GP News

Autumn 2017

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Wollongong Private Hospital
Part of Ramsay Health Care

Lawrence Hargrave Private Hospital
Part of Ramsay Health Care

Figtree Private Hospital
Part of Ramsay Health Care

Wollongong Private Hospital
360 – 364 Crown Street
Wollongong NSW 2500
wollongongprivate.com.au

Lawrence Hargrave Private Hospital
72 Phillip Street
Thirroul NSW 2515
lawrencehargraveprivate.com.au

Figtree Private Hospital
1 Suttor Place
Figtree NSW 2525
figtreeprivate.com.au

From the **CEO's Desk**

David Crowe, CEO Wollongong Private Hospital

On 18 January 2017, Wollongong Private Hospital celebrated its first birthday. In our first year of operation the hospital admitted 15,000 patients, performed almost 14,000 surgeries and delivered over 950 babies. Patient numbers continue to grow.

At the end of 2016 Wollongong Private Hospital commenced using the Mazor Renaissance Robot for Neurosurgery. This is piece of equipment is the gold standard in neurosurgery and will improve patient outcomes with increased accuracy in pedicle screw placement for spinal surgery. This along with a higher level Intensive Care Unit has allowed for an increased in the number of complex neurosurgical cases being performed at WGPH.

We have also seen an increase in the number of Orthopaedic and General Surgical cases since moving across from Figtree Private Hospital 12 months ago.

Our new services of Interventional Cardiology and Day Oncology continue to grow and assist our patients to be able to stay in the Illawarra. We still continue to plan to commence Cardiothoracic Surgery within the next 6 months.

I'd like to take this opportunity to thank you all for your support during our first 12 months. We are always open to feedback and would like to hear from you if you think we could make improvements to our service.

Paul McKenna, CEO Figtree Private Hospital

Last year, following an extensive redevelopment, Figtree Private Hospital was unveiled as a rehabilitation facility providing a solid range of inpatient programs, medical care and sleep study assessments. Referrals have been growing steadily since the facility's reopening and I'd like to thank you for giving Figtree Private Hospital the opportunity to care for your patients.

In 2017, the hospital will continue to evolve through further expansion of its rehabilitation program offering to benefit a broader group of patients, commencing with the introduction of Cardiac day programs in the coming months. Lastly, the hospital will shortly undergo further renovations in preparation to introduce an innovative hospital service to the region – more news to come in the next few months.

As always, I encourage you to contact the hospital with any feedback you may have regarding our services, patient care or hospital processes.

Robyn Ashe, CEO Lawrence Hargrave Private Hospital

Welcome to another edition of GP News. Lawrence Hargrave Private Hospital continues to provide a quality rehabilitation service to patients from all areas of the Illawarra. We have availability of inpatient, day patient and outpatient services with access to facilities including the region's largest hydrotherapy pool.

In October 2016, the hospital commenced a new neurological day program suitable for patients who have been affected by stroke, brain or spinal cord injury; undergone spinal surgery and neurosurgical interventions; or suffer from a chronic condition such as MS or Parkinson's disease. The newly developed program focuses on enabling patients to regain functional abilities and independence in the community.

For your senior patients, we offer a 6 week falls prevention and active aging program with emphasis on strengthening and conditioning, promoting independence and cognitive retraining. Many participants have been so impressed they have asked to attend on multiple occasions.

Remember you can refer your patients directly to any of our rehabilitation programs including our individual and group based hydrotherapy programs. If you would like to discuss your patient's suitability for any of our rehabilitation programs, please do not hesitate to contact the hospital for a discussion.

Production and Content:
This publication is produced and distributed by the Wollongong Private Hospital Marketing team.

If you do not wish to receive this newsletter or other marketing materials from Ramsay Health Care, please contact the Marketing Department.

FOR CONTENT SUBMISSIONS AND FEEDBACK PLEASE CONTACT:
Rachel Zerner – Marketing & Communications Manager
P: 0438 912 211 | E: ZernerR@ramsayhealth.com.au

FOR GP LIAISON ENQUIRIES PLEASE CONTACT:
Kelly Garvey – GP Liaison Officer
P: 0439 070 220 | E: GarveyK@ramsayhealth.com.au

CALL: 0427 621 661
24 HOURS A DAY / 7 DAYS A WEEK

NEW
Ezi Access GP Direct Patient Admission Hotline

One Number, Three Private Hospitals to choose from

If your patient requires hospitalisation for medical care or rehabilitation, our Operational Managers are available now to facilitate a direct admission at one of Ramsay Health Care's three premier Illawarra facilities.

When you call the dedicated GP direct admission number, our Operational Manager will:

- Discuss suitability of the patient referral
- Refer your patient to a suitable VMO
- Locate bed availability at either Wollongong, Figtree or Lawrence Hargrave Private Hospitals
- Conduct patient health fund check and provide estimate of expenses to the patient
- Facilitate a comprehensive clinical handover

Which patients are eligible for Ezi Access Direct Admission?

- Management of diabetes
- Anaemia for investigation
- Mild heart failure
- Mild renal impairment (GFP>50)
- Cellulitis
- Pneumonia
- Exacerbation of COPD
- Pain management
- Inpatient rehabilitation

What patient information do I need to provide when calling?

- Full name
- Date of Birth
- Health fund details
- DVA details
- Provisional diagnosis
- Past medical history
- Medications

T: 0427 621 661 – 24 hours a day / 7 days a week

GP Ezi Access

REMEMBER, IN AN EMERGENCY DIAL 000

Electronic Discharge Summaries

If your patient has been admitted and discharged from any of our facilities in the Illawarra, your practice will automatically receive an Electronic Discharge Summary (EDS) from the hospital. To assist you with providing care to your patients post-admission, the EDS will detail your patient's principle diagnosis, principle procedure, tests and investigations ordered, where you can find test results, medications list and recommendations for follow-up appointments.

