practice matters

The newsletter for GPs from The Wellington Hospital

SPRING
MAY 2012

WHEN TIME IS OF THE ESSENCE

CASE STUDIES FROM THE ACUTE ADMISSIONS UNIT

The latest news, views and features from the largest independent hospital in the United Kingdom

WELCOME

Springtime has meant celebration time for us this year, as we celebrated the hospital's 38th birthday in April, the Wellington Diagnostics and Outpatients Centre's (Golders Green) 5th birthday and the Platinum Medical Centre's 1st birthday in May

When the hospital first opened it had a simple philosophy: to provide the very best in healthcare. Since 1974, the hospital has gained an international reputation for providing precisely this, and I am please to say after 38 years – we are still growing and expanding.

This issue focuses on our recently opened Acute Admissions Unit (AAU), which has proved to be a real success. With over 250 patients treated so far – we have received many positive accolades from consultants, GPs and relatives alike about this state-of-the-art unit. On **pages 4-6** we highlight a selection of case studies – featuring patients who have been treated at our AAU in the last few months.

Remember, if you need to admit a patient urgently, call the AAU on **0207 483 5999**; where there will be a dedicated clinician ready to organise a smooth and efficient admission with you.

We have two lively interviews this issue: Bernadette Phelan, our Breast Care Nurse talks to us about our innovative Breast Care Unit on **page 7**; and Wellington Diagnostic Centre Manager, Ursula Stiemert updates us on future developments underway at our outpatient centre in Golders Green, including a breast screening service and pain management unit.

The Wellington is a keen investor in new technology, viewing it as vital to continually improving our patients' care, and this doesn't just mean medical and surgical technology; we have recently introduced 'iris scanning' for patient identification. Some of your patients may have already experienced this exciting technology, which aims to make patient registration quicker and easier. Once your patient's iris pattern has been scanned, this data is securely stored - ready for their next visit.

You can keep up to date with this information and much more by visiting our extensive website: **www.thewellingtonhospital.com**. Our blog is also a source of engaging information, and if you enjoy Practice Matters, the blog offers an ever growing library of articles from our renowned consultants and news updates from our marketing team.

If I can urge you to do one thing this month, do book a place on one of our GP seminars; see our events listings on **page 16** for further details on how to book.

As always, thank you for your continuing support

Keith D Hague CEO

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SPRING 2012

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‘Top Up’ on Hands Part two: De Quervian’s

For the second instalment of ‘Top Up’ on Hands, London Hand and Wrist Unit Manager, Melita Ryan looks at the signs, symptoms and treatments for De Quervian’s.

Melita Ryan is a Senior Hand Therapist and Manager of the London Hand and Wrist Unit

De Quervain’s

First identified by the Swiss Surgeon Fritz De Quervain in 1895, De Quervain’s (also known as washer woman’s syndrome or mother’s wrist) describes the condition of pain at the first dorsal compartment, where the extensor pollicus brevis and abductor pollicus longus pass. For a variety of reasons the tunnel can become occluded or the synovium can become inflamed - causing pain, swelling and limitation of movement in the thumb. Fluid changes during and after pregnancy can also cause these symptoms.

Signs and Symptoms

The most common symptom of De Quervain’s is pain over the wrist at the base of the thumb. It can be a sharp pain on movement or a dull ache after prolonged activity. Symptoms may occur slowly over time or suddenly as a result of over-use or trauma. Activities involving the thumb such as pinching and gripping or movements of the wrist may increase the pain.

Swelling over the thumb-side of the wrist may also be present. In advanced cases of De Quervain’s, a ‘crunchy’ feeling may be felt in the area, and/or there may be numbness over the back of the thumb.

New mothers often present with De Quervain’s, due to the new motion of picking up the infant, where thumb extension is repetitively used and this exacerbates the synovium of the first dorsal compartment. A positive Finkelsteins Test is an indicator of De Quervain’s, although not always a definitive test. Ultrasound can also be used to assess the extent of tissue damage.

Differential diagnosis include base of thumb CMC joint arthritis, and posterior interosseous syndrome; an X-ray will rule out arthritis.

Treatment

De Quervain’s is best treated early, and prompt referral to therapy is pertinent. Treatment will initially aim to decrease the irritation: enlisting ice, anti-inflammatories and rest. In order to best rest the inflamed first dorsal compartment a splint is often prescribed. For most patients an off the shelf splint may not suffice and a custom made splint is fabricated. Our therapists will also assess their patients’ postures throughout the day and work to eliminate repetitive strain at the wrist.

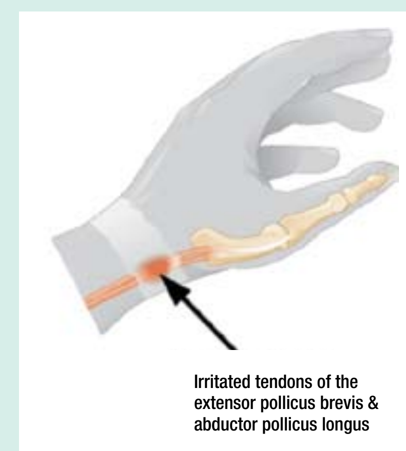
Teaching new mothers alternative lifting methods and safe postures for breast feeding reduces the repeat irritation during these tasks.

> Once the pain has settled therapy then concentrates on strengthening and returning to occupational tasks with gentle range of motion exercises.

Prognosis

If symptoms persist after six weeks of splinting, an injection into the area or non-steroidal anti-inflammatory medication may be prescribed. Our therapists liaise closely with consultants at the London Hand and Wrist Unit in this case. For patients whose symptoms persist, surgery may be considered. This involves a small incision over the first dorsal compartment and release of the tunnel to allow free tendon gliding.

With consulting times available throughout the week, should you suspect your patient has De Quervain’s, we are able to arrange a consultant or therapist appointment at their convenience.



Irritated tendons of the extensor pollicus brevis & abductor pollicus longus

Consultants at the London Hand and Wrist Unit are available to give breakfast, lunch or evening talks at your practices in the following areas:

- Carpal Tunnel
- Dupuytrens
- De Quervain’s Tenosynovitis
- Wrist Fractures
- Hand Trauma
- Arthritis
- Work Related Upper Limb Disorders
- Finger Injuries – Mallet Fingers and Volar Plates
- The Thumb
- Ganglions/ Lumps and Bumps of the Hand and Wrist
- Wrist Pain /TFCC Injuries
- Nerve Injuries in the Hand

To arrange a talk, please call the dedicated GP Liaison Officer for your area, or call the Enquiry Helpline team on 020 7483 5148.

