



East Sydney Private Hospital Multidisciplinary Journal

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East Sydney
Private Hospital

It is with great enthusiasm that I welcome you to this special edition of the East Sydney Private Hospital Multidisciplinary Journal. As we continue to navigate a rapidly evolving healthcare landscape, the importance of collaboration across specialties has never been more critical. Our mission is not only to advance knowledge but to foster a multidisciplinary approach that enhances patient outcomes and strengthens the future of medicine.

East Sydney Private Hospital has always been at the forefront of innovation and patient-centered care. Since its establishment in 2014, our hospital has grown into a leading boutique healthcare facility in Sydney, offering state-of-the-art surgical and medical services across orthopaedics, general surgery, bariatrics, spine surgery, ophthalmology, and more. We are proud to be one of the first private hospitals to provide no-gap joint replacement surgery and transparent self-insured fees under the Rapid Path to Treatment program—ensuring that high-quality surgical care is accessible even to those without private health insurance.

This issue brings together a diverse collection of articles and case studies, reflecting the breadth of expertise within our medical community. Topics range from minimally invasive approaches to pain management to metabolic surgery advancements, post-partum recovery strategies, and emerging treatments in ophthalmology and urology. These contributions not only offer valuable insights but also highlight the necessity of cross-specialty collaboration in optimising patient care.

I extend my sincere gratitude to our contributing authors, medical experts, and research teams who have dedicated their time and expertise to this edition. Their work underscores the spirit of innovation and excellence that defines East Sydney Private Hospital.

As you explore the pages ahead, I encourage you to reflect on how multidisciplinary cooperation can continue to reshape the future of medicine. I hope this journal serves as both an informative resource and a catalyst for ongoing discussion, learning, and professional growth.

Thank you for being part of this journey with us.

Sarah Gluyas

Business Development & Marketing Manager

Editor, East Sydney Private Hospital Multidisciplinary Journal

In this edition

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Dr Alan Nazha
Anaesthetist &
Specialist Pain Physician



Figure 3

Pulsed Radiofrequency Therapy for Lumbar Radicular Pain: Prolonged Relief for Enhanced Rehabilitation

Lumbar radicular pain, or sciatica, affects many individuals and can cause debilitating symptoms, such as shooting pain, numbness, and leg weakness. It often results from nerve compression due to herniated discs or foraminal stenosis, following a dermatomal pattern.

Initial treatment for lumbar radicular pain includes conservative approaches like oral analgesics, physiotherapy, and sometimes corticosteroid injections. These injections reduce inflammation around the nerve root, offering temporary relief for several weeks. However, many patients experience recurring symptoms after the injection's effects wear off, posing a challenge for both patients and clinicians, as long-term pain control is essential for engagement in physiotherapy and other conservative treatments.

Pulsed radiofrequency (PRF) therapy is a minimally invasive solution for patients needing more sustained relief and those wanting to avoid or delay surgery. Unlike traditional radiofrequency ablation, which uses heat to destroy nerve tissue, PRF modulates pain signals without causing permanent damage. This article explores PRF targeting lumbar nerve roots in patients who experienced short-lived relief from corticosteroid injections but require longer-lasting results for recovery. PRF can be performed using either fluoroscopic or CT guidance depending on the Interventional Pain Physician's preference and patient tolerance. In our practice, we prefer CT guidance, though for patients who cannot tolerate CT, we perform the procedure in theatre with fluoroscopy and sedation.

Case Presentation

Complex Lumbar Spine Surgery with Persistent S1 Radicular Pain

A 48-year-old woman presented with a three-year history of chronic S1 radicular pain following a herniated L5-S1 disc. She initially underwent a microdiscectomy, but her pain recurred within six months, leading to a second procedure, an anterior lumbar interbody fusion (ALIF) at L5-S1. Although the fusion provided temporary relief, the pain returned after one year.

As her symptoms worsened, with sharp pain radiating into the right leg along the S1 dermatome, she underwent a posterior lumbar fusion (PLIF) from L4 to S1. Despite this, she continued to experience the same S1 radicular pain. Imaging confirmed a successful fusion without structural complications, suggesting ongoing neuropathic pain.

To manage her symptoms, she received several corticosteroid injections targeting the S1 nerve root. While the injections offered short-term relief, the effects lasted only about a week, following which she was referred to our clinic for pulsed radiofrequency therapy targeting the S1 DRG. Following the procedure, she reported a 50% reduction in pain, which lasted nine months. This extended relief allowed her to participate in physiotherapy and self-management, improving functionality. Satisfied with her progress, the patient declined repeating the procedure.

Why PRF?

Pulsed radiofrequency (PRF) therapy is an effective treatment for patients with chronic radicular pain, particularly those who have had limited success with previous surgeries or short-lived relief from corticosteroid injections. Unlike corticosteroids, which provide short-term inflammation reduction, PRF offers longer-lasting relief by modulating nerve activity at the nerve root or dorsal root ganglion (DRG). This non-destructive approach makes PRF particularly beneficial for patients who have undergone procedures like discectomies or fusions, where further surgery poses higher risks. PRF provides a safe, minimally invasive option for addressing neuropathic pain.

Mechanism of Action

PRF delivers short bursts of high-frequency electrical current to the affected nerve root or DRG without heating surrounding tissues above 42°C. This method preserves nerve integrity while altering nerve excitability and disrupting pain signal transmission along sensory fibres, such as C-fibres and A-delta fibres. Additionally, PRF likely reduces the release of pro-inflammatory cytokines and modulates the neuro-inflammatory environment, contributing to sustained pain relief. By avoiding nerve destruction, PRF effectively targets the root cause of neuropathic pain without the risks associated with nerve ablation.

Clinical Evidence

A 2023 systematic review and meta-analysis by Marliana et al. confirmed that pulsed radiofrequency (PRF) significantly reduces radicular pain and improves functional outcomes, with effects lasting up to six months. This review consolidated evidence from multiple studies, reinforcing PRF's role as a viable, non-surgical option for patients with lumbar disc herniation.

In addition to the 2023 review, other clinical studies have consistently shown that PRF provides extended pain relief with minimal adverse effects. These studies highlight PRF's safety and effectiveness in managing chronic lumbosacral radicular pain, offering a minimally invasive alternative to further surgery in patients who have exhausted conservative treatments.

Patient Selection

Ideal candidates for PRF therapy include:

- **Short-lived relief from corticosteroids:** Patients who benefit briefly (1-2 weeks) from nerve root injections can achieve longer-lasting relief with PRF.
- **Previous spinal surgeries:** Patients with persistent pain post-surgery (e.g., microdiscectomy, fusion) may benefit when structural correction alone is insufficient.
- **Avoiding further surgery:** Suitable for patients wanting to delay or avoid more invasive procedures.
- **Engagement in physiotherapy:** PRF's extended relief supports rehabilitation and conservative management.
- **Comorbidities:** Ideal for those at higher surgical risk (e.g., cardiovascular conditions, advanced age, anticoagulant use).

