MEDISCENE

The Bupa Cromwell Hospital magazine for General Practitioners

ISSUE 02

IN THIS ISSUE

BUPA CROMWELL HOSPITAL

Bupa

WELCOME

Philippa Fieldhouse

We are very excited to announce the opening of our new Women's Centre this June. The centre combines comfort, convenience and clinical excellence all under one roof. Our expert consultants will offer a wide variety of high-quality services for your patients, including gynaecology and sexual health, menopause screening, breast care, cardiology and endocrinology.

In honour of the opening we have decided to focus the entire second issue of *MEDIscene* on women's health. Based on our conversations with GPs, we've chosen topics you've expressed an interest in, such as the management of irritable bowel syndrome, advances in breast surgery and approaches to women's heart disease. We look forward to hearing your thoughts and hope you will find this edition informative and educational.

With warm regards,

Philippa Fieldhouse
Director of Operations
Bupa Cromwell Hospital

MEET THE GP LIAISON TEAM

Richard Longes

Amit Sharma

The GP Liaison team provides a bespoke service for GPs. We can assist you in any enquiry and help facilitate patient referrals via our dedicated referral line – **Cromwell Direct.**

We understand that our GP colleagues want to keep up-to-date on new treatments, diagnostics and services. Therefore, we work closely with the hospital consultants to coordinate our educational programme, which can be found on our website in the health professionals section. If you are unable to attend, we can arrange a practice visit talk at a time convenient for you.

If you have any questions or would like more information about Bupa Cromwell Hospital please contact us:

Richard Longes
07714 386 680
020 7460 5909
richard.longes@cromwellhospital.com

Amit Sharma
07912 560 096
020 7460 5842
amit.sharma@cromwellhospital.com

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

BREAST CANCER TREATMENT

HALSTED TO 2012

Mrs Jaqueline Lewis

Mrs Jacqueline Lewis MB BCh BAO FRCS(Plast) is a consultant breast surgeon at Bupa Cromwell Hospital and Charing Cross Hospital.

Breast cancer treatment has come a long way since the time of our grandmothers. There have been advancements in adjuvant therapies, diagnostics and surgery, and the multi-disciplinary approach has revolutionised care. Surgeons are no longer frequently faced with having to cut away large chunks of cancerous tissue with a wide margin of normal surrounding flesh for an advanced fungating tumour.

Surgery

In 1889 Halsted described a novel procedure for the treatment of breast cancer – the radical mastectomy. At the turn of the 20th century breast cancer was a devastating disease with no documented successful treatment, surgical or otherwise. In addition, it was uncommon to operate for palliation, and as a result, most women suffered with their cancerous growths spreading and invading the chest wall. Halsted's operation of en-bloc removal of the breast, lymph nodes and muscles of the chest wall had the immediate impact of removing the necrotic foul-smelling tumour and offered real hope for victims of breast cancer at the time, even if cure was not always possible.

As time has gone by, the surgical pendulum has swung from the radical mastectomy to removing less and less tissue – breast conserving surgery. This is because the survival rates of women having breast conservation surgery and mastectomy are comparable (if not equivalent) because of the addition of effective adjuvant therapies. This concept however, has led to a significant number of women feeling they were left 'mutilated' despite conserving their breast.

Oncoplastic techniques

The UK Department of Health has been a leader in supporting an innovative programme to expand training in breast reconstruction in the United Kingdom. Over the last decade, over 100 trainee surgeons have participated in this programme aimed at producing surgeons fit to practice in modern oncoplastic and reconstructive breast surgery. Patients in the UK are now better able to access surgeons with experience in the full range of procedures encompassed by oncoplastic breast reconstructive surgery, which include:

- appropriate adequate surgery to extirpate the cancer
- partial reconstruction to correct wide excision defects
- immediate and delayed total reconstruction with access to a full range of techniques
- correction of asymmetry of the reconstructed and the contralateral unaffected breast

Continued >>

NURSE CONSULTANT IN BREAST CARE

Harriet Kennedy

Our breast care service is run by a nurse consultant in breast care, offering support and practical advice to people dealing with any breast condition, particularly breast cancer. Harriet holds a Master's degree in advanced cancer nursing practice and is an independent nurse prescriber. She has considerable experience in all aspects of breast care. Her calm, friendly yet professional approach makes her a great support for patients.

Harriet has spent many years helping patients through the experience of breast cancer, including as an oncology nurse, and can help to guide those who are making decisions about surgery, chemotherapy and radiotherapy treatment. She can also help arrange appointments for your patients with any member of our breast team and accompany your patient to their specialist consultation or imaging appointment.

