the risk of hospitalisation and death due to COVID-19 by up to 90%.

Self-collected swabs for respiratory virus/COVID-19 PCR offer a convenient, reliable alternative to RATs and clinician-collected swabs. To arrange a respiratory virus/COVID-19 PCR self-collection:

1. Complete a DHM pathology request form with one of the following test requests:
 - a. COVID-19 PCR – only COVID-19 (SARS-CoV-2) will be tested
 - b. Respiratory virus PCR – COVID-19 (SARS-CoV-2) plus other respiratory viruses (influenza, RSV, adenovirus, rhinovirus, parainfluenza, human metapneumovirus) will be tested
 - c. Please indicate 'self-collect' in clinical notes
2. Provide your patient with:

- a. A respiratory virus/COVID-19 PCR self-collect swab with patient instructions and specimen bag (available from DHM Stores Department using code D01499; also available at DHM Collection Centres)
 - b. A signed DHM pathology request form for each swab
3. Completed tests are returned by the patient to the specimen drop-off point at a DHM collection centre. Please instruct your patient to clearly label the tube prior to returning their sample.
 4. Results are typically available within 24 hours following receipt of the sample in our laboratory.
 5. All results are sent to the requesting doctor as per their usual results pathway. COVID-19, influenza and RSV PCR results are also sent by SMS directly to the patient.





Dr Jim Newcombe

BMedSci (Hons), MPH (Hons),
MBBS, FRACP, FRCPA

Dr Jim Newcombe is Director of Microbiology and Deputy CEO at Douglass Hanly Moir Pathology. He is a paediatric and adult infectious diseases physician and clinical microbiologist with a special interest in molecular microbiology and COVID-19 diagnostics.

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Emeritus Consultant appointments

Congratulations to two of our dedicated doctors on their Emeritus Consultant appointments, awarded in recognition of their contribution at Sydney Adventist Hospital.

CONGRATULATIONS

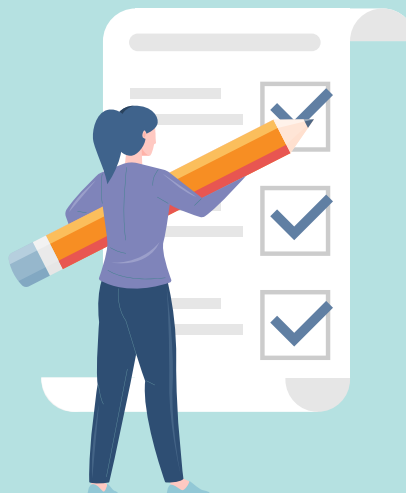
to Dr Rod Brooks receiving an
Emeritus Consultant in Orthopaedic Surgery.

CONGRATULATIONS

to Dr Ross Bradbury receiving an
Emeritus Consultant in Infectious Diseases and Microbiology.

Did you know?

**Adventist HealthCare has agreements in place
with all major Australian health funds**



**Adventist
HealthCare**

AN ARTICLE
BY SAN
DOCTORSA/Prof & Dr Stephen
Craig Lynch & Pillinger
& Dr Praveen
RavindranWITH
CONTRIBUTION
FROMDr Amy & Dr Laura
Marks & Moore

Robotic Colorectal Resection in the Elderly – is 80 the new 70?

The surgeons at Australian Robotic Colorectal Surgery (ARCS) reviewed the outcomes of robotic colorectal surgery in the elderly. As our population ages it is very important to ensure surgery can be performed safely for this cohort, particularly for common conditions such as bowel cancer. ARCS have presented outstanding results for this group of patients at the recent Royal Australasian College of Surgeons Congress earlier this year.

Purpose

As our population ages, the number of elderly people requiring colorectal surgery has increased. Robotic surgery offers a minimally invasive approach with many small series showing an improvement in outcomes. However, outcomes in the elderly population in Australasia have not been well described within the literature. We aimed to examine the safety of robotic surgery in patients over 80 in Australia.

