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Paediatric Laparoscopic Hernia Service

Bupa Cromwell Hospital has launched a Paediatric Laparoscopic Hernia Service which provides quick and effective treatment of inguinal hernias in children.

What are the benefits?
The benefits of laparoscopic surgery over open hernia surgery are significant:
- It is a quicker procedure, causes less pain and has a faster recovery period.
- It is possible to check for and repair a second hernia on the opposite side of the body during the operation.
- As smaller incisions are used, laparoscopy may be more appealing for cosmetic reasons.
- Most newborns and children are able to go home the same day or the next day.

For further information please call 0800 783 9229

Have your say on the future of MEDICscene

To ensure that we provide the most useful news updates and consultant articles we want to hear your feedback on this magazine. Do you think we should:
- keep the printed copy of MEDICscene
- keep the content but convert it to a digital magazine (pdf)
- instead of a quarterly magazine, post regular articles on our website for you to read on the go

Please go to bupacromwellhospital.com/go-survey to vote. All entries will go into a hat with a chance to win a £100 John Lewis voucher. Closing date 11 December 2015.

Thank you

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Front Cover: Hormone replacement therapy (HRT) pills. Circular dispenser of HRT tablets, with the days of the week seen next to each pill.
Photo - © Science Photo Library

The opinions expressed in this magazine are the personal views of the authors and do not necessarily reflect those of Bupa Cromwell Hospital.
Welcome to MED/scene

Welcome to issue 15 of MED/scene. As we near the end of a very busy year I wanted to reflect on some of the key achievements, new services and consultants included here, and give a taste of what’s coming up in 2016.

On the page opposite you’ll read about the opening of our newly revamped Starfish Ward. This was redeveloped as part of our wider hospital refurbishment programme, which has seen two entire floors of rooms transformed including our 4th floor orthopaedic ward (see Mr Matthew Solar’s foot and ankle article on page 7), as well as our Chemo Day Unit, Dialysis Unit and other clinical areas.

It has been incredibly rewarding to hear such positive feedback on these new environments, particularly from the children on Starfish Ward who love the new decor and features.

Our luxurious Royal and Presidential suites are also reopening in November, providing the most exceptional patient rooms and en-suite bathrooms have been fitted to a very high standard, and there is a fun underwater theme throughout to help children relax. Brand new patient rooms and en-suite bathrooms have been fitted to a very high standard, and there is a fun underwater theme throughout to help children relax.

We’ve been doing more than just improving the hospital building though. Our new Memory Clinic (see page 5) has had a great response from GPs, and new consultants including Dr Richard Shaffer (page 16) are enabling us to expand our clinical offering and provide the most effective treatments for patients.

As ever, do let me know if you have any feedback on MED/scene or on your experience of our services. Your comments are essential in helping us tweak or introduce services where necessary to provide the very best for your patients. I look forward to hearing from you.

With warm regards,

Philippa Fieldhouse
General Manager
Bupa Cromwell Hospital

THE GP LIAISON TEAM

The GP Liaison team provides a bespoke service for GPs. We can assist you with any enquiries you may have, and help facilitate patient referrals via Cromwell Direct – 0800 783 9229. This is a dedicated line for GPs wishing to refer patients (both children and adults) for appointments with consultants, diagnostic tests and admission to the hospital.

We understand that GPs want to keep up to date with new treatments, diagnostics and services, and work closely with our consultants to coordinate our educational programme. Please see the health professionals area of our website for more information.

We are pleased to welcome Simran Sidhu our GP Liaison Co-ordinator who will be the first point of contact for educational events including our symposium series.

We would be happy to arrange a practice visit at a convenient time for you in order to:
• discuss the latest developments at the hospital
• explore how we can work together more effectively
• introduce new consultants

If you would like to discuss your educational needs and arrange a practice visit, or require further information about Bupa Cromwell Hospital, please contact us:

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We are very pleased to announced that our Starfish paediatric ward reopened in September after a major refurbishment programme that has transformed the environment and service for our youngest patients.

Paediatric Sister Emma Reid says: “I would like to say a massive thank you from all the staff in paediatrics for the time and effort that has gone into the refurbishment. When we transferred the patients they were overwhelmed with the new facilities.

The layout of the ward works really well and the team are very excited. We honestly could not have asked for a better ward to provide care for our patients and families.”

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Beleza do momento
Keeping you connected

Our social media pages are designed to keep you up-to-date with the latest news and developments across the healthcare sector. Make sure to keep an eye out for our regular competitions - you could win a variety of prizes, from John Lewis vouchers to Basic Life Support training for your practice.