When Time is of the Essence

When patients require acute care, time is crucial. Unique in the private sector, this innovative unit provides outstanding acute care for urgent cases.

Mr Colin Elton, Consultant General and Colorectal Surgeon at The Wellington Hospital highlights how time really is of the essence at the Acute Admissions Unit...

An 18 year old girl presented to the Acute Admissions Unit (AAU) at The Wellington Hospital late on a weekend with a 24 hour history of periumbilical pain moving to the right iliac fossa. She had four similar episodes in the previous two years which had settled without requiring a hospital admission. She did not have urinary symptoms and her last menstrual period was three weeks previous to this episode. She was subsequently referred.

Mr. Elton explains: "That evening I was the general surgeon on-call at the AAU, after just finishing emergency surgery for another case referred by the AAU – I immediately saw this patient. On examination the patient was well and apyrexial. Her abdomen was soft but she had moderate tenderness in the right iliac fossa without guarding. Blood tests and an ultrasound scan were performed within two hours and revealed a leukocytosis of 16, with ultrasound features of acute appendicitis".

The patient underwent a successful laparoscopic appendicectomy for a gangrenous appendix and was discharged well, 24 hours after surgery.

We hear from Antti Kivimaki, who leads the nursing team at the Acute Admissions Unit (AAU), and three case studies from both the consultant and GP perspective - highlighting exactly how the unit works for all referrers.

Our dedicated, skilled and knowledgeable AAU nursing team is led by Head of Clinical Services, Antti Kivimaki. Here he discusses why this unique unit is so well equipped to deal with acute admissions…

Antti Kivimaki

Since the Acute Admissions Unit opened on 20th February 2012 over 250 patients, with numerous medical and surgical conditions including critical care patients, have been cared for in this environment.

The AAU is a unique concept in the private sector; bringing an acute care environment and critical care facility together in one place. As the unit is situated in The Wellington Hospital South Building, every patient has easy access to our vast support services, which may be required during their hospital stay.

This purpose-built unit contains 10 beds, all of which are centrally monitored and linked to our critical care facility located in the same building. Three of the 10 beds are equipped with state-of the-art double critical care pendants and a further three rooms are equipped with single critical care pendants. The entire AAU is set-up and equipped so we are able to safely and effectively deliver full intensive care support for all our patients, if required.

At The Wellington Hospital we take pride in delivering world class health care and service for our patients and their relatives. On every shift the nurse in charge is a skilled critical care nurse, with extensive expertise in critical care nursing. These expert practitioners have the skills and competency, along with experience within a critical care setting, to ensure that immediate intervention and action can be undertaken as required.

Using the latest high tech medical equipment and technology, alongside dedicated professional nursing personnel and medical teams, our patients are ensured a quantum level of care and service is delivered 24 hours a day.

For any GPs and consultants who need to refer their patients please call **020 7483 5999**. Our designated referral line is manned 24hrs a day by senior nursing personnel, these senior nursing practitioners are able to assist you with the entire admission procedure.

A GP's Experience

Dr Lisa Anderson

The launch of the AAU has made it easier for me as a GP to admit a patient who requests private treatment. There is the safe knowledge that there are rotas of specialists covering the unit and as long as the patient is stable enough and is not suspected of having one of the excluded conditions; it makes my job as the referrer much simpler.

My first experience of the AAU was after a home visit to an 88 year old lady with abdominal pain. My provisional diagnosis was that of intestinal obstruction, secondary to an incarcerated abdominal hernia. Once we had established she was insured, I contacted the Acute Admissions Unit. Transport was not needed on this occasion, although I was made aware that the unit could organise a private ambulance if required.

The patient was admitted into the AAU, by which time she had separately contacted her own medical consultant who agreed to take over her care. On admission, an IV line was set-up, and she was rehydrated, then assessed and investigated, having all the necessary blood tests and investigations before my diagnosis was confirmed. The on call surgeon was contacted who came to see her later that day. When she was stable, she was transferred to the ward, followed by surgery and a lengthy recovery period.

From the patient's point of view her comments were that she did not have to wait around in a crowded A&E dept, she had a dedicated nurse and all the latest equipment monitoring her. Although she was fearful at first, the level of care she received in the Acute Admissions Unit reduced this.

A Consultant's Experience

Mr Haroon Mann

Mr Haroon Mann, Consultant Orthopaedic Surgeon describes the case of a female, 48 yr old Clinical Psychologist...

The patient sustained a small graze to her right index finger; 36 hours later cellulitis had spread along the finger to the palm of her hand. Following admission to the Acute Admissions Unit she was diagnosed with Flexor Tenosynovitis.

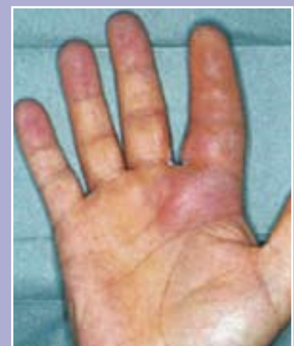
Flexor tenosynovitis causes disruption of normal flexor tendon function in the hand. A variety of aetiologies are responsible, but direct inoculation of bacteria following a cut, graze or penetrating injury are the main causes. Occasionally chronic inflammation as a result of diabetes, overuse, or arthritis can occur.

The four cardinal signs, described as Kanavel's cardinal signs are:

(1) Finger held in slight flexion

(2) Fusiform swelling of the digit

(3) Tenderness along the flexor tendon sheath



(4) Pain with passive extension of the digit

The process has the ability to rapidly destroy a finger's functional capacity and is considered an orthopaedic emergency.

The patient was taken to theatre the same evening and the flexor sheath copiously irrigated. Following 48 hours of intravenous antibiotics she was discharged to our London Hand and Wrist Unit for hand therapy and rehabilitation.

If you have any enquiries about any of these new projects, or would like a tour around our facilities, please contact the Enquiry Helpline on 020 7483 5148.

The First Patient's Story

When the Acute Admissions Unit opened on 20th February, Julie Hartley was the first patient through its doors. Mr Haroon Mann, Consultant Orthopaedic Surgeon explains why cases such as Julie's need urgent attention...

There are few trauma and orthopaedic admissions that require immediate attention.

A displaced calcaneal avulsion fracture, causing heel skin necrosis is one of them. Most calcaneal fractures are initially treated with rest, ice and elevation. Once the swelling subsides definitive management is then planned.