Method

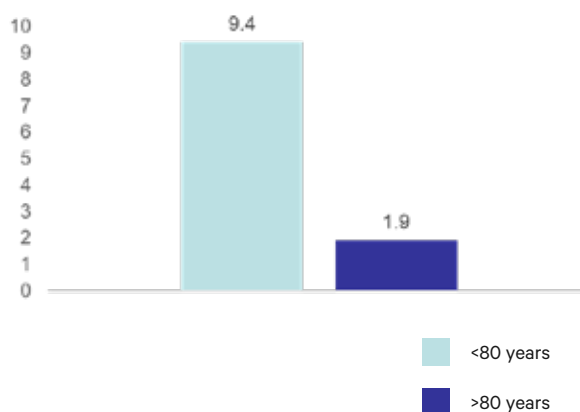
A prospectively collected database from Sydney Adventist Hospital was retrospectively analysed. All patients who had robotic colorectal resections with anastomosis on a Da Vinci Xi system were stratified into two groups – younger than 80 and older than 80. Patient demographics, indications for surgery, operative findings, and postoperative outcomes were recorded. Endpoints included 30-day morbidity and pathological outcomes.

Results

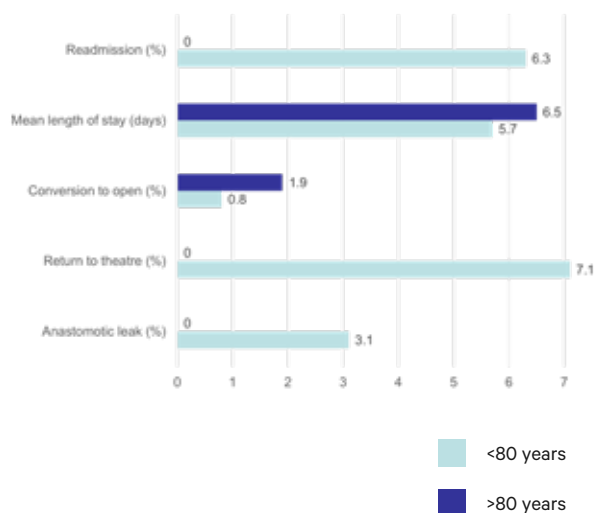
180 patients had robotic colorectal resections with anastomosis between 2014 and 2021 (127 patients under 80, 53 patients over 80, median age 70.3, range 21-92). There were no mortalities within 30 days in either group. Major morbidity (including anastomotic leak, conversion to open and return to theatre) was significantly lower in the elderly group, 1.9% (n=1) compared with 10.2% (n=13).

There was no significant difference in length of stay (mean 5.7 days compared with 6.5 days for the older cohort). Readmission was more likely in the younger group (6.3% compared with 0%). Pathological outcomes were comparable, with only one patient in the younger group having an involved margin.

Adverse event (%)



Outcomes



Conclusion

Robotic colorectal surgery appears feasible in an elderly population with excellent outcomes observed in our older cohort. Our data supports consideration of a robotic approach in this group.



Associate Professor Craig Lynch

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A/Professor Lynch is a Robotic & Colorectal Surgeon and practices at Sydney Adventist Hospital in Sydney and the Epworth Hospital in Melbourne. He has extensive experience managing Colorectal Cancer, in particular using a minimally invasive approach with both laparoscopic and robotic surgery. He is an Associate Professor at the University of Melbourne, completing his General Surgical Fellowship in New Zealand, with post-fellowship training at the Cleveland Clinic, Ohio, and St Vincent's Hospital in Melbourne. He is a Fellow of the Colorectal Surgical Society of Australia and NZ and an International Fellow of the American Society of Colon & Rectal Surgeons

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Dr Praveen Ravindran

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Praveen Ravindran is currently a Consultant Colorectal & Robotic Surgeon with Australian Robotic Colorectal Surgery working through Sydney Adventist Hospital and East Sydney Private Hospital. The major focus of his work is minimally invasive laparoscopic and robotic surgery, hernia surgery, as well as diagnostic and intervention colonoscopy. He also maintains a strong interest in Pelvic Floor & Perianal pathology as well as functional bowel disorders.

