



East Sydney Private Hospital Multidisciplinary Journal

JULY 2025 – EDITION 2



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East Sydney
Private Hospital

Welcome to our second edition—and what a quarter it's been!

This issue is packed with smart thinking, powerful collaboration, and clinical innovation that continues to push us forward as a team.

We've had more than 500 public-in-private cases completed in just three months. That's not just a milestone—it's proof of what can happen when we work together to support the public system and deliver timely, high-quality care.

This edition also showcases the kind of work that sets ESPH apart. From the launch of the Sydney Breast Implant Check Service by Dr Stuart Hoffman to practical insights on frozen shoulders by A/Prof Mark Haber and ventral hernias by Dr Robert Gandy—we're proud to be a platform for surgeons sharing real-world experience and excellence in care.

You'll also read about breast reduction surgery for macromastia from Dr Kelly Thornbury, a look into the underdiagnosed condition of R-CPD (aka "Doctor, I can't burp") by A/Prof Daniel Novakovic, and a sharp piece on modern approaches to hip resurfacing from Dr Paul Thornton-Bott.

On top of all that, we've expanded our pain management service with onsite specialist consults, inpatient ketamine and local anaesthetic infusions, day programs, and full-circle psychological support—helping us deliver truly integrated care.

There's plenty in these pages to inspire, inform and celebrate. As always, I'd love to hear your thoughts or feedback—just drop me a line at sgluyas@esphospital.com.

Enjoy the read,

Sarah Gluyas
Business Development & Marketing Manager
Editor, East Sydney Private Hospital Multidisciplinary Journal

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Introducing our Pain Management Team

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- With 24/7 coverage supporting the diagnosis of pain conditions, our Brand New CT scanner supports our specialists in diagnosing conditions such as herniated disc in the spine.
- Technology supported pain relief programs with CT guided spine and joint pain relief injections.
- A committed team of allied health professionals including physiotherapists and exercise physiologist, creating personalised and structured exercise and functional restoration activities. Along with pre-habilitation and post-surgery support following spine or joint surgery.
- Development of pain management plans in collaboration with a pain physician, treating surgeon and allied health team to help patients achieve pain management goals.
- Patient education and empowerment programs focused on learning self-directed pain management techniques such as at-home stretch and exercise routines.
- East Sydney Private Hospital supports our neurosurgeons and orthopaedic surgeons during minimally invasive spine and joint replacement surgery boasting six operating theatres with state of the art equipment and dedicated theatre nursing teams.
- Experienced ward nursing staff with 32 inpatient beds, supported by onsite physicians and physiotherapy teams post-surgery care.

MEET THE SPECIALISTS



Dr Alan Nazha
Interventional Pain Specialist

Dr Alan Nazha is a dual qualified Anaesthetist and Specialist Pain Physician with subspecialisation as an Interventional Pain Specialist. Dr Nazha has expertise in minimally invasive pain therapies and is qualified with a Fellowship in Interventional Pain Practice (FIPP).

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Dr Tim Ho
Interventional Pain Specialist

Dr Tim Ho is an Interventional Pain Specialist with a focused expertise in neuropathic pain, musculoskeletal pain, and cancer pain management.



Dr Tze Chow Chow
Pain Specialist & Consultant
Anaesthetist

Dr Tze Chow Chow is trained in all aspects of pain medicine, including multidisciplinary pain management and interventional pain medicine techniques.

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Dr Michael Zhao
Pain Management Specialist

Dr Michael Zhao is a highly skilled and dedicated pain specialist with extensive expertise in managing chronic pain conditions.



**To find out more call our team
on 1800 167 846**



Sydney Breast Implant Check Service

All women with breast implants should undergo regular check-ups throughout the life of the implants, regardless of whether they were used for breast reconstruction or cosmetic augmentation. The risk of developing complications, such as capsular contracture and rupture, increase over time, and these can often go unnoticed by the patient. Many women receiving breast implants are followed-up for 6 months to 1 year, but then are left to initiate their own assessments going forward.

With this in mind, Dr Hoffman established the Sydney Breast Implant Check Service which offers comprehensive **breast implant ultrasound** by a specialist Plastic Surgeon, one of the first of its kind in Sydney. Dr Hoffman has pursued extensive training in bedside ultrasound of breast implants at the International Breast Implant Check Clinic (IBICC) in Stockholm, Sweden, one of the most highly regarded breast implant follow-up clinics in the world, located within Victoriakliniken.

Having a specialist Plastic Surgeon perform the ultrasound rather than going to a radiology centre is beneficial, as the ultrasound images can be interpreted with added clinical understanding. This is combined with clinical examination, to guide future treatment options. The implant check service involves only **one visit to one clinic**, so it is very

convenient for patient's busy lives. Dr Hoffman will perform the ultrasound, and the patient will leave with an understanding of the specific implant status, and advice regarding any future care or procedures. It is reassuring for patients to know their implants are stable and intact, and detecting problems early can result in more simple operative solutions.

Why?

The NSW Agency for Clinical Innovation (ACI) published a Breast Implant Safety document in 2022 recommending patients with breast implants undergo a routine check-up annually, and medical imaging every 2-3 years.^{1,2} Breast implants do not last forever, and it is vital that patients receive regular follow-up for the duration of the time that they have implants.

Along with common, long-term changes in aesthetic appearance, there are some more serious and very rare diseases related to breast implants, including Breast Implant Associated Anaplastic Large Cell Lymphoma (BIA-ALCL). Fortunately, this is uncommon, however it may go undetected if routine check-ups are not performed. Systemic symptoms such as fatigue, memory loss and joint pain may be associated with breast implants. The term Breast Implant Illness (BII) has been used, and researchers are investigating these symptoms to better understand their origins. In some cases, removal of breast implants for these women has resulted in resolution of their symptoms.

Extensive information and advice relating to breast implant devices can be found online at the Breast Implant Hub, by the Therapeutic Goods Administration (TGA).³

What?

During the consultation, a thorough history of the patient's breast surgery is compiled from any information available, and any concerns around the appearance and feel of the breasts are discussed.

A full clinical assessment is **combined with an ultrasound assessment** during the appointment. It is fast, painless and requires zero exposure to radiation.

Ultrasound examination in the office can assess:

- Presence of rupture (silicone leak)
- Capsule thickness and capsular contracture (hardening or shape distortion)
- Type of implant surface (smooth or textured)
- Implant rotation or malposition
- Fluid around the implant (seroma)
- Implant position (above or below the muscle)

The ultrasound images are visible on the wall mounted monitor, with real-time AI-derived colour coding of different tissues. This allows patients to themselves observe and understand the status of their implants, a powerful aid in increasing baseline education and enhancing patient experience.