The calcaneus is the largest tarsal bone in the foot. Avulsion fractures usually occur at the point of insertion of the Achilles tendon. Injury occurs as a result of sudden ankle dorsiflexion by the powerful gastrocnemius muscle, leading to avulsion of a segment of the calcaneus.

Three types exist of which the type 2 also known as a 'beak' type, because of its shape, is most common. This type causes avulsion of a large segment of bone from the posterior aspect of the calcaneus and causes direct pressure on the skin directly over the posterior aspect of the heel. The skin in this area once traumatised can lead to rapid necrosis and exposure of the underlying bone, requiring extensive soft tissue reconstruction. Hence the urgent treatment required to alleviate the local pressure and restore healing and function of the Achilles tendon with this type of injury.

Other causes of avulsion fractures include sprinting, blunt trauma, diabetes and osteoporosis.

Julie Harley was admitted with this exact injury on the day that the AAU opened. She was admitted at 1pm and underwent immediate X-rays and CT scan. Surgery was carried out that same day at 7pm. The avulsed heel bone was restored to its position and the pressure on the overlying skin relieved.

Julie's Experience

"On the evening of 16th February 2012 I collided with my dog on the stairs of our home, falling down seven stairs, resulting in a broken heel, bruising and skin damage around the fracture.

I was admitted to my local hospital and after several scans I was advised an operation was needed and I was on the list for the following day. However, I was later informed that the consultant surgeon specialising in the area of my injury would not be operating for another two weeks.

On Monday 20th February I called Veronica Brown, a GP Liaison Officer at The Wellington Hospital for some help and advice. Within 15 minutes Veronica's assistant called me back with the words – "when can you get here?"

I was taken to the brand new Acute Admissions Unit at lunchtime and visited by Mr Mann shortly after my arrival. He immediately put my mind at ease with his knowledge and understanding of my injury.

I was operated on the evening of my arrival at The Wellington and treated exceptionally well by the staff at the AAU, where nothing was too much trouble. After a few days I was transferred from the AAU to my own room within the hospital, which went very smoothly.

I want to pass on my heartfelt thanks to Mr Mann and the team at The Wellington, as without you my suffering would have continued and my injuries worsened, as your quick response and treatment avoided any further deterioration. You have my eternal thanks and respect."

■ Mr Haroon Mann is a Consultant Trauma & Orthopaedic Surgeon and Honorary Senior Lecturer at the Royal Free & UCL Medical School.

Meet the Team

Bernie Phelan, Clinical Nurse Specialist at our Breast Care Unit talks to us about the support she provides to her patients and why she loves being part of this new state-of-the-art unit…

For more information or to make an appointment, call The Enquiry Helpline Team on 020 7483 5148. To contact Bernie directly, please call 020 7483 5562.

Patients come to see me for many different reasons, some come for breast screening; some have questions as they go through further diagnostic testing; others have been diagnosed with a breast cancer and need ongoing support as they undergo surgery and /or further treatment. My role as clinical nurse specialist is to provide a patient focused service, always acting in the patient's best interests by providing advocacy, emotional and psychological support, information and practical advice. Every patient who comes to our unit is treated individually, with dignity and respect.

When patients are seen in our Breast Unit, what is most apparent is that a breast cancer diagnosis can be the beginning of a traumatic, anxiety provoking experience in a woman's life. Many women can feel quite isolated as they embark on their breast cancer journey because they may not wish to burden friends or family with their private fears or concerns. It is imperative that women with breast cancer are provided with ongoing psychological support at a time when they often feel a sense of isolation and are very vulnerable. Support from the clinical nurse specialist can significantly reduce psychological morbidity in women undergoing breast cancer surgery, and help them cope with the impact of the disease on their quality of life.

> I am passionate about my job; every day is different. I get a great deal of satisfaction helping my patients through what can be a very difficult time.

I trained as a nurse at the Royal City of Dublin Hospital. I came to London in late 1980s and worked as a senior staff nurse in operating theatres. I was promoted to junior sister and on completion of my theatre course to senior sister. I worked in all areas of theatre nursing for five years. I managed the operating theatre department for four years and eventually felt it was time for a change. After completing a BSc (Hons) in health studies I entered into the breast care nursing profession, and went on to further studies in counselling. I was lead clinical nurse specialist at the North London Breast Screening Unit for 10 years and finally, on leaving there, I went on to work at the Mount Vernon Cancer Centre to gain experience in oncology nursing; whilst there I completed a post graduate diploma in Breast Care at King's College Hospital, London.

I am passionate about my job; every day is different. I get a great deal of satisfaction helping my patients through what can be a very difficult time. Our Breast Unit at The Wellington uses state-of -the-art equipment and I am privileged to work alongside a team of top multi-professional clinicians, of who several have major international profiles, and who are experts in the field of breast care management.

The Breast Unit at The Wellington Hospital provides technologies with superior diagnostic capabilities used to diagnose and treat breast cancer. The centre provides innovative, integrated, high quality breast services to women in a caring and compassionate manner. Our guiding principle is to be a 'centre of excellence' and one that makes the patient's journey convenient and expedient through the use of a multidisciplinary approach for the treatment of breast disease.

Bernie will be hosting Practice Nurse's training workshops in The Wellington Hospital Boardroom, please call your GP Liaison Officer or the Enquiry Helpline on **020 7483 5148** to book a place.

Total Hip Replacement: Raising the Bar

Mr Paul Culpan discusses the contemporary approach to hip replacements…

Total hip replacement has been referred to as the operation of the 20th century, due to the dramatic change in quality of life patients come to expect following this procedure. Last year approximately seventy thousand total hip replacements were performed in the UK, with 90% of patients expressing satisfaction thanks to the resulting cure to their chronic pain and an associated improvement in their mobility and overall level of activity.

Despite undeniably impressive results, there are potential risks with such surgery and a range in the functional level patients experience as their final outcome. This may vary from a complication resulting in a hip that dislocates, to a patient that finds his leg lengths are not equal (either shorter or longer), or perhaps a patient who finds after walking for a distance they develop a limp or the hip feels tired.

So, why do some hip replacements have a better functional result than others?

To answer this we need to understand what has to be achieved by a hip replacement to provide the patient with the feeling of a normal hip, and resultant high level of function. This level of outcome can only be accomplished when the patient's normal anatomy has been exactly restored by the hip replacement. This involves more than just ensuring the leg lengths have been equalised, it is also dependent on accurately restoring the abductor arm (the transverse distance from the centre of the femoral head to the greater trochanter, into which the hip abductor muscles insert). If the length and the lateralisation of the hip abductor muscles are not precisely restored, the most important muscle group for normal walking cannot function optimally. The extent to which this impacts on the patient depends on how far it is from the patient's normal anatomy.