Dr Ravindran is a member of CSSANZ and the Section of Colon and Rectal Surgeons Royal Australasian College of Surgeons.

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Dr Stephen Pillinger

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Dr Pillinger is a Consultant Colon and Rectal Surgeon, having commenced consultant practice in 2005. The major focus of his practice is benign and malignant colorectal pathology, and he has particular expertise in minimally invasive laparoscopic and robotic surgery, transanal endoscopic microsurgery, diagnostic and interventional colonoscopy. He has trained in robotic surgery in the US and South Korea and is one of the busiest robotic colorectal surgeons in NSW.

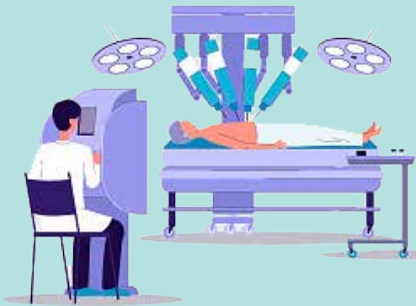
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AN ARTICLE
FEATURING

**Dr James
Symons**

Innovative use of robotic surgery to remove schwannoma



In an Australian first, urologist Dr James Symons removed a rare retroperitoneal tumour located behind the abdomen using the San's Da Vinci Xi Robotic Surgical System.

Camille Payne, 23 years old, had been living most of her memorable life with non-specific abdominal flank and back pain. For over a decade this had been labelled by several doctors as variations of musculoskeletal back pain and, later, a broken rib. After living with symptoms for 10 years, her new GP organised a community CT, which was reported as being consistent with a large (10cm) renal cyst. She was referred to San urologist Dr James Symons.

“Camille had a legitimate pain problem that was not appropriately scanned and diagnosed,” said Dr Symons, a senior urologist at the San. “Schwannomas are notoriously difficult to diagnose, so without performing the right imaging, patients can go undiagnosed for years, as was the case with Camille.”

The CT scan was re-assessed at the San, where an ultrasound confirmed the lesion was not a cyst, but rather a much rarer tumour arising adjacent to the kidney from one of her intercostal nerves. A biopsy confirmed the 10cm mass to be a schwannoma, a rare and mostly benign tumour that forms in the glial cells – specifically, the Schwann cells – of the peripheral nervous system.

Schwannomas are typically referred to general surgeons who resect the mass through a rib-splitting incision. However, in Camille's instance, the location of the mass and her young age led Dr Symons to consider performing the resection himself utilising skills learned over many years of robotic training.

“As a urologist, I operate in the retroperitoneal space all the time,” said Dr Symons, who underwent robotic surgery training at St Vincent's Hospital and subsequently completed a fellowship in minimally invasive surgery in Manchester, England. “In this case, because the tumour was close to the kidney, it made sense for me to perform the procedure.”



“I teach the surgical endoscopy unit in the Master of Surgery course at the University of Sydney, and one of the key principles I instil in my students is to try to look at clinical problems from a different angle. The aim for me with Camille was to spare her the unnecessary trauma of a large incision, and try to give her the best cosmetic and functional outcome. Drawing on robotic kidney training, I thought we could potentially apply this approach to her para-renal tumour.”

Given the complexity of the case, and the novel surgical approach, Dr Symons worked with a team of San colleagues. After extensive planning, both cardiothoracic surgeon Dr Tristan Yan and upper GI surgeon Dr Christou Apostolou were on standby. The 90-minute procedure went extremely well, with the patient able to return back home five days later.