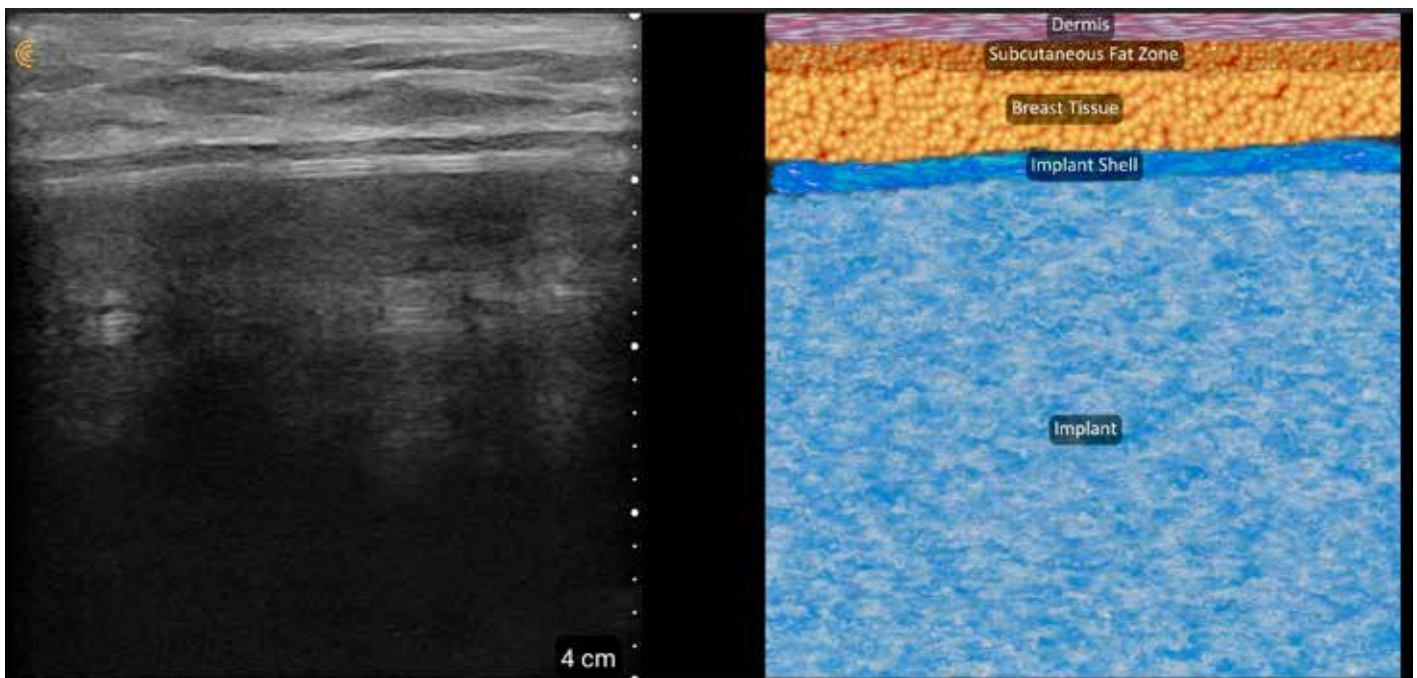
It is important to note that this ultrasound assessment is targeted at the implant only, and does not assess breast tissue changes, nor does it replace breast screening tools such as mammography.

Who?

All patients with breast implants are encouraged to attend, regardless of where prior surgery was performed, which implant was used, and whether it was used for aesthetic augmentation or breast reconstruction. Patients are encouraged to provide as much information as possible about their implants, to aid in assessment and formulation of future care plans.

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3. Therapeutic Goods Administration. Breast Implant Hub: Breast implants – things to consider. Canberra: TGA; updated 19 Sep 2023. Available from: <https://www.tga.gov.au/products/medical-devices/breast-implant-hub>



Above: Ultrasound view of a breast implant. The left side is the standard sonographic view, which is used for diagnostics. The right side utilises AI-derived software to colour-code the tissue in real-time, so the patient can follow on screen what the surgeon is seeing.

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Is It a Frozen Shoulder?

A clear definition of frozen shoulder is crucial for an accurate diagnosis which is essential for optimum treatment because it helps us understand the natural history and differentiating it from other shoulder conditions. A clear diagnosis is crucial as the treatment will vary. A frozen shoulder (FS) can be primary or secondary, A primary FS is often referred to as an adhesive capsulitis (AC).

However, the use of the terms FS or AC can be a trashcan / garbage can diagnosis, meaning, it doesn't tell you what the specific problem is. It implies there is pain and stiffness which does not constitute a diagnosis nor help in treatment. The term is often used when one can't figure out exactly what's wrong with the shoulder. Many different shoulder problems (like rotator cuff injuries, arthritis etc) can all cause stiffness and pain.

They are not a FS! It was Drs. Neviaser and Neviaser in 1987, who described "frozen shoulder" as a "waste-can diagnosis" This label stems from its historical use as a catch-all term for various shoulder conditions presenting with pain and stiffness, often without a precise underlying cause identified. The term stems from its historical use as a catch-all term for various shoulder conditions presenting with pain and stiffness, often without a precise underlying cause identified. Importance of Accurate Diagnosis Given the complexities and overlapping symptoms of shoulder

conditions, it's crucial for healthcare professionals to conduct comprehensive assessments. I would like to stress that a clear definition is essential to make an accurate diagnosis which helps the healthcare professionals tailor treatment plans to address the specific needs of each patient about their condition and treatment options. This may include a combination of physiotherapy, medications, cortisone injections and occasionally more invasive procedures. If there is no clear definition of FS there is no clear diagnosis.

What is a Frozen Shoulder?

To properly understand this confusing condition, I will first start by discussing a working definition and classification. The International Society, ISAKOS, recommends using the terms:

- **Stiff shoulder** – to describe the patient who presents with a restricted range of motion regardless of aetiology, either primary or secondary causes.
- **Frozen shoulder** – to be used exclusively for idiopathic stiff shoulder.
- **Secondary stiff shoulder** – for a stiff shoulder with a known aetiology.
- **Adhesive capsulitis** – not to be used because there is no adhesions.

The American Shoulder and Elbow Surgeon's Society defines a true frozen shoulder (also called a Primary capsulitis) as "a condition of uncertain cause which is characterised by significant stiffness, both active and passive, of the shoulder joint in the absence of any known underlying shoulder condition". That is, with no significant history of injury or investigations which can explain the pain and stiffness.

Classification of the “Stiff shoulder”

The stiff shoulder can be divided into a primary and secondary.

1. primary frozen shoulder (primary capsulitis) or true frozen shoulder as defined above.
2. secondary frozen / (secondary capsulitis) is shoulder pain and stiffness from a known cause such as shoulder injury, for example after surgery, a fracture etc.

An interesting research paper on “Consensus Survey of Shoulder Specialists” using a questionnaire on definition, classification, utilization of diagnostic modalities, was sent to 95 shoulder specialists in Korea. This paper outlines current thoughts.