In order to correctly restore the patient's specific hip anatomy it first has to be clearly defined. Surprisingly, the current standard practice for assessing hip anatomy preoperatively is still a basic X-ray, which is notoriously inaccurate. Ironically, with the development of digital imaging, fewer surgeons currently perform any preoperative surgical templating. Morphological studies have demonstrated a considerable range in defining what is 'normal' and demonstrated how misleading a 'normal' hip X-ray can be.

The most reliable technique to define these anatomical parameters is with a CT scan, and with the application of specific software an exact surgical plan can be undertaken. This allows a precise surgical templating to be achieved; defining which combination of components will result in an accurate restoration of all anatomical parameters, and anticipation of any surgical challenges that may be encountered. This also identifies any anatomical outliers for which a custom made prosthesis would be beneficial.

Does the surgical approach matter?

The ideal surgical approach provides excellent visualisation and access to the joint, whilst causing the least amount of soft tissue damage possible. Such an approach facilitates the surgeon in aiming to implant the prostheses in the optimal orientation (which we know to be critical to the implants long term function and survival). Given the importance of the hip abductor muscle function, the optimal surgical approach preserves them, and this also leads to a faster post operative recovery and return to normal gait.

The two approaches that do not violate the hip abductors are the posterior approach and the direct anterior approach. Both approaches can provide an excellent exposure. The great appeal of the direct anterior approach is that, in addition to preserving hip abductors, it also preserves the short external rotators. It is therefore the most conservative approach used for hip replacement surgery, resulting in a rapid post operative recovery. It is also associated with a lower dislocation rate and therefore lessens the requirement for hip restrictions after surgery.

> If the length and the lateralisation of the hip abductor muscles are not accurately restored, the most important muscle group for normal walking cannot function optimally.

The final element is in implanting a prosthesis which will recreate all the anatomical parameters that have been quantified by the planning CT scan. As previously mentioned, the 'normal' hip anatomy has a considerable range over several parameters, and therefore a very limited range of size and shape options are offered in many hip systems, which results in some compromise. This great variability in anatomy can be addressed using a versatile modular system, with a predefined combination of components that will reliably and accurately reconstruct the patient's anatomy. In approximately 10% of cases, even this system does not offer an accurate reconstruction due to outlying anatomy; in these cases a custom made component is manufactured and no compromise is required.

This contemporary approach to hip replacement, focused on preserving and restoring the patient's anatomy, leads to a predictably high functional outcome and rapid postoperative recovery.

■ Mr Paul Culpan is a Hip Surgeon based at St Bartholomew's and the Royal London and at The Wellington Hospital.

Employing Cardiac MRI (CMR) in Adult Cardiology

■ **Profile: Dr Mark Westwood is a Consultant Cardiologist at The Wellington Hospital and The London Chest Hospital.**

Non-invasive imaging has always had a pivotal role in cardiology. The first cardiac MRI (CMR) assessments were performed in the 1980s, when the technique was time consuming and of limited use. Recent developments within the last five years have enabled CMR to become a rapid, reliable and accurate clinical tool, which is both well validated and calibrated, complementing other non-invasive tests for cardiac imaging. Images are readily obtainable in most patients in a 30 minute assessment. Cardiac MRI is safe and well tolerated by almost all patients. It also benefits from the lack of ionising radiation compared to PET, CT or nuclear imaging techniques.

Cardiac MRI is performed at the Platinum Medical Centre at The Wellington Hospital (including stress perfusion imaging).
For further information please contact the Enquiry Helpline on 020 7483 5148

Indications for CMR and clinical CMR service:

CMR has a valuable and unique role in many areas of adult cardiology.

This includes assessment of:

- Ventricular function
- Ischaemic heart disease (including myocardial viability and ischaemia)
- Cardiomyopathy
- Cardiac tumours and masses (including ventricular thrombus) and pericardial diseases

It has also transformed the evaluation of congenital heart disease.

CMR is now widely accepted as the 'gold standard' for the assessment of global and regional left and right ventricular function. Due to the lack of ionising radiation, multiple serial CMR assessments are possible to monitor small changes in ventricular function over time. An example of this would be the ability to assess ventricular function over time, during administration of cardiotoxic chemotherapy.

> In the assessment of ischaemic heart disease it can reliably image myocardial infarction, particularly small subendocardial myocardial infarctions, which can be missed with other modalities.

It is non-inferior to PET imaging for the assessment of myocardial viability. It is non-inferior, and possibly superior to nuclear perfusion imaging for the assessment of myocardial ischaemia. Ventricular function, myocardial viability and ischaemia can all be assessed within a single 'one stop' CMR assessment, making it a perfect technique in this setting.

This makes CMR ideal for the assessment of new onset chest pain, which can be challenging. Sudden onset chest pain is stressful for patients, with the potential sequelae of the diagnosis of significant coronary artery disease and the resultant consequences. It is important to reach the correct diagnosis rapidly, and not to miss a presentation of potentially significant coronary artery disease. Invasive coronary angiography, the gold standard for the detection of coronary artery disease, provides anatomical rather than a functional assessment of coronary artery disease.

It has a small but significant risk of important complications, hence the need for non invasive functional testing, which has now virtually replaced routine treadmill exercise testing in patients with chest pain. Although patients with a low risk factor profile will generally require a CT coronary angiogram, the majority of patients usually present with a slightly higher risk, requiring functional non invasive cardiac imaging. CMR for the reasons outlined above is an excellent, reliable and reproducible test for this purpose.

Our knowledge and understanding of cardiomyopathy has changed significantly with the use of CMR, particularly to detect patterns of focal myocardial fibrosis. Assessment with CMR is now considered essential in hypertrophic cardiomyopathy, dilated cardiomyopathy and arrhythmogenic right ventricular cardiomyopathy, both for initial diagnosis and for risk stratification and monitoring. It is also useful in the assessment of myocarditis both in the acute and chronic setting; drug induced cardiac toxicity, cardiac amyloidosis and cardiac sarcoidosis.

Mr Howard Ware looks at common complaints in runners at the height of their marathon training and treatments for these troublesome conditions…

Marathon Man

■ Mr Howard Ware is a Consultant Orthopaedic Surgeon at The Wellington Knee Unit and Chase Farm Hospital.