“Robotic-assisted laparoscopic surgery, which avoids the trauma of open surgery, is very advantageous to the patient,” explained Dr Symons. “Through just a 3cm right loin cut, I was able to remove all of the dissected tumour. The tumour extended from the kidney underneath the liver into the retropleural space. In addition to dissecting the kidney, to safely access the tumour, the procedure also required mobilisation of the liver and incision across the diaphragm and pleura.

“Had we performed the case as a traditional open surgery, it would have involved a long muscle-splitting cut, division of the rib and thoracotomy – all with significant pain post-operatively. It would also have left a 30cm scar across her flank.

“Searching the literature, I found no existing case reports of a robotic approach to remove a schwannoma, although several open cases have been done. I was delighted to be able to perform this innovative surgery for a patient at the San.”

Camille says that the first two weeks after the operation were painful, but then she recovered rapidly and is now completely pain free.

“I am absolutely fine now,” she said. “I realise, looking back, that I could ‘feel’ the tumour without knowing it was one – a stabbing pain in my back and side that was so relentless, and my hair was falling out. I knew something was up, but I avoided it and tried to live with the pain.

“I had a great experience at the San. It’s such a lovely hospital and everyone was so kind and caring. It’s just a huge relief to have it all behind me.”

The San has a busy robotic surgical program across multiple specialities, with routine urology, cardiac, gynaecology and general surgery use. Many of these robotic-trained surgeons have developed a sub-specialty interest.

“One of the strengths of operating on patients at the San is the breadth of surgical colleagues,” said Dr Symons. “This means that complex or unique patients, such as seen in Camille’s case, can be discussed with supportive multidisciplinary colleagues.”

The San now has two Da Vinci robots, and has grown to offer the busiest robotic program in Sydney.



Dr James Symons

MBBS(Hons) BMedSc MS(Urology)
FRACS(Urology)

Dr James Symons is an experienced Urologist specialising in robotic and laparoscopic surgery.

Dr Symons is a Fellow of the Royal Australasian College of Surgeons, a faculty member at the University of Sydney, a founding member of the St Vincent’s Community Hospital Medical Advisory Committee, and holds membership with the Urological Society of Australia and New Zealand, Australian Medical Association, European Association of Urology, American Urological Association, Australian – Canadian Prostate Cancer Research Alliance, International Continence Society, Academy of Surgical Educators, and Royal College of Physicians & Surgeons of Glasgow.

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AN ARTICLE
FEATURING

San Syncope -
Blackouts &
Faints Clinic

One-stop -shop syncope clinic at the San

With a suite of specialists on site, the San's Syncope Clinic is the first in NSW to offer patients a comprehensive service in a single location for the diagnosis and management of syncope.

Most people experiencing syncope have benign underlying causes for the condition. Anxiety, heat, fear of injections as well as low blood pressure when standing can cause people to faint. However, around 15–20 per cent of people who lose consciousness temporarily do so from heart conditions.

“While it's important to understand the cause of all syncope cases, those with heart-related abnormalities are the most concerning,” said Dr Greg McDonald, specialist in the hospital's Syncope Clinic.

“Of the 15 per cent of syncopal episodes that are heart-related, the potentially dangerous diagnoses are arrhythmia, valve disease (particularly aortic valve) or abnormal heart anatomy. Evidence shows that for those who faint from one of these problems that goes undiagnosed, up to 30 percent will die within a year.”

“It's very important to work out what is going on fairly quickly in these cases. Yet these patients typically attend several medical consults and have up to 12 investigations and are often still left with an inadequate diagnosis. It's a lengthy, uncertain and often convoluted journey.”

The San's Syncope Clinic offers patients a single location for all investigations by a team of relevant experts. It helps both those with benign conditions and those who are at risk. The team includes an experienced physician and cardiac nurses with subsequent access to the best diagnostic investigations. A cardiologist is directly available to the clinic. A neurologist, geriatrician, ENT surgeon, radiologist and others are on site at the San and available, if required.