Please remember, our discharge summaries are compiled by nursing staff. If you require further detail regarding your patient, we recommend you contact the admitting specialist for more information.

If your practice is not receiving Electronic Discharge Summaries, or if you would like to provide feedback on our EDS service, please contact Kelly Garvey on 0439 070 220 to discuss.

Introducing Prudence Buist Director of Clinical Services

Wollongong Private Hospital is pleased to welcome Prudence Buist to the position of Director of Clinical Services. Prue brings a wealth of experience to the Executive team having held prior executive and management positions at a number of private hospitals in Australia and New Zealand. Prue is a Registered Nurse with Post Graduate qualifications in Finance and Health Service Management.

Robotic Spinal Surgery now available at Wollongong Private Hospital

Wollongong Private Hospital is pleased to announce the Hospital has recently acquired the Mazor Robotics Renaissance Guidance System for Spinal Surgery. As one of only two hospitals in NSW offering Mazor Robotic System, Wollongong Private Hospital delivers world leading technology, right here in the Illawarra.

What is the Mazor Robotic Renaissance System?

If your patient presents with a spinal condition such as chronic lower back pain, broken vertebra, spinal deformity, spinal weakness or spinal instability, they may be a candidate for spinal surgery with the Mazor Robotic Guidance System.

With guidance from the robotic system, surgeons are able to pre-plan spinal surgery using 3D imaging software, providing surgeons with a unique patient surgical blue print. During the procedure, the robotic system attaches to patient's spine and guides the surgeon's tools in accordance with the surgical blueprint, to place implants safely and accurately using minimally invasive techniques.

Benefits of Robotic Spinal Surgery

Surgical treatment of the spine requires planning and precision, and each patient's anatomy has unique challenges. Surgery with Mazor Robotics Renaissance provides increased safety and precision and in some cases, allows for minimally invasive surgery. Clinical research has shown that benefits to patients can include:

- Fewer surgical complications
- Reduced postoperative pain
- Faster recovery and return to daily activities
- Fewer intraoperative x-rays resulting in reduced radiation exposure

Which VMOs can perform surgery with the Mazor Robot?

All Neurosurgeons accredited at Wollongong Private Hospital have access to this new technology at the hospital. Please refer your patient to any of the following specialists who can investigate your patient's condition further:

Dr Ravi K. Cherukuri
Ph: 02 4210 7870

Dr Jerry Day
Ph: 02 4229 2255

Dr Matthais Jaeger
Ph: 02 4227 4363

Dr Peter Moloney
Ph: 02 4228 0460

Diverticular Disease

A common condition which occurs due to the ageing of muscles that make up the wall of the large bowel.

- Diverticular disease is extremely common
- Almost 2/3 of patients over 65 have diverticular disease
- Slight female predominance
- Most common location in developed countries is sigmoid
- Right sided diverticular disease common in Asian populations
- 80% asymptomatic and detected on colonoscopy or imaging (CT)

Causes

The true cause of diverticular disease is not known. There are a number of theories, all with weak evidence to support them. The combination of them all, rather than alone, is most likely responsible for the development of diverticular disease.

Low dietary fibre

The theory behind low fibre in the development of diverticular disease is probably the most widely known, but not necessarily accepted. Low levels of dietary fibre result in lower colonic transit times and firmer stool, resulting in the colon generating higher pressures to propel and expel stool, in turn leading to the formation of diverticular disease in the high pressure sigmoid colon. This theory has not been supported in randomised controlled trials to date.

Structural abnormalities in the colonic wall

This theory advocates that the wall of the colon changes with age, with the thickening of the smooth muscle layer of the colonic wall due to deposition of elastin and weaker collagen types, resulting in weakening and diverticular formation. In addition, the motility of the colon decreases with age due to degeneration of the neutrons regulating motility within the wall.

Once established diverticular disease occurs, only 25-30% of patients will develop symptoms, including diverticulitis or its complications (obstruction, perforation and bleeding). Approximately one third of these patients will have recurrent attacks, and less than 10% will have a recurrence of complications of diverticulitis. What this means is that only a very small proportion of patients will have significant problems related to diverticulitis after an initial attack. There is weak evidence to support a high fibre diet in reducing attacks of diverticulitis. Smoking and obesity may increase the risk of diverticulitis.

High resolution contrast CT scan remains the most sensitive modality in diagnosing acute diverticulitis and its complications. Colonoscopy does not have a role in the acute setting, other than for very selected cases of diverticular bleeding.

Treatment

1. Uncomplicated diverticulitis (ie. no perforation or obstruction) – broad spectrum antibiotics for 7-10 days along with diet modification to reduce fibre intake in the acute phase.
2. Complicated diverticulitis – perforation and obstruction require surgical intervention, which may be performed by laparoscopic techniques in certain instances. A non-operative approach may sometimes be adopted in cases of perforation in a clinically well patient. Localised perforation with abscess formation may be managed conservatively, radiologically or surgically.
3. Diverticular bleeding – the majority of patients will settle down with no intervention required. A small proportion of patients may require radiological, endoscopic or surgical intervention to control problematic bleeding.

Conclusion

Diverticular disease is common in Western countries and asymptomatic in the majority of patients. The exact mechanism leading to diverticular formation is unclear, although low fibre diets and age related changes in the wall of the colon may play a major role. Approximately one quarter of patients with diverticular disease will develop symptoms of diverticulitis or its complications (perforations, obstruction, bleeding). The incidence of repeated attacks or complications is quite low. Patients should be counselled to ensure they have a high fibre diet, plenty of physical exercise and to cease smoking to ensure a healthy lifestyle and minimise the risk of diverticulitis and its complications. Patients should have endoscopic examinations of their colon by way of colonoscopy following an initial attack of diverticulitis, to exclude any other inflammatory or neoplastic pathologies.