During the spring and summer, when the marathon season is in full swing, the numbers of runners we see with problems with one or both knees increases.

As far as the knees are concerned, running is a safe sport; there is no evidence to suggest that running damages the knee joint. However, if there is an underlying problem, such as osteoarthritis, then running can aggravate it and cause the joint to deteriorate faster than normal.

OVERUSE

Most of the problems we see are essentially 'overuse'; a muscle or tendon has been strained and becomes inflamed - causing pain. In many cases this will respond to simple therapy, and if rest and ice doesn't work then anti-inflammatories can be used to calm things down, and physiotherapy is of course very helpful in resolving the problem in many cases too.

A common complaint seen in runners relates to the iliotibial band. As it runs down the side of the leg to its attachment below the knee, it can become inflamed as it rubs on the adjacent structures, causing pain and tenderness in the area. In severe cases an MRI or ultrasound will diagnose this and treatment is often followed by a referral to a physiotherapist. In cases where this is ineffective, an ultrasound guided steroid injection is tried. This is a safe treatment option, with no significant side effects, and as the radiologist is able to image the site of pain clearly – the results can be very swift.

ANTERIOR KNEE PAIN

Anterior knee pain is another common soft tissue complaint seen in runners. This can be due to a problem with any one of the several structures at the front of the knee. Pain may be due to inflammation or overuse of the tendons, but more commonly in the patella tendon and occasionally the quadriceps tendon.

The area most commonly affected in the patella tendon is typically due to inflammation of the attachment of the tendon (on the inferior pole of the patella tendon). Pain is felt at the lower part of the tip of the patella and the area is often tender. In most cases the pain comes on when exercising, but is fine during other normal activities. Again, a MRI or ultrasound is useful in making the diagnosis. The treatment is similar to iliotibial band syndrome and in this case physiotherapy, as well as a careful review of the runner's biomechanics and shoe wear, can be helpful. This can be a very difficult problem to resolve and in some cases the marathon training may have to be abandoned.

One cause of anterior knee pain, that we now recognise more due to better quality MRI machines, is fat pad impingement syndrome. Just behind the patella tendon is a large expanse of fat; also described as Hoffa's fat pad. In these cases the MRI demonstrates an area of inflammation in the fat, usually the antelateral pad, which is at the site of the pain. An ultrasound guided steroid injection can often cure the problem and if it recurs this can be repeated.

Problems in the patella can also cause anterior knee pain; this can be due to underlying wear of the articular cartilage or maltracking of the patella. Typically the pain is worse going up a slope or stairs. After a diagnosis with MRI physiotherapy typically follows, and in severe cases surgery can be performed, but where possible this is best avoided.

LIGAMENT INJURIES

Running like any sport can also produce injuries to the meniscus or the ligaments. Invariably ligaments are damaged following a significant injury, such as a bad fall, and not due to training itself.

Sometimes patients present with a swollen knee, and little in the way of other symptoms. In most cases this is the result of some irritation of the joint, resulting in a diffuse inflammatory reaction and not of an underlying disease. Some people develop recurrent swelling, or effusions, with no obvious underlying cause. Typically they are hypermobile, with an ability to extend the knee beyond a 'normal' range. Little can be done apart from taking an anti-inflammatory to calm the knee down, and occasionally the fluid may have to be aspirated. Sometimes there is a significant condition which needs treatment, like a rheumatoid disease, but in general this is very rare.

MENISCUS TEARS

The meniscus can be injured as a result of running or training. Invariably this means that the knee has been twisted catching the meniscus, usually the medial between the femur and tibia, and tearing it. As we age the meniscus becomes more brittle: the collagen molecules lose their ability to retain water molecules, and are thus more susceptible to a tear. If the tear is small and relatively painless while training, then it may be possible to carry on. If the pain is compromising the training, or the symptoms are more mechanical involving locking or giving way, then surgery may be required. This involves a minimum recovery of six weeks before returning to training.

THE AGE FACTOR

In younger people, where the bone is still growing, one of the growth centres may be affected -causing pain. The commonest is where the patella tendon attaches onto the front of the tibia: the tibia tuberosity. This growth centre can produce pain with activity, typically in the early teenage years. The area is tender and often lumpier than the other knee; occasionally both knees are affected. If rest and rehabilitation are ineffective then there is nothing that can be done. There is no harm continuing with exercise, but it is painful and many people have to temporarily give up running. In most cases the pain settles when skeletal growth ends, but in a small number the problem persists in adult life.

BONE OEDEMA

Running, or indeed any exercise, can cause phenomena called 'bone oedema'. Any one, or more, of the three bones that form the joint can be affected. The symptoms vary from severe pain to a dull ache. MRI images show that the bone is very inflamed. We do not clearly understand why this develops in normal knees. It can be extremely painful, even if the area involved is quite small, and the pain is often continuous even at rest. This can mean that training has to stop completely and it can take several weeks to settle. Occasionally, if regular analgesics are ineffective, other drugs such as bisphonanates are injected intravenously.

OTHER CONSIDERATIONS

Of course, the pain may not be due to a problem in the knee itself. Osteoarthritic hips can sometimes present with pain just in the knee on the same side, with no symptoms in the hip at all. However, adolescent runners may also have a developmental problem in the hip such as a slipped epiphysis or perthes disease. While arthritis is something we would expect to see in older runners, it is very important to examine the hip in all patients who present with a painful knee. Problems with the spinal column may also cause referred pain in the knee, although typically this presents with a radiating pattern of pain passing down the leg, and is less commonly only localised in the knee itself.

In general many conditions will settle with rest, ice, and time. If there has been a clear injury then further assessment by a specialist knee surgeon is advisable and an MRI essential.

To make an appointment, please call the Enquiry Helpline on **020 7483 5008**; The Wellington Knee Unit now offers a same day referral service.

Capital Neurosurgeons at The Wellington Hospital

The Wellington Hospital was the first private hospital in the United Kingdom to establish a comprehensive, self-contained Neurosurgical Unit. Since its inception in 1990, the unit has continued to develop its facilities and is now widely regarded as the country's leading private neurosurgical service.

Expertise

Capital Neurosurgeons are a group of nine of London's leading neurosurgeons; together they provide a dynamic and expert service for all neurosurgical conditions.

Each consultant has worked at The Wellington Hospital extensively; developing this progressive and prestigious unit, whilst also part of senior teams at nearby teaching hospitals.