“Because there are many causes for syncope, the team determines immediately if the problem is heart-related or not,” explained Dr McDonald. “Seizure, medication side effects, standing up too rapidly – these can all be possible causes and are looked at in the process.”

“Nurses conduct initial observations and blood tests. The patient receives a resting ECG and an echocardiogram. We also offer the wearable device HeartBug, through which we can monitor a patient's heart rhythm for four weeks. After that time, we receive a report, but anything urgent during the four weeks gets reported immediately to

us. We also have ready access to Implantable Loop Recorders for patients suspected of significant arrhythmias.”

The clinic also has a Tilt Table to confirm a diagnosis of vasovagal or other postural blood pressure disorders like POTS (Postural Orthostatic Tachycardia Syndrome). The San is one of only a few locations to perform Tilt Table tests, which play an important role in assessing syncope because many cases involve orthostatic postural disorders.

“Importantly, the journey for the patient attending the San is straightforward,” said Dr McDonald. “After a patient is seen by the relevant specialists, we come to a diagnosis and a plan for the patient. We can do this because all the resources needed to diagnose syncope accurately are around the clinic.”

“I don't see many follow-ups from patients who have visited the clinic because we organise all the assessments here, the diagnosis is made and the patient is managed successfully.”

“For GPs who are trying to work through a syncope case with multiple specialist referrals and a still-elusive explanation, it is advantageous to refer the patient to a single clinic where a suite of experts can assess the case. Our access to the facilities of the San and devices like Loop Recorders are other great advantages.”

The San's Syncope Clinic is the first of its kind in NSW. All activities conducted within the clinic are bulk billed.

San Syncope (Blackouts & Faints) Clinic

The San's Blackouts & Faints Clinic streamlines the process for patients, eliminating visits to multiple specialists at multiple locations, reducing appointment times and consultation costs, cutting out duplicate testing and limiting the anxiety associated with waiting for a diagnosis.

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CONGRATULATIONS!

Sydney Adventist Hospital ranked in the Newsweek World's Best Specialized Hospitals



Sydney Adventist Hospital has once again been ranked in the Newsweek World's Best Specialized Hospitals 2023 survey for Oncology, while also being ranked for the first time for Cardiology.

The Newsweek ranking features the top 300 hospitals for cardiology and 250 for oncology, with Sydney Adventist Hospital listed in both categories.

The research included 20 countries and was conducted by market research company Statista in partnership with Newsweek. Data was gathered from three sources: recommendations by doctors via an online survey from these countries, publicly available patient satisfaction survey results, and publicly available medical KPIs on hospitals.

Clinical Professor Gavin Marx, Clinical Director, San Integrated Cancer Centre, said that the Hospital is delighted with the news.

"This is the second time we've made it into Newsweek's world top ranking oncology centres, and it is wonderful to see we are also climbing up the ranks and coming in higher than last year," he said.

"Over many years, we have developed a high-volume cancer service at the San run by some of the most outstanding health professionals in NSW. It's clear that our highly skilled team and constant innovation have led to excellent patient outcomes and an impressive reputation in Australia and internationally."

"We are consistently leading the way in our State surveys as well," said Prof Marx. "For three consecutive years the San Integrated Cancer Centre has achieved some of the highest ratings in the Bureau of Health Information patient survey, conducted in partnership with the Cancer Institute of NSW."

Key features of the multidisciplinary San Integrated Cancer Centre include state-of-the-art imaging, a full range of high-quality surgical and reconstructive services, comprehensive medical oncology services, expert onsite cancer genetics, extensive cancer support services and patient navigators.

The co-located Icon Cancer Centre Wahroonga provides the latest in radiation therapy technology and techniques for all cancer types.

Providing patients with access to novel medical therapies, the Centre's Clinical Trials Unit participates in international trials in breast, colorectal, prostate, melanoma and other cancers. Patients also have access to lifestyle programs designed to reduce their cancer risk.

Adventist HealthCare Limited (AHCL), CEO Brett Goods says he is incredibly proud of the excellent work by all members of the San's cancer teams, and their recognition in an international context.