They strongly agreed a Frozen shoulder can be defined as: “a self-limiting disease characterized by pain and functional restriction in both active and passive shoulder motion lasting more than 1 month, for which radiographic findings of the shoulder joint are unremarkable.”

Primary frozen shoulder is considered a diagnosis for all cases in which specific trauma, known comorbidity, or underlying aetiology cannot be identified.

Secondary frozen shoulder is considered when known associated conditions are identified.

They did however agree frozen shoulder diagnosed in patients with systemic disease such as thyroid disease or hyperlipidaemia should be considered secondary.

Unlike the definition of FS, the classification of FS appears to be controversial. In a study of members of the society: American Shoulder and Elbow Surgeons.

Only 2/3 agreed the division of secondary types of FS into intrinsic (example: rotator cuff tears), extrinsic (An identifiable abnormality remote to the shoulder itself such as humeral shaft fracture) or systemic. There is however a lack of consensus about whether patients with systemic disease such as thyroid disease, diabetes etc should be still considered primary or secondary.

What is the cause?

The cause of a true FS remains poorly understood. Despite extensive research. The clinical features of FS both primary and secondary capsulitis warrant describing as it may help to understand the causes.

Incidence

The condition of FS is very common. 2% of the general population develop a true FS, while diabetics have a risk of over 10% and Insulin dependent diabetics have a 40% chance of developing a FS/ secondary capsulitis.

Women are more commonly affected than men, by a ratio of female : male, 5 : 2. The most striking clinical feature

of primary frozen shoulder is its predilection for people in their 50's. Frozen shoulders can occur in people in their mid to late 40's to mid to early 60's but far more commonly are in their 50's. Women are slightly younger than man on average when they develop this condition with the average age of women developing a frozen shoulder is 52 years old and men 55 years old.

Once you have developed a frozen shoulder on one side you are at increased risk of developing it in the other side. 15% of people develop a frozen shoulder on both sides. Rarely it can occur simultaneously but more typically it affects the other shoulder within the 5 years after the first shoulder. Surprisingly, recurrence in the same shoulder is extremely unusual.

There is also a genetic risk which is higher in diabetes than hypothyroidism.

Pathology

In a FS the capsule initially becomes very inflamed which causes a deep ache in the shoulder joint radiating very diffusely down the arm.

After the development of inflammation, the surrounding capsule and ligaments contract which restricts shoulder motion causing gradual and increasingly severe stiffness.

The body perceives the shoulder as being injured/degenerative and therefore triggers an inflammatory response to try to heal it. As the inflammatory cascade occurs, healing tissues including white cells and platelets and subsequently fibroblasts migrate towards the shoulder joint diffusely. These migrating tissues attempt to “heal” the shoulder joint, and this creates a domino effect as more and more inflammatory factors are produced and ongoing inflammation and healing occurs.

Like the falling dominos it does not matter what triggers the initial domino falling but subsequent dominoes continue to fall unrelated to the initial insult. Eventually the domino's run out, the inflammatory phase passes.

The cells responsible for healing are the fibroblasts. Typically, tissue damage stimulates migrations and growth of these fibroblasts, and these cells are responsible for the production of scar tissue in the capsule, restricting movement.

Cytokines are the chemicals which trigger the fibroblasts activity; they bond to the fibroblast and stimulate scar formation. Special fibroblasts called myofibroblasts are responsible for shrinking scar tissue. So, when the fibroblasts accumulate in the shoulder joint, scar tissue is laid down and the myofibroblasts shrink that scar tissue. This inflammatory process occurs largely in the lining tissues of the shoulder joint and the capsule with their surrounding ligaments. Because of this, the tissues of the joint (synovium, ligaments and capsule) which are normally extremely thin and elastic becomes thickened, hard and inelastic.

How do we diagnose a FS?

Diagnosing a frozen shoulder typically involves a combination of medical history, physical examination, and appropriate imaging studies. Here are some common steps in the diagnostic process:

MEDICAL HISTORY:

Symptoms, including when and how the pain started and how the symptoms have progressed help in the diagnosis. The gradual onset of pain and stiffness in the absence of any injury is highly suggestive of FS.

Previous injuries, surgery or systemic conditions as mentioned above could be related to a secondary FS.

PHYSICAL EXAMINATION:

The characteristic limitations in movement associated with frozen shoulder is typically an active and passive and global restriction in movement, which differentiates from things like rotator cuff tears.

IMAGING STUDIES:

While imaging studies can help rule out other potential causes of shoulder pain and stiffness which would suggest a secondary FS. The diagnosis of a true FS is a diagnosis of exclusion.

X-rays can help identify structural issues such as arthritis, trauma or calcific tendonitis etc.

Ultrasounds can be very helpful if they reveal rotator cuff pathology which implies a secondary FS, or they can reveal a shoulder joint effusion with a biceps tendon sheath effusion alone which is highly suggestive of a primary or secondary capsulitis. The report of a “bursitis” does not help either way.

Magnetic Resonance Imaging (MRI) can be ordered to exclude soft tissue lesions such as ruling out conditions like rotator cuff tears or early glenohumeral joint osteoarthritis. Like ultrasound, joint effusion with a biceps tendon sheath effusion alone is highly suggestive of a true FS.

Overall MRI only plays a valuable role in diagnosing frozen shoulder if the diagnosis is unclear by providing evidence of inflammation and tissue thickening and excluding other pathological changes. Blood Tests: In some cases, blood tests may be helpful to rule out conditions that could cause similar symptoms, such as autoimmune diseases. They may also assess systemic diseases such as diabetes and thyroid disorders,

To conclude: Imaging including plain radiography, ultrasonography, or MRI are used to exclude other causes of shoulder pain and stiffness and therefore are NOT diagnostic on their own but can be complementary in the diagnosis.

Unfortunately reports of imaging almost never state the imaging is essentially normal. ultrasound nearly always

report bursitis. This is rarely the diagnosis. MRI almost always states acromio-clavicular joint arthritis. This is often a normal finding.

It is all about Pattern Recognition. As we said in the definition above, in the primary frozen shoulder there is no known underlying disorder. X-rays, ultrasounds and even MRI are therefore, on their own do NOT diagnose primary FS but may diagnose another reason for pain and stiffness of secondary FS.

There is an old expression “if it looks like a duck and quacks like a duck and walks like a duck, it must be a duck”. So, we therefore rely on typical clinical features to suggest the diagnosis of a frozen shoulder.

However, if there are red flags, meaning features are not typical, (maybe it is not a duck) such as symptoms occurring in both shoulders simultaneously or in an unusually young (less than 45 years old) or unusually old patient (greater than 65 years old), then further investigations are warranted. Blood tests to exclude thyroid disease, raised cholesterol or blood sugars may be of some benefit but will not help confirm the diagnosis.

What is its Natural History?