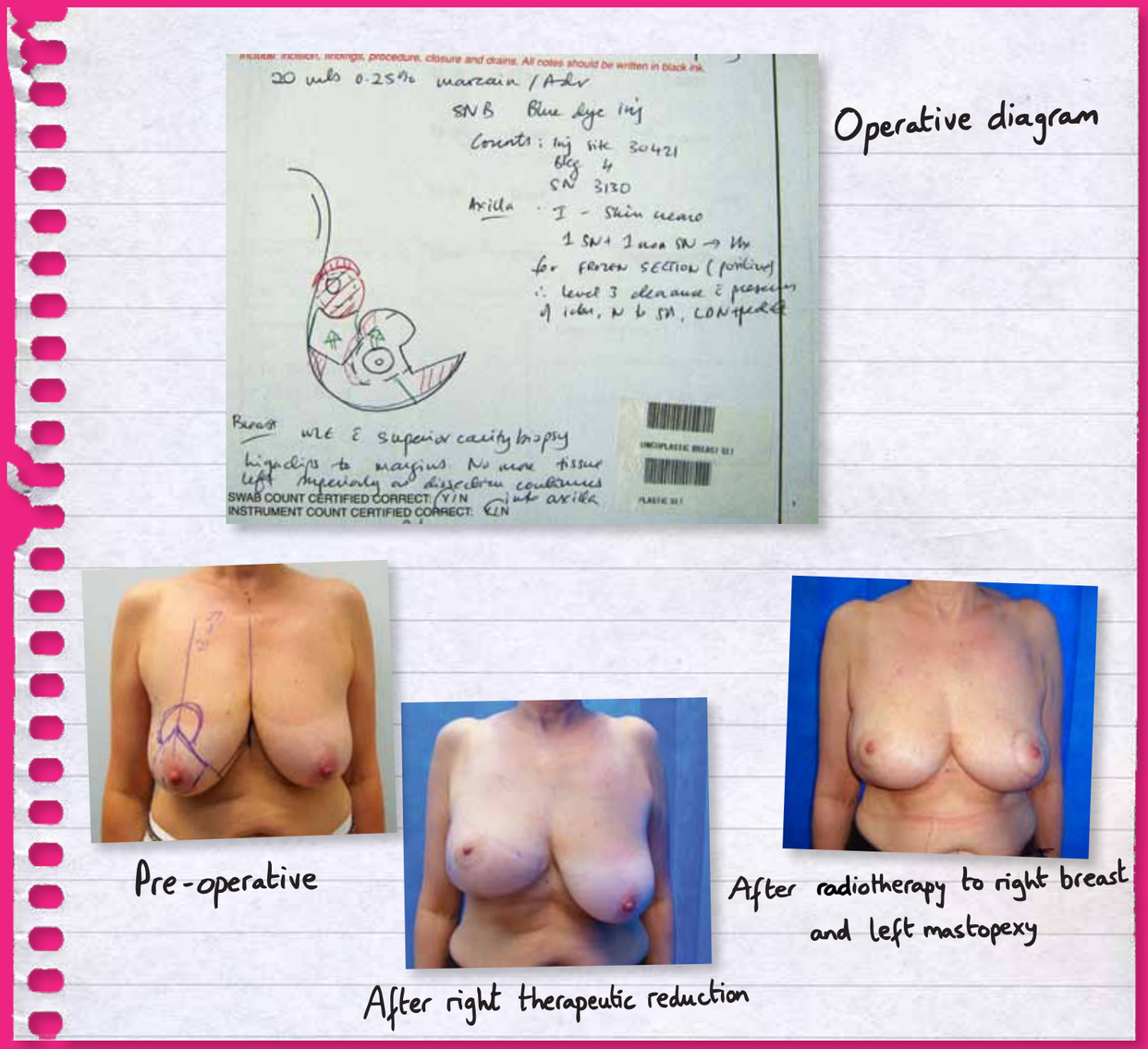
To make an appointment for one of your patients, please call +44 (0)20 7460 5890.

BREAST CANCER TREATMENT
A CASE STUDY

One type of oncoplastic procedure is the 'therapeutic reduction'. It allows a wide excision margin and reshaping of the breast based on mastopexy or breast reduction principles, often offering a very satisfactory cosmetic result.

Ms R is a 50 year old woman who found a lump in the upper outer quadrant of her right breast. There was a spiculate mass on the mammogram corresponding to the palpable lump and ultrasound showed a hypo echoic lesion. Needle core biopsy showed a Grade III invasive ductal carcinoma.

She had a right breast wide local excision and therapeutic breast reduction, sentinel node biopsy and level 3 axillary clearance for this 25 mm cancer with micro metastases in the sentinel node. Post-operatively she had chemotherapy, radiotherapy and 15 months later had a symmetrising left mastopexy.



Sentinel node biopsy

A frequently asked question and most feared complication regarding axillary node surgery is the likelihood of lymphoedema or swelling of the arm. It occurs in 15 to 40 percent following axillary node clearance and is more likely if combined with radiotherapy to the axilla. With the advent of sentinel node biopsy, unnecessary axillary clearance can be avoided, thereby reducing the number of women with this complication.

Sentinel node biopsy involves removal of the first node receiving lymphatic drainage from an area of interest. It involves the injection of a radioactive and blue dye so that the 'hot' blue node can be removed and carefully studied histologically for cancer cells.

With a positive sentinel node (containing cancer), a completion axillary clearance or radiotherapy to the axilla are undertaken. Further surgery gives more prognostic information about the number of nodes that contain cancer.

Early diagnosis

Early diagnosis as a result of 'breast awareness' and mammographic screening has meant that for most women, breast cancer is diagnosed at an early stage where the aim of treatment is cure rather than palliation.

In 2010-2011, the UK NHS Breast Screening Programme detected 14,725 cancers in women aged 45 and over, a rate of 7.8 cases per 1,000 women screened. Of these, 80 percent of the cancers were invasive. Most of the detected cancers were small (less than 15 mm diameter) invasive or non-invasive cancers.

While the opponents of mammographic screening argue that more non-invasive cancers are picked up that would never cause any trouble and that women are put through unnecessary biopsies causing unnecessary anxiety, it remains a fact that earlier diagnosis of breast cancer leads to better survival outcomes.

Most women undergoing mammographic screening have a normal result. Only three to seven percent (higher number called back after first rather than subsequent screening mammogram) of women screened are called back for an assessment where further mammogram views are taken and a breast ultrasound performed. Most of these women can then be reassured that they do not have breast cancer. Forty percent of those called back for assessment go on to have a needle core test or fine needle aspirate.

Adjuvant therapy

With the advent of new and effective adjuvant therapies, less extensive surgery is more often possible. Upfront chemotherapy or endocrine treatment can be used to downsize large tumours to allow breast conservation surgery rather than mastectomy. Neoadjuvant therapies also allow switching of drugs if the response to the first regimen is poor.