These highly skilled consultants deal with the full range of adult neurosurgical disorders including tumours of the brain, cranial nerves, spinal cord and spinal column; degenerative disease of the spine including nerve compression; vascular conditions such as cerebral aneurysms and arteriovascular malformations; and traumatic damage to the brain, cranium and spine.

Support

The Wellington Hospital is well facilitated for neurosurgical care, being home to one of the largest imaging departments in the country, and utilising some of the most state-of-the-art technology and imaging equipment available.

The Capital Neurosurgeons group is also supported by an award-winning Intensive Care Unit, the UK's largest private Neurological Rehabilitation Unit and specialist nursing and theatre teams, ensuring all patients receive the very best in healthcare.

Specialties

The Capital Neurosurgeons group treats a number of conditions, from the common to the complex, these include:

- Neuro – oncology
- Skull base surgery
- Stereotaxis and Neuronavigation
- Raised Intracranial Pressure
- Hydrocephalus
- Head Injuries
- Brain Tumours
- Subarachnoid Haemorrhage
- Spinal Surgery including disc replacement, fusion, discectomy and kyphoplasty among other procedures
- Degenerative Spinal Disorders
- Spinal Tumours
- Stroke
- Gamma Knife

OUR SPECIALIST CONSULTANTS:

Mr Robert Bradford
Special Interests: Skull Base Surgery (including Acoustic Neuroma), Brain Tumours, Stereotactic Neurosurgery, Spinal Surgery
NHS Hospital: The Royal Free Hospital & the National Hospital for Neurology & Neurosurgery

Mr David Choi
Special Interests: Spinal surgery, Complex spine operations for tumours, Degenerative disease, Trauma and Infection. Skull Base tumours, Craniocervical junction, Endoscopic approaches, Transoral Surgery, Arthroplasty and Spinal Fusion
NHS Hospital: The National Hospital for Neurology & Neurosurgery

Mr Neil Dorward
Special Interests: Spinal Surgery (including Cervical Disc Replacement & minimally invasive Spinal Fusion techniques), General Neurosurgery such as Brain Tumours, Image-Guided and Stereotactic Neurosurgery, Pituitary Tumours (Endoscopic Surgery & extended Endoscopic Skull Base procedures)
NHS Hospital: The Royal Free Hospital & National Hospital for Neurology & Neurosurgery

Mr Andrew Elsmore
Special Interests: Neuro-oncology (brain tumour), Gamma Knife Radiosurgery NHS Hospital: Barts and The London NHS Trust

Mr Neil Kitchen
Special Interests: Intracranial Microneurosurgery
NHS Hospital: The National Hospital for Neurology & Neurosurgery

Mr Andrew McEvoy
Special Interests: Brain Tumours, Cervical and Lumbar Spine, Epilepsy Surgery, Peripheral Nerve Surgery, Hydrocephalus, Head Injury, Brain Haemorrhage, Trigeminal Neuralgia and Gamma Knife
NHS Hospital: The National Hospital for Neurology & Neurosurgery

Mr Ian Sabin
Special Interests: Skull Base Surgery (including Acoustic Neuromas, Pituitary Tumours and Trigeminal Neuralgia), Spinal Surgery (including Complex Cervical Spine), Gamma Knife Radiosurgery, Image Guided Neurosurgery
NHS National Hospital: St Bartholomew's Hospital and The National Hospital for Neurology and Neurosurgery

Mr Lewis Thorne
Special Interests: Brain Tumours, Head Injury, Awake Surgery, Skull Base Surgery, Spinal Surgery, Hydrocephalus, and Facial Pain
NHS Hospital: The Royal Free Hospital and the National Hospital for Neurology & Neurosurgery

Mr Mark Wilson
Special Interests: acute brain injury (including traumatic brain injury) and its very early management
NHS Hospital: Imperial College Healthcare Trust

Dr Paul Mulholland, Medical Oncologist
Specialist Interests: Brain cancer, chemotherapy, new agents
NHS Hospital: The National Hospital for Neurology and Neurosurgery

Capital Neurosurgeons

Expertise and innovation in one dynamic group

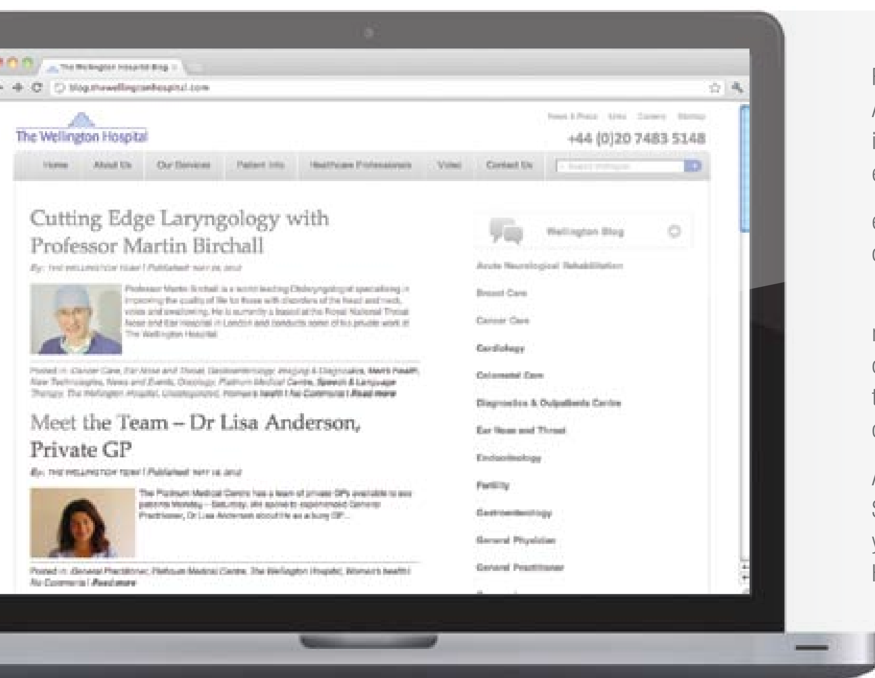
Widely regarded as the country's leading private neurosurgical service, Capital Neurosurgeons offer your patients clinical expertise and the latest treatments, supported by award-winning critical care units and an internationally accredited Acute Neurological Rehabilitation Unit.

For more information, or to arrange an appointment please call the Enquiry Helpline on **020 7483 5148**.

The Wellington Hospital is dedicated to supporting GPs…

Signed, sealed, delivered.