Once we understand the natural history of a FS, which is different from a secondary FS we can determine what can be done about it. For example, diabetes is a very poor prognostic factor for clinical outcome, thus it is better classified as a secondary FS and may require different treatment. The same applies for cases with rotator cuff pathology, etc.

Traditionally FS are arbitrarily divided into 4 stages: Preadhesive, Freezing, Frozen and Thawing Stages.

Codman, stated in 1934 that “even the most severe cases recover with or without treatment in about 2 years” The perception that the natural history of FS is benign and self-resolving within 2 years has been assumed to be correct by many.

However, a systematic review by C.K. Wong et al on the natural history of FS revealed: “Low-quality evidence of longstanding assumptions about FS”. And concluded that “Contradictory evidence and a lack of supporting evidence shows that the theory of recovery phases leading to complete resolution without treatment for FS is unfounded.”

This leads to a recommendation that reference to the theory that FS progress through stiff to recovery phases leading to full resolution without supervised treatment should be discontinued. The author suggests correcting professional and public misconceptions about a FS may reduce delays in people seeking treatments that demonstrate moderate to strong evidence for improvements in pain, range of motion and function.

A study by Hand, looking at the long-term outcome of FS, even at 4½ years 40% of patients still had some degree of ongoing symptoms. Overall, these were usually quite mild but 5% of patients still had severe pain and stiffness.

What can be done to treat it?

For many patients whose symptoms are tolerable, a wait and see approach is quite reasonable. Typically, if symptoms are tolerable at the 6 months following onset, no intervention will be required.

However, optimizing treatment depends on the recognition of the clinical stage at presentation. For example: physiotherapy may exacerbate the pain in the first few months following the onset of symptoms, nevertheless when the inflammation has settled, physiotherapy and stretch exercises might accelerate recovery in range of motion.

Cortisone injections reduce inflammation and therefore may be useful early in the condition but not late when the inflammation has settled, and stiffness is due to the thickened capsule. For it to be effective in FS the injection should be initially performed into the glenohumeral joint (GHJ, usually under ultrasound guidance) , but not initially in the bursa which is what is usually injected. If successful, injections can provide at least 3-4 weeks of symptomatic relief and usually only 2 or 3 injections are required to alleviate the worse of the symptoms.

If the symptoms do not respond to cortisone injections and are prolonged or intolerable, an arthroscopic capsular release is an arthroscopic day-surgery operation in which the inflamed and thickened capsule can be released. This provides often dramatic relief in the severe pain and accelerates recovery in the range of motion. The trend toward treating these patients with arthroscopic capsular release in stiff shoulders is becoming more standard for failed conservative treatment. Arthroscopy also significantly helps in confirming the diagnosis as well as treating the symptoms.

Conclusion

In conclusion, once a definite diagnosis of a true FS has been made (which can be difficult) , a wait and see approach can sometimes be taken. If pain is disturbing, an early cortisone injection into the GHJ can be very helpful in improving the pain. If this relieves symptoms we can go back to a wait and see approach or repeat the injection if necessary. If stiffness persists, VERY gentle physiotherapy which does not exacerbate the pain, can be helpful. Nevertheless, if these modalities do not provide significant relief and symptoms are severe or persistent (greater than 6 months), arthroscopic capsular release is an option worth considering.

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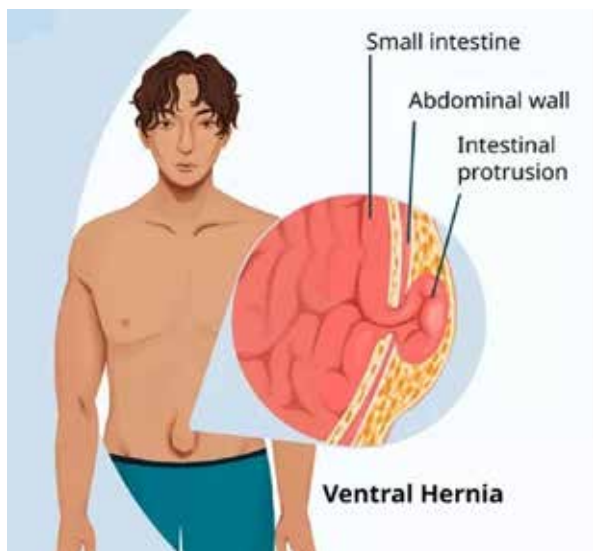
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Ventral Hernias

What is a ventral hernia?

A ventral hernia occurs when tissues or an internal organ (such as the intestine) bulge through a weakness or opening in the abdominal wall muscles.^{1,2}



Ventral hernia³

There are several types of ventral hernias:⁴

- **Epigastric hernia:** Develops between the belly button and the breastbone.
- **Umbilical hernia:** Forms at the belly button, often present from birth, accounting for 30% of cases.¹
- **Incisional hernia:** Occurs at the site of a previous surgical incision where the abdominal wall has weakened or thinned.

Ventral hernias are a common condition that can affect an individual's quality of life and may lead to hospitalisations.¹

What are the symptoms?

Not all ventral hernias will cause symptoms, and they may take weeks or months to appear.^{3,5} A visible bulge on the abdomen is the hallmark symptom, often becoming more noticeable with straining, coughing, or prolonged standing. Other symptoms include:

- Abdominal pain, especially localised to the bulge area
- Discomfort or a dragging sensation
- Bloating or a feeling of abdominal fullness
- Difficulty with bowel movements

Emergency surgical management may be necessary if experiencing a painful, hot, swollen hernia that is painful to touch.

What are the risk factors?

- Previous abdominal surgery: Particularly extensive procedures with large incisions or multiple re-operations.
- Increasing age
- Chronic straining: Due to heavy lifting, chronic cough, constipation, or straining during bowel movements.⁴
- Obesity: Extra weight places pressure on the abdominal muscles, making them weaker.
- Injury to the bowel area⁵
- Abdominal wall stretching: Occurs with pregnancy or with repetitive weight gain / weight loss.
- Connective tissue disorders: Such as Marfan syndrome or Ehlers-Danlos syndrome.
- Smoking: Impairs healing and weakens tissues.

How is it diagnosed?

Ventral hernias are usually diagnosed through a physical examination. The GP will feel the abdomen to identify bulges and may ask patients to cough or strain to assess the prominence of the hernia.

Imaging tests such as ultrasound, CT scans, or MRIs may be used in complex cases to determine the hernia's size and contents. Ultrasound is typically preferred for small hernias, while CT scans may be necessary if an incarcerated bowel or strangulation is suspected.

What are the complications of ventral hernias?

If left untreated, ventral hernias can enlarge, leading to serious complications and making repair more difficult.⁵

Potential complications include.^{5,6}

- **Incarceration:** The intestine becomes trapped within the abdominal wall and cannot be pushed back into the abdominal cavity. This can lead to a blocked intestine or strangulation.
- **Strangulation:** Blood supply to the intestine is cut off, causing symptoms such as obstipation (inability to pass stool), bloating, generalised abdominal pain, and vomiting. This requires immediate surgery to release the trapped intestine and restore its blood flow otherwise part of the intestine may die or start to decay.