New chemotherapeutic regimes, endocrine therapies (ie aromatase inhibitors like anastrazole, exemestane, letrozole), monoclonal antibodies (ie Herceptin), and radiotherapy as a single treatment intraoperatively (TARGIT), potentially make breast cancer treatment less invasive with more promising outcomes.

Chemotherapy is one of the most feared treatment modalities for breast cancer with women dreading the frequent hair loss, nausea and fatigue. While it is clear that most women with large, node positive, oestrogen receptor negative cancers will benefit from having chemotherapy, it is often unclear as to as whether a woman with a relatively small, node negative, oestrogen receptor positive breast cancer should have chemotherapy. There is now the option for an assay of an individual woman's cancer with the use of Oncotype DX (a multigene breast cancer assay) that can predict whether she would benefit from chemotherapy. This test has proved to be extremely valuable in selected cases, so much so that the cost of the assay is covered by most private health insurance companies.

Treating breast cancer is an ever-evolving specialty, with challenging aspects. We do now however have so many more tools to enable us to tailor treatment to fit each individual patient according to their informed choice.

INVESTIGATION AND TREATMENT OF IRRITABLE BOWEL SYNDROME (IBS)

Professor Ingvar Bjarnason MD, MSc, FRCPath, FRCP, DSc is a consultant physician and gastroenterologist at Bupa Cromwell Hospital and Professor of Digestive Diseases at King's College Hospital.

Abdominal bloating, abdominal pain, rumbling or a gurgling noise (borborygmus), a change in bowel habits, constipation and or diarrhoea, incomplete evacuation, post-prandial urgency to defaecate, tiredness, lack of initiative, pelvic floor pain, food intolerances, etc. Do these symptoms sound familiar? If so, is your first thought whether this represents IBS, inflammatory bowel or coeliac disease, or some more sinister gastrointestinal pathology? Almost certainly!

IBS is one of the most common disorders of the digestive system in the UK. About one in six people have occasional symptoms of the disease. Women are more likely to get IBS than men, as well as to have more severe symptoms.

We are all familiar with the dilemma of how aggressively and thoroughly we should be investigating patients with these symptoms. No one wants to miss a significant pathology such as colitis or colorectal cancer that may present with similar symptoms, but neither do we want to subject patients to unnecessary, invasive and sometimes painful investigations, which by themselves carry risks of complications. However, there have been significant advances in the non-invasive and positive diagnosis of IBS and certainly by taking a co-ordinated approach to medical, dietary and lifestyle-psychiatric treatments or changes, we are now realistically approaching a goal of getting IBS patients 70 percent better.

Making an accurate diagnosis of IBS

Diagnostic symptomatology can be assessed by the ROME III criteria, which stipulates that given a patient with recurrent abdominal pain or discomfort at least three days a month in the last three months, associated with two or more of the following:

- improvement with defaecation
- onset associated with a change in frequency of stool
- onset associated with a change in form (appearance) of stool

– and no red flag symptoms (PR bleeding, anaemia, significant weight loss, etc) – then there is a good probability of the patient having IBS. However, the certainty of the IBS diagnosis can be improved four-fold with some simple non-invasive investigations that are now available at Bupa Cromwell Hospital. These include:

- intestinal absorption-permeability test (abnormal in most small bowel disease)
- faecal calprotectin, which is a uniquely sensitive measure for intestinal inflammation and virtually raised in all patients with untreated IBD and most patients with colonic disease
- quantitative intestinal disaccharidase test (establishes lactase or sucrase deficiency and predicts the response to dietary treatment)
- wireless capsule enteroscopy

Given a positive ROME III symptom score and normal faecal calprotectin, +/- intestinal permeability, +/- capsule enteroscopy there is almost no other possible diagnosis than IBS, especially in patients under 50 years of age. By employing these criteria most patients do not require colonoscopy, CT colonography, CT or MRI-enterography or duodenal biopsy.

When to refer patients

IBS is a lifelong disease, frequently associated with extra-intestinal symptoms (fibromyalgia, interstitial cystitis, menstrual irregularities, sexual dysfunction, headaches, hyperventilation, tachycardia, anxiety and depression, etc.) each of which may otherwise require symptomatic treatment. Given that an integrated approach to IBS treatment by enthusiasts yields a much better outcome, it is better to refer to the specialist sooner rather than later, so that a comprehensive treatment schedule can be formulated. An important consideration is that endometriosis can mask under the umbrella of IBS so a close collaboration with a gynaecologist is essential, especially for patients with pelvic pain.

Modern approach to treatment

The mainstay of IBS treatments is changing rapidly. Having made the diagnosis from the above tests it is important to address the principal symptoms and their possible treatments.

The conventional treatments of bulking agents (for constipation), opioid receptor antagonists (for diarrhoea), antispasmodics (mebeverine and buscopan, peppermint preparations) and antidepressants (for pain) are well tested and largely ineffective and certainly not evidence-proven. As a result many patients seek alternative treatments, most of which are equally unproven.

The first treatment is the consultation where the specific and most problematic symptoms are elucidated and discussed. Gynaecologic referral may be made, depending on symptoms and it is useful to exclude endometriosis in women as investigation and treatments may differ significantly.

Because of its location, Bupa Cromwell Hospital attracts a number of very driven professional individuals that are under undue stress in their jobs. My first consultation therefore always explores underlying lifestyle issues and anxieties about the symptoms. With the investigational results to hand, I try to reassure the patient that the symptoms are functional. A minority of patients then express a wish to proceed to invasive investigation, such as gastroscopy. If endoscopy/colonoscopy/ERCP, etc, is required then Bupa Cromwell provides these services quickly and at a level par excellence.

Psychiatric and lifestyle issues

Anxiety and worry (at times approaching panic attacks), sleeping disturbances and lifestyle issues are best addressed by a dedicated psychiatrist who more often than not manages to treat these symptoms by one of the various forms of CBT and by other non-pharmacologic measures (depending on symptoms and severity).

