August Bulletin 2017

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GPpartners
Advancing General Practice

From the Chair.

It is that time of year when our thoughts turn to the GPpartners AGM in October. We have one director's position open for election this year. Dr Jeanne Carpenter and Dr Murray Bingham survive for another year as directors. I am stepping down to take over the position of Chief Operations Officer for GPpartners. How busy that makes me depends on our finding innovative projects to help GPs at the coalface. We have a couple that need some more attention so my time will be spent there.

Times are changing. I have been following the discussion in Business for Doctors and younger GPs are looking at how to run the Business of General Practice. Although Corporates are making inroads into the ownership of General Practice GPs are wanting to manage their own work places. Interestingly there has been some push back as far as Medical Homes go. Although the concept is good the planning and financial arrangements need to come from General Practice.

The Board is looking for a GP with strategic ideas to join as a director.

The paperwork and nomination forms will be emailed shortly. If you are interested and want to find out more please ring me 0407 550 106.

Recently we had a successful education event about" Surgical and Non Surgical treatment of skin lesions." We had 32 GPs register for a practical session of suturing and how to treat non malignant and malignant sunspots. A summary of the evening is included in this bulletin.

Unfortunately, I was unable to get to the radiology session run by Dr Ben Ong and Dr Stanley Ngai at Metro radiology. The topics were 3T MRI & Cardiac Imaging.

The Perinatal Mental Health Education event at Pine Rivers Hospital has been deferred until the 15th of September. A comment from the GPs in my practice initiated the thinking around this education. It is confusing initially diagnosing perinatal depression and anxiety what is normal as it is a very tumultuous time with a new baby and then what medications are able to be used safely in pregnancy and breast feeding . Is it useful to use the Edinburgh depression scale postnatally and what does the score mean. Come and find out on the 15th September.

Jayne Ingham
Chair, GPpartners

Meet the Board.

Dr Jayne Ingham
Chair

Dr Murray Bingham
Director

Dr Jeanne Carpenter
Director

Upcoming Education Session.

'Pregnancy: Management of

Bipolar Disorder & Antidepressants'

Presenters & Topics:

Dr Thomas George, Psychiatrist

Management of Bipolar Disorder in Pregnancy

Dr Usha Shri Kissoon, Psychiatrist

Management of Antidepressants in Pregnancy

Date: 6.15pm for a 6.30pm start, Tuesday, 12th September 2017

Venue: Pine Rivers Private Hospital, 34 Dixon Street, Strathpine

Please register below. If you have any trouble, please email contact@gppartners.com.au and we'll be happy to register you.

Register now for 'Pregnancy Mental Health' Ed - 12 Sep

Invitation for 'Pregnancy Mental Health' Ed - 12 Sep

Education Summaries.

Education Summary

'Skin Talk'

on 3rd August at North Lakes Day Hospital

by Dr Jayne Ingham

Dr Ben Carew

Non surgical treatment of solar skin lesions. Before start treatment full skin check with shave biopsy of any suspicious lesions or full treatment of obvious lesions. Mainly talking about treatment of Actinic Keratoses. Cryotherapy freeze to lateral margin of lesion the freeze thaw time starts then with 5 seconds of freezing then thaw through 2 cycles.

Think of the 4Cs when treating Cure convenience cost cosmesis.

Field therapy topical treatments 70% clearance. Efudix most effective it is cytotoxic need to limit treatment to small areas eg a patch of treatment particularly on the face. Maybe do the forehead then the cheeks. Need to review after 2 weeks can use it twice daily until the skin is red and scaly then reduce to daily for another 2 weeks.

Bowens disease needs 6 week treatment with review after 2 weeks.

Use on the chest once daily as sensitive skin topical steroids post treatment decreases the erythema. If the lesions become scaly can use saline soaked gauze to lift the scale.