What are the non-surgical treatment options?

Some patients may not be suitable for surgery due to underlying medical conditions.⁷

Alternative management options include:

- **Watchful waiting:** Some hernias that are small or do not cause symptoms may not need to be repaired.
- **Hernia belts or binders:** Provide support and help reduce discomfort.
- **Lifestyle modifications:** Weight management, avoiding heavy lifting, and managing chronic conditions can help minimise symptoms.

When is surgery recommended?

Surgery may be recommended if.⁴

- The hernia cannot be pushed back in
- It causes frequent symptoms, such as pain
- It's large enough to become trapped or cause complications
- The patient's overall health allows for surgery

What are the surgical treatment options?

Ventral hernia surgery aims to push the bulging intestine back into the abdomen and repair the opening in the abdominal wall.^{4,6} Additionally, it restores the abdominal wall's shape and tone by closing the hole and repositioning the muscles. In some cases, surgical mesh is used to reinforce the repair.⁴

Modern surgical techniques offer various options based on the hernia's complexity and the patient's specific needs. These include:

OPEN REPAIR

Traditional approach: Involves a single incision over the hernia site.

Suitable for: Smaller, uncomplicated hernias.

Techniques:

- **Suture repair:** The hernia is closed using sutures to repair the weakened abdominal wall.
- **Mesh repair:** A synthetic mesh is placed over the hernia to reinforce the abdominal wall.

LAPAROSCOPIC REPAIR

Minimally invasive: Performed through small incisions using a laparoscope (a thin tube with a camera).

Benefits: Smaller incisions, shorter recovery time, less pain.

Suitable for: Larger, more complex hernias, or patients with multiple hernias.

Techniques:

- **Transabdominal preperitoneal (TAPP):** The mesh is placed behind the abdominal wall.
- **Totally extraperitoneal (TEP):** The mesh is placed outside the peritoneum (the lining of the abdominal cavity).

ROBOTIC-ASSISTED LAPAROSCOPIC REPAIR

Advanced technique: Uses a robotic surgical system to perform the procedure.

Benefits: Greater precision, improved dexterity, enhanced visualisation.

Suitable for: Complex hernias, patients with previous abdominal surgery, or those with underlying medical conditions.

The choice of surgical technique depends on factors such as:

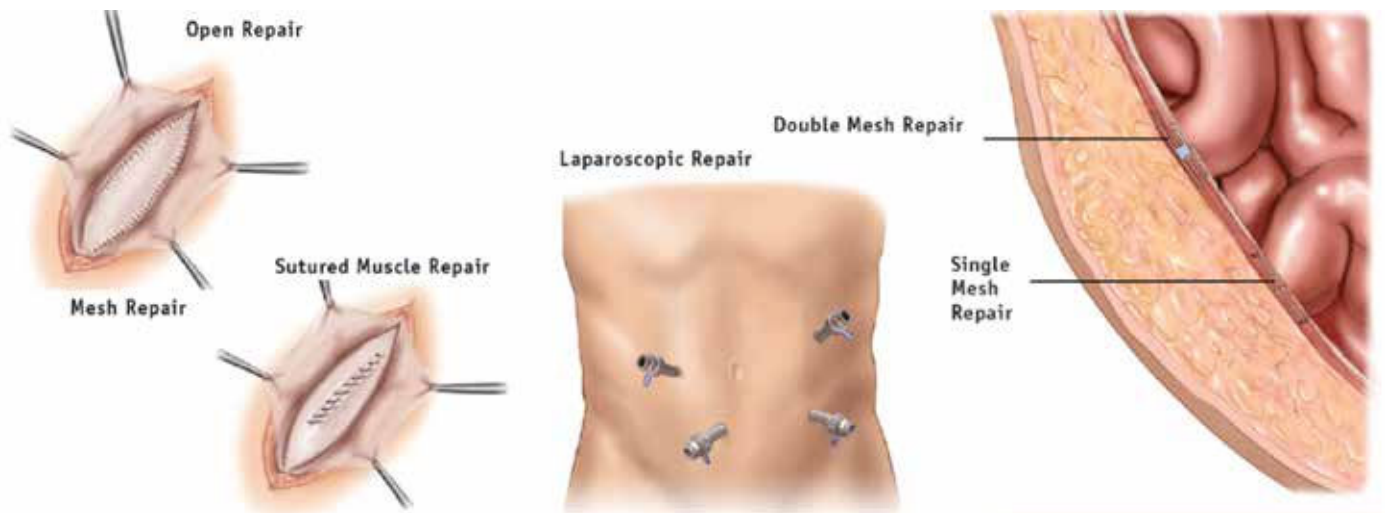
- Hernia size and location
- Patient's overall health and medical history
- Surgeon's preference and expertise

It's important to discuss these options with your surgeon to determine the best approach for your individual situation.

What happens post-surgery?

Post-operative management of ventral hernias involves:

- **Pain management:** Appropriate pain medication can help manage discomfort and promote healing.
- **Wound care:** Monitoring the incision for signs of infection, such as redness, swelling, or drainage.
- **Activity restrictions:** Avoiding strenuous activity, heavy lifting, or excessive straining for a specified period to allow for proper healing.
- **Follow-up:** Attending regular follow-up appointments so the doctor can monitor wound healing, assess for any complications, and offer ongoing support.



Open repair vs Laparoscopic repair vs Mesh repair ⁹

- Prevention of constipation: Consuming a high-fibre diet and drinking plenty of fluids to prevent straining during bowel movements.

What are the complications of hernia repair?

- Seroma formation: Fluid collection at the hernia site. This is very common and usually self-resolving if there are no signs of infection.
- Wound infection: Occurs in 2-4% of cases, with higher risk in diabetics, smokers, and obese individuals. Requires referral to the treating surgeon.
- Deep infection: Can present as skin infection of the abdominal wall and may result in mesh infection.
- Early hernia recurrence: Now very rare but typically associated with infection. Patients should be immediately referred back to the operating surgeon for investigation. ⁸

How to prevent recurrence?

Several factors, such as obesity, chronic cough, and multiple prior surgeries, can increase the risk of hernia recurrence. Preventive measures include:

- Maintaining a healthy weight, managing chronic conditions, and avoiding excessive straining.
- Using advanced surgical techniques, such as the use of mesh and robotic-assisted surgery, can help reduce the risk of recurrence.