Dr Murtaza Jamnagerwalla
Colorectal Surgeon
30 Osbourne Street,
Wollongong
NSW 2500

P: 02 **4228 1088**
F: 02 4227 3004

Newly Accredited **VMOs**

The opening of Wollongong Private Hospital and the redevelopment of Figtree Private Hospital to a rehabilitation facility has attracted many new specialists to the Illawarra. Below are just a few of the newly accredited specialists now providing care to patients at our hospitals.

Dr Simon Winder Obstetrics & Gynaecology **Ph: 4226 6007**

Dr Winder provides a range of Obstetric services including pregnancy planning, early pregnancy management (miscarriages and terminations) antenatal, labour and postpartum care, cervical screening, contraception, management of menstrual disorders, menorrhagia, menopause, incontinence, diagnostic and minor laparoscopic procedures.

Dr Matthew Threadgate Urology **Ph: 1300 247 008**

Dr Threadgate has recently opened his independent private practice in Wollongong, Matthew Threadgate Urology. He has trained in all aspects of urology with a particular focus on urological cancers, reconstructive urology and minimally invasive surgical techniques.

Dr Murtaza Jamnagerwalla Colorectal & General Surgeon **Ph: 4228 1088**

Dr Jamnagerwalla is a specialist colorectal surgeon with interests in laparoscopic surgery, transanal minimally invasive surgery and endoscopy for both malignant and benign conditions. Dr Jamnagerwalla also performs most minimally invasive general surgical procedures.

Dr Dharmesh Kothari Obstetrics & Gynaecology **Ph: 4288 8080**

Dr Dharmesh Kothari has been practicing Obstetrics and Gynaecology since 2002. During this time he has gained invaluable experience in high risk obstetrics, emergency gynaecology, and advanced gynaecological procedures including abdominal, vaginal and laparoscopic surgeries. He is available to accept all gynaecological and obstetric referrals in his new private clinic.

New Neurological Rehabilitation

If your patient is living with a chronic neurological condition, or has experienced an acute neurological event, they may be a suitable candidate for the new Neurological Rehabilitation program now available at Lawrence Hargrave Private Hospital.

The new program takes a multidisciplinary approach to enabling individuals to regain functional abilities and independence. Patients will participate in individualised sessions with a physiotherapist and occupational therapist. Additional therapies including clinical psychology, speech pathology, dietetics and hydrotherapy are incorporated into the patient's custom program as required.

The new Neurological program is suitable for patients with the following presentations:

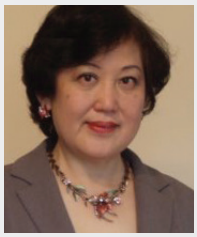
- Stroke
- Neurosurgical intervention (tumour removal, VP shunt)
- Spinal Surgery
- Incomplete Spinal Cord Injury
- Brain Injury
- Multiple Sclerosis
- Parkinson's Disease

Please refer to one of our experienced Rehabilitation Physicians to arrange admission for your patient. Visit www.lawrencehargraveprivate.com.au for a list of physicians accredited at the hospital.

Dr Ali Tafreshi Medical Oncology
Ph: 4225 1133

Dr Ali Tafreshi has extensive experience in treating different solid tumours including gastrointestinal tract tumours, breast cancers, lung cancers, genitourinary tumours, gynaecology cancers and brain tumours. Dr Tafreshi has been extensively involved in research and is currently the principal and co-investigator of multiple international clinical trials. His aim is to provide holistic approach and personalised therapy to cancer patients and their family in the region.

Dr Juliani Rianto Rehabilitation Physician
Ph: 4255 5000



Dr Rianto is a Rehabilitation specialist at Figtree Private Hospital with a special interest in Geriatric Medicine, Neurology and patients with Intellectual Disabilities. She provides post-operative hip, knee and back rehabilitation services and runs outpatient rehabilitation programs for geriatric patients.

Dr Bindu Murali Gynaecology
Ph: 4228 1999

Dr Murali is a meticulous surgeon with tremendous clinical experience. Her special interests include vaginal surgeries, prolapse repair, sling surgery and urogynaecology. She is happy to see all general gynaecological referrals in her private clinic.

Dr Moreena Kwa Rehabilitation Physician
Ph: 4255 5000

Dr Moreena Kwa brings a broad range of rehabilitation experience to Figtree Private Hospital. She provides care for patients with disabilities post stroke and post injury which include spinal cord injuries, traumatic brain injuries, chronic pain management, orthopaedic rehabilitation after joint replacement and post-fractures, amputee rehabilitation and people with neurodegenerative disorders including Parkinson disease and Multiple Sclerosis. Dr Kwa also has a special interest in the geriatric population with expertise in managing the rehabilitation of their chronic pain, and reconditioning from any further complex medical issues.

Professor Michael Vallely Cardiothoracic Surgeon **Ph: 02 9099 4424**

Professor Vallely has clinical and academic interests in minimising the invasiveness of cardiothoracic surgery and is a world authority on total arterial, anaortic, off-pump coronary artery bypass surgery. He also has interests in minimally invasive cardiac surgery, transcatheter cardiac surgery, thoracic aortic surgery, geriatric cardiac surgery and hybrid procedures including the use of ECMO. Professor Vallely has a special interest in electrophysiological (pacemakers, defibrillators and CRT) devices and performs more than 250 implants per year.

GP Education at Wollongong Private Hospital

Planning for our 2017 GP Education program is well underway. We have a number of informative education events in the pipeline and based your valued feedback have arranged commonly requested topics such as orthopaedics, paediatrics, neurosurgery and breast cancer and ophthalmology.

This year you will notice we have reduced the frequency of GP Education events run at our hospitals. In line with amendments to the 2017-2019 RACGP Triennium requirements, we will be focusing on helping you meet your quality improvement "PLAN" through the delivery of tailored Small Group Learning sessions held at your practice.

If you would like to request a Small Group Learning session at your surgery, please contact our GP Liaison Officer, Kelly Garvey on 0439 070 220 to discuss your learning needs.