Superficial BCCs use Aldara to activate the immune system review after 2 weeks. 80% cure rate after full treatment. If BCC on the face best to remove surgically. Erythema oedema erosion shows aldara working. Lesions bigger than 2.5cm diameter 50% clearance rate . Bigger lesions may be better treated with curette and cautery. The aggressive subtypes need formal excision. If using aldara and get a cold or flu more likely to get myalgia. Picato activates the inflammatory pathway. It involves 3 applications but often patients only need 2 as they blister prior to third application. Use the lower strength causes a pustular reaction often better to use spot therapy esp on the face not the full face.

A useful combination is daylight PDT and picato spot treatment . Photodynamic therapy PDT.

Photosensitivity cream activated by visible light taken up by the more active cells penetrates the skin surface to rice kernel size so superficial.

DVA funded 70 to 80% cure so need to review 3 monthly initially. Daylight PDT new treatment for sunspots. Use chemical sunscreen first which blocks UVA and UVB not the barrier type sunscreen because these block visible light too. Apply photosensitizing cream sit in the sun for 2 hours the visible spectrum penetrates and activates the cream . less painful mild sunburn reaction for 7 to 10 days. TGA approved for face and scalp. Can be used elsewhere but off label. $280 per tube which would cover the full face and scalp. Actinica is the recommended sunscreen to use for this treatment Medvix is the PDT.

Calmurid and Salacylic Acid can be used to descale prior to treatment .

Lips with actinic lesions difficult area to treat shave biopsy offers diagnosis and treatment.

Dr Matthew Peters - Surgical Management
BCC solid BCCs should be surgically removed. Be aware of perineural invasion particularly on the face may need radiation.

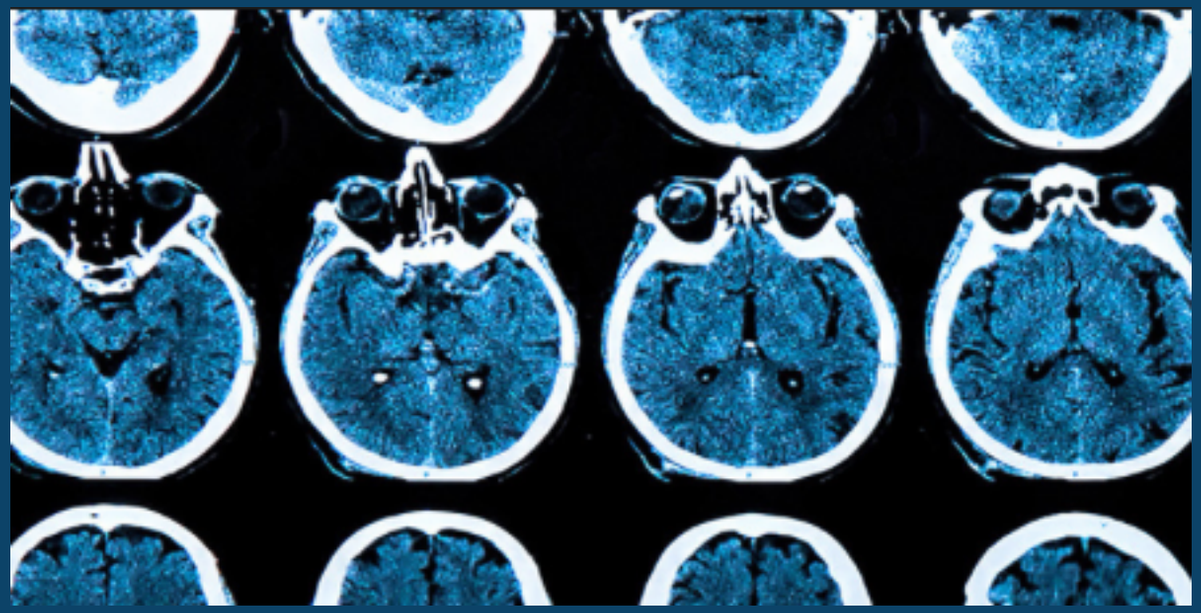
SCCs
Be aware of nonhealing wounds particularly in chronic scars and burns can be SCCs. Well differentiated and moderately differentiated SCC tend to be scaly but severe poorly differentiated can be fleshy. Intraepidermal carcinoma or Bowens disease depends on the extent of atypia transformation rate of 6 to 8 %. Manage like an SCC may need to do a graft because they are often large.