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TYPES OF SCARS THAT ARE FREQUENTLY TREATED

Surgical scars

Acne scars

Traumatic / burn scars

Symptomatic scars

Scars with pigment changes

Pathological scars & Keloids

Radiation Fibrosis

Scars following other medical treatments

Unstable scars/wound breakdowns

TREATMENT MODALITIES

Traditional conservative scar management options

Lymphdrainage & vacuum-therapy (LPG® Endermologie® Medical)

Microdermabrasion

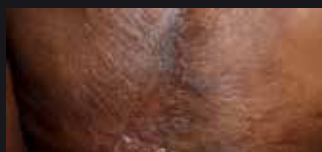
Various light based therapies, including vascular, pigment lasers, & the newest ablative fractional CO2 ULTRApulse® ALPHA & ablative fractional cold fiber UltraClear® lasers

Paediatric scar services

Surgery

Pain & itch treatment services

Radiotherapy





Breast reduction surgery for the treatment of macromastia

Macromastia is defined as the presence of disproportionately large breasts in relation to an individual's body weight or frame, affecting approximately 1-5% of the female population. This condition is often associated with a range of physical and psychological symptoms, including chronic upper back, neck, and trapezius pain, intertrigo, bra strap indentations, and psychological distress. Women with macromastia frequently encounter difficulties with physical activity, clothing choices, and may experience unwanted attention. Breast reduction surgery aims to alleviate these burdens by reducing breast volume and reshaping the breast to improve overall quality of life.

Indications for Breast Reduction Surgery

The decision to proceed with breast reduction surgery is typically influenced by both medical and psychological factors. Key indications for the procedure include:

- **Physical Discomfort:** Patients commonly report significant pain in the back, neck, and shoulders due to the weight of enlarged breasts, limiting physical activity and daily functioning.

- **Dermatological Issues:** Skin irritations or infections beneath the breasts can lead to chronic dermatologic conditions, further compounding patient discomfort.
- **Postural Concerns:** The substantial weight of large breasts can contribute to poor posture and musculoskeletal problems, adversely affecting the patient's quality of life.
- **Psychosocial Impact:** Many individuals experience anxiety, depression, or diminished self-esteem related to breast size, which can impair social interactions and overall well-being.
- **Clothing Challenges:** Difficulty in finding appropriate bras or clothing to accommodate larger breast sizes leads to frustration and embarrassment.
- **Activity Limitations:** Patients may actively avoid physical activities or sports due to discomfort or self-consciousness related to their breast size.

Surgical Procedure

Breast reduction surgery involves significant volume reduction, repositioning the nippleareolar complex, reducing areolar size, and contouring the remaining breast tissue. The procedure is performed under general anaesthesia in an accredited surgical facility.

Various surgical techniques are employed to optimize safety and outcomes. The surgery generally spans approximately three hours, followed by an overnight stay for postoperative monitoring and pain management.

Outcomes of Breast Reduction Surgery

Evidence in the literature supports the efficacy of breast reduction surgery. A systematic review by Singh and Losken (2011) indicates several significant postoperative benefits:

- Patients with symptomatic macromastia often exhibit degenerative changes in the spine (III).
- Over 50% of preoperative headaches resolved postoperatively (IIB).
- A 35% reduction in low back compressive force was recorded postoperatively (IIB).
- There was a 76% decrease in postoperative disability (IIB).
- Functional outcome indices improved significantly (IIB).
- Reduction in the frequency of back, shoulder, and neck pain (IIB).
- Significant improvements in forced vital capacity (FVC) (IIB).
- Enhanced exercise tolerance post-surgery (IIB).
- Reduction in sleep disturbances (IIB).
- Improvement in respiratory difficulties (IIB).
- Notable enhancement in rhomboid and trapezius muscle function (IIB).
- Improved neck mobility (IIB).

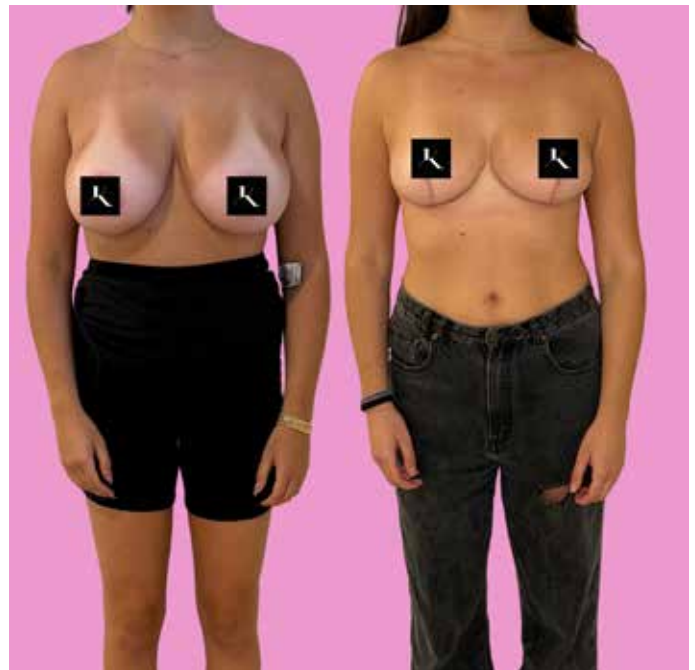
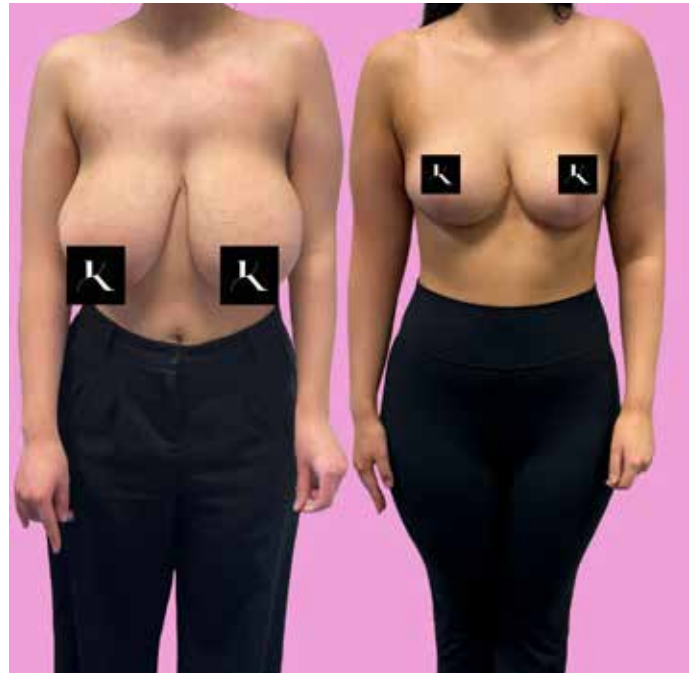
Patients have reported that breast development affected their weight management, and subsequent breast reduction often resulted in improvements in bulimia, enhanced exercise, and weight loss. Notably, the success of breast reduction outcomes is not dependent on the patient's preoperative weight.