Please visit wollongongprivate.com.au for more information about our 2017 GP Education calendar.

Figtree Private Hospital **is rehabilitated**

L to R: Paul McKenna, CEO Figtree Private Hospital; Chris Rex, Ramsay Health Care Managing Director and Gordon Bradbery OAM, Lord Mayor Councillor.

2016 was a year of change for Figtree Private Hospital as the small surgical and maternity facility, that has serviced the Illawarra for the past three decades, was transformed into a brand new Rehabilitation centre. The first stage of hospital redevelopment included the addition of two fully equipped physiotherapy gymnasiums, occupational therapy facilities, activities of daily living kitchens, spacious integrated sleep study rooms and 68 renovated patient rooms and ensuite bathrooms.

The hospital was officially reopened in August 2016 by the Lord Mayor Councillor Gordon Bradbery OAM and Ramsay Health Care Managing Director Chris Rex.

Figtree Private Hospital now offers a selection of inpatient rehabilitation programs including orthopaedic, neurological, reconditioning and pain management. Medical patients are also cared for at the newly redeveloped hospital. Future plans for the hospital include the addition of day and outpatient rehabilitation programs, construction of a hydrotherapy pool and additional gymnasiums to service the growing patient admissions.

Please visit www.figtreeprivate.com.au for more information on how to refer your patients for inpatient rehabilitation or medical care at Figtree Private Hospital.

New VMO **Practice Locations**

Please note the following VMOs have moved rooms and can now be contacted on new numbers listed below:

Dr John Tawfik Orthopaedic Hand Surgeon
Seaview Clinic, Suite 703, Level 7
Wollongong Private Hospital
360-364 Crown Street
Wollongong NSW 2500
P: 02 **4210 7870**
F: 02 4227 1502

Dr Warren Davis Obstetrics and Gynaecology
403 Crown Street
Wollongong NSW 2500
P: 02 **4271 5440**
F: 02 4271 6148

Dr Matthew Threadgate Urologist
Suite 503, Level 5
Wollongong Private Hospital
360-364 Crown Street
Wollongong NSW 2500
P: **1300 247 008**
F: 02 4210 7343

Wollongong Private Hospital **turns ONE!**

A year has quickly passed since Wollongong Private Hospital opened its doors, and recently the hospital celebrated its birthday with a group of little patients who also just reached this special milestone. Many of the very first babies born at Wollongong Private Hospital, along with the hospital's first inpatients, revisited the facility to join in the birthday celebrations.

Since Wollongong Private Hospital began servicing the region in January 2016, patients have had access to a number of new local private health care services such as advanced Neurosurgery, Interventional Cardiology and Day Oncology. New equipment installed at the hospital, including the much anticipated Mazor Robot for spinal surgery, has meant that patients have access to world leading technologies without leaving the Illawarra.

Patient feedback collected during the first year of operation has consistently revealed that that patients have been delighted by the brand new facilities and luxurious accommodation, but equally impressed that the hospital has continued to provide the same personable, quality care they have become familiar with at Figtree Private Hospital.

In the hospital's first year of operation, Wollongong Private Hospital has delivered 951 babies and performed close to 14,000 surgical procedures. The new private hospital has attracted 80 new doctors and employed 170 new staff members.

1. Wollongong Private Hospital CEO, David Crowe and Maternity Services Manager, Julie Walsh
2. Wollongong Private Hospital's first patients Elaine, Robyne and Edmund
3. Wollongong Private Hospital's first babies Lachlan, Elliot, Elsie, Edward and Eden

Day Oncology Services at Wollongong Private Hospital

Wollongong Private Hospital operates the region's newest day oncology centre for the treatment or management of chronic illness and cancer. Our purpose designed unit offers eight spacious treatment areas with serene views of the Illawarra escarpment.

Treatments are delivered in a welcoming, safe and supportive environment with all the comforts of home at hand. Our staff are dedicated to providing a personalised and professional service, taking some of the anxiety and inconvenience away from receiving treatment.

Wollongong Private Hospital's specialised team of Medical Oncologists and Nurses are skilled to deliver the following services:

- Chemotherapy
- Haematological treatments
- Immunoglobulin infusions
- Iron Infusions
- Blood transfusions
- Specialist drug Infusions

Patients of Wollongong Private Hospitals Day Oncology Unit have access to the following staff and services:

- Experienced Medical Oncologists
- Oncology Nurses
- Breast Care Nurse
- Physiotherapy services
- Social Worker
- Dietician
- Hospital Pharmacist and retail Pharmacy available onsite
- Pathology and Radiology services available onsite

To arrange treatment at our Day Oncology Unit, please refer your patient to one of the hospital's accredited VMOs listed under Medical Oncology in our EziFind Directory.

Lawrence Hargrave Private Hospital helping older patients **stay healthy & active**

Did you know Lawrence Hargrave Private Hospital offers a falls prevention and active ageing program specifically tailored for older patients?

The 6 week program, operating on Monday and Wednesday afternoons, is designed to provide attendees with valuable skills to help improve their balance, mobility, functional independence and safety in the community. Each class incorporates two exercise sessions – Tai Chi and another land-based activity – as well as an education component covering relevant topics such as home safety, healthy eating, managing stress, sleep and time management.

Past participants have consistently reduced their risk of falls, improved strength and endurance and reported increased community independence.

This program is suitable for patients with a history of falls, recent medical or surgical interventions, osteoporosis, Parkinson's disease and diabetes. For entry to the program, simply refer to one of our Rehabilitation Specialists or Geriatricians.

Onsite Diagnostic Services

Did you know that a full range of diagnostic, nuclear medicine and pathology services are available on site at Wollongong Private Hospital? These services are available to both inpatients and the general public.