Attending our educational events? Join in the conversation by hashtagging #GPeducation from any of our symposia, breakfast or evening events. The more input we get from our audience, the better we can tailor our events to meet their needs.

Stay tuned with what’s happening across the hospital (including updates on our exciting refurbishment programme, which is transforming the hospital environment) by following us on Twitter.

Our LinkedIn page is a fantastic resource with consultant interviews, hospital tours and overviews of clinical areas, and a host of other information. Our experts give advice on everything from how to treat IBS to explaining the difference between a headache and migraine. We’re constantly adding new content, so why not subscribe to our channel and we’ll let you know as soon as videos are added.

Want to know more? If there’s something we’re missing from your social media feed or if you’d like any more information on running a social media account, email us at info@cromwellhospital.com or call 020 7460 5578.

Bupa Cromwell Hospital has launched London’s first Memory Clinic in a private hospital setting. Led by consultant Psychiatrist Dr Justin Sauer and consultant Neurologist Dr Angus Kennedy, the Memory Clinic offers assessment and early diagnosis of dementia and other memory related conditions.

An initial consultation is followed by comprehensive, same day diagnostic tests including MRI leading to prompt diagnosis. Patient care is personalised and may include treatment with medication and risk factor modification.

Dementia investigation at the Memory Clinic is covered by health insurers, and an all-inclusive self-pay package is also available. The clinic offers a dedicated email advice service to support any non-urgent clinical enquiries you may have before referring a patient. This service is available 09.00 – 17.00, Monday to Friday, with emails answered within 24 hours (excluding weekends and bank holidays).

For further information contact: memoryclinic@cromwellhospital.com / 020 7460 5573.

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MEMORY CLINIC

What made you want to become a Therapist?

I think it chose me actually - it seemed to find me. I’d been managing a music department at Harvey Nichols in Knightsbridge but was made redundant after five years. I took six months off and had some time to myself, before deciding I needed to go back to work. Becoming a therapist came to me like a flash of inspiration, I suddenly knew what I should be doing. So I booked myself on to a Massage Therapy course which took about a year, and then I got a job shortly after qualifying.

How did you end up in your speciality?

I have 25 years experience of working with patients in a hospital environment, who mentioned that the treatment for anxiety, depression, drug and alcohol addictions was greatly improved when patients received complementary care. The hospital also had a stress unit at Bupa Cromwell Hospital, so my time was split between here and the other hospital until 2011, when I decided to become permanent at Bupa Cromwell. At this time complementary therapy was introduced as part of the package for oncology patients, so I spent most of my time seeing patients from the chemotherapy day unit, oncology ward or radiotherapy.

What kind of patients do you see?

I see everyone in the hospital who would like a massage, but mainly oncology patients as they have four complementary sessions included in their treatment plan.

Complementary therapy at the Bupa Cromwell Hospital involves many different kinds of massage. Patients from the chemotherapy day unit mainly want foot or neck and shoulder massages, so I go to the department for this. Patients on the oncology ward are normally treated in their rooms, and radiotherapy patients usually come to the therapy room for a variety of treatments. I work on the emotional side of therapy as well as the physical. I talk to the patients, find out how they are feeling and then create a therapy plan which I think will help them most effectively. Everyone is so different, yet almost all experience some anxiety or depression which is why I try to help them. Emotions and feelings become somatised within the physical body so it is extremely important to locate where these blocks are and then use different techniques to help the release on an emotional level, which in turn will create more harmony within the physical body.

What’s the best thing about your job?

Making a difference to how someone is feeling is the most important thing for me. For example, if someone comes in terrified of having a portacath inserted so they can start chemotherapy, and I can chat to them, and help take their minds off what they are going through, that is incredibly rewarding. A combination of massage and talking works very well.

People are so nervous when they get a cancer diagnosis, so being able to support people when they are going through such an awful time, and undergoing treatments that make them feel ill, is a lovely thing to do and creates a harmony between patient and therapist.

What is the hardest thing about your job?

Nothing. I honestly find it totally stress free.

What advice would you give to someone hoping to follow in your footsteps?

This job is completely about the patient not about yourself. It’s about treating people with love, kindness, compassion, and empathy. Helping someone to release fear and anxiety, and encouraging them to talk openly about their feelings and emotions when they are going through such a difficult time. I can’t think of anything I’d rather do.
Quick assessment of foot & ankle injuries = faster recovery

Life is full of ups and downs. Sometimes it’s the little things that make a big difference. An injury that initially seems like a disaster may in fact need a lot less “treatment” than your patient was initially told in the Accident and Emergency department.