For patients needing longer-lasting pain control to engage in physiotherapy and conservative strategies, PRF serves as an ideal intermediary treatment, reducing the likelihood of requiring further surgery.

Practical Application and Post-Procedure Care

PRF is a day procedure performed by Interventional Pain Physicians under local anaesthesia. Using either fluoroscopic or CT guidance, a thin insulated needle is positioned near the affected nerve root. The electrical pulses are delivered in brief bursts to avoid nerve damage.

Patients return home the same day, and post-procedure soreness is minimal and short-lived. Following the procedure, patients are encouraged to resume physiotherapy and conservative management to maximise the benefits of the extended pain relief. Follow-up appointments are scheduled to monitor progress and assess whether additional PRF treatments are necessary.

Conclusion

For patients with persistent lumbar radicular pain, especially those with a history of spinal surgeries or short-lived relief from corticosteroid injections, pulsed radiofrequency therapy offers a safe, minimally invasive treatment option. By providing extended pain relief without damaging nerve tissue, PRF allows patients to re-engage with rehabilitation programs and improve their quality of life. PRF represents a useful intermediate treatment for managing chronic radicular pain, helping patients delay or avoid further surgical interventions.

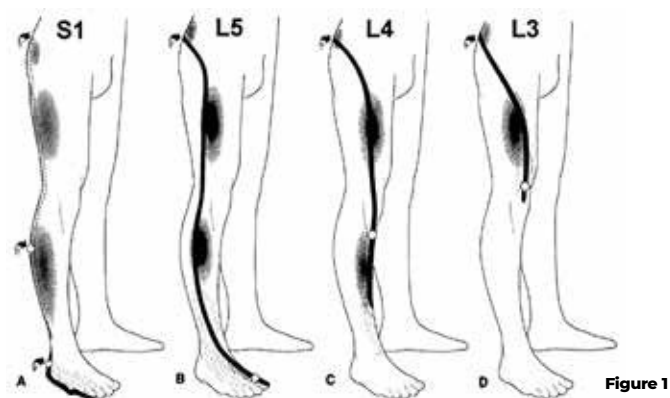


Figure 1

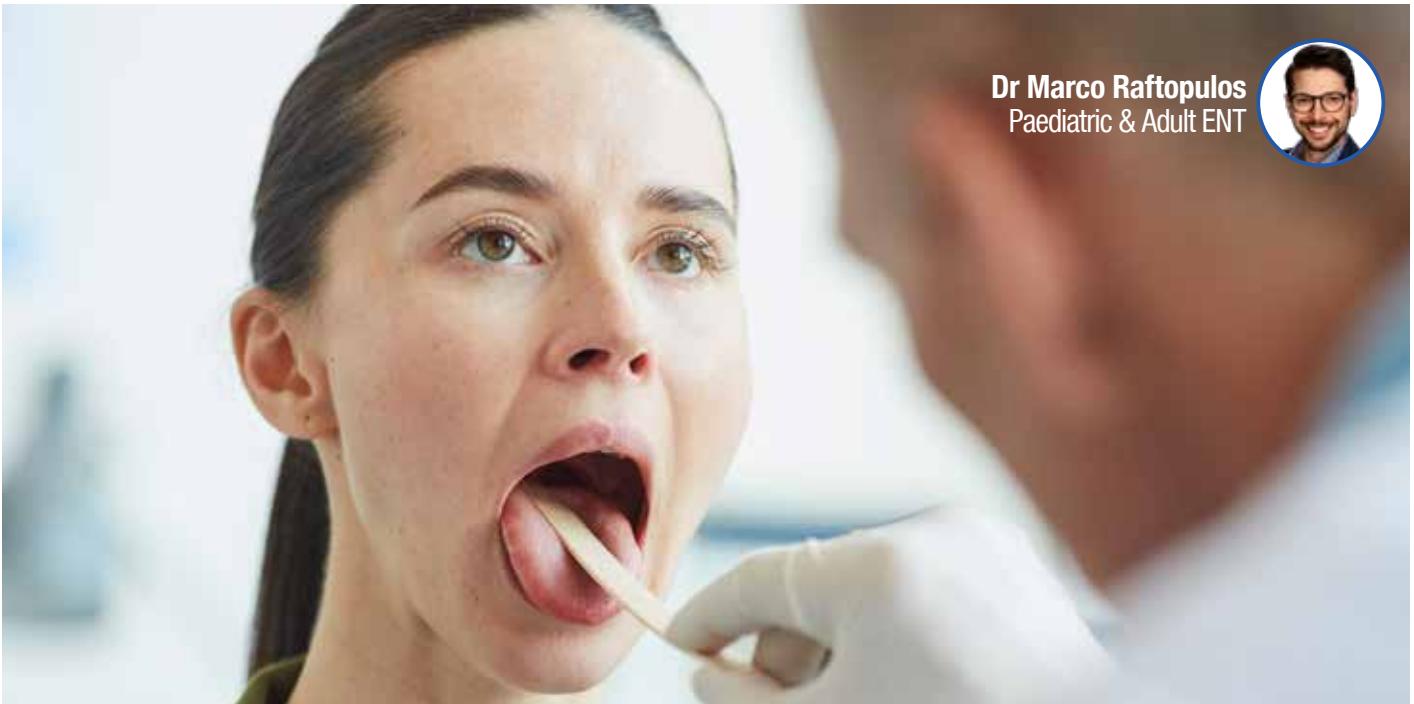


Figure 2

Picture 1: Radicular Pain: Pattern of pain following a dermatomal distribution, with potential numbness or tingling sensations.

Picture 2: Axial low dose CT image: Needle placed near S1 DRG (dorsal root ganglion) by Interventional Pain Physician.

Picture 3: Pulsed radiofrequency therapy to the DRG: Can be used to target either lumbar or cervical nerve roots as an alternate option for radicular pain affecting the upper or lower limb.



Dr Marco Raftopoulos
Paediatric & Adult ENT

Contemporary Approach to Tonsillar Disease

What are the problems?

- Recurrent tonsillitis
- OSA/SDB
- Tonsil stones
- Halitosis
- Malignancy

Recurrent Tonsillitis

- **Children:**
 - ~ About 10-15% experience recurrent tonsillitis at some point.
- **Adults:**
 - ~ Lower prevalence, estimated around 2-5% of adults having recurrent episodes.
- **Overall prevalence (all ages):**
 - ~ Likely 5-10% of the total population affected by recurrent tonsillitis at any given time.
- **Australia's population:** ~26 million people
 - ⇒ Approx. 1.3 to 2.6 million people may experience recurrent tonsillitis.

Adults - Obstructive Sleep Apnoea (OSA) in Australia

- **Estimated 9%-38% of Australian adults** have some degree of OSA, depending on severity and diagnostic criteria used.
 - ~ Moderate to severe OSA: Around 9%-12% of adults.
 - ~ Mild OSA (including undiagnosed cases): Up to 30%- 38%.
- **Gender & Age Breakdown:**
 - ~ More common in males.
 - ~ Increases with age, obesity, and associated conditions like hypertension or type 2 diabetes.