Breast Cancer Considerations

It is crucial to note that breast reduction surgery does not alter the risk of developing breast cancer; thus, patients should continue with recommended oncological surveillance. Furthermore, the procedure does not interfere with breast cancer diagnosis.

For patients over the age of 40 considering breast reduction, it is advisable to conduct a mammogram and breast ultrasound prior to surgery to ensure comprehensive evaluation. A thorough clinical assessment will help determine the suitability of breast reduction surgery for addressing patient concerns.

BEFORE AND AFTER BREAST REDUCTION RESULTS



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“Doctor, I can’t burp”

Understanding Retrograde Cricopharyngeal Dysfunction (RCPD)

A/Prof Daniel Novakovic
Otorhinolaryngologist



Scan to
view my
profile



A Missed Diagnosis Hiding in Plain Sight

General practitioners are often the first port of call for patients experiencing upper aerodigestive tract symptoms. While complaints such as throat discomfort, bloating, or chest pressure are common, there is a lesser-known condition that may be the underlying cause in a surprising number of cases: Retrograde Cricopharyngeal Dysfunction (RCPD).

RCPD is a condition characterised by an inability to burp, medically referred to as *abelchia* or *aburpia*. Though it may initially sound trivial, the downstream effects on quality of life can be substantial and debilitating.

What Is RCPD?

First described in 2019 by Dr Robert Bastian (Chicago), RCPD is attributed to a failure of the cricopharyngeus (CP) muscle—also known as the upper oesophageal sphincter (UES)—to relax in response to retrograde pressure in the oesophagus. This is the physiological mechanism that allows gas to escape upwards (i.e., burping). While this muscle relaxes appropriately during swallowing, patients with RCPD have a specific dysfunction in its retrograde opening reflex.

The underlying cause of RCPD remains unknown but it appears to be a problem with oesophageal motility and reflexes, causing an inability to burp, without affecting the ability to swallow. It differs from regular cricopharyngeal dysfunction which also causes difficulties swallowing (dysphagia).

Recognising the Symptoms

RCPD commonly presents in otherwise healthy individuals, often in their 20s or 30s, although many report symptoms dating back to childhood. Men and women are affected equally. The condition is frequently misdiagnosed as gastro-oesophageal reflux disease (GORD), irritable bowel syndrome (IBS), or simply dismissed as anxiety-related.

Symptoms are related to excess buildup of unreleased gas, including:

- Inability to burp
- Pressure or fullness in the neck or upper chest
- Loud gurgling noises, particularly after meals which can be socially embarrassing
- Chest or upper abdominal discomfort
- Excessive abdominal bloating
- Excessive Flatulence

Symptoms range from mild to severe and are typically aggravated by carbonated drinks

Making the Diagnosis

RCPD remains under-recognised, and many patients live for years without an accurate diagnosis. Diagnosis is clinical, based on a characteristic history and physical examination. Structural causes such as laryngopharyngeal or oesophageal pathology must be excluded, but no specific radiologic or endoscopic test currently confirms the diagnosis.

As ENT surgeons familiar with this condition, we are increasingly diagnosing and treating RCPD based on its distinct clinical picture. GP awareness and early referral can significantly shorten the diagnostic journey for these patients.

Treatment and Outcomes

The most effective treatment to date is botulinum toxin (BTX) injection into the CP muscle. This can be performed under general anaesthetic via endoscopic approach, and in select cases, as an office-based procedure under local anaesthesia.

Outcomes are excellent:

- Over 85% of patients report restoration of the ability to burp
- Symptom improvement typically occurs within 2–3 weeks
- Adverse effects are minimal, with some patients experiencing temporary mild dysphagia lasting less than two weeks

Importantly, most patients require only a single injection. The relaxation of the muscle appears to allow the brain to “relearn” the burping reflex, offering long-term resolution.

When to Refer

Our practice has extensive experience in the diagnosis and treatment of RCPD. We encourage referral for patients with any of the following:

- Persistent inability to burp with associated bloating or discomfort
- Unexplained gurgling sounds in the neck or chest
- Refractory bloating not responsive to dietary changes or PPI therapy

With increased awareness, GPs can play a vital role in recognising this treatable condition and providing relief to patients who may have spent years suffering in silence.

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The Re-Surfacing of Hip Resurfacing

Hip Resurfacing is an alternative to conventional hip replacement allowing walking, running and most sports, even at a professional level, and it was originally designed to manage established arthritis and hip pain in younger or athletic patients, but is now available to all patients who wish to retain a high level of activity. It is a bone preserving technique and utilises an implant that has exceptional wear, impact and dislocation resistance, allowing patients to return to high levels of activity.

In **Hip Resurfacing**, the femoral head is not removed, but is instead trimmed of damaged cartilage and bone and an artificial surface (a cap) is secured over the top of the femoral head. The damaged bone and cartilage within the socket is removed and replaced with a metal or ceramic shell, just as in a traditional total hip replacement.

Hip resurfacing

Total hip replacement



WHAT IS THE DIFFERENCE BETWEEN HIP RESURFACING AND A CONVENTIONAL METAL (STEM)?

In **Total Hip Replacement** procedures, the femoral head and neck (ball of the hip) is removed, and a stemmed implant (rod) is placed into the femur (upper thigh bone). The acetabulum (socket of the hip) is replaced with a metal shell and a plastic or ceramic liner. A new ceramic ball is placed onto the stem that is free to move within the new socket (acetabulum).



Hip Resurfacing

Total Hip Replacement



Metal



Ceramic



X-rays of Hip Resurfacing. Total Hip Replacement

These modern components offer options for younger, active, athletic men and women of all shapes and sizes.

WHAT ARE THE ADVANTAGES OF HAVING A HIP RESURFACING?

More Normal Walking Pattern

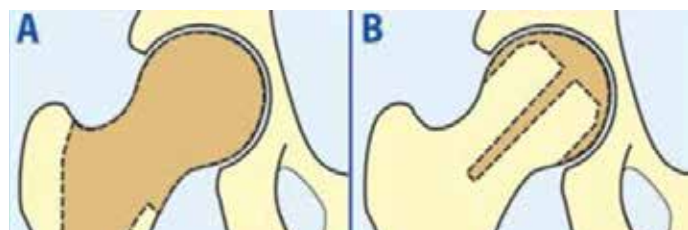
Studies have shown that walking patterns are more natural following Hip Resurfacing compared to traditional hip replacement. Increased loading of the hip and improved push-off have also been seen in gait analysis. Patients also report that the hip resurfacing feels very natural.

Increased Activity

Hip Resurfacing uses impact and wear resistant bearing surfaces that are more suitable for higher activity demands. This is true of the traditional Adept, metal-on-metal resurfacing implant and the new ceramic ReCerf implant. This, along with the preservation of bone means Hip Resurfacing patients are more able to return to activities such as running and impact sports.