Dietary measures

It is important for a dietitian to assess specific food sensitivities. Many patients have already identified common foods such as tomatoes and cucumbers, but there are many others causing abdominal pain, diarrhoea, etc. Many place these symptoms in the context of "food allergy" which is actually a very rare occurrence in adults. There are extensive panels of specific serologic antibodies for a wide variety of foods available, but their impact on clinical decision-making is still being evaluated.

The most common offending food contributing to IBS symptoms, especially abdominal bloating, is wheat. A consultation with a dietitian with an information sheet on how to avoid dietary wheat is helpful for many patients with bloating (a very common and problematic symptom in women) and is relatively simple to adhere to.

More recently a low FODMAP (stands for Fermentable, Oligo-, Di- and Mono-saccharides and Polyols) diet is used to describe a regime largely excluding fermentable short-chain carbohydrates. The advantage of this treatment is that it is not particularly restrictive in the amount of food that the patients can eat and after three months of adherence patients can often successfully re-introduce the sugars to their diet without detriment to symptoms. A low FODMAP diet has been shown to be particularly effective for bloating. This diet has undergone (open-labelled) trials and shows great promise. It requires a 45-60 minute consultation with a specialist dietitian, again available at Bupa Cromwell Hospital.

The Candida diet (starch, wheat and mould-free) is reserved for the extremely rare patient and few can adhere to this diet in the long-term.

Probiotics

Of the hundreds of probiotics that are available over the counter only a few have undergone rigorous clinical trials. All of the probiotics differ in their bacterial composition and the results from a trial using one of these cannot be extrapolated over to the other as the outcomes depend on the amount of bacterial principal delivered, their viability and their specific strains. The probiotic VSL-3 has shown some promise in patients with IBS although its main use may be in pouchitis.

However a probiotic called Symprove (a liquid mixture of live bacteria) has just shown itself to be significantly better in reducing IBS symptom severity in a double-blind, placebo-controlled trial. The main effect is on abdominal pain and bowel habits.

Summary

Bupa Cromwell Hospital is in a unique position as it provides all of the non-invasive diagnostic tests needed to confidently diagnose IBS, without resorting to colonoscopy or imaging procedures other than ultrasound in the vast majority of cases. Furthermore, by taking an integrated and individualised approach to the treatment of IBS through bringing together a dedicated team of experts, we are achieving increasingly greater symptom relief in patients with IBS with great potential for improvement in their quality of life.

A GENDER DIFFERENCE IN HEART DISEASE:

Cardiovascular disease is NOT just a man's disease

Dr Raffi Kaprielian MB BS MA MD FRCP is a cardiologist at Bupa Cromwell Hospital, West Middlesex Hospital and Hammersmith Hospital (Imperial NHSTrust)

Cardiovascular disease remains the leading cause of death in women in most developed countries including the UK, exceeding the combined deaths from stroke, lung cancer, chronic obstructive pulmonary disease and breast cancer.

The rates of population and in-hospital cardiovascular mortality have significantly declined in Europe and USA since the year 2000, but higher rates of cardiovascular deaths in women continue to exist (in Europe 54 percent of all females' death are from CVD compared with 43 percent in men).

Despite the prevalence of heart disease in women, many doctors, and indeed the public themselves, may still regard heart disease as a man's disorder. As a consequence, the success of tackling the known risk factors for the development of heart disease in women - and even treatment of symptomatic women presenting with established heart disease - remains sub-optimal and outcomes are significantly worse than for men.

GPs and obstetricians/gynecologists can play important roles in tackling heart disease in women. This includes increased patient education regarding cardiovasular disease prevention, screening in the primary care setting, increased treatment in primary care and increased referral to cardiologists (especially for assessment of symptoms and for primary prevention in moderate to high-risk patients).

Does primary prevention differ between the sexes?

The risk factors for developing heart disease are very similar between men and women. These include:

- diabetes mellitus*
- hypertension*
- hypercholesterolaemia
- smoking
- central obesity
- sedentary life style*
- adverse family history
- lack of exercise
- dietary patterns

**stronger effect on cardiovascular risk then for men*

The perception that women are relatively protected means these risk factors may not be treated aggressively. However, women have an accelerated incidence of ischaemic heart disease in the post-menopausal years, presenting approximately five to ten years after men on average.

These presentations have higher incident mortality, higher mortality of cardiac intervention including invasive procedures such as coronary angioplasty and coronary artery bypass surgery and poorer control of cardiovascular symptoms (despite their documented lower angiographic disease burden).

How is cardiovascular disease associated with menopause?

After menopause, a woman's risk of cardiovascular disease increases with reduced levels of oestrogen. In women who have undergone early menopause (before age 50) or surgical menopause, the risk of cardiovascular disease is also higher, especially when combined with other risk factors.

A reduced level of oestrogen causes:

- increased rate of development of atherosclerosis
- measurable changes in the plasma lipids: increase in LDL and decrease in levels of HDL
- an increase in fibrinogen levels (pro-thrombotic)

What is the role of hormone replacement therapy (HRT)?

Preliminary observational research showed that HRT could reduce the risk of heart disease in post-menopausal women. However it now appears that this effect was likely due to the lifestyles of women taking HRT rather than the medical benefits.

More recent large-scale studies of women, such as the Heart and Estrogen/Progestin Replacement Study (HERS) and the Women's Health Initiative (WHI) concluded that the overall health risks of HRT exceeded the benefits.

Women in the HERS study had an increased risk of heart attack and stroke during the first year of taking HRT. After two years of treatment, this risk appeared to be reduced.