Casts and crutches get in the way of work, travel, driving, bathing and just about every aspect of daily routine. They also have a nasty habit of affecting people at the most inconvenient time. This is why it can be highly frustrating to find out later that there was no need for the injury to be strapped up quite so heavily and that the aching hands and shoulders could have been spared, since crutches were unnecessary.

Accident and Emergency Departments – quite rightly – play everything safe. Their goal is to detect an injury, provide first aid and then arrange for a fracture appointment.

Sadly, the fracture clinic appointment may be many days (or even weeks) ahead, and even then the advice will be “safety first”.

What if this was a professional sportsperson? Surely it is possible to get proper answers more efficiently? At the London Foot and Ankle Centre we treat every patient as if they are a professional athlete. The sporting elite are treated “functionally” – with the minimum of splintage and early physiotherapy. This is how they return to competition so quickly – they do not actually mend any faster than mere mortals! In our Centre everyone is managed with this philosophy.

At the London Foot and Ankle Centre, (LFAC) we specialise in the rapid diagnosis and speedy recovery from all injuries to the foot and ankle. Of course some injuries really do require rest in a proper cast, but for the vast majority of injuries the doom and gloom of the initial prognosis and information from Accident and Emergency can be lifted. Occasionally it turns out that nothing was actually broken at all! If your patient is frustrated by the inevitable delays in the system and want to have a definitive plan for optimum recovery, then we would be pleased to help.

The following examples cover common situations where LFAC has been able to assist (names have been altered):

Broken toe

Painful – yes; swollen – for sure; black and blue – of course. But 99.9% of toe fractures do not need crutches, plasters, strapping or special shoes. The exception is if the fracture goes into one of the joints of the toe.

David plays professional cricket. He broke his big toe which was X-rayed and heavily strapped. He was warned that he may need an operation – with the resultant time away from bat and ball.

At LFAC he was delighted to be told that the strapping could be removed immediately and that no operation was required. The fracture was close to, but not into, the joint. Some physiotherapy to help stop the toe getting stiff was arranged along with advice that the swelling would last for a few months and not just a couple of weeks. He was allowed back to the nets immediately and permitted to run as soon as the discomfort would permit.

David and his team were all pleased that the original prediction of months away from sport was so favourably revised.

Metatarsal fracture

A simple stumble - the same sort that sprains an ankle – frequently leads to a fracture of the fifth metatarsal. The pain and swelling are on the outer side of the foot, not far from the ankle bone. In Casualty this type of injury often gets missed – because the ankle X-ray does not clearly show the correct part of the foot.

There are various types of injury - some more serious than others - so A&E play it safe. A cast to the knee and crutches are routinely recommended, but only rarely are they actually needed.

Cathy was stone cold sober when the last step caught her unawares after a party, and she rolled her ankle. The cast and crutches were a disaster; she had the school run for three kids for the last two weeks of term, and then a long awaited holiday in the sun, so her plans were in tatters.

At LFAC her cast was removed, then the foot and X-rays re-assessed. Her fracture was determined to be Type 1 and needing nothing more than time, painkillers, relative rest and a little sympathy. She was advised that it was absolutely safe to walk as normally as she is able to, and that she would need the crutches for up to three months.

An MRI scan was arranged to determine whether surgery was necessary, and that she would need the crutches for up to three months.

Ankle fracture

One in every ten people in Casualty are there because of an ankle injury. Some are admitted for surgery while others are allowed home in a cast with crutches. There is then a (sometimes long) wait before the Fracture Clinic appointment. Traditionally the cast is changed and then removed after six weeks.

Meenha had never been skiing before. Ironically it was the ice outside her chalet that she fell on, not the piste. The doctors in the resort applied a cast from her toes to her thigh and gave crutches and anticoagulants for the flight home. She was told that an operation may be necessary and that she would need the crutches for up to three months.

She left the London Foot and Ankle Centre walking with no crutches in a removable “ski boot” (irony not intentional) and with a physiotherapy appointment. Her fracture was of the more common “stable” type and so suitable for functional rehabilitation. She didn’t even need any further X-rays, because this type of injury heals so predictably and reliably, and found it safe and easy to take the boot off for sleeping and showering. Simple pleasures can be the best!

Ankle sprain

In the busy A&E department ankle sprains are a very low priority. If the patient can hobble they may not even be X-rayed if an X-ray is taken, then subtle signs of injury can easily be overlooked. So, sadly, the injuries that least need them are given crutches and a cast. Meanwhile those that may require surgery are dismissed as “nothing broken”.