Diagnosed Cases:

- ~ Actual diagnosis rates are lower (many people remain undiagnosed).
- ~ Approximately 5%-10% of adults are formally diagnosed and treated (CPAP, surgery, etc.).

Prevalence (Adults)

- **Moderate to severe OSA affects approximately 9-12% of Australian adults**, with total OSA prevalence (including mild cases) estimated up to **38%**.
- **Reference:**
 - ~ Deloitte Access Economics. (2017). Economic impact of sleep disorders in Australia. Report for the Sleep Health Foundation.

Children - Sleep Disordered Breathing (SDB) in Australia

- **Overall SDB (including primary snoring to OSA):**
 - ~ Affects **10%-12% of Australian children**.
- **Obstructive Sleep Apnoea (clinically significant cases):**
 - ~ Around **1%-5% of children**.
- **Peak age:**
 - ~ Ages **3 to 8 years**, when tonsillar and adenoidal hypertrophy is most common (leading to obstruction).
- **Diagnosis & Treatment:**
 - ~ SDB is a leading cause of paediatric tonsillectomy in Australia.
 - ~ Many mild cases go undiagnosed but can still affect behaviour, learning, and quality of life.

When to refer to ENT - recurrent tonsillitis

Recurrent Acute Tonsillitis

- **Children:**
 - ~ **≥7 episodes per year** of acute tonsillitis in the **last 12 months**.
 - ~ **≥5 episodes per year** in the **last 2 years**.
 - ~ **≥3 episodes per year** in the **last 3 years**.
- **Adults:**
 - ~ **≥5 episodes per year**
 - ~ Frequent episodes that severely affect **health** or **quality of life**.

Complications of Tonsillitis

- **Peritonsillar abscess (quinsy)**
- **Obstructive sleep apnoea (OSA)**
 - ~ Secondary airway obstruction
- **Systemic symptoms**
 - ~ If tonsillitis results in **fever, fatigue**, and persistent symptoms that affect daily life, such as recurrent infections requiring frequent antibiotic use.

Other Considerations for Referral

- **Failure to respond to antibiotic therapy** or other medical management.
- **Significant impact on quality of life:** For example, frequent school or work absenteeism, severe episodes affecting daily living, or other health complications.
- **Enlarged tonsils causing significant difficulty breathing**, particularly in children, or causing other health issues like obstructive sleep apnoea (OSA).

Summary of Criteria for Referral - recurrent tonsillitis

RECURRENT ACUTE TONSILLITIS

Children: ≥7 episodes/year (1 year)

Adults: ≥5 episodes/year

CHRONIC TONSILLITIS

Children: Ongoing >6 months

Adults: Ongoing > 6 months

COMPLICATIONS (e.g., abscess, airway obstruction)

Children: Peritonsillar abscess, OSA

Adults: OSA, quinsy, complications

FAILURE OF CONSERVATIVE TREATMENT

Children: Yes

Adults: Yes

IMPACT ON QUALITY OF LIFE

Children: Frequent school absences, pain

Adults: Frequent work absences, pain

REFERRAL PROCESS

Children: GP ⇒ ENT

Adults: GP ⇒ ENT

Criteria for Referral for Tonsillectomy for Paediatric Sleep Disorders in Australia

History

- **Night symptoms**
 - ~ Snoring/mouth breathing
 - ~ Apnoeas
 - ~ Restlessness/wakeups
 - ~ Diaphoresis
 - ~ Bed wetting
 - ~ Bruxism
- **Day symptoms**
 - ~ Poorly rested
 - ~ Daytime tiredness
 - ~ Concentration/hyperactivity
 - ~ Academic

Clinical Exam



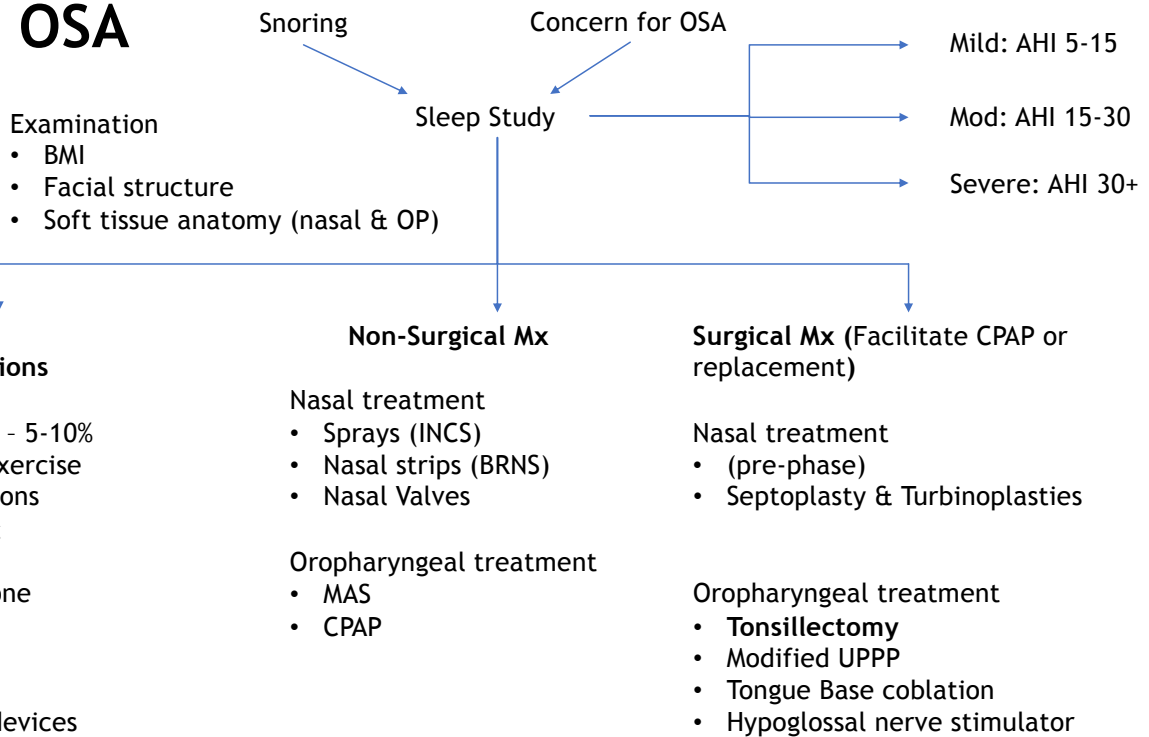
SDB and ADHD

- **Approximately 25% to 50% of children with ADHD exhibit symptoms of sleep-disordered breathing.**
- **Cortese et al. (2009) - Meta-analysis:**
 - ~ Found a **strong association between ADHD and sleep-disordered breathing** in children.
 - ~ Estimated **up to 30%-50%** of children diagnosed with ADHD also meet criteria for SDB, especially OSA.
- **Youssef NA, et al. (2011):**
 - ~ Found that **25%-35% of children diagnosed with ADHD have significant symptoms of OSA or SDB.**
 - ~ Also noted improvement in ADHD symptoms after treatment of sleep disorders (e.g., tonsillectomy for enlarged tonsils causing OSA).
- **Huang et al. (2018):**
 - ~ Estimated **40% prevalence of SDB** in children with ADHD.
 - ~ Demonstrated bidirectional worsening: untreated SDB can exacerbate ADHD symptoms, while ADHD-related hyperactivity can impact sleep patterns.