"It is wonderful to see us appear in the Newsweek ranking again this year for oncology. I would also like to commend our San cardiology team who have been ranked in the world's top cardiology centres for the first time. This is a truly outstanding achievement," Mr Goods explained.

The San has established a reputation as one of NSW leading providers of private cardiac care, since 1979, when it was the first private hospital in the State to offer a complete private cardiothoracic service with a Cath lab and full open heart surgery program.

Head of Department for San Cardiology, Dr Elizabeth Shaw, explained how delighted she was with the news that the department was ranked 200 out of 300 in Newsweek's Top Specialized Hospitals - Cardiology. "The San is fortunate to have an outstanding cohort of Cardiologists, supported by specialist nurses, allied health and other support staff, which enable us to undertake complex cardiology procedures and provide the best care for our patients" Dr Shaw explained.

"The San has been leading the way in private cancer and heart care for decades," Mr Goods explained. What sets us apart is that we not only provide our patients with access to NSW's leading health professionals and modalities, but also our whole person approach to patient care. Our health professionals don't simply treat conditions; they take a multidisciplinary approach to personalised care.

When you come to the San, you know there is a team of the best experts behind you every step of the way and it's nice to see us being consistently recognised for providing our community with outstanding care."

AN ARTICLE
FEATURING**Dr Wahid
Mohabbati**

Complex Regional Pain Syndrome:

A MISDIAGNOSED AND DEVASTATING CASE

Sarah's case of Complex Regional Pain Syndrome was never properly diagnosed and led to long-term disability. After decades, her pain was successfully treated at the San using a neuromodulation device implant. GPs are advised to refer patients suspected of having CRPS to a pain specialist urgently for further assessment.

At the age of nine, Sarah Procter developed a condition where her ligaments and tendons wouldn't attach to the bone. By her late 20s, she had had a series of ankle operations. After her third operation, intractable nerve pain started. Various pain clinics and specialists around Sydney were unable to treat Sarah's pain – and CRPS was never offered as a diagnosis.

"I was left to live a life with pain, which doctors told me was caused by my original condition," said Sarah. "I struggled on and about three years ago, my legs started collapsing resulting in serious falls up to 10 times a day.

"I was 40 and headed for a life of braces, walkers and wheelchair. I was not eligible for NDIS support and not able to work. I didn't know exactly what the future held, but it didn't look good."

Last year, Sarah's long-term physician Dr Rod Brooks referred her to Dr Wahid Mohabbati, interventional pain and palliative medicine specialist at the San, who finally diagnosed Sarah with a type II CRPS where there is evidence of nerve injury as well as CRPS.

"CRPS is a nasty, painful condition often caused by nerve or joint injury," said Dr Mohabbati. "It's common in the extremities – hands, wrists, ankles and feet – and often starts with a strain or fracture and rarely without any inciting injury. It's so devastating that without proper treatment people often become permanently disabled with a lifetime of pain and suffering.

"Specialists are often hesitant to make the diagnosis because it mimics other conditions like cellulitis or arthritis, yet it's important for GPs or specialists to pick this up early because early aggressive treatment can prevent a person from long-term devastating consequences."

Dr Mohabbati, following some initial conservative treatments failure, suggested a spinal cord stimulator, which Sarah trialed for two weeks after day surgery to have the electrodes implanted and a battery attached externally. Sarah was uninsured but decided to go through with it, paying several thousand dollars for the electrodes, external battery and day surgery.

The trial was successful and a few weeks later Sarah underwent full implantation of a permanent spinal cord stimulator where two electrodes and a battery were implanted under the skin, again in a day surgery procedure. Sarah achieved significant improvement which meant she was able to walk without mobility aids and drive for short periods as well as losing weight.



Guidelines for GPs

Complex Regional Pain Syndrome (CRPS) carries such high risk of morbidity and disability and is so debilitating that it is treated as an 'emergency' in pain medicine.