Carole was late and rushing when she fell at the bottom of the escalator. She hobbled to the train and iced the injury at home. Convinced it was “just a sprain” she elevated and applied ice all weekend. Despite this, the swelling and bruising went from her toes to well above her ankle bone. Eventually she heeded her husband’s advice to get it checked. A&E could see no fracture on X-ray and agreed that it was “only a sprain”. They gave her an elastic bandage.

Ten days later Carole was still struggling and came to the London Foot and Ankle Centre for review. The most painful area was a bit higher than that of the ordinary sprained ankle. Special X-rays were suggestive of a “high sprain”. An MRI scan was arranged to determine whether surgery would be needed. As Carole said; “Two weeks →
supervised by the right physiotherapist, but left untreated the condition can become very stubborn and much harder to recover from.

“Zumba sounds like a fun way to lose weight and get fit” thought Rachel. She didn’t connect the new exercise class Dr Google (“take anti-inflammatory pills and roll your foot on a frozen bottle of coke”) didn’t seem to help either. After four months, by which time the pain intensified so that simply standing for 20 minutes was uncomfortable, she sought advice from the LFAC. Assessment in our “One-Stop” Heel Pain Clinic provided an accurate diagnosis, full explanation and advice regarding treatment and a timetable for recovery. Rachel even had clear instructions about what to do and who to contact in the unlikely event of further help being needed.

Child’s injury

The growing skeleton has lines on X-ray that can be misinterpreted as fractures. Many a youngster with a sprain or even just bruise is plastered and given crutches with instructions to attend Fracture Clinic after an unspecified interval. In fracture clinic the conclusion may be a hurried “Good news, nothing broken. Don’t need to see you again” after the cast is taken off. “But he can’t walk very well…” he does seem to fall more than his friends… what about school activities… will our holiday plan be affected?”

Toby thinks he was kicked in a 50-50 challenge at his friend’s soccer-party. No-one really saw what happened. He half hopped and was half carried to A&E where the verdict was probably broken. Cast. Crutches. Rest. Elevate. Calpol. Fracture Clinic. Only nine days until the flight for the family holiday. Can it really be broken if he needs reminding to use the crutches? Fracture Clinic appointment delayed due to the Bank Holiday. Aagh!

The appointment at the London Foot and Ankle Centre saved the day. There was a minor fracture at the growth plate of the ankle, which can be treated like a sprain; he had a sports brace and the all clear to fly as planned the following week. He should even be able to swim by then.

To make an appointment with Mr Matthew Solan or another of our leading orthopaedic consultants please call 0800 783 9229.

Mr Matthew Solan FRCS (Tr and Orth) is a Consultant Orthopaedic Surgeon at London Foot and Ankle Centre and Bupa Cromwell Hospital

To make an appointment please call 0800 783 9229

A Cancer Patient’s Journey

Ms Barbara Addison

Afer suffering from Dysphonia (muscle spasms in the voice box causing a loss of voice), Barbara was referred by her GP to an ENT specialist who discovered leukoplakia on her vocal cords, and a small lump in her throat. After a biopsy and CT scan, Barbara was diagnosed with an early stage, non-aggressive cancer of the larynx and, and soon after began TomoTherapy treatment at Bupa Cromwell Hospital.

Did you have any knowledge of TomoTherapy before your treatment?

No, I’d never heard of it. I knew what radiotherapy was, however, and the team explained how precise TomoTherapy was; that they could pinpoint the exact treatment location.

Do you feel that your treatment was efficiently planned and specifically for you?

Yes, my treatment was absolutely tailored for me. For example, I wanted to wear a face mask whilst lying on the machine, which was clipped into place to ensure I didn’t move whilst having treatment. This was made specifically for me. Every detail of the treatment was customised for me.

What are your views on the treatment environment you were in?

It felt very positive and secure. I was always welcomed and the entire team was professional towards each patient. It was a positive experience to go in every day for six weeks purely because of the attitude of the people who worked there.

What are your views on the timescale of TomoTherapy treatment?

The treatment took six weeks. 30 treatments in all, some falling over Christmas and New Year, and a couple of times I had two treatments in a day. I found the routine of visiting the hospital in the mornings very structured and such a key part of my day that when the treatment finished, I felt slightly lost.

Did you ever have any concerns during the treatment?

On one occasion the machine stopped halfway through, but I was immediately reassured by the team and it was running perfectly again in a matter of minutes. I felt apprehensive for the first treatment but that soon passed. I didn’t notice any physical difference after the first week of treatment, so had no concerns. When I noticed some changes a few weeks later the team were always reassuring.

What are your views on the treatment overall?

For me it was a huge success. Six weeks after my treatment finished, I was given the all clear by my ENT consultant which was terrific! I can’t thank the entire radiotherapy team enough; they are the heroes.

Have there been any side effects of the treatment?