Continued >>

Women in the WHI study had an increased risk for breast cancer, coronary heart disease (including nonfatal heart attacks), stroke, venous thrombosis, and gall bladder disease. Thus:

- HRT should not be used for cardiovascular protection.
- The use of HRT for preventing osteoporosis should be carefully considered and the risks weighed against the benefits. Women who have existing coronary artery disease should consider other options.
- HRT may be used for short-term treatment of menopausal symptoms.
- Long-term use is discouraged because of increased risk for heart attack, stroke, and breast cancer.

How does heart disease present differently between the sexes?

It is now clear that the basic pathophysiological mechanisms and presentation of cardiac disease (both ischemic heart disease and cardiac failure) differ between the sexes.

Ischaemic heart disease

Presentation

The symptoms of cardiac ischaemia in women are often unusual. Instead of the classic crushing chest pain, sweating and shortness of breath that is described in the text books, women also often complain of vague symptoms - fatigue, an upset stomach, or pain in the jaw or shoulders. This may lead to delays in diagnosis and referral.

Men present more often than women with ST-segment elevation myocardial infarction and have a higher prevalence of CAD adjusted to age. However, women present more frequently for the evaluation of chest pain and are more frequently hospitalised for it.

Pathophysiological differences

These clinical differences reflect basic pathophysiological differences between the sexes. Important factors in women include smaller coronary artery size and less obstructive coronary artery disease seen along the entire spectrum of acute coronary syndromes and across all age groups. This 'advantage' appears more marked in the coronary tree than in other vascular beds. The burden of coronary atheroma appears less using CT calcium scores or with intravascular ultrasound. Women are seen to have more concentric atheroma than men (as opposed to eccentric obstructing plaques).

Coronary microvascular dysfunction is postulated as an important aetiological factor for IHD in women and a frequent determinant of chest pain in the absence of significant coronary obstruction. The presence of microvascular dysfunction is not benign: it has been significantly related to increased risk of major adverse outcomes (death or hospitalisation for non-fatal AMI, congestive heart failure or stroke), with an adjusted hazards ratio of 1.14 per unit decrease in log-transformed coronary flow reserve.

Cardiac failure

Cardiac failure is a disease of the elderly with incidence and prevalence rising steeply above the age of 70. The prevalence is in fact more common in men, apart from in the 80+ age group. Women with clinical heart failure (breathlessness, easy fatigue, ankle oedema, orthopnoea, raised BNP) will tend (in comparison with men) to:

- be older - often over 80 years
- have preserved systolic function (so-called diastolic heart failure)
- have associated atrial fibrillation
- have a history of hypertension
- have a poorer response to therapy; indeed there are few proven therapies to be effective in diastolic heart failure (eg candesartan)

Recognition of the syndrome, accurate diagnosis and institution of effective therapies especially in systolic failure (including ACE inhibitors, beta-blockers, angiotensin antagonists, aldosterone antagonists and anticoagulation), has improved although there is clearly an ongoing need for better care coordination, including the close consultation of primary care physicians with cardiologists.

When should you refer to a cardiologist?

Primary prevention

If you have a female patient with one or more cardiovascular risk factors (ie moderate to high risk for future events) and you are uncertain whether to commence pharmacological intervention, then a referral for a full cardiovascular assessment is justified. Intervention in women from a younger age will help prevent the development of the atherosclerotic process.

Hypertension and heart failure

Development of heart failure with preserved function is a common presentation in women over 80. This condition is difficult to manage. Referral to a cardiologist should be considered for early recognition and treatment of hypertension to prevent the onset of symptoms, as well as for assessment and treatment in symptomatic patients.

Ischaemic heart disease

The development of exertional symptoms, even if not typical for angina or heart failure, warrants referral to a cardiologist for a full assessment. Detailed investigations including functional testing with imaging modalities such as stress echocardiography and CT angiography can be used to establish diagnosis and assess the need for invasive tests and revascularisation.

ENDOMETRIAL CANCER: AN UPDATE

Miss Jane Bridges

Miss Jane Bridges MBChB FRCOG is a gynaecologist at Bupa Cromwell Hospital and Chelsea and Westminster Hospital.

Endometrial cancer is the most common gynaecological cancer in the developed world. In Great Britain the incidence is increasing in post-menopausal women and it is now the fourth most common cancer in women in the UK after breast, colon and lung.

Who gets the disease?

The majority of women developing endometrial cancer are post-menopausal (90 percent). Risk factors for the disease include factors which increase chronic exogenous or endogenous exposure to oestrogen (see below). The rise in obesity levels has been attributed to the increase of this disease within the UK.

Risk factors for endometrial cancer
Post-menopause/increasing age
Obesity
Early menarche and late menopause
Polycystic ovarian syndrome
Low parity family history
Lynch syndrome
Diabetes
Oestrogen-secreting tumours
Hypertension
Breast cancer
Hormone replacement therapy
Tamoxifen
Previous pelvic radiotherapy
Unopposed oestrogen
High fat/high carbohydrate diet

Symptoms at presentation and making the diagnosis

Symptoms in pre-menopausal women usually present as prolonged irregular or inter-menstrual bleeding. Post-menopausal bleeding, however, has always been the traditional symptom that raises suspicion of endometrial cancer, although it is estimated that of all women with PMB, only five to ten percent will have any sinister pathology.

Post-menopausal bleeding should always be investigated and the first line investigation of choice after a clinical examination should be a transvaginal ultrasound. This allows visualisation of the endometrium so that the thickness can be measured and any other pathology, such as uterine polyps, can be detected. In those women with a single episode of bleeding, who have an endometrial thickness of less than 5 mm, and no other obvious pathology, it is safe to adopt a conservative approach. All other women should have an endometrial sample performed to obtain tissue for histology. This can be performed in an out-patient setting (pipelle biopsy +/- out-patient hysteroscopy) or as an in-patient (hysteroscopy dilation and curettage).