Shave biopsy of lesion go deep to bleed adequate for pathology and often treat lesions at same time. Keratoacanthomas rapid onset plateaus then resolves. If easy to excise can do a shave or blunt dermal curette blunt separates the planes of the skin. If difficult observe as most resolve.

Dermatofibrosarcoma protuberans. Occur more frequently in women 30 to 40 who have been pregnant. Aggressive tumour needs 3 to 5 cm margin chemotherapy and radiotherapy.

Melanomas 10% are familial spread lymphatically depends on the thickness what margin to take depth down to fascial layer. Some discussion looking for sentinel lymph nodes or wait until nodal involvement. Tend to refer to PAH but there is a melanoma unit at RBWH. New immunotherapy treatments are promising.

Merkel Cell Carcinoma purplish lesion Radiation sensitive. After the presentations Dr Peters showed us some secret plastic surgery suturing techniques.



Education Summary

'3T MRI & Cardiac Imaging'

on 8th August at Metro Radiology, Ashgrove

Dr Ben Ong - 3T MRI
Dr Ong went through the advantages of 3T MRI, which include:

- Quicker scan time
- Better image quality
- The magnet is shorter, so less claustrophobic
- It can capture multiple sequences at the one time.

The 3T MRI digital is superior to the analogue as there is no loss of image quality. The integrated coil is now under the patient, rather than on top and the reduced noise during scan is significant.

Dr Ong went through a number of case studies looking at when to use MRIs vs bone scans. It came down to a combination of cost and exposure. Bone scans are bulk

billed but there is no medicare for MRI, so out of pocket approx $180. MRI are also good at picking up other pathology, such as soft tissue bursitis. MRI offer younger patients no radiation.

Other points on MRI: Average scan is 15 minutes. If patient gets good position and stays still, takes 10 minutes. Less dose for smaller/slimmer patients. Weight limit on machine is 180kg and 60cm wide.

Dr Stanley Ngaio - Cardiac Imaging
Coronary Artery Calcium Scoring (CACS)
CACS is a screening tool, giving a specific marker of atherosclerosis. A CAC score of zero shows no measurable plaque in coronary arteris with 98% certainty.

It does not assess the degree of luminal stenosis in coronary arteries or presence of non-calcified plaques.

It is convenient – like an x-ray, just turn up, non-invasive and quick. Radiation exposure typically 1mSV.

No medicare rebate – out of pocket approx $150.

Useful for asymptomatic patients with low to moderate cardiovascular risk, or are over 40 with diabetes.

CT Coronary Angiogram (CTCA)
Images the coronary arteries for use in diagnosing coronary artery disease (CAD) and looking at previous bypass grafts. Radiation dose typically 2-5mSV. Injects contrast dye.

Patient must fast for 2 hours and no caffeine containing foods or drinks for 12 hours before.

Useful for low-intermediate cardiovascular risk.

Not used for known coronary disease – cardiologist catheter angiogram. AF makes timing difficult, as it needs a predictable hearth rhythm. If calcium score >400, the calcium can get in the way of lumen, making it less effective. Can be a problem when patient moves, irregular heart beat or calcium is too dense.

Myocardial Perfusion Scan (MPS)
Around for 30+ years, it is a form of ultrasound. MPS is bulk-billed.

2 scans – rest scan & stress scan. Stress is applied by exercise or medication (adenosine or dobutamine). Scan looks for reversible perfusions/differences.

Fast for 2 hours and no caffeine containing foods or drinks for 24 hrs before. No need to stop cardiac-related medications. Radiation dose typically about 11mSV.

Useful for intermediate risk patients, chest pain, new heart failure, high calcium score (>400), asymptomatic high risk patients, before non-cardiac surgery.

Compared to a stress test, it has higher sensitivity and specificity.

Compared to stress echocardiogram, it is similar but has no ionising radiation.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