Dr Glenn & Partners Medical Imaging

Diagnostic and Interventional Radiology services are provided by Dr Glenn & Partners Medical Imaging, located on Ground Floor of the hospital. The practice offers a comprehensive range of services including MRI, Barium studies, DEXA, Multislice CT, Low Dose CT, CT Angiography, CT & Ultrasound Guided Intervention / Injection, General Radiology, OPG, Mammography, Ultrasound and Non-Invasive Vascular Imaging procedures.

All examinations performed at Dr Glenn & Partners are bulk-billed excluding non-rebateable MRI and Nuchal Scanning.

DR GLENN & PARTNERS MEDICAL IMAGING

Southern Nuclear Imaging

Located on Level 7 of the hospital, Southern Nuclear Imaging provides the Illawarra region with the highest quality, comprehensive Nuclear medicine and Bone Mineral Densitometry service. They employ some of the most experienced Nuclear Medicine staff anywhere in Australia. Their Consultant Physicians have each had extensive experience in all aspects of the contemporary (and traditional) practice of nuclear medicine.

SOUTHERN NUCLEAR IMAGING

Southern Pathology

Southern Pathology is located on ground floor of the hospital, offering a wide range of pathology and related services. The laboratory is equipped with modern instrumentation, which is operated and maintained by a team of highly qualified and experienced laboratory personnel.

SOUTHERN . IML PATHOLOGY
Quality is in our DNA

Please contact Kelly Garvey on 0439 070 220 if you would like to order referral pads for any of the above services.

Featured VMOs

Dr. Fred Nouh MBBS, BSc (Med), FRACS (Ortho)
Orthopaedic Surgeon

Dr. Fred Nouh is an Australian trained Orthopaedic Surgeon Specialising in all aspects of arthroscopic & reconstructive Knee surgery, Hip and Knee replacement, arthroscopic shoulder surgery and trauma.

Having graduated from the University of NSW in 1999, Dr Nouh was selected by the Australian Orthopaedic Association for advanced training in Orthopaedic surgery. He completed his Orthopaedic training in 2009.

His primary interest is in joint replacement for the treatment of arthritis of the hip and knee. He performs both primary joint replacements and revision joint replacement surgery, minimally invasive Anterior approach Hip Replacement and Patient Specific Instrument (PSI) Total Knee replacement. Having performed thousands of operations during his time as an Orthopaedic surgeon, he is highly experienced and a leading surgeon in knee ACL reconstruction and Knee arthroscopy meniscus repair surgery.

Dr Nouh is committed to providing expert orthopaedic care that is personalised to each patient to help them obtain the best outcomes from their surgery. His practice prides itself on dedicated personal care and attention, and exceptional surgical results. Dr. Nouh provides high quality care for both private and public patients, and offers urgent care for trauma and workers compensation injuries.

Professional Memberships include:
- Fellowship of the Royal Australasian college of Surgeons.
- Clinical and Research Fellowship in Knee surgery, North Sydney Orthopaedic and Sports Medicine Centre, the Mater Hospital, Sydney
- Joint Arthroplasty Fellowship at the Whitlam Joint Replacement Centre, Fairfield

Dr. Fred Nouh
MBBS, BSc (Med), FRACS (Ortho)
Orthopaedic Surgeon
Illawarra Medical Specialists,
Piccadilly Centre
Suite 5b, 341-349 Crown St
Wollongong NSW 2500
P: **1300 208 080**
F: 02 4620 8086
www.frednouh.com.au

Dr Dharmesh Kothari
MBBS FRANZCOG
Obstetrician, Gynaecologist
& Laparoscopic Surgeon
Suite 503, Level 5
Wollongong Private Hospital
360-364 Crown Street
Wollongong NSW 2500
P: 02 **4288 8080**
F: 02 4288 8089

Dr Dharmesh Kothari MBBS FRANZCOG
Obstetrician, Gynaecologist & Laparoscopic Surgeon

Dr Dharmesh Kothari has trained both in Australia and internationally and has immense clinical experience. He has been practicing Obstetrics and Gynaecology since 2002, initially at one of Asia's largest maternity units, which performs over 10,000 births per year. He gained invaluable experience in high risk obstetrics and emergency gynaecology during this time.

After coming to Australia in 2009, Dr Kothari trained in the Australian Public Health System for six years, three of these having been in Royal Hobart Hospital, the main tertiary referral centre for the state of Tasmania. His focus during this time was in high risk obstetric care provision, through the obstetric high risk clinic.

Prior to being elevated to the Fellowship of the Royal Australian and New Zealand College of Obstetrics and Gynaecology in 2016, Dr Kothari trained as a senior registrar at Calvary Hospital, Canberra for two years and his main focus during this training period was advanced laparoscopic gynaecology. He has performed numerous total laparoscopic hysterectomies and advanced laparoscopic procedures under the guidance and supervision of leading laparoscopic gynaecologists.

Dr Kothari feels both humbled and privileged to have spent fourteen years practicing obstetrics and gynaecology both internationally and within tertiary referral centres in Australia. Dr Kothari has a vision for developing models of care that will deliver excellence in healthcare in partnership. Care will be professional, coordinated, respectful and compassionate.

Dr Kothari is available to accept all gynaecological and obstetric referrals in his private clinic. He offers low out of pocket fees for obstetric patients and bulk bills all antenatal appointments. Patients will be offered an appointment within 7 days of your referral.

The **"big issue"** in Obstetrics

Maternal obesity in pregnancy is increasingly common and represents a significant threat to maternal and fetal/neonatal well-being. A reported 35% of Australian women between the ages of 25-35, (equating to 57,983) are either overweight or obese. Obesity in pregnancy is an independent risk factor for obstetric, fetal and neonatal complications and risks are amplified with increasing degrees of maternal obesity.

Definition of obesity

A pregnancy-specific definition of obesity has not been standardized so pregnant women are considered obese or non-obese based on their pre-pregnancy BMI.