Pathology

The majority of women will have Type 1 tumours (80 to 90 percent), which are oestrogen dependent adenocarcinomas, generally of good prognosis. Type 2 tumours are more aggressive and have a much higher risk of presenting with metastatic disease at presentation and of subsequent relapse. These tumours are generally of clear cell or serous papillary type.

In those women who are diagnosed with endometrial hyperplasia, rather than a frank malignancy, the risk of a developing a subsequent endometrial cancer must be considered. Simple or complex hyperplasias have a relatively low risk of malignancy (one to three percent) and hormonal therapy with progestogens may be appropriate. Those women with complex hyperplasia with atypia however have a 30 to 40 percent chance of a concurrent carcinoma at the time of presentation.

Continued >>

Treatment

The majority of women with endometrial cancer will present with Stage 1 disease, ie disease confined to the uterus. In these patients total hysterectomy with bilateral salpingoophorectomy is the treatment of choice. This can be performed both abdominally and via a laparoscopic approach, although most cancer centres within the UK now favour the latter as recovery time after surgery is much improved.

The use of staging MRI prior to surgery enables invasion of the myometrium, cervical or ovarian involvement and enlarged lymph nodes to be identified, which together with the grade of pathology at diagnosis, will influence the decision as to whether a pelvic and or para aortic lymphadenectomy should be performed. The role of lymphadenectomy has been much debated over the last few years with conflicting data from around the world. In general, however, the consensus is that with Grade 1 early stage tumours there is probably no role for lymphadenectomy, while in high risk patients it may help plan adjuvant therapy.

Adjuvant therapy

In those women with early stage, low-grade disease no adjuvant therapy is required, including hormonal manipulation, which was given in the past. In high-risk patients with deep involvement of the myometrium and/or cervical involvement, adjuvant therapy consisting of radiotherapy (brachytherapy +/- external beam) is the treatment of choice. Those women with nodal involvement or distant disease at the time of presentation will be offered chemotherapy, often followed up by radiotherapy to help local control. Although progestogens may have a role in metastatic disease, many high-risk tumours are receptor negative and are therefore unlikely to respond to this form of treatment.

Survival

The overall survival of women with endometrial cancer is approximately 80 percent. If we are to make improvements in survival rates then early presentation and diagnosis of women must be improved together with careful individualisation of patient treatment plans depending on the tumour type, stage and grade.

THYROID DISEASE IN WOMEN

Mr Khalid Amed

Mr Khalid Amed MB BS MRCP(UK) FRCP is an endocrinologist at Bupa Cromwell Hospital and West Middlesex.

Thyroid disorders are some of the most prevalent medical problems affecting up to one percent of the general population. The female-to-male ratio is up to 20-to-1, making it predominantly, although not exclusively, a female disorder.

Thyroid disease can have a significant effect on a woman's health including menstrual disturbances and fertility problems. Hence its inclusion in this women's healthcare issue of *MEDIscene*.

There two active thyroid hormones - Tetraiodothyronine (T4) and Triiodothyroinine (T3). T4 is produced exclusively by the thyroid gland, while T3 is produced in small amounts by the thyroid gland but is mostly produced peripherally by deiodination of T4. T3 is the more effective hormone, with up to 20 times the efficacy of T4.

Thyroid hormones exert their effects by binding to nuclear receptors in virtually every cell in the body. They control energy production, hence the widespread effects in body systems seen with thyroid dysfunction.

Primary hypothyroidism

Primary thyroid failure is the most prevalent thyroid problem in the general population. Hashimoto's thyroiditis is the most common cause. Other causes include post-partum thyroiditis and iatrogenic thyroid failure (thyroidectomises or radio-iodine therapy).

Its incidence is around six new cases per 1,000 of the population annually and affects up to two percent of the female population.

Presenting symptoms include:

- lethargy
- weight gain
- dry skin
- hair loss
- general muscle aches
- sub-fertility
- disturbed menstrual cycle (menorraghia or oligomenorrhea)

Biochemical findings

- Elevated thyroid stimulating hormone (TSH)
- Low normal or low free T4
- Positive thyroid peroxisomal antibodies (anti-TPO antibodies)

Treatment

Levothyroxine (T4) is the standard treatment. It is usually started at a low dose and titrated upwards to achieve biochemical euthyroid state and symptom relief. The use of combined T4/T3 is not recommended as an initial approach. A minority of patients may benefit from this combination, but it should be used with great caution in view of the high risk of toxicity.

Pitfalls in the diagnosis of hypothyroidism

The 'sick euthyroid state' is a reflection of the body's own adaptive mechanisms to combat acute illness. It is mainly reflected in the thyroid stimulating hormone (TSH) levels. TSH is low during acute illness and will rise above the upper limit of normal during the recovery phase. It can take up to 12 weeks to reach equilibrium. Therefore, a diagnosis of hypothyroidism should be made with great caution during acute illness and the recovery period after acute illness.

Post-partum thyroiditis

This is an autoimmune mediated destructive thyroiditis occurring in the weeks and months after delivery. It can occur up to nine months after delivery with a median of 13 weeks. Its incidence has been reported to be five to nine percent of unselected post-partum women.

It starts with an initial biochemical and clinical thyrotoxic phase due to overspill of thyroid gland stores as a result of the inflammatory state. This is followed by a hypothyroid phase with ultimate complete recovery in the majority of patients.

It is vital to recognise this condition as the management is different from other causes of thyroid dysfunction.

During the toxic phase, beta-blockers, if not contraindicated, could be used to control symptoms of thyroxin excess. Anti-thyroid drugs are not indicated as the condition is that of a destructive thyroiditis, not of overproduction.