As the internet has become more readily available on our phones and other devices, reading has progressively moved online. We can now read anything we like, any where we like. Following your feedback in 2011, a large percentage of our readers wanted to be able to read Practice Matters online too. Not wanting to disappoint – we will be introducing our first electronic version next issue, but don't worry – for those who enjoy the printed version, this will still be available.



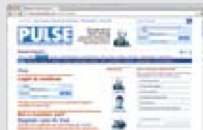
For those who wish to receive the new electronic edition, please email or call us. All we'll need is your name, your surgery and the address that Practice Matters is usually sent out to. However, if you wish to receive both the printed and electronic versions, that's fine too, just let us know.

email: **claire.allen@hcahealthcare.co.uk**
or telephone: 020 7483 5109

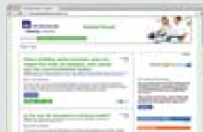
Every quarter we will email your fresh copy straight to your inbox: no pesky mailing delays, no misplacing it, or spilling your well-deserved morning coffee on it, just there in your inbox when ever you want to read it. We wouldn't want to spoil all the surprises that new electronic edition will have in store, but we are certain you'll love what we have up our sleeves.

At Practice Matters we encourage intelligent, interesting and engaging writing. So to support more online reading we thought we'd share some of our finds with you. Some display pure medical savvy, others cool wit; we hear The Wellington Hospital blog is pretty good too: **blog.thewellingtonhospital.com**

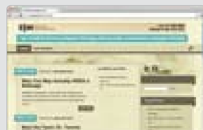
- **Wellcome Trust Blog: www.wellcometrust.wordpress.com**
  "This blog is about science and biomedicine, their crossover with arts and history, and the many other activities related to the work of the Wellcome Trust".



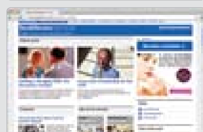
- **www.pulsetoday.co.uk/comment-blogs**
  Available through the Pulse website, this is great if you want to read multiple blogs all on one website. With the choice of 13 different writers, there is something to satisfy every GP's interest. Copperfield's wryness is a personal favourite.



- **AXA PPP: www.axappphealthcareblog.co.uk**
  A good all-rounder, they also hold regular web discussions, and live chats with medical experts.



- **Spine and Sports NYC: spinesportsnyc.com**
  Our website expert Jaci says they are very friendly on Twitter too, if you have any questions.



- **The healthcare network: www.guardian.co.uk/healthcare-network**
  A wonderful mixture of interviews, health politics and the latest reports and news. There is a lively community of followers to this network – so comments are always intriguing too.

Let us know if you recommend any other blogs or websites that you find particularly interesting, or perhaps you write your own? We'd love to hear from you.

MAKING A DIFFERENCE...

Our GP Liaison Officers highlight some of our specially designed education events for GPs and their practices.

Are you making the most of our free educational seminars and workshops on offer to you and your practice?

The GP Liaison team here at The Wellington are continually updating our approach to educational events – aiming to help our GPs access our services more easily. We have spoken to GPs, practice managers, clinical and non-clinical staff to establish what is useful to you, and what makes a difference to your practice. The question is – are you making the most of what is on offer?

> **"THE WELLINGTON HAS BEEN VERY RESPONSIVE IN SUPPORTING OUR EDUCATIONAL AFTERNOONS AT THE SURGERY. THEY HAVE PROVIDED A RANGE OF CONSULTANT SPEAKERS, WHO HAVE TAILORED MATERIAL RELEVANT TO A GP PRACTICE, AND HAVE BEEN ENGAGING FOR OUR CLINICIANS TO PARTICIPATE IN."**
>
> **MR DAVID WILLIAMS, ADELAIDE MEDICAL CENTRE, NW3**

The Wellington Hospital provides educational support for medical professionals in many areas, including:

- Basic Life Support: As recently highlighted by the successful resuscitation of a premier league footballer– teaching and maintaining BLS skills can improve outcomes and save lives. Our training sessions, which are supported by our cardiac consultants, are open to all medical professionals and are held monthly in our boardroom (South Building). We can also offer on-site training to our referring GPs.
- Following the success of our monthly 'Practical Spirometry' talks and workshops for practice nurses and HCAs, Damian Muncaster, our Clinical Respiratory Physiologist at the Lung Function Lab is now available for practice visits. If you would like to arrange a workshop at your practice to include spirometry training and analysis of results – or to discuss the full range of basic and complex lung function tests, we would be very happy to arrange this for you.
- The Practice based talks, seminars and workshops we organise are tailored to suit your practice needs; provide you with the opportunity to update your knowledge of relative health issues and build relationships with our leading consultants. Whether you choose to have these educational sessions at breakfast, lunchtime or during the evening; these can be arranged at your convenience.
- Alternatively, you may wish for your GP Liaison Officer to organise practice 'away-time', visit The Wellington Hospital and tour the facilities, meet and greet consultants or have a specially tailored educational session in our boardroom.

(Free catering and certificates for the purpose of CPD are provided for all attendees).

Individually, GP Liaison officers organise many events in their dedicated areas; we are currently working with commissioning groups, their GPs and practice managers, in addition to practice patient groups and nursing groups assisting with sponsorship and organising their educational needs.

Please call us – we can be of assistance and make a difference for you and your patients too.

OUR FORTHCOMING EVENTS INCLUDE:

- A Practice Managers Mini Symposium; topics to include Employment Law, Medical/Legal Aspects of Running Your Practice and related CQC requirements.
- Consultant led talks for GPs are held monthly at TWH Boardroom and WDOC
- A programme of educational seminars for the North London, Bedfordshire, Hertfordshire & Buckinghamshire areas.