Tonsillectomy as part of Adult OSA Management

- **MDT model**
 - ~ GP
 - ~ Sleep physician
 - ~ ENT
 - ~ Dietician/Bariatric Sx
 - ~ MaxFac Sx
 - ~ Psychology

Adult OSA



Modern Tonsillectomy Techniques

TECHNIQUE

Cold Steel

Electrocautery

Bipolar Diathermy

Coblation

Harmonic Scalpel

Laser

Microdebrider

ADVANTAGES

Low cost, reliable

Efficient

Precise, controlled bleeding

Less thermal damage, reduced pain

Minimal bleeding, precise

Excellent haemostasis, precision

Less pain, faster recovery

DISADVANTAGES

More bleeding, more postoperative pain

Increased postoperative pain

Postoperative pain

Higher cost, delayed bleeding risk

Expensive, similar recovery as electrocautery

High cost, specialized training needed

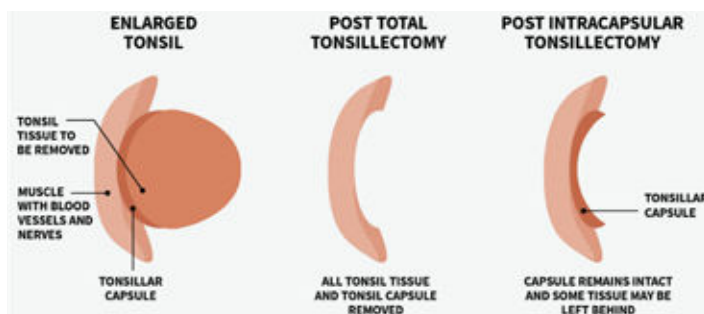
Tonsillar regrowth possible in some cases

Electrocautery Extracapsular Tonsillectomy

Feature	Description
Technique	Uses high-frequency electric current to cut and coagulate tonsillar tissue.
Temperature Range	High heat: ~400°C to 600°C.
Haemostasis	Good intraoperative haemostasis due to cauterization of blood vessels.
Postoperative Pain	Higher pain levels due to thermal injury and exposed muscle bed.
Bleeding Risk	Moderate risk of postoperative haemorrhage : 5% Paeds, 10% adults
Recovery Time	Longer recovery period : approximately 10-14 days.
Risk of Tonsil Regrowth	None (as entire tonsil and capsule are removed).
Effectiveness	Highly effective for both recurrent tonsillitis and obstructive sleep apnoea (OSA).
Thermal Damage	Higher degree of thermal injury to surrounding tissues compared to other techniques (e.g., Coblation).

Intracapsular Coblation (Adeno) Tonsillotomy – an updated technique

Extracapsular Tonsillectomy vs Intracapsular Tonsillotomy



Intracapsular Coblation (Adeno) Tonsillotomy

• Coblation = “Controlled Ablation”

- ~ **Technology:** Uses low-temperature radiofrequency (RF) energy combined with a saline solution to create a plasma field.
- ~ **Temperature:** Operates at 40°C-70°C, much lower than electrocautery (400-600°C), minimizing thermal damage.

Benefit & Explanation

Lower Postoperative Pain

Minimal nerve/ muscle disruption due to capsule preservation and low-temperature energy. No opioids.

Reduced Bleeding Risk

Excellent haemostasis with lower risk of secondary bleeding due to less thermal injury. (approx. 1%)

Faster Recovery

Quicker return to normal diet/activities (5-7 days) compared to traditional techniques.

Effective for OSA/SDB

Sufficient tissue removal for airway relief in obstructive sleep apnoea and sleep-disordered breathing.

Minimal Thermal Injury

Low-temperature Coblation prevents excessive thermal spread and surrounding tissue damage.

Preserved Speech/Swallowing

Capsule left intact, maintaining normal velopharyngeal function and reducing speech/swallowing complications.

Lower Infection Risk

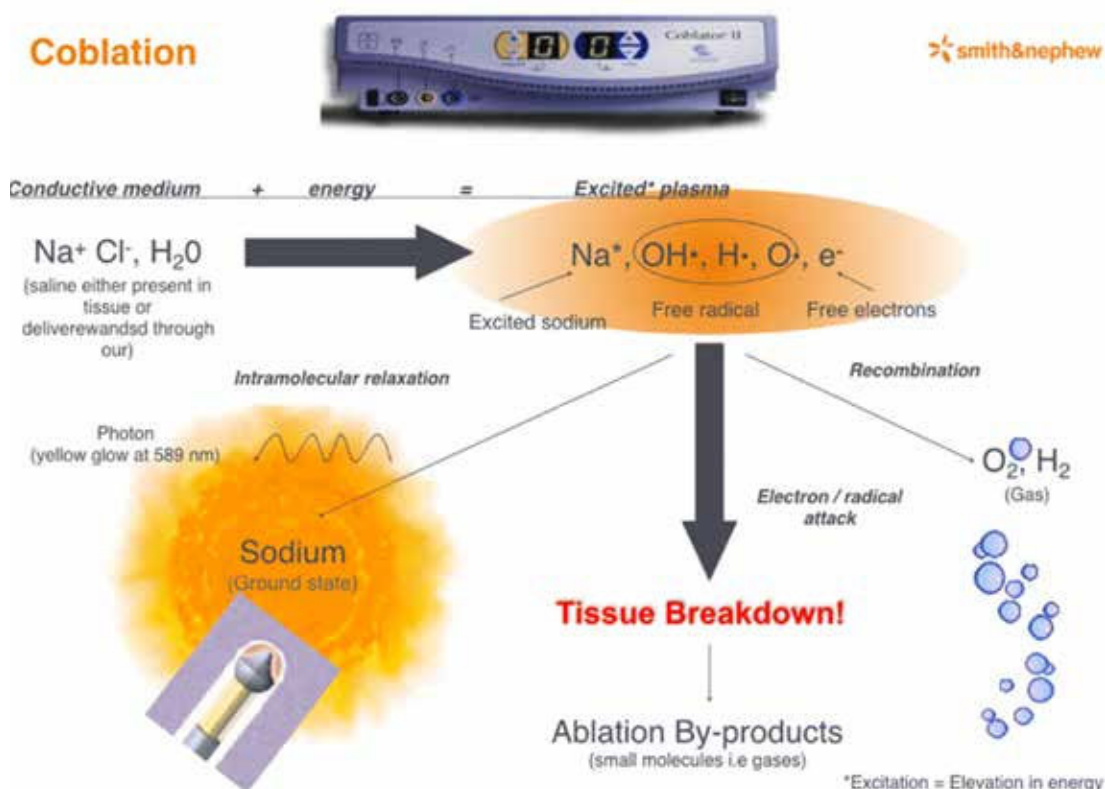
Less raw tissue exposed to bacteria, reducing the risk of infection and dehydration postoperatively.