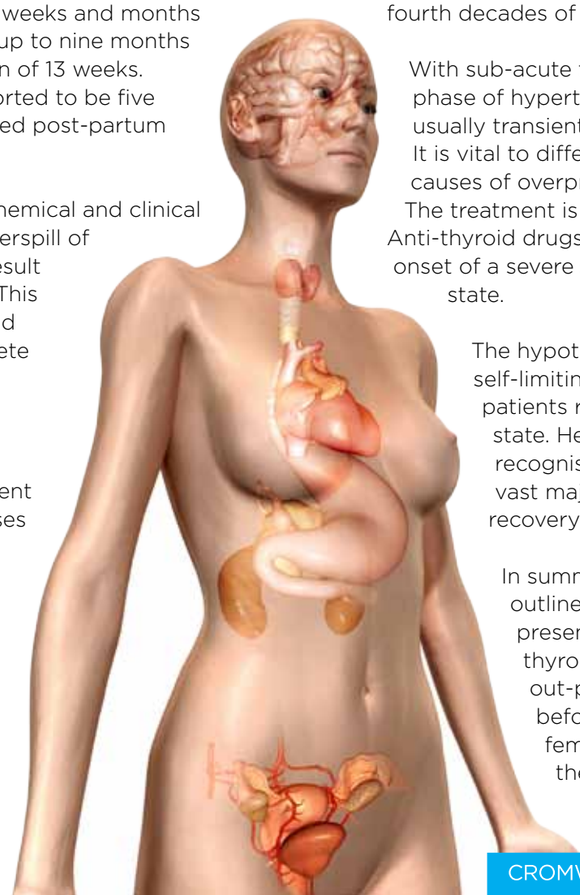
In the hypothyroid phase, the management is dictated by the severity of symptoms. In some patients one might be able to monitor without thyroid hormone treatment. In others, the severity of symptoms dictates treatment with thyroxin for up to 12 months. At that stage one can consider withdrawal of treatment for up to eight weeks and observing for potential recovery of the thyroid gland.

These patients should have thyroid function tests at annual intervals if fully recovered. In the presence of positive anti-TPO antibodies, up to 50 percent are likely to become permanently hypothyroid within seven years.

We should be aware that Graves' thyrotoxicosis can present de novo in the post-partum period, necessitating careful evaluation of these patients prior to diagnosis and treatment.

Sub-acute thyroiditis

Sub-acute thyroiditis is a transient inflammatory thyroiditis thought to be of viral aetiology. It usually follows an upper respiratory tract viral illness. Patients can present with neck discomfort or symptoms of thyroid hormone excess or deficiency. Females affected outnumber males by up to six-to-one with a prevalence of cases in the third and fourth decades of life.



With sub-acute thyroiditis there is an initial phase of hyperthyroxinaemia followed by a usually transient phase of hypothyroidism. It is vital to differentiate this from other causes of overproduction thyrotoxicosis. The treatment is that of symptom control. Anti-thyroid drugs can precipitate a rapid onset of a severe symptomatic hypothyroid state.

The hypothyroid phase is usually self-limiting, with up to 90 percent of patients recovering to normal thyroid state. Hence, the importance of recognising this condition, as in the vast majority of cases complete recovery without treatment is likely.

In summary, we have briefly outlined some of the common presentations and pitfalls of thyroid disease in an endocrine out-patient clinic. As mentioned before, it is not exclusive to females, but they constitute the vast majority of thyroid patients.

AUDIOLOGY AND HEARING AID SERVICE

Audiology services

Our well reputed and long established audiology department offers a comprehensive range of advanced adult and paediatric diagnostic tests within a purpose built soundproofed environment. Due to the success and demand for audiology services, we have recently purchased the most up-to-date equipment for testing the hearing of children aged 6 - 30 months (visual reinforced audiometry). We have also invested in a new portable otoacoustic emissions machine (to check cochlear outer hair cell function), capable of delivering rapid results, essential when testing babies and young children.

We provide the following diagnostic tests:

- pure-tone audiometry for assessing adults and children
- visual-reinforced audiometry, play audiometry and performance testing for assessing children
- middle ear and outer hair cell function are tested using tympanometry and otoacoustic emissions respectively
- auditory brainstem function for testing thresholds of patients unable to cooperate for subjective hearing tests
- full vestibular investigations are performed on patients referred for balance disorders

We liaise with ENT consultants, speech and language therapists and other health professionals to deliver an efficient and high standard of care. We aim to co-ordinate appointments for patients' convenience and offer flexible appointment times, including some evening clinics.

Hearing aid service

We offer the latest digital technology available on the market in a variety of sizes and colours, including the most discreet in-the-ear fitting, to suit a client's individual requirements. Clients have a 30-day trial period during which time a full refund is offered if they are not satisfied with their hearing aids. Hearing aids have a two to five year warranty, and clients are entitled to an unlimited number of hearing aid follow-up appointments. For clients' convenience, flexible appointment times can be arranged.

When to refer a client

- Hearing loss at any level (mild - profound) that does not require an ENT opinion.
- As a potential method of reducing the perception of tinnitus. Clients may become less aware of their tinnitus while a hearing aid is being worn to aid an associated hearing loss in that ear.
- A noise reduction strategy is required in the form of customised noise plugs.

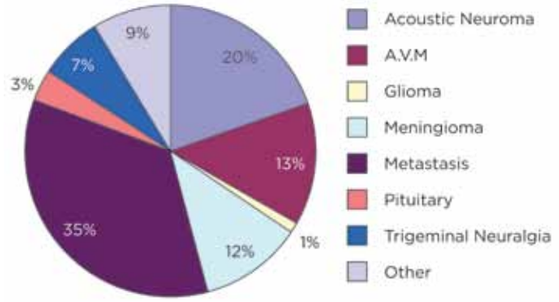
For more information on audiology services at Bupa Cromwell Hospital, please contact Lead Audiologist, Scott Drummond, on +44 (0)20 7460 5771.