Obesity is defined as body mass index (BMI) ≥30 kg/m2 further stratified by class:

> class I (BMI 30.0 to 34.9 kg/m2)

> class II (BMI 35.0 to 39.9 kg/m2)

> class III (BMI ≥40 kg/m2)

> A new class of super obese (BMI ≥50 kg/m2) has been proposed

Complications during pregnancy and delivery of obese women include:

- Hypertensive disorders of pregnancy (8% increase in pre-eclampsia)
- Gestational diabetes (70% of obese women with gestational diabetes are reported to develop type 2 diabetes within 15 years of delivery)
- Induction — increased risk for induction and induction failure
- Difficulties with anaesthesia - multiple attempts at placing an epidural, difficult airway if a general anaesthetic required
- Trial of labour after caesarean delivery is less likely to result in vaginal birth
- Prolonged labour (macrosomia), increased instrumental delivery (ventouse and forceps), increased caesarean section rates (associated anaesthetic and surgical complications), maternal genital tract laceration, and postpartum hemorrhage.
- Longer maternal stays
- Carpal tunnel syndrome

Complications Postpartum

- Venous thromboembolism
- Infection - wound, episiotomy, endometritis
- Increased postpartum depression

Adverse effects on the fetus

- Increased risk of congenital malformations and first trimester spontaneous abortion
  - neural tube defects (NTDs)
  - hydrocephaly
  - cardiac malformations
  - cleft palate, cleft lip and palate
  - anorectal atresia
  - limb reduction abnormalities

  Maternal obesity reduces the ultrasound detection of fetal anomalies by at least 20 percent compared with women with a normal BMI – fewer optimal examinations, reduced antepartum diagnoses and reduced pregnancy terminations.
- Macrosomia (birth weight >4000 g) is more common and an important risk factor for shoulder dystocia
- Death – miscarriage, stillbirth, perinatal death, neonatal death, and infant death are all increased
- Childhood and adult obesity - having one obese parent increases the risk of obesity by two - to threefold, and up to 15-fold if both parents are obese.

Pre-conception management

- Refer to O & G
- Ideally, the following should be discussed well before conception:
  - the adverse effects of obesity on fertility
  - potential pregnancy complications
- Evaluate for comorbidities e.g. diabetes, hypertension, obstructive sleep apnoea
- Counsel about the benefits of weight loss before conception
- Pre-pregnancy weight loss :
  - diet
  - exercise
  - behaviour modification
  - +/- medical therapy or bariatric surgery

NB. All drugs prescribed for weight reduction have adverse fetal effects and should not be used during pregnancy.

Pregnancy management general advice for GPs

- Refer early (following dating ultrasound and before 12 weeks)

First trimester baseline assessments

- Maternal weight and body mass index (BMI)
- Blood pressure (appropriately sized cuff).
- Early ultrasound to establish gestational age and fetal number
- Medication review:
  - discontinue weight loss medication
  - oral anti-hyperglycemic drugs (often discontinued in favour of insulin therapy)
  - anti-hypertensives, ACE inhibitors are contraindicated
- Diabetes screening
- Consider urine protein creatinine ratio, platelet count, and liver function tests
- Limiting gestational weight gain may reduce the risk of some adverse pregnancy outcomes, such as macrosomia. Recommended weight gain for BMI is on page 2 of the new antenatal record (SMR060.455). NB weight loss has been associated with an increased risk of small for gestational age newborns
- Exercise - emphasise the multiple health benefits

Fetal aneuploidy screening

Obese women are not at increased risk for fetal aneuploidy however, obesity can affect screening test performance. Cell-free fetal DNA screening is more likely to result in test failure or an inaccurate result

in obese women because they may have a lower fetal fraction of the cell-free DNA. First and second trimester serum-based screening tests are adjusted for maternal weight; thus, obesity does not affect test performance. However, accurate nuchal translucency measurement may be more difficult to obtain.

Referrals
Dietician for ongoing consultation can provide patients with dietary plans and goals as well as guidance about healthy lifestyle changes.

+/- cardiologist

+/-sleep specialist

Postpartum Management

Breastfeeding:
Contact with a lactation consultant before discharge from the hospital and soon after discharge can be helpful since obese women are prone to difficulty with lactation.

Contraception:
Intrauterine contraception is safe and effective, and may be safer and more effective than oestrogen-progestin contraceptives (still an acceptable choice).

Gestational diabetes:
Women with gestational diabetes should be screened for glucose intolerance 6 to 12 weeks after delivery.

Postnatal depression:
This is more common in obese women.

Dr Simon Winder Obstetrician
Illawarra Womens Specialist Centre
Suite 703, Level 7
Wollongong Private Hospital
360-364 Crown Street
Wollongong NSW 2500

P: 02 4226 6007
F: 02 4227 2003
E : info@illawarrawomens.com.au

Management of **Acute Scaphoid Fractures**

Introduction

Scaphoid fractures are common and are predominantly a fracture of young fit people. They are almost five times more likely to occur in males compared to females. The majority (80%) of scaphoid fractures occur at the waist with the distal pole, tubercle and proximal pole making up the rest. Management of Scaphoid fractures depends on the site and displacement of the fracture as well as patient factors such as age and occupation. Treatment can be surgical or non-surgical (Conservative).

Diagnosis

History and Examination

The patient often gives a history of a fall onto an outstretched hand. This often results in pain and swelling in the wrist. Presentation can sometimes be delayed as the patient may feel the wrist is only "sprained."

Clinical examination reveals swelling as well tenderness to palpation in the anatomical snuffbox and over the scaphoid tubercle. There is pain on movement of the thumb and wrist. The scaphoid compression test involves axial compression of the thumb metacarpal towards the wrist and is often positive.

Imaging

Plain x-ray specifically requesting 'scaphoid views' is the first-line investigation.

If no fracture is identified then early treatment with a scaphoid cast is commenced in order to avoid the complications of missed fractures, including non-union, avascular necrosis, carpal instability and osteoarthritis.

Conventional practice is to repeat the x-ray and clinical examination after one-two weeks.