Potential Cost-Effectiveness

Fewer complications, faster recovery, and reduced need for post-op care may lower overall costs.

Possible Immune Function Retention

Tonsillar tissue partially preserved, potentially maintaining some immune function.



In summary, Intracapsular Coblation Adenotonsillotomy offers:

- a highly effective low-morbidity option for tonsil and adenoid surgery especially in paediatric populations
- benefits such as reduced pain, faster recovery, and lower complication rates compared to traditional techniques.



Dr Ross Calopedos
Urological Surgeon Specialising
in Men's Health



Inside An Implant: Device Mechanics & Selection Tips

Types of Penile Implants

There are two main types:

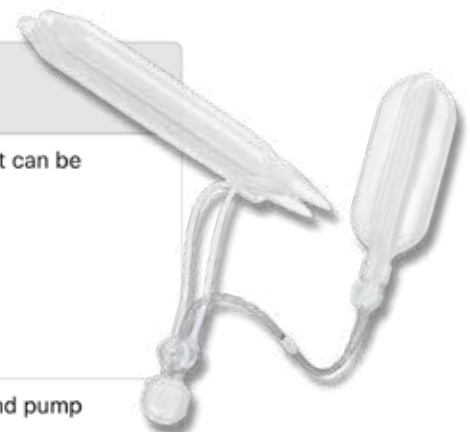
- **Malleable (Semi-Rigid) Implants:** These bendable rods remain firm yet can be positioned as needed for sexual activity or concealment.
- **Inflatable Implants:** These devices create a natural-looking erection when inflated and return to a flaccid state when deflated. They consist of:
 - ~ Two cylinders inserted into the erectile bodies of the penis,
 - ~ A pump placed in the scrotum,
 - ~ A reservoir positioned in the pelvis or abdominal wall.
 - ~ The system is filled with saline (sterile salt water) and operates as a closed circuit.

Choosing the Right Implant

While switching implant types is possible, my goal is to select a solution that stands the test of time.

The table below summarises the key differences:

Implant Type	Advantages	Disadvantages
Malleable	• Easy to use • No reservoir or pump required • Shorter operating time • More economical • Fewer parts reduce malfunction risk	• Penis remains slightly rigid, though it can be concealed
Inflatable	• Provides a more natural erection • Easier to hide in the flaccid state	• Requires placement of a reservoir and pump



Which is the Best Penile Implant Available Today?

- Penile implants are produced by three main companies - Coloplast, Rigicon and Boston Scientific / AMS.
- There are notable differences between devices made by each company. I will highlight these in your patients' consultation to ensure they select the best penile implant for their specific goals and penis type.

How does an Inflatable Penile Prosthesis Work?

- Contrary to the name, Inflatable penile implants are not filled with air. When you squeeze the pump in the scrotum, fluid moves from the reservoir into the cylinders in your shaft to create an erection.
- When you press the deflate mechanism on the pump in the scrotum, the fluid moves out of the penis and back into the reservoir for a natural looking flaccid state.
- The device is a closed-system and the fluid does not need to be changed or topped up.

Recovery Roadmap

A Glimpse of What's Ahead for Your Patients

For Out-of-Town Patients

- Arrange travel so they remain locally for at least 72 hours after surgery.
- Plan on two full days of bed rest immediately following the procedure.

On the Day of Surgery

- Performed under IV sedation with local anaesthesia or general anaesthesia.
- They will receive IV antibiotics (Vancomycin and Gentamicin) in addition to their oral regimen.
- No urethral catheter is used-bladder is simply emptied voluntarily before surgery.
- Device inserted via a small infrapubic incision for faster recovery and reduced infection risk.

Post-Operative Restrictions & Activity

- Avoid lifting items heavier than a 2L milk bottle during the first week.
- Refrain from straining (any activity that causes a "grunt") for 4 weeks.
- Begin gentle, longer walks after the first two days to promote circulation.
- Sexual activity is deferred until cleared (typically 14-21 days post-surgery).
- Gradually resume light exercise in week 2 and normal routines by weeks 4-6.

Drain Management

- A small surgical drain will remove excess fluid and blood to prevent swelling and pain
- Patients will be shown how to monitor and periodically empty their drain.
- The drain is usually removed 2-3 days after surgery.

Implant-Specific Post-Op Care

- **Pump Management:** From the day after surgery, patients are advised to gently pull down on the pump in their scrotum each time they empty their bladder to keep it low in the scrotum.
- **Cycling the Implant:** They will receive instructions on inflating and deflating the device 7-10 days post-surgery.
- **Using the Implant:** Once cleared-typically 14-21 days after surgery-your patients can begin using their implant.

Important Notes

- Avoid baths, pools, or ocean swimming for 1-2 months to minimise infection risks.
- For any concerns-persistent pain, redness, swelling, urination difficulties, or signs of infection (fever, unusual discharge)-contact Dr. Ross directly.

Regular Post-Operative Outpatient Schedule:

- 2-3 days: Wound review and drain removal
- 7 days: Wound review, device activation, and patient education
- 10-14 days: Staple removal and penile rehabilitation training
- 6 weeks: Post-surgical review
- Any additional appointments as needed are included up to 3 months.

Why Consider a Penile Implant?

Other Treatments Have Failed

When conventional treatments-such as medications or injections-fall short, a penile implant offers a reliable, long-term fix.

A Permanent, Life-Changing Solution

Instead of gambling with pills or injections, the procedure allows on-demand rigidity, enabling spontaneous intimacy without ongoing treatments.

Penile Atrophy

If chronic erectile dysfunction has led to a loss in penile size, a penile implant can restore function and prevent further tissue shrinkage.

Peyronie's Disease

For men facing both erectile dysfunction and penile curvature from Peyronie's disease, a penile implant not only addresses ED but also acts as a tissue expander, helping to correct deformities and halt further changes.

**For referrals or queries,
please contact:**

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Getting better Sooner

Hip and Knee Replacements are some of the most common operations not only affecting the senior members of our society but increasingly debilitating in much younger age groups too.

Whilst the results of Hip and Knee replacements have also improved remarkably in the last decade with longevity expected to be over 2 decades according to the Australian Joint Registry, they remain major operations.

Despite all these developments in technology, the recovery times and morbidity associated is still significant. The Length of Stay in hospital alone, a reflection of early functional recovery, is still 3-5 days followed by weeks of rehabilitation and months of recovery.

Technology has evolved at an exponential rate with patient specific instrumentation, navigation and most recently, robotics making a robust entry. Despite all the hype, none of these advances have been conclusively shown to make a difference to the outcomes as perceived by the patient. We have learnt that technical success does not always equate to patient perceived success.

In this context, a methodology that aims to reduce the surgical and physiological insult and thereby achieve quicker functional recovery, known as Enhanced Recovery After Surgery or ERAS, has emerged. It has wide applicability across all surgical specialties but in joint replacements specifically, the impacts are major with patients being up and about sooner, a reduction in complications, some improvement in patient satisfaction as well as major cost benefits.