BRAIN SURGERY WITHOUT A SINGLE INCISION

Gamma Knife is a non-invasive neurosurgical tool for treating conditions affecting the brain, head and neck. It allows shorter hospital stays and less straining treatment.

The Gamma Knife Centre at Bupa Cromwell Hospital was the first in London and opened in 1998. Since that time, we have successfully treated over 2,000 patients. Gamma Knife uses a single dose of highly focused radiation to destroy tumours and leave the surrounding healthy tissue undamaged. It is particularly useful for treating metastatic tumours, acoustic neuromas, trigeminal neuralgia (an excruciating spasmodic pain), arteriovenous malformations as well as skull base tumours meningiomas and pituitary tumours.

Gamma Knife uses 192 Cobalt-60 radioactive sources to produce the gamma rays. Collimators channel the rays into beams and focus the radiation to an accuracy of within 0.5mm. A complex computer planning system allows the medical team to accurately simulate the radiation fields in the patient's head before treatment.



The Gamma Knife Centre is under the direction of Professor Christer Lindquist and Professor Bodo Lippitz, who between them have over 45 years of gamma knife surgery experience. They have also been responsible for training neurosurgeons all over the world how to use the Gamma Knife.

For more information on Gamma Knife please call +44 (0)20 7460 5938.

PAEDIATRIC INTENSIVE CARE UNIT (PICU)

Our five-bed unit is one of only three private paediatric intensive care units in London. We provide level 3 PICU care to patients with the following conditions: respiratory; general surgery; gastroenterology; neurology and neurosurgery; infectious diseases; liver and gastrointestinal; craniofacial, plastic and ENT surgery. We offer acute care to infants and children from both the UK and from overseas, including the Middle East, Europe and United States.

In addition to acute care we provide long-term care for complex needs patients and also support patients from our Paediatric Ward in the event of unexpected transfer. The highlight of the unit is its provision of high dependency post-operative care (HDU) to patients from our paediatric wards. The unit is staffed by experienced PICU nurses and Clinical Fellows. All of our consultants have extensive PICU experience and are well established intensivists at leading NHS hospitals in London. All sub-specialists are highly specialised in their respective fields and work in world-renowned NHS hospitals.

The unit is supported by the paediatric physiotherapy and occupational therapy departments, who are extensively involved in the management of patients within the unit. To help aid swift recovery, we have a 24-hour visiting policy for immediate family members and family members involved in the care of the child. Dr Akash Deep, lead PICU intensivist said, "At the Bupa Cromwell Hospital PICU we provide holistic care to young patients who come to us from all over the world. I am especially proud of our multi-disciplinary team which makes such a big difference to their treatment."

NEW CONSULTANTS

Mr Martin Klinke
orthopaedic surgeon

Dr Raj Khattar
cardiologist

Dr Tushar Salukhe
cardiologist

Mr Eric Lim
thoracic surgeon

Dr Oliver Seagal
cardiologist

Dr Iqbal Malik
cardiologist

Dr Nickolaos J Pantazopoulos
cardiologist

Dr Peter Kroker
physician

Mr Amit Amin
orthopaedic surgeon

Dr Nilesh Sutaria
cardiologist

Dr Ranjan Suri
paediatric respiratory physician

To make an appointment with any of our consultants, please call Cromwell Direct on 0800 783 9229

List of services at Bupa Cromwell Hospital

- Allergy
- Angiography
- Audiology
- Bariatric surgery
- Breast care service
- Breast surgery
- Cardiology
- Cardiothoracic surgery
- Chemotherapy day unit
- Colorectal surgery
- Craniofacial surgery
- CT scans
- Dermatology
- Diagnostic services
- Dialysis
- Ear, nose and throat surgery
- Endocrine surgery
- Endocrinology and diabetes
- Endoscopy
- Gamma Knife surgery
- Gastroenterology
- Gastro-intestinal (upper) surgery
- General medicine
- General practice
- General surgery
- Genito-urinary medicine
- Gynaecology
- Haematology
- Haemato-oncology
- Health screening and assessments
- Hearing centre
- Hepato-pancreato-biliary surgery
- Intensive care - adult and paediatric
- Lymphoedema
- MRI scans
- Musculo-skeletal services
- Neurology
- Neurophysiology
- Neurosurgery
- Nuclear medicine
- Nutrition and dietetics
- Occupational therapy
- Oncology - clinical (radiation)
- Oncology - medical
- Ophthalmic plastic surgery
- Ophthalmology
- Oral and maxillofacial surgery
- Orthopaedic and trauma surgery
- Orthopaedic medicine
- Paediatric allergy
- Paediatric audiological medicine
- Paediatric dentistry
- Paediatric dermatology
- Paediatric ear, nose and throat surgery
- Paediatric endocrinology and diabetes
- Paediatric general surgery
- Paediatric general medicine
- Paediatric occupational therapy
- Paediatric orthopaedic surgery
- Paediatric out-patients
- Paediatric physiotherapy
- Paediatric plastic surgery
- Paediatric speech language therapy
- Paediatric spinal surgery
- Paediatric urology
- PET/CT scans
- Pharmacy
- Physiotherapy
- Plastic surgery
- Ponseti method clubfoot clinic
- Pulmonary rehabilitation (COPD)
- Radiology
- Radiotherapy
- Respiratory medicine
- Rheumatology
- Sleep clinic
- Speech and language therapy
- Thoracic surgery
- Transplant surgery - pancreatic
- Transplant surgery - renal
- Urology
- Vascular surgery
- Weight management

2012 SYMPOSIA SERIES @IMAX CINEMA

Finger on the pulse - cardiology and cardiothoracic surgery
Saturday, 15 September, 9am - 2pm at the Science Museum

Please RSVP by calling 020 7460 5901, registering online at www.bupacromwellhospital.com/gpeducation or emailing gpeducation@cromwellhospital.com

bupacromwellhospital.com