There were. My throat became incredibly sore, my voice became croaky; I lost my appetite and sense of taste. My throat was at its worst two weeks after the treatment, and I found it very hard to swallow or maintain normal conversation. The discomfort subsided after a few weeks and now my voice sounds like it did years ago!

How has TomoTherapy enabled you to continue with your lifestyle?

Well, I can speak properly which is the most incredible thing for me! I used to dread the phone ringing in the office because I’d never know if the entire word would come out of my mouth or not. I would experience terrible coughing fits mid-sentence, and taking a phone call would become an embarrassing experience. It is very liberating to be able to pick up the telephone and speak clearly. TomoTherapy has seriously improved my lifestyle.

Do you feel that the Radiotherapy department has given you support following your treatment?

I have regular check-ups so still come and see everyone, which is a pleasure. Any questions I ask are always answered and the team still show an interest in me which I really appreciate.

Overall, how do you feel about your experience as a TomoTherapy patient?

Once I started the treatment, it became a part of my daily life and I looked forward to seeing everyone in the team before I had to head into work. I was interested in the treatment, how it would cure me, why, and what was so special about TomoTherapy.

For me, it was a hugely positive experience and I feel very lucky and grateful. The chance of the disease reoccurring is very small – less that 5%. The experience made me think about this disease and how the word cancer is synonymous with death. Of course, very sadly, people do die of cancer, but a lot don’t. It made me look at the illness in a different way and I found the experience both interesting and educational. Thank you to the Radiotherapy Team!
Hormone Replacement Therapy (HRT) consists of an oestrogen combined with a progestogen in women who have had a hysterectomy. It can be administered in a sequential or continuous way.

When HRT is indicated, which regimen or preparation should you choose for your patient? Which is the best option, and what’s the benefit of the transdermal route?

**SEQUENTIAL COMBINED HRT**

This consists of continuous oestrogens and 10 to 14 days of progestogens usually given from day one of the cycle. It should produce bleeding at a regular time each month, if bleeding is irregular the treatment needs to be assessed. Is it being taken properly? Are there enough progestogens, any absorption problems or drug interaction? 80% of cases of hormone unbalance are related to bleeding, and if these factors are ruled out then further investigation is needed, a transvaginal ultrasound and/or hysteroscopy. Uterine pathology is responsible for 30% of abnormal hysteroscopy. Uterine pathology and investigations are often negative, and the treatment needs to be assessed. If a withdraw bleeding occurs then a combined HRT should be continued, but if there is no bleeding, then non-opposed oestrogens can be safely given. Interestsingly the WHI (Women’s Health Initiative) study has not reported any increased incidence of breast cancer with use of non-opposed oestrogens.

**CONTINUOUS COMBINED HRT**

Continuous oestrogens given with continuous progestogens should avoid menstrual bleeds, bleeding on most menopausal women is looking for. However, light bleeding or spotting is not unusual during the first few months and don’t require investigation. After six months the majority will become amenorhoeic. Women can start with continuous combined HRT 12 months after their last menstrual period. Women who started sequential HRT whilst menstruating can change to the continuous combined regimen after 12 months if they are over 50, or after two years if they are under 50. The switch from sequential to combined HRT is best done at the end of a withdraw bleeding, when the endometrium is thin.

**The minimum dose given orally for endometrial protection:**

<table>
<thead>
<tr>
<th>Oestrogen</th>
<th>Progestogen</th>
<th>Total dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>10mg dydrogesterone</td>
<td>75mcg levonorgestrel</td>
<td>175mg</td>
</tr>
<tr>
<td>10mg medroxyprogestrone acetate</td>
<td>1mg norethisterone</td>
<td>11mg</td>
</tr>
<tr>
<td>1mg norethisterone</td>
<td>150mcg norgestrel</td>
<td>157mcg</td>
</tr>
<tr>
<td>200mg micronized progesterone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Oestrogen patch**

The levonorgestrel releasing intra uterine system (IUS) can also be used for endometrial protection. This is very useful as some perimenopausal women already use the IUS as contraception, but in this indication, the IUS is only licensed for four years continuous use.

**CONTINUOUS COMBINED HRT**

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**The minimum dose of progestogen required to prevent endometrial hyperplasia is lower.**

**Tibolone** is a particular oral continuous HRT which combines oestrogenic, progestogenic and androgenic properties, with the additional effect of improving libido. Non-opposed oestrogens can be used for women who have had a hysterectomy. In cases of subtotal hysterectomy some endometrium may remain in the cervical vault, and a course of combined sequential HRT can be given. If a withdraw bleeding occurs then a combined HRT should be continued, but if there is no bleeding, then non-opposed oestrogens can be safely given. Interestsingly the WHI (Women’s Health Initiative) study has not reported any increased incidence of breast cancer with use of non-opposed oestrogens.