An early diagnosis can be made with MRI, which can exclude a fracture and can potentially reduce time spent in a cast, time off work and the overall cost of over-treating patients with pain and no fracture.

CT is the preferred modality for assessing the degree of displacement and union status of a fracture. Displacement is defined as more than a 1mm gap at the fracture site.

Management

Management of scaphoid fractures depends on site of fracture (waist vs. proximal pole), displacement, time since fracture, age and activity level of patient.

For an undisplaced scaphoid waist fracture traditional treatment in a scaphoid cast results in around 90% union rate.

A CT scan should be used as the first step to ensure that a fracture is truly undisplaced as 1mm of displacement can be difficult to assess on plain x-ray alone.

Surgical fixation with a percutaneous screw results in less time in a cast, an earlier return to work and sport and a faster time to union. It remains debatable as to whether screw fixation for an undisplaced fracture leads to a higher union rate.

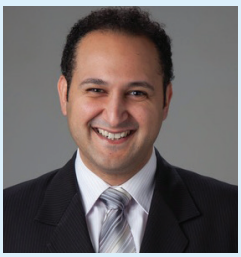
For some patients, such as the self-employed manual worker the benefits of early return to function and faster union with percutaneous fixation may outweigh the risks.

In a patient with an undisplaced scaphoid waist fracture confirmed on CT and who is happy to be treated in a cast I would recommend 6 weeks immobilisation and then repeat the CT scan. If there is no evidence of healing then I would recommend percutaneous screw fixation.

For acute displaced scaphoid waist fractures and for all proximal pole fractures the management is surgical to try and reduce the risk of non-union and mal-union, both of which have been associated with the development of arthritis in the longer term. Fixation with a screw can be performed using either an open or percutaneous technique.

Conclusion

The management of acute scaphoid fractures can be either operative or non-operative. Early MRI is an accurate and cost-effective method for excluding fractures as early as 48 hours after the injury. For patients with a confirmed fracture treatment is individualised taking into consideration fracture characteristics such as site and displacement as well as patient factors such as age and occupation.



Dr John Tawfik, Orthopaedic Surgeon

Seaview Clinic
Suite 701, Level 7
Wollongong Private Hospital
360-364 Crown Street
Wollongong NSW 2500

P: 1300 829 345
F: 02 8079 0679

An Update in the Management of **Small Renal Masses (SRMs)**

Dr Matthew Threagate FRACS Urological & Robotic Surgeon

Approximately 60% of renal cancers are discovered incidentally during abdominal ultrasound or computer tomography (CT) completed for other indications. Small renal masses (SRMs) are almost always asymptomatic and by definition less than 4cm in maximal diameter.

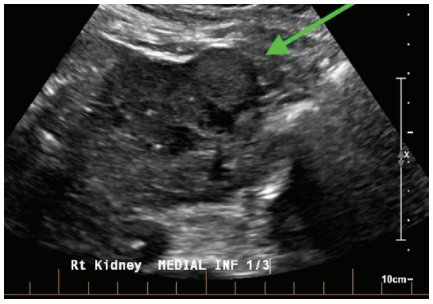


FIGURE 1. Solid renal lesion 2.2cm diameter

Over the past 30 years increased detection has doubled the incidence of renal cancer but the death rate has remained steady. This brings in to question the need to treat SRMs.

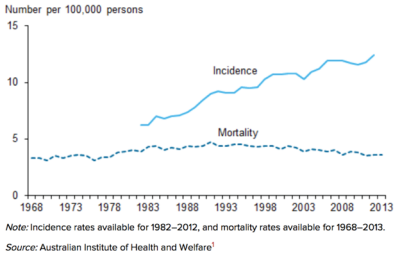


FIGURE 2. Age standardized incidence and mortality for kidney cancer.

No reliable marker exists to predict the metastatic potential of SRMs. Cure rates approach 95% following surgical extirpation of SRMs but fall to 25 to 40% for locally advanced tumours. Despite the advent of effect systemic treatments for metastatic renal cancer cure is exceptionally rare. Given the poor outcomes in advanced renal cancers patients with SRMs often undergo surgical extirpation prior to disease progression.

Diagnosis

SRMs are best assessed by multiphase contrast enhanced CT. Eighty percent of SRMs demonstrating contrast enhancement will be malignant with the remaining 20% consisting mostly benign renal oncocytomas. SRMs that demonstrate no enhancement can be safely monitored. Ultrasound and Gadolinium MRI are useful when iodinated contrast is contra-indicated. CT provides excellent loco-regional staging and a CT chest is the standard exclusion of pulmonary metastases.

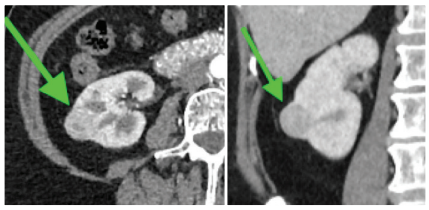


FIGURE 3. SRM seen on contrast enhanced CT in axial and coronal images (same lesion seen in figure 1).

The utilisation of radiological guided core biopsies of SRMs varies across Australia. Core biopsy may indicate tumour type however cannot reliably differentiate benign renal oncocytoma from malignant chromophobe renal cell cancer. Biospsy should be reserved for selected cases where results will change treatment decisions.

Treatment

Renal cancer is relatively insensitive to cytotoxic chemotherapy and radiotherapy. Targeted molecular therapy (such as tyrosine kinase inhibitors and mTOR inhibitors) prolong survival in metastatic disease but have no role in the treatment of SRMs.

Surveillance is an option for elderly or co-morbid patients. Treatment is only instituted on progression of disease (typically seen as rapid growth on serial ultrasound or CT). Surveillance avoids treatment related harms for non-aggressive SRMs while allowing curative treatment for those demonstrating concerning features.