Rapid Recovery in Joint Replacements is a concept that aims to achieve quicker functional recovery after joint replacements making them well enough that they don't need to be in hospital for long, in addition to all the other benefits.

A/ Prof Sol Qurashi is a pioneer of this concept in Australia having performed the first day only hip replacement many years ago and now routinely performing outpatient Hip and Knee replacements in appropriate patients with excellent short and long term results. He has extensively published on the subject and is a Key Opinion Leader.

He will share his results and some of the tricks as well as information that would be of value to your patients and you as their treating doctors.

Some of the evidence based multimodal interventions include:

- Patient and family engagement
- Managing expectations and education
- Perioperative optimisation
 - ~ Social
 - ~ Nutritional
 - ~ Thermal
 - ~ Cryotherapy
- Anaesthetic techniques
 - ~ Pre-emptive analgesia
 - ~ Narcotic sparing
 - ~ TIVA
 - ~ Steroids
 - ~ LIA
- Pre-emptive Postoperative Nausea and Vomiting control
- Minimal / Micro invasive surgical techniques
 - ~ SuperPATH in Hip replacement
 - ~ Customisation in Knee replacements
- Opioid minimisation
 - ~ Use of synthetic opioids
- Postoperative optimisation
 - ~ Allied supports
 - ~ Home rehab
- Point of contact
 - ~ Direct line to surgical team

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**Get back to the things
you love doing sooner**

**No Gap Joint
Replacement Program**



**East Sydney
Private Hospital**

Connected Orthopaedic Care
No need to let joint pain slow you down



The Sydney Hernia & Diastasis Clinic

GP Assessment & Referral Checklist: Postpartum Rectus Diastasis (RD)

1. Patient History

- ☐ Recent or previous pregnancy (include number, size, twins, etc.)
- ☐ Mode of delivery: ☐ Vaginal ☐ C-section
- ☐ Time since last delivery:
- ☐ Onset of symptoms:
 - ☐ Immediate postpartum ☐ Delayed onset

2. Symptom Screening

- ☐ Abdominal bulge along the midline (especially with movement or straining)
- ☐ Core weakness or instability
- ☐ Chronic lower back pain
- ☐ Difficulty with caregiving tasks (lifting children, pushing pram)
- ☐ Sensation of abdominal “emptiness” or lack of support
- ☐ Urinary incontinence or pelvic floor symptoms
- ☐ Negative impact on self-esteem, intimacy, or mental health

3. Physical Examination (if appropriate)

- ☐ Palpation of inter-recti distance at rest and on exertion
- ☐ Associated hernia: ☐ Yes ☐ No ☐ Suspected
- ☐ Assessment of skin quality and laxity
- ☐ Core activation ability or postural dysfunction

Optional: refer to women's health physiotherapy for functional assessment or conservative management trial.

4. Initial Management

- ☐ Physiotherapy commenced: ☐ Yes ☐ No
- Duration of therapy: months
- Outcome: ☐ Improved ☐ No change ☐ Worsened

5. Referral Reason

- ☐ Failed conservative management ($\geq 3-6$ months)
- ☐ Significant functional limitation (e.g. pain, caregiving challenges)
- ☐ Suspected or confirmed hernia
- ☐ High psychosocial impact
- ☐ Seeking surgical opinion after informed discussion

Referral to:

Sydney Hernia & Diastasis Clinic

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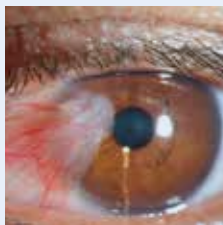
P.E.R.F.E.C.T for Pterygium

WHEN TO REFER

- Reduction of vision
- Direct obstruction
- Astigmatism
- Prior to Cataract surgery
- Foreign body sensation/irritation/ inflammation
- Cosmesis
- Concerns about other entity
- OSSN
- Other benign/malignant lesions

Warning Features:

- Elevated, thickened, grayish plaque
- Leukoplakic
- Gelatin-like
- Papillomatous appearance
- Accompanying blood vessels
- Tethered
- Rapidly Enlarging



Pterygium



Leukoplakic



OSSN



Conjunctival Naevus

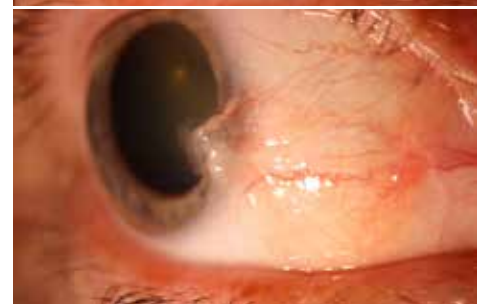


Accompanying blood vessels



Conjunctival Intraepithelial Neoplasia

Before Surgery



3 Mths After Surgery





Dr Wei How Lim
Specialist Gynaecologist &
Endoscopic Surgeon

Trends and outcomes of ruptured ovarian cysts

ABSTRACT

Background Ruptured ovarian cysts are common gynaecological presentation to health institutions with abdominal pain. While this phenomenon is generally self-limiting, surgery may be necessary in cases of haemodynamic compromise or association with torsion. The aim of this audit is to identify the trend of hospital presentations, as well as the review the management of modern gynaecology practice.

Methods A retrospective audit of all women who presented to the emergency department with an imaging diagnosis of ruptured ovarian cysts was conducted over a 5-year period at St Vincent's Hospital, Sydney.

Results During the study period, 408 women were identified. There was a trend towards conservative management, as observed in 84.7% of women, while the remaining 15.4% underwent surgery. Haemorrhagic or ruptured corpus luteum was the most common diagnoses. As expected, women who had surgical intervention were more likely to have larger cysts (20 vs 50%; $p < 0.05$), and larger free fluid findings on imaging (1.4 vs 23.8%; $p < 0.05$) compared with those managed conservatively. There were no statistically significant differences in location of ovarian cysts (right or left) or antecedent to hospital presentation (vaginal intercourse or trauma).

Conclusion Ruptured ovarian cysts of both functional and non-functional types remained a common clinical presentation of acute pain for women to the emergency department. Majority of women were managed conservatively in our cohort, and indications for surgery were large ovarian cysts and large free fluid seen on imaging findings. Surgery was largely feasible with minimal complications.

INTRODUCTION

Rupture of an ovarian cyst is a common presentation for women of reproductive age to emergency department with abdominal pain.¹ While it is usually a self-limiting physiological process, haemorrhage or an association with torsion may occur requiring surgical intervention. The spectrum of such phenomenon includes functional (eg, follicular, corpus luteum) and non-functional cysts (eg, teratoma, endometrioma, cystadenoma). Because of the wide spectrum of pathophysiological findings, a standard management protocol for ruptured ovarian cysts with is not well established.