**Topical oestrogens** contain estradiol cream and pessaries, estradiol vaginal tablets and a low dose estradiol vaginal ring. These are very useful for addressing vaginal dryness and urogenital symptoms such as recurrent urinary tract infections, and can be used alone or with systemic HRT. There is very little or no systemic absorption, however this can be a concern for women who have had breast cancer, and each case should be discussed individually with the oncologist.

The vaginal ring is more suitable for older women; it is changed every three months and licenced for continuous use for two years. The pessaries and cream are used nightly for two weeks initially and then twice a week thereafter. The cream may be preferable when symptoms are mainly urological as it can also be rubbed on the urethral meatus. Testosterone is sometimes prescribed for women whose main problem is lack of libido. A small dose, such as one sachet of 50mg testosterone gel spread over a week, has been proven very helpful in restoring libido. It is not licensed in the UK for women, however, and should be monitored by specialists.

**Phytoestrogens** are plant substances which have a mild estrogenic effect. They are sold as supplements over the counter in pharmacies and are sometimes also recommended by doctors in the perimenopausal period. The most important group, isoflavones, is found in soybeans, chickpeas and redclover.

The interest in phytoestrogens comes from studies of Japanese women who consume a diet high in isoflavones. They have very little vasomotor menopausal symptoms and a low rate of breast cancer and cardiovascular disease. Further randomised studies are needed however to determine the role and safety of phytoestrogens. Bio identical hormones are claimed to have identical molecules to those produced by the body and therefore safer than “traditional HRT”. In fact they are made by compounding chemists who often follow salivary measurements, and the accuracy and usefulness of such tests are highly questionable. Their production is not monitored by government drug regulatory authorities so dosage may be inaccurate or inconsistent, and their safety is not tested. They are not recommended by the British Menopause Society as they cannot assure their safety and effectiveness.

Some ‘traditional’ HRT are actually bioidentical, using 17-beta oestradiol which is the natural oestrogen, and micronised progesterone capsules, which is the natural human hormone.

**Non-opposed oestrogens** can be used for women who have a hysterectomy.

**Bio estrogenic compounds** are made from soybeans, chickpeas and redclover. They are sold as supplements over the counter in pharmacies and are sometimes also recommended by doctors in the perimenopausal period. The most important group, isoflavones, is found in soybeans, chickpeas and redclover. They are sold as supplements over the counter in pharmacies and are sometimes also recommended by doctors in the perimenopausal period. The most important group, isoflavones, is found in soybeans, chickpeas and redclover.
A world class diagnostic centre in west London

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Mr Wayel Jassem
(MD PhD) Consultant Hepatobiliary Surgeon.

Mr Wayel Jassem trained in General Surgery at the University of Ancona, Italy, in kidney transplantation at the Nuffield Department of Surgery, Oxford University and in liver transplantation and hepatobiliary surgery at King’s College Hospital, London. His research interests include ischemic preconditioning and protection of the liver during resection and living donor liver transplantation.

Why did you study medicine?
I thought it would be a very exciting profession due to the interaction you have with people, and the opportunity to help so many of them.

What made you pursue your speciality?
Initially I wanted to do sports medicine, as I was very sporty growing up and also very afraid of blood! But after attending a conference on micro-surgery and finding it so fascinating I knew it was for me. After graduating from medical school I carried out micro-surgery for a number of years and that led me on to where I am now.

What is the most challenging part of your job?
As I work with patients who generally have this one chance at transplantation to survive, the biggest challenge is when they don’t do well after surgery. Most of them do well, but when they don’t it can be very hard. Many of my patients have been suffering for years, so it’s very upsetting when I can’t make them better.

What is the most rewarding part of your job?
I love seeing people healthy again, and carrying on their lives with their families. Being able to put someone back on the path to recovery is incredibly rewarding and makes the whole job worthwhile.

Can you describe a typical working day?
My working hours are usually 8am - 9pm, but when I’m on call I can be up all night taking calls regarding liver transplants for example. I move between my NHS base and Bupa Cromwell Hospital, so I tend to see patients at one location until around 7pm and then move to the other to see my patients there.

Can you tell us about an achievement that you consider to be significant to your career?
I did a project on improving the quality of an organ for transportation – I was lucky enough to do the first trial and that was very rewarding. Seeing something new created that was so positive for the patient was the most rewarding thing that I have done.

What do you enjoy doing in your spare time?
I like taking part in triathlons – I am doing an ironman and will be raising money for a liver disease charity and Alzheimer’s charity.