GPs should look out for undue prolonged pain – especially if a patient has had a fracture, strain/sprain or period of immobilisation and the pain continues beyond the typical 4–6-weeks healing time. Additionally, GPs should take note if an injured area is sensitive to touch (allodynia), remains swollen, changes colour, or feels unusually hot, cold, sweaty or dry. Sometimes patients might develop tremor. Movement might become stiff or difficult.

In the majority of cases, the pain is clearly disproportionate to the injury. The first referral should be to a pain specialist.



About the Pain Clinic

The Sydney Pain Management Centre (SPMC) has a practice at the San. SPMC's Multidisciplinary Team Pain Clinic is made up of pain specialists, interventional pain specialists, palliative care specialists, rehabilitation physicians, anaesthetists, general physicians, geriatrician as well as pain physiotherapists, psychologists, exercise physiologists, occupational therapists and practice nurses. Treatment is the work of a whole team and not just the device. Interdisciplinary care amongst SPMC pain team and orthopaedic surgeons, neurosurgeons, spine surgeons and other physicians has been very close and proven effective in managing a multitude of complex painful conditions.



Dr Vahid Mohabbati

MD, FFPMANZCA, FACHPM

Dr Mohabbati is an interventional pain and palliative medicine physician at the Sydney Adventist Hospital who treats chronic and complex cancer and non-cancer pain conditions using advanced cutting-edge pain therapies. He is the Director of Sydney Pain Management Centre and Sydney Pain Research Institute.

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AN ARTICLE
FEATURING

**Professor Payal
Mukherjee**

3D-printed ear earns San-based ENU surgeon a finalist spot in the 2022 Eureka Awards



ENT surgeon Professor Payal Mukherjee and Bioengineer Professor Gordon Wallace

An interdisciplinary network of clinicians and scientists have developed an innovative bio-ear for children with microtia, and have been named a finalist in this year's prestigious Australian Museum Eureka Awards – the country's most comprehensive national science awards.

The innovative project, called NEW EARS (iNtegrated nEtWorks for Ear Additive Reconstructive Science) is an Australian first for hybrid bio-printed ear reconstruction, achieved by integrating the science of 3D printing, cell biology and materials engineering.

NEW EARS addresses a previously challenging surgical pathway for children with ear deformity by reducing morbidity and importantly, co-ordinating hearing rehabilitation and performing ear reconstruction at the same time.

Sydney Adventist Hospital (SAH) ENT specialist Associate Professor Payal Mukherjee, who is leading the project with Professor Gordon Wallace from University of Wollongong, says that ear deformities can significantly slow a child's development by compromising language acquisition. In addition, ear deformities can lead to bullying and psychosocial harm.

"A child with microtia should ideally have their hearing rehabilitation surgery planned by age four or five, but hearing rehabilitation and ear reconstruction are seldom co-ordinated as the ear reconstruction is often delayed until the child's ear is fully grown at around age 10," explained Dr Mukherjee.

"With children commonly submitted to repeated surgical procedures, many become so traumatised that by their early teens, they start to reject health care – even if it means living with deafness and deformed chronically infected ears."

The NEW EARS solution includes, firstly, research into regenerating 3D-printed ear cartilage using a technology called bioprinting, a project currently in the second phase of animal trials. The shape of the ear is uniquely crafted for each individual child. The clinical research and hospital deployment part of the study has been developed at SAH by Associate Professor Mukherjee and the Wollongong team using SAH's onsite own cell culture laboratory at the Australian Research Institute.

The team has also developed a 3D-printed prosthetic ear using silicone technology. This is as an interim, low-cost and more tangible solution for patients undergoing chemoradiotherapy after surgery. With Sophie Fleming, a clinical anaplastologist on the NEW EARS team, the researchers are running a clinical trial on this device.