Consultant Led Talks

The GP Liaison team offer referring medical staff a menu of talks in addition to The Wellington's existing event schedule. Breakfast, Lunchtimes or Evening talks are available and can be held either in our boardroom or at your own practice. To arrange a talk call The Wellington Enquiry Helpline or visit the Medical Professionals section on The Wellington Hospital website at **www.thewellingtonhospital.com**

Consultant Led Talks For the full listing, please go to: **www.thewellingtonhospital.com/Healthcare-Professionals-Talks.aspx**	B	L	E
ALLERGY			
Dr H Kariyawasam		■	■
CARDIOLOGY			
Dr A Ghuran	■		
Dr A Chow	■	■	■
COLORECTAL & GEN SURGERY			
Mr J Wilson	■	■	■
Mr K Moorthy		■	■
DERMATOLOGY			
Dr S Mansoor		■	
ENT			
Prof S Saeed	■	■	■
GASTROENTEROLOGY			
Dr B Prasad	■		■
Dr D Suri	■	■	
GENERAL MEDICINE			
Dr A Qureshi	■	■	■
LIVER			
Mr G Fusai	■	■	
NEPHROLOGY			
Dr M Wahba		■	
Prof A Warrens		■	
NEUROLOGY			
Dr D Heaney	■	■	■
OPHTHALMOLOGY:			
Dr H Zambarakji	■	■	■
ORTHOPAEDICS:			
Mr W Aston (Hip and Knee)			■
Mr R Carrington (Hip and Knee)			■
Mr M Herron (Foot and Ankle)			■
Prof E Schilders (Hip)			■
Mr N Toft (Hand and Wrist)			■
PLASTICS			
Mr N Toft		■	■
RESPIRATORY			
Dr M Beckles	■		
Dr B O'Connor	■		■
SPORTS MEDICINE			
Dr C Speed			■
UROLOGY			
Mr T Lane	■		
Mr A Kaisary	■		
VASCULAR			
Mr H Flora	■	■	
Mr T Hussain	■	■	

■ B = breakfast L = lunchtime E = evening

To take advantage of these talks: choose a consultant, pick a time & we'll bring these talks to your surgery. Email our GP Liaison Officers or call The Enquiry Helpline to book.

NURSES CORNER

Practice Matters caught up with Ursula Stiemert, Centre Manager at the Wellington Diagnostics and Outpatients Centre (WDOC) in Golders Green. Ursula is well-known for her positive attitude and infectious friendliness. Claire Allen talked to her about her role and the exciting developments happening at the centre…

PM: Tell us about your busy role as centre Manager?

US: Day-to-day I provide clinical and administrative input, management and operational direction to provide a first-class service for the Wellington Diagnostics and Outpatients Centre users, including patients, consultants and staff.

Although my role is mostly administrative, I do get the chance to perform clinical duties with the nurses (phlebotomy, dressings, ECGs etc.) I really value this, as I get to have a chat with our patients and they clearly enjoy having management look after them as well.

I work closely with other multi disciplinary teams from The Wellington Hospital and the Platinum Medical Centre in St. Johns Wood, so I'm always up-to-date with the latest developments and always finding new ways to improve healthcare for our patients visiting the centre in Golders Green.

PM: You were a nurse before coming to WDOC, what did you specialise in?

US: I trained as a midwife and a theatre nurse, and remained working in theatres for nearly 20 years before I came to the UK. Not wanting to end my career in theatres, I chose to look for a job in a totally different area of healthcare and was lucky enough to be offered a managerial role in the outpatients department at The Wellington Hospital. From this I was promoted to centre manager here at the Wellington Diagnostics Centre in Golders Green, in 2007.

PM: You are someone who clearly enjoys your job, but what do you enjoy the most?

US: I get to work with people who are always in need of care and advice. That I can give this to them is very rewarding and makes my job a pleasure to do.

I also have a very enthusiastic nursing team who make my life much easier, and I am able to rely on them 100%, especially when under pressure.

PM: Tell us something about WDOC that we might not know:

US: Well, this May the centre celebrates its 5th Birthday, and five years of providing excellent health care services to the North West London community.

After five successful years we have expanded to the first floor, which now includes an additional nine consulting rooms, a minor operating theatre (for X-ray guided injections under local anaesthetic or sedation) with a two bed recovery area and a mammography suite, and we will be launching the pain management and breast screening service very soon. We have also recently joined forces with The Lister Fertility Clinic to provide local outreach facilities for IVF treatment.

PM: If you weren't Centre Manager, what would you be?

US: I am fascinated by ancient history and the deep blue sea, so quite possibly an archaeologist or a marine biologist….

EVENTS DIARY

Educational events for the next three months are outlined below. For further information and booking please visit the medical professionals section of the website.
www.wellingtonevents.co.uk

23.05
Clinical Vignettes for The Wellington Acute Admissions Unit – Lords Cricket Ground, Grace Gate

07.06
GP Seminar, Bariatrics, Dr Shidrawi & Mr Mannur, The Wellington Boardroom, South Building

13.06
GP Seminar, IVF, Mr Liberman – WDOC Golders Green

16.06
Orthopaedic Masterclass, Mr Moyes, Mr Haddo & Mr Sforza – Lords Cricket Ground, North Gate

20.06
GI New Unit Launch – Lords Cricket Ground, Grace Gate

04.07
London Orthopaedics Clinic Networking Evening – WDOC Golders Green

05.07
GP Seminar, Respiratory Unit – The Wellington Boardroom, South Building Malcolm Percy

As always, there will be no educational seminars in August. Seminars will resume on Thursday 6th September, with our monthly GP seminar at The Wellington Hospital Boardroom.

Please remember that we can arrange consultant talks at your practice: you choose the consultant, the topic and the date and the GP Liaison team will organise the rest, including lunch. Call **020 7483 5148** if you would like book a date in the diary.

NEW CONSULTANTS

Dr Andrew Archbold Consultant Cardiologist, Barts and the London NHS Trust

Dr Salim Janmohamed Consultant Endocrinologist, Royal Free Hospital

Thomas Setchell Consultant Gynaecologist, St Mary's Hospital

Professor Paul Ellis Consultant Medical Oncologist, Guy's and St Thomas' NHS Trust

Dr David Miles Consultant Medical Oncologist, Mount Vernon Hospital

Dr Peter Harper Consultant Medical Oncologist

Dr Rohit Lal Consultant Medical Oncologist, Guy's and St Thomas' NHS Trust

Dr Jonathan Shamash Consultant Medical Oncologist, Barts and the London NHS Trust

Dr Sarah Slater Consultant Medical Oncologist, Barts and the London NHS Trust

Dr Maurice Slevin Consultant Medical Oncologist, Barts and the London NHS Trust

Professor Amanda Ramirez, Consultant Psychiatrist for oncology patients – Kings College

Dr Michael Cavendish Private GP

Dr John Pasi Consultant Haematologist, Barts and the London NHS Trust

Mr Murid Chaudary Consultant Breast Surgeon, Private, previously West Herts NHS Trust

Miss Bareen Shah Consultant General Surgeon, Ealing Hospital

Mr Branavan Sivakumar Plastic and Reconstructive Surgeon, The Royal Free & GOS

Mr Sudhanshu Chitale Consultant Urologist, The Whittington Hospital