What is your most prized possession? My Garmin watch – it organises my life.

Where is your favourite place in the world? I’d probably say Italy where I spent my young life. I would like to go back to the place I grew up actually.

The best soundtrack for a dinner party is...? Big fan of ‘the boss’ – Bruce Springsteen! The boss has to be on.

If you had one super power what would it be and why?
To make the world a better place.

If you could be any dessert, what dessert would you be and why? I’d be a Ben’s Cookie because I love chocolate, and when I was younger I wanted to work in a chocolate factory.

If you were a movie character who would you be? Maximus in Gladiator.
Radiotherapy for Dupuytren’s Disease of the Hand

Use of radiotherapy for benign disease varies widely between different countries, but it is particularly prevalent in Germany, where a study from 1996 showed that c.20,000 patients were treated for benign conditions annually, with 146 of these being for Dupuytren’s disease (Seegenschmidt, 2000).

Dupuytren’s Disease

Dupuytren’s disease of the hand is a benign proliferative disorder of the palmar fascia. It forms part of a group of fibromatoses that also includes plantar fibromatosis (Ledderhose disease of the foot) and penile fibromatosis (Peyronie’s disease). The causes of these diseases are unknown, but they appear to have a genetic component. Additional risk factors for Dupuytren’s disease include trauma to the hand, diabetes, and anti-epileptic use, such as diabetes mellitus, smoking and alcoholism. It is a common condition, particularly in Northern European Caucasians, occurring in males more than females, and with onset typically at 50 - 60 years of age. The early stage consists of subcutaneous palmar nodules, skin retraction and cord formation. Eventually the cords thicken and contract, causing fixed flexion of the metacarpophalangeal or proximal interphalangeal joints of the fingers, known as Dupuytren’s contracture. The speed and extent of the disease varies considerably, but it tends to be more severe in males, those with a family history, early age of onset, bilateral disease, and where there are ectopic lesions (e.g. Ledderhose disease). The staging of Dupuytren’s disease is illustrated in Table 1, where stage N is disease with no contracture, stage N/I is disease with up to 10 degrees of contracture, and subsequent stages indicate disease with more severe contracture.

Radiotherapy is effective in the early stages of Dupuytren’s disease, where there is no contracture (stage N), or at a contracture of up to 10 degrees (N/I). Only patients whose disease has progressed within the last 6 - 12 months should be treated with radiotherapy. With the aim to treat nodules and cords to the level of the periostium of the hand bones. Patients with more advanced disease should instead be offered surgical release.

Radiotherapy Effectiveness

A prospective trial randomising patients between two dose levels looked at 129 patients (Seegenschmidt 2001), all of whom had disease that had progressed within the last six months. Patients were treated to a depth of 5 - 15 mm (down to the periostium of hand bones), with untreated areas shielded with lead. Patients were randomised to 12 Gy in 7 fractions, each (with an eight week gap between phases, so total dose 30 Gy), or 21 Gy in 7 fractions, given on alternate days over a period of 15 days. The treatment was well tolerated, with acute grade 1 toxicity of 38% and grade 2 toxicity of 6%. There was a chronic grade 1 toxic rate of 5% at 12 months. At 12 months follow-up the overall treatment failure rate was 8%, with 2% needing corrective surgery. Progression by stage was: 0% in stage N, 5% in N/I, 10%, in N II, 40% in N III. There was no significant difference in efficacy or toxicity between the two dose groups.

Radiotherapy for Benign Diseases

Whilst radiotherapy is mostly used to treat cancer, it is also used to treat benign disease due to its anti-inflammatory and anti-proliferative effects. The anti-proliferative effect for example can be used to reduce the risk of heterotopic ossification following hip replacement, and the anti-inflammatory effect for the treatment of thyroid eye disease. The dosages of radiotherapy for the treatment of benign conditions are generally below the range used to treat cancer, and so for most patients acute toxicity is not a problem.