The diagnosis of a ruptured ovarian cyst is often made with a combination of the patient's clinical history in the luteal phase of menstrual cycle, with or without medical imaging supporting the diagnosis. Despite a common clinical presentation, there are few studies available reporting the modern management and outcomes of ruptured ovarian cysts. Historically surgical intervention rates were high, and most studies concentrate on specific ovarian cysts with small number of subjects.^{2,3} We reviewed the management and outcomes of such acute gynaecological presentation over a 5-year period at St Vincent's hospital, a tertiary metropolitan hospital in Sydney with an overall average of over 40 000 general emergency presentations per annum.

MATERIALS AND METHODS

A retrospective cohort study of all women who presented to the emergency department of St Vincent's Hospital, Sydney with an acute gynaecological pathology between January 2013 and December 2018 was conducted. Patients were identified through the hospital's emergency department patient information computer system. Women who were diagnosed with a ruptured ovarian cyst made on medical imaging (ultrasound or CT) in association

with the clinical presentation, or intraoperatively during surgery were included in the study. We excluded other causes of acute presentation (eg, ectopic pregnancy, pelvic inflammatory disease, appendicitis), those who had a clinical diagnosis of ruptured cyst without imaging modalities, as well any elective surgery for ovarian cysts.

The demographic, clinical and radiological information of included patients were collected. Data extracted from electronic medical record of all patients identified included age, body mass index (BMI), ethnicity, menstrual cycle status and contraception use. Clinical characteristics included initial presentation to hospital, medical history, haemoglobin level, white cell count and C reactive protein during admission. Other data obtained included surgery approach, intraoperative findings and outcome. Short-term complications were defined as transfusion, postoperative bleeding, readmissions to hospital, and infections requiring treatment within 30 days of the original admission.

The imaging diagnoses of various ruptured ovarian cysts were as per published guidelines.⁴⁻⁶ Ovarian cyst rupture with normal ovaries are supported by clinical history as well as site specific tenderness and free fluid in the Pouch of Douglas on ultrasound. Information obtained included location of cysts, largest dimensions of cyst and free fluid volume. Free fluid volume or haemoperitoneum was graded as 'minimal' (trace in Pouch of Douglas), 'moderate' (up to pelvic brim) and 'large' (extending up to Morrison's pouch).

Statistical analysis

Statistical analysis was conducted using InStat V.3.1 (GraphPad Software). Descriptive statistics were reported using mean with IQR for continuous data and frequencies with percentages for categorical data. Data were compared using Fisher's exact test and χ^2 . Medians with IQRs were compared using Mann-Whitney U test. All reported p values are two sided, and $p < 0.05$ was considered significant. Multivariate analyses were not performed given the small sample size.

RESULTS

During the study period, 408 women were identified. The incidence of women diagnosed with a ruptured ovarian cyst is estimated at 0.2%. The mean age was 28 years (SD 3.2) and 360 women (88%) were in the BMI $< 25 \text{ kg/m}^2$ group. All women presented with acute onset of lower abdominal pain, associated with nausea or vomiting. Antecedent to clinical presentation was documented in 35 women, where 28 women presented after vaginal intercourse and six after trauma. One patient presented after a spontaneous rupture of an ovarian cyst during transvaginal sonography for investigation of abdominal pain. Contraceptive pill (OCP) was documented in 77/408 women (18.8%) and 113/408 women (27.6%) had the intrauterine device (IUD). An accurate menstrual history was documented in 154/408 women (37.7%), with 50 women (12.2%) in the luteal phase at the time of clinical presentation. Forty women were diagnosed in first trimester of pregnancy (6–11 weeks gestation) and 215/408 women (52.6%) were diagnosed in the summer period. No significant medical comorbidity or coagulopathy were identified.

Diagnoses of ruptured ovarian cysts were made on 393/408 women (96.3%) on ultrasonography, with 13/408 women (3.1%) on CT scan. Two patients were diagnosed intraoperatively during diagnostic laparoscopy for suspected appendicitis. Conservative management was observed in 345/408 women (84.5%). These women were successfully treated with observation and analgesia, with no surgical intervention required. Diagnosis of a haemorrhagic or ruptured corpus luteum was made in 166/345 women (48.2%), with a maximal cyst diameter of 2.3 cm (SD 1.4) and mild to moderate free fluid on imaging. Other radiological diagnoses included cystadenoma 50/345 (14.4%), endometrioma 14/345 (4%) and non-specific cysts 115/345 (33.3%).

Surgery management was required for 63/408 women (15.4%), where 61 women had an operative laparoscopy performed. There were two conversion to laparotomy due to ovarian cysts $> 20 \text{ cm}$ in size. An ovarian cystectomy was performed in 52 women, with a maximal cyst diameter of 14.8 cm (SD 3.4). A concurrent diagnosis of ovarian torsion was made in 10 women. A primary diathermy procedure to control haemorrhage from ruptured corpus luteum was performed in 23 women, with concurrent cystectomy performed in 10 women. Median haemoperitoneum were 1092 mL (IQR 237–1500). There were no immediate complications noted. There were no visceral organ injury or return to theatre observed. Among the histopathological diagnoses were serous and mucinous cystadenoma 12/63 (20%), mature teratoma 7/63 (12%), follicular 5/63 (8%) and endometrioma cysts 3/63 (5%). There was one endometroid ovarian carcinoma diagnosed.

A comparison between conservative and surgical approach is presented in table 1. Women who had surgical intervention were more likely to have larger cysts (20 vs 50%; $p < 0.05$) and larger free fluid findings on imaging (1.4 vs 23.8%; $p < 0.05$) compared with those managed conservatively. Larger cysts also contributed to the higher probability of associated torsion. There were no statistically significant differences in location of ovarian cysts (right or left), being on hormonal supplements (OCP or IUD) or antecedent to hospital presentation (vaginal intercourse or trauma).

DISCUSSION

Our findings confirm that ruptured ovarian cysts are a common clinical presentation of acute pain for women of reproductive age in Australia. There was a rise in incidence over this period of study, with a trend towards conservative management with observation and analgesia. This is in line with other studies where conservative management has been the preferred approach.⁶⁻⁸ Vaginal intercourse, right-sided pathology and the use of IUD were previously identified as risk factors for clinical presentation, however, this was not reflected in our cohort.^{6,9}

The rising incidence of ruptured ovarian cysts in our cohort is likely to be multifactorial; one variable to note is related to the influx of hospital presentation from overseas travellers during summer seasons. A high percentage of women also had an unpredictable menstrual cycle history that may have prompted imaging investigations when in casualty. Serum markers on initial presentation did not influence management approach. Tumour markers such as CA-125

Table 1 Characteristics of 408 women and outcomes of conservative and surgical management