Increased Stability

Because the size of the ball and socket is similar to the original hip, the risk of dislocation is much lower for Hip Arthroplasty in comparison to conventional Total Hip Replacement, even in activities that require a high range of motion such as surfing, tennis and football.



Hip Preservation and Revision

A Hip Resurfacing preserves more of your natural bone. Because the components (called implants) used in hip replacements and hip arthroplasty are mechanical parts, they can wear out or loosen over time and require a second operation called a revision. If revision of a hip resurfacing is required in the future, preserving this bone makes the procedure far easier and is similar to performing a standard total hip replacement.

AM I SUITABLE FOR A RESURFACING?

Up until recently, hip resurfacing was reserved for young active males with a femoral head size over 50mm in diameter. This was because high failure rates had been seen in metal-on-metal resurfacing in women and patients with small femoral heads. With the introduction of ReCerf, a ceramic-on-ceramic implant, these limitations have been removed, and resurfacing can now be offered to ALL active patients. The only limitations that remain are patients with Dysplastic (Abnormal shaped) hips or severe Avascular Necrosis where the bone of the femoral head has died and cannot support the resurfacing implant.

THIS IS WHAT CAN I EXPECT IN HOSPITAL.

With standard instrumentation, Hip Resurfacing has traditionally been performed through a **posterior approach**. Although an excellent approach, this more invasive procedure requires detachment and then reattachment of muscle to bone and usually requires some precautions for several weeks following the surgery to protect this reattachment whilst it heals.

You will be mobilising as quickly as 4 hours after surgery and can expect to be in hospital for 2-3 days. Rehabilitation can be arranged as an in-patient, out-patient or in your own home.

HOW SUCCESSFUL IS HIP RESURFACING?

Conventional total hip replacement (THA) is a highly successful operation, providing pain free function in the majority of patients for more than 20 years. The rate of revision, or second operation due to failure of the THA, is low. However, in the younger, more active population, the rate of revision is much higher. Hip Resurfacing using established devices such as the Adept, are now being seen to outperform THA in all patients. We do not yet know how long resurfacing devices will last, but the rate of failure is very low and we expect to see these implants lasting 30+ years, and possibly the life of the patient.

ADEPT®
Hip Resurfacing
System



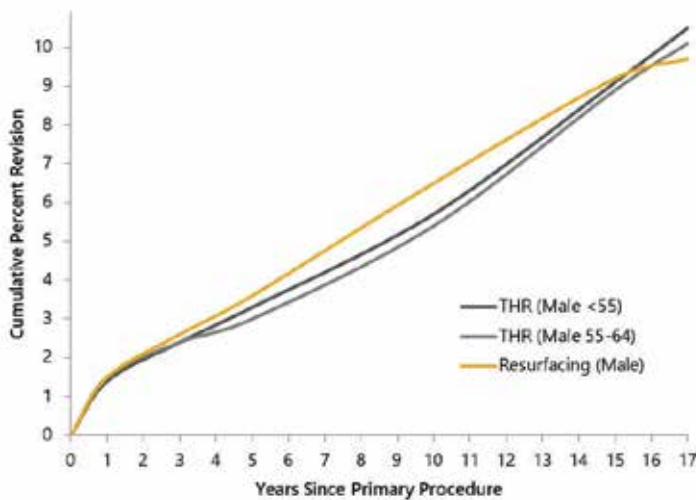
RECERF CERAMIC ON CERAMIC HIP RESURFACING

Ceramic bearings wear minimally, and any wear debris is inert to tissues. Utilising the successful design of the Adept MoM device, a ceramic version was developed to overcome the limitations of MoM resurfacing. This device, called **ReCerf** allows resurfacing to be available to all patients, irrespective of sex or size of femoral head. First implanted in 2018, Recerf has recently completed all the necessary TGA regulatory protocols, has excellent results in several studies and is now available in Australia.

RECERF - ALL THE BENEFITS OF HIP RESURFACING WITH NONE OF THE LIMITATIONS OF METAL ON METAL

Recently reported on Channel 9, we believe ReCerf is a game changer in hip replacement surgery. It can be implanted into almost any patient to give them a hip replacement on which they can be as active as they want. It is only available for implantation by select Hip surgeons in Australia.

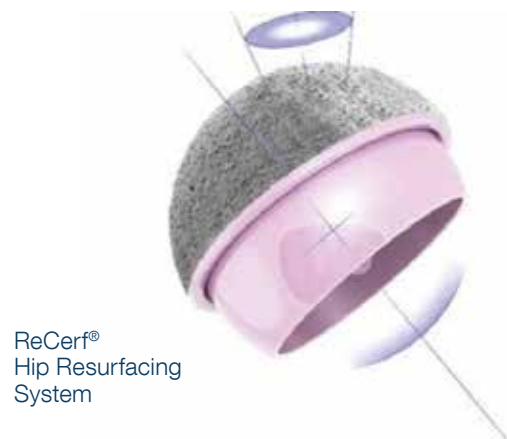
Dr Thornton-Bott is one of these surgeons and is now able to offer ReCerf to his patients at East Sydney Private Hospital.



Above: Cumulative revision rates for younger male hip replacement patients in the AOA NJRR showing that beyond 15 years after their primary operation those who received a hip resurfacing are less likely to have required a revision operation than those that received a total hip replacement.

WHAT IS ALL THE FUSS ABOUT CERAMIC RESURFACING?

Historically, hip resurfacing has used metal-on-metal (MoM) devices. Due to some poor designs, there was a period where many of these devices failed. They created metal debris which damaged bone, muscle etc and had some systemic effects in patients too. This experience identified that men with small femoral heads and all women were at risk of premature failure with MoM resurfacing. The Adept MoM resurfacing has, due to excellent design, out-performed most of the other MoM resurfacing designs, which have all but one been withdrawn. However, it is still not recommended in this group of patients with small femoral heads.



ReCerf®
Hip Resurfacing
System

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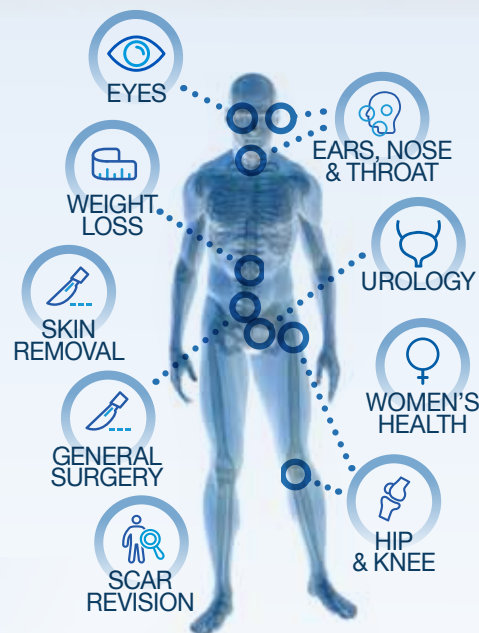


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