Table 1: Staging classification of Dupuytren’s disease (Tubiana, Radford)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Clinical symptoms</th>
<th>Extent of extension deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Nodules, cords, skin retraction etc</td>
<td>None</td>
</tr>
<tr>
<td>N/I</td>
<td>As stage N + deformity of fingers</td>
<td>1 - 10°</td>
</tr>
<tr>
<td>I</td>
<td>As stage N + deformity of fingers</td>
<td>11 - 45°</td>
</tr>
<tr>
<td>II</td>
<td>As stage N + deformity of fingers</td>
<td>46 - 90°</td>
</tr>
<tr>
<td>III</td>
<td>As stage N + deformity of fingers</td>
<td>91 - 135°</td>
</tr>
<tr>
<td>IV</td>
<td>As stage N + deformity of fingers</td>
<td>&gt;135°</td>
</tr>
</tbody>
</table>

Table 2: Treatments for early and advanced stages of Dupuytren’s disease

<table>
<thead>
<tr>
<th>Stage</th>
<th>Treatment Options</th>
<th>Radiotherapy</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>N/I</td>
<td>Collagenase</td>
<td>Radiotherapy</td>
<td>NA</td>
</tr>
<tr>
<td>I</td>
<td>Needle saponuotomony</td>
<td>Radiotherapy</td>
<td>NA</td>
</tr>
<tr>
<td>II</td>
<td>Collagenase</td>
<td>Radiotherapy</td>
<td>NA</td>
</tr>
<tr>
<td>III</td>
<td>Collagenase</td>
<td>Radiotherapy</td>
<td>NA</td>
</tr>
<tr>
<td>IV</td>
<td>Collagenase</td>
<td>Radiotherapy</td>
<td>NA</td>
</tr>
</tbody>
</table>

Traditional flowchart for treatment of Dupuytren’s disease

Nodules \→\ Cords \→\ Contracture \→\ Release of Contracture

Radiotherapy Effectiveness

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A long-term follow-up of this study [Seegenschmiedt] looked at the outcomes of patients followed up for at least five years. 406 patients were treated with radiotherapy, (total dose 21 Gy or 30 Gy, as above), with a non-randomised control group of 83 patients consisting of those who chose to be observed rather than treated. All had progressive disease in the last 6 - 12 months. Side-effects in the irradiated group were acute toxicity in 28% (2% grade 2), and chronic toxicity in 14% (all grade 1). Acute and chronic toxicity rates were increased in the 21 Gy group compared with the 30 Gy group, and overall disease progression by stage was: stage N = 10%, N/I = 43%, I = 58%, II-IV = 89%.

Regarding efficacy, significant reduction in disease progression and the need for surgery was demonstrated in both treatment groups compared with the control group, although there was no significant difference between the two treatment groups (see table 3 below).

**Table 3:** Effectiveness of radiotherapy at 8.5 years, compared with no treatment (control group)

<table>
<thead>
<tr>
<th>Regressions/stable (%)</th>
<th>Progression (%)</th>
<th>Surgery (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control (n=122)</td>
<td>38</td>
<td>62</td>
</tr>
<tr>
<td>30 Gy (n=245)</td>
<td>80</td>
<td>20</td>
</tr>
</tbody>
</table>

**Conclusion**

Radiotherapy is an effective and well-tolerated treatment when used in early Dupuytren’s disease. It reduces the formation of contractures and the need for corrective surgery.

**References**


**NEW CONSULTANTS**

Bupa Cromwell Hospital gives a warm welcome to the consultants below who were recently granted Practice Privileges. Our consultants are committed to an extremely high level of care and provide an excellent service to our patients.

- Dr Anselm Uebing, Consultant Cardiologist, Adult and Paediatric Privileges
- Dr Julian Collinson, Consultant Cardiologist, Adult Privileges
- Dr Ian Gabriel, Consultant Haematologist, Adult Privileges
- Dr Tarig Husain, Consultant Anaesthetist, Adult Privileges
- Dr Javid Khan, Consultant Anaesthetist, Adult Privileges
- Dr Robin Kumar, Consultant Anaesthetist, Adult Privileges
- Mr Krishna Menon, Consultant Surgeon, Adult Privileges
- Dr Kate Newbold, Consultant Clinical Oncologist, Adult Privileges
- Dr Francesca Rubulotta, Consultant Anaesthetist, Adult Privileges
- Dr George Samandouras, Consultant Neurosurgeon, Adult Privileges
- Dr Richard Shaffer, Consultant Clinical Oncologist, Adult Privileges
- Dr Donald Whittaker, Consultant Cardiothoracic Surgeon, Adult Privileges

The following two consultants have had their Practice Privileges updated: Mr Ahmed Ahmed, Consultant GI and Bariatric Surgeon, privileges extended to include bariatric practice for 11-17 year olds. Dr Gavin Wright, Consultant Anaesthetist, privileges extended to include paediatric patients.

- Mr Ahmed Ahmed, Consultant GI and Bariatric Surgeon, privileges extended to include bariatric practice for 11-17 year olds.
- Dr Richard Shaffer MBBS, BSc (Hons), MRCP, FRCR is a Consultant Clinical Oncologist at the Royal Surrey County Hospital and Bupa Cromwell Hospital. To make an appointment please call 0800 783 9229.