Ablative therapies include; radiofrequency ablation, cryotherapy and high dose stereotactic radiotherapy. These treatments remain at the periphery as local recurrence rates are higher when compared to surgery.

Surgical extirpation is the mainstay of treatment. Radical nephrectomy involves removal of the entire kidney along with the SRM. Partial nephrectomy involves removal of the SRM with a small margin of normal renal tissue. The subsequent renal defect (renorraphy) is repaired using sutures. Both techniques are commonly done using minimally invasive laparoscopic or robotic assisted techniques.

SRM size and location often dictate the surgical approach. Central SRMs in close proximity to major renal vessels and the renal collecting system make for a more challenging and higher risk renorraphy. In these cases surgeons may choose radical nephrectomy to minimise operative risks.

During partial nephrectomy temporary occlusion of the main renal artery is usually required. This allows for a near bloodless field facilitating the renorraphy closure. Renorraphy is a time critical step as renal tissue sustains irreversible ischaemic injury if the warm ischaemic exceeds 30 minutes.

Zero ischaemia techniques (no renal artery occlusion) are possible and is the authors preferred approach for SRMs located away from major arterial branches and the renal collecting system. This approach provides maximal renal function preservation and allows for minimally invasive partial nephrectomy in patients with multiple SRMs or an SRM in a single functioning kidney.

Complications of Partial Nephrectomy

Post-operative haemorhage or urine leak occurs in approximately 5% of cases. Haemorrhage usually presents as haematuria and treatment is by angiographic embolisation performed under local anaesthetic.

Urine leak presents as flank pain often with associated fever. Urine exits renorraphy site due to failure of primary closure. Treatment is by radiologically guided percuneous drainage of any urinoma and placement of a ureteric stent and indwelling catheter. The stent and catheter encourage antegrade urine flow.

Summary

Surgical extirpation is likely to remain the mainstay of treatment until a reliable marker of metastatic potential is found. Surgical extirpation must be done as safely as possible balancing the increased short-term risks of partial nephrectomy with the long-term risk of chronic kidney disease associated with radical nephrectomy.

Footnote: The lesion seen in figure 1 and 3 was excised using a robotic assisted zero ischaemia approach, histopathology revealed a benign renal oncocytoma.

Dr Matthew Threadgate
Urological Surgeon
Suite 503, Level 5
Wollongong Private Hospital
360-364 Crown Street
Wollongong NSW 2500
P: 1300 247 008 F: 02 4210 7343

Wollongong Private Hospital

ezifind

Visiting Medical Specialist

360-364 Crown Street, Wollongong NSW 2500
wollongongprivate.com.au

April 2017

General Enquiries
02 4286 1000

Hospital Facsimile
02 4286 1001

Operational Manager
02 4286 1237

Day Surgery Unit
02 4286 1055

Intensive Care Unit
02 4286 1055

Maternity Unit
02 4286 1077

Oncology Unit
02 4286 1153

BARIATRIC SURGERY
Dr Ulvi Budak	02 4229 6355
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Dr Allan Mekisic	02 4227 4600
Dr Tony Palasovski	02 4228 1088

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Dr Krishna Kathir*	02 4227 1840
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Dr Pratap C. Shetty	02 4227 1840
Dr Aaron Yeung	02 4227 1840

CARDIOLOGY – GENERAL
Dr Divina Brillante	02 4228 1623
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Dr Jai Seema Bagia	02 4227 3733
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Dr Andrew Malouf	02 4228 0586
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Dr Tony Palasovski	02 4228 1088
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Dr Agus Kadir	02 4229 9116
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Dr Hamish Rae*	02 8005 5 111
Dr Gregory Stackpool	02 4229 9116
Dr John Tawfik	1300 829 345

PALLIATIVE CARE
Dr Gregory Barclay	02 4223 8380

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Dr Christopher Dunn	02 4228 5564
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Dr Raj Ramakrishna	02 4229 9400
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Dr Niladri Ghosh	02 4222 5898
Dr Spyridon Miyakis*	02 4221 3818

PHYSICIANS – PAIN MANAGEMENT
Dr Guy Bashford	02 4267 2 8 1 1
Dr Roman Jaworski	02 4226 6800

PHYSICIANS - RENAL
Dr Cheng Wen	02 4222 5443

PHYSICIANS - RESPIRATORY
Dr Christopher Dunn	02 4228 5564
A/Prof. Graham Hart	02 4226 6980
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Dr Peter Marantos	02 4225 2221

PHYSICIANS – REHABILITATION
Dr Guy Bashford	02 4267 2811
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Dr Roman Jaworski	02 4226 6800
Dr John Riordan	02 4226 118 0

PLASTIC SURGERY
Dr Peter Haertsch	02 9868 5155
Dr Adrian Sjarif	02 4226 6111

RADIATION ONCOLOGY
A/Prof. Andrew Miller	02 4222 5200

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Dr David Greening	02 4271 3900
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Dr Bruce Ashford	02 4226 6111
Dr Stuart MacKay	02 4226 1055
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Dr Stephen Pearson	02 4226 1055

UPPER GI
Dr Ulvi Budak	02 4229 6355
Dr James Chau	02 9525 5322
Dr Mouhannad Jaber	02 4226 2600
Dr Jai Seema Bagia	02 4227 3733

UROLOGY
Dr Peter Chin	02 4271 6644
Dr Elizabeth Dally	02 4271 6644
Dr Paul Kovac	02 4271 6644
Dr Spencer Murray	02 4271 6644
Dr Rahul Rindani	02 4271 6644
Dr Timothy Skyring	02 4271 6644
Dr Matthew Threadgate	1300 247 008

VASCULAR SURGERY
Dr Andrew Bullen*	02 4226 9333
Dr David Huber	02 4226 9333
Dr Richard Kerdic	02 4226 9333
Dr Tam Nguyen	02 4226 9333
Dr Arthur Stanton	02 4229 9466
Dr Laurencia Villalba	02 4226 9333

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