"In both the bio-ear and the prosthetic silicone ear, because these are 3D-printed, age is no restriction anymore, which means children with microtia can get their hearing back sooner," explained Dr Mukherjee.

"Other benefits include remote planning and, importantly, access for rural and remote patients. Cost is minimised, as are the number of trips to the clinic as technology and clinical services are developed side-by-side in this project. The prosthetic ear is a very important option for patients who are recovering from morbid resections for head and neck cancer.

"We continue to innovate the efficiency by which we deliver care to restore both the structure and the function of the ear. Digital solutions are allowing us to care for interstate and international patients, which we are feeding back into the research pathway to improve any technology barriers that prevent future access."

3D printing using cartilage and other bio-materials is a rapidly developing field and the NEW EARS project has been able to overcome the major challenge of replicating the complex 3D ear structure unique to each patient. It is also a celebration of the impact that interdisciplinary teams with diverse skill sets from diverse institutions can make to deliver patient-focused innovations.

About the TEAM



Associate Professor Payal Mukherjee
ENT Surgeon

Professor Gordon Wallace
Bioengineer

Ms Sophie Fleming
Clinical Anaplastologist

Dr Johnson Chung
Bioprinting Scientist

Mr Kai Cheng
Design Engineer

Dr Sepidar Sayyar
D Printing Scientist



The Australian National University partners with one of the nation's oldest and largest private hospitals to advance Whole Person Health in medicine

The Australian National University (ANU) and Adventist HealthCare Limited (AHCL) which operates Sydney Adventist Hospital (the San) and San Day Surgery Hornsby, have signed a Master Relationship Agreement to establish a dynamic new healthcare education partnership in Australia.

The Master Relationship Agreement follows an earlier Memorandum of Understanding to develop joint educational, research and clinical programs.

The first cohort of six ANU medical students took up their rotations at the San in May of 2021. This year, the San has hosted over 50 medical students as it moves towards full capacity.

The formal affiliation of AHCL clinicians with ANU through a range of academic positions and titles is a key part of the partnership – as is the establishment of research projects.

AHCL CEO Brett Goods said that the partnership is designed to ensure the retention and development of a health workforce at AHCL and elsewhere that can provide high-quality clinical care, education and research.

“Our collaboration with ANU is not only about ensuring an adequate number of doctors and medical professionals for the future,” he said. “It’s also about ensuring the advancement of healthcare in Australia through high-quality health and medical research that is translated into both clinical settings and health policy.

“With two long-standing, well-respected organisations like AHCL and ANU coming together, we hope to achieve a competitive edge when it comes to recruiting the best doctors and students, and tapping into funding to support both research and

the ongoing acquisition of best-in-class technology for the benefit of patients.”

Professor Russell Gruen, Dean of the ANU College of Health and Medicine, said “This Agreement formalises our commitment to work with AHCL and everyone at The San who have a longstanding reputation for outstanding health care and clinical education. Together, we will push the boundaries of education, research and development of the healthcare workforce and health systems for the future.

As the national university, we’re taking bold steps to advance science and service to the nation, including innovative ways of advancing whole person wellbeing, which is very much in keeping with the San’s philosophy.”

The formalisation of the partnership is celebrated with the unveiling of new signage on Fox Valley Road that incorporates the logos and coats of arms of AHCL, ANU and Avondale University– the San’s academic partner for nursing education.

Newly Accredited Doctors



Professor Saxon D Smith AM

MBChB MHL PhD GAICD FAMA IFAAD FACD

Clinical Professor Smith is a consultant dermatologist in St Leonards and Gosford. He has extensive clinical and research interests including atopic dermatitis, psoriasis, hidradenitis suppurativa, melanoma, non-melanoma skin cancer, adverse cutaneous drug eruptions, and managing the complex skin needs of oncology/haematological patients and transplant recipients. He has an interest in lasers, microneedling, UltraformerIII and injectables for medical and cosmetic purposes including acne and burns scarring, and hyperhidrosis. He sees adults and children.

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