Variable	Conservative (n=345)	Surgery (n=63)	P value
Age, years (median (IQR))	29 (25–33)	29 (25–33)	0.47
Race, n (%)			
Caucasian	283 (82.0)	49 (77.7)	0.48
South East Asian	16 (4.6)	1 (1.5)	–
European	31 (8.9)	10 (15.8)	–
Not specified	15 (4.3)	3 (4.7)	–
Body mass index (kg/m ²)			
<25	305 (88.4)	55 (88.7)	–
25–30	20 (5.7)	4 (6.4)	–
>30	20 (5.7)	4 (6.4)	–
Nulliparity, n (%)	121 (35.0)	10 (15.8)	–
Menstrual cycle, n (%)			
Follicular phase	92 (26.6)	12 (19.0)	0.27
Luteal phase	42 (12.1)	8 (12.6)	–
Not specified	211 (61.1)	43 (68.2)	–
Antecedent to presentation, n (%)			
Intercourse	20 (5.7)	7 (11.1)	0.16
Trauma	4 (1.1)	3 (4.7)	–
Others	86 (24.9)	10 (15.8)	–
Not specified	235 (68.1)	43 (68.2)	–
Contraception, n (%)			
OCP	65 (18.8)	12 (19.0)	1
IUD	101 (29.2)	12 (19.0)	0.12
Others	70 (20.2)	24 (38.0)	–
Not specified	109 (31.5)	15 (23.8)	–
Season of presentation, n (%)			
Summer	185 (53.6)	30 (48.3)	0.41
Autumn	48 (13.9)	12 (19.3)	–
Winter	50 (14.4)	7 (11.1)	–
Spring	62 (17.9)	14 (22.5)	–
Shock, n (%)	60 (17.3)	20 (32.2)	0.1
Serum markers on presentation, n (SD)			
Haemoglobin, g/L	125±3.2	110±4.5	–
White cell count, 10 ⁹ /L	13.1±1.3	15±1.8	–
C reactive protein, mg/L	8±1.2	12±1.8	–
Imaging diagnosis, n (%)			
Ultrasound	302 (87.5)	60 (95.2)	–
CT	43 (12.4)	3 (4.7)	–
Location of cyst, n (%)			
Left ovary	183 (53.0)	27 (42.8)	0.17
Right ovary	129 (37.3)	26 (41.2)	0.57
Bilateral	33 (9.5)	10 (15.8)	0.17
Median size of cyst, cm (median (IQR))	4.8 (1.2)	9.6 (2.3)	<0.01
Radiological possibility of torsion, n (%)	10 (2.8)	30 (47.6)	<0.01
Free fluid, n (%)			
Minimal	235 (68.1)	41 (65.0)	–
Moderate	105 (30.4)	7 (11.2)	–
Large	5 (1.4)	15 (23.8)	<0.01
Estimated blood loss, median mL (SD)	–	906.5 (610)	–
Blood transfusion, n (%)	2 (0.5)	6 (9.6)	0.1
Length of hospital stay, days (median (IQR))	4 (3–6)	6 (3–11)	<0.01
Infection, n (%)	0	1 (1.5)	–
Visceral organ injury, n (%)	–	0	–
Readmission to hospital, n (%)	0	0	–

IUD, intrauterine device; OCP, contraceptive pill.

were not routinely examined in our cohort due to its low specificity in the acute setting and in a woman of reproductive age, being raised with any cause of peritonitis, including haemorrhage and infection as well as menstruation, fibroids and endometriosis.^{1 10}

Haemorrhagic or ruptured corpus luteum was the most cause of clinical presentation. When surgery was required, a primary diathermy procedure was effective in securing haemostasis, replacing the need for lutectomy or wedge resection which is phasing out in modern gynaecology practice.³ Our surgical practice is reflective of the high probability of ovarian torsion when cysts >5 cm, as well as the poor predictive value of Doppler flow on ultrasound for diagnostic confirmation.^{1 11} Other risk factors for surgery included failure of ovarian cysts to resolve, complex cysts indicative of suspected malignancy, as well as low diastolic pressure on initial presentation.^{8 12 13} As expected, women who had surgery had a longer length of hospital stay.

Large free fluid on medical imaging may suggest ongoing intra-abdominal haemorrhage. The use CT imaging has been shown to be useful in the differentiation of different ovarian cysts and between peritoneal fluid or blood, and the better objective quantification of haemoperitoneum however this is not routinely employed as the first-line investigation for suspected acute gynaecological pathology in Australia.^{6 8 14} Ultrasound is a highly sensitive method for detecting ovarian cysts, and avoids the unnecessary risks associated with irradiating the pelvis.

The limitation of our study is the lack of control group and its retrospective nature, with inherent selection bias that may have influenced the results. There were large numbers of variables such as antecedent to clinical presentation and accuracy of menstrual history which were undetermined or not specified, limiting concrete statistical correlation or conclusion. The exclusion of ruptured ovarian cysts diagnosed clinically may have underestimated the true incidence. However the strengths of our study included a large cohort of patients with an objective finding of ruptured ovarian cysts on imaging. While a diagnosis can be made clinically, we decided to include only imaging findings to support the clinical presentation due to the wide range of differential diagnoses, as well as the non-specific signs and symptoms during examination.

CONCLUSION

Ruptured ovarian cysts of both functional and non-functional types remained a common clinical presentation of acute pain for women to the emergency department. Majority of women were managed conservatively in our cohort, and indications for surgery were large ovarian cysts and large free fluid seen on imaging findings. Surgery was largely feasible with minimal complications.

Main messages

- ⇒ This study supports conservative management for uncomplicated ruptured ovarian cysts for women on initial presentation.
- ⇒ Outcomes for both conservative and surgical management were favourable.
- ⇒ Surgery is warranted when there is a suspicion for ovarian torsion or concerns for ongoing intra-abdominal haemorrhage on medical imaging.

Current research questions

- ⇒ What is the recurrence rate of physiological ruptured ovarian cyst in women of reproductive ages?
- ⇒ What is the role of primary healthcare provider in managing women with uncomplicated ruptured ovarian cysts?
- ⇒ Are primary and secondary prevention strategies implemented for women with recurrent ovarian cysts formation?

What is already known on the subject

- ⇒ Ruptured ovarian cysts are common presentation for women of reproductive age.
- ⇒ Management includes both conservative and surgical, with the latter indicated if there are associated haemoperitoneum or torsion.

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Competing interests None declared.

Patient consent for publication Not required.

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Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as online supplemental information. All data relevant to the study are reported in the manuscript, which are included in the article or uploaded as supplemental information.

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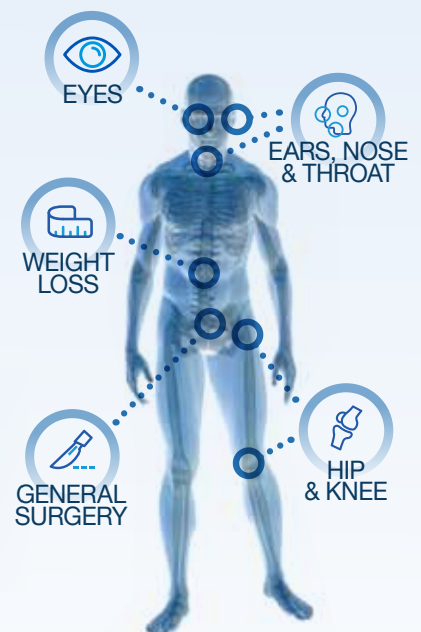


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