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Berkeley Vale Private Hospital
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BERKELEY VALE PRIVATE HOSPITAL

Anterior Hip Replacement - A New, Old Operation

Despite all the recent interest, hip replacements through anterior incisions are actually not new. In fact, this particular surgical approach was first described in 1881, and French surgeon Robert Judet introduced the procedure using a form of replacement almost 60 years ago. What is new, however, is the minimally invasive instrumentation which, combined with the anterior approach and hip rehabilitation, is making an already great operation potentially better.

The success of hip replacement surgery is impressive. In two generations it has restored quality of life to millions of people who would otherwise have suffered with the debilitating pain of osteoarthritis. Not only is the improvement in the patients' quality of life dramatic, so equally is the survival rates of the orthopaedic implants. We now consider a 90 % survival rate at 20 years to be a realistic expectation. Given that most of the replacements to date were done through posterior or lateral approaches, it is reasonable to ask why there is a need for something different.

The answer lies in improvements in how "user friendly" the procedure is for patients, and in particular relates to their ability to return to the basic activities of everyday life as quickly as possible. Not only do these benefits include increased comfort from being able to sleep on one's side rather than having to sleep flat on one's back for example, but they also include the earlier independence that being able to put on shoes and socks allows. Minimising post- operative restrictions is especially beneficial for patients who have difficulties in remembering an array of instructions and "do's and don'ts". Rightly or wrongly, patients have been limited in their return to activities of daily life following a posterior approach, primarily due to concerns of posterior dislocation. By contrast, this problem is extremely rare with the anterior approach.

There are advantages and disadvantages with the different approaches of hip replacement surgery. The anterior approach hip replacement is a muscle splitting approach; think of this as similar to when you separate drawn curtains on a curtain rail. In the body this means that you don't cut across muscle or tendons, and is theoretically the reason for the faster recovery period. When considering the posterior approach, however, very little muscle is actually cut. While most people may be suitable for the anterior approach, some people will not be, such as those with some congenital or paediatric hip disorders causing secondary osteoarthritis. The aim in all cases remains to give patients a pain-free joint that will restore quality of life and last many years, in some cases more than twenty years.

Regardless of the approach used, hip replacement is one of the great operations of the latter half of the 20th century. Time will tell whether the minimally invasive anterior approach will be an advancement in the long run, however the results to this point are encouraging, giving confidence that the procedure can be offered to the right patients. I have been performing this procedure at Berkeley Vale Private Hospital for over a year now, and am happy to continue doing so.

Dr Jim Hasn
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Orthopaedic Surgeon, Central Coast Orthopaedics

Haemorrhoids

Article by: Dr Adrian Burke (General Surgeon Medical Advisory Committee)

Dr Adrian Burke completed his undergraduate medical training at St Bartholomew's Hospital in London. Initially undertaking physician training, he obtained his MRCP, then switched to surgery obtaining FRACS Ed in 1978 and FRCS in 1979. In 1979 he was appointed Lecturer in Surgery at the University of Adelaide and he obtained the FRACS in 1982. Working as a VMO in Adelaide from 1984 until 1997 he then took up a position as a VMO with Central Coast Health. Dr Burke is an Honorary Senior Lecturer at the University of Newcastle, as well as RACS Supervisor of Surgical Training at Wyong Hospital.

Conditions associated with haemorrhoids or piles are common in general medical practice. Medical students are largely taught in hospitals which deal with the more severe spectrum of illness. Haemorrhoids are included in the long list of conditions which produce considerable suffering but are not lethal (eg ingrown toenails and skin rashes). Personally I received minimal teaching on perianal conditions and have learnt all I have "on the job" seeing patients. Does that sound familiar?

Most haemorrhoids respond to simple conservative over the counter medication or life style changes. Rectal bleeding is the most common presentation.

Some myths I would like to dispatch

- External haemorrhoids cause rectal bleeding
- Internal haemorrhoids are palpable with a finger
- Haemorrhoids are painful

External haemorrhoids are not a cause of bleeding and are rarely the source of symptoms. However odd looking perianal lesions should be biopsied as perianal SCC can occur.

Internal haemorrhoids are not palpable and are diagnosed at proctoscopy as they are visible. (Surprisingly colonoscopy is not particularly helpful).

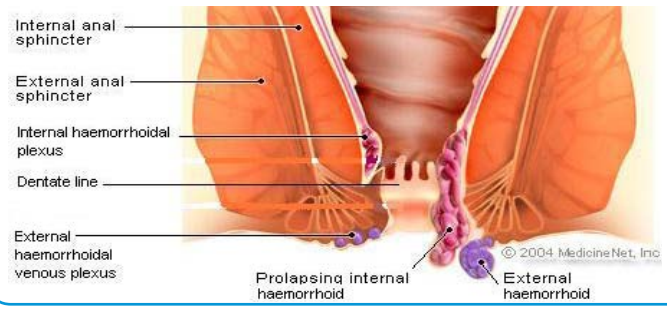
Acute pain can occur with external and internal haemorrhoids but anal fissures and sepsis are a more frequent cause.

ANATOMY

The external haemorrhoidal venous plexus (see Figure A) lies just under perianal skin, which is innervated by the somatic nerve system just like the rest of the outside of the body. Pain and light touch etc are felt normally as elsewhere.

The internal haemorrhoidal plexus lies above the dentate line in visceral autonomic territory. Pain is not felt with needles or pinching of mucosa. It is composed of 3 or 4 cushions of a network of arteriovenous vessels. Their purpose is to assist continence and maintain an air and watertight seal after a bowel action. They are a normal part of the anal anatomy. When they cause problems by bleeding or prolapsing they are called haemorrhoids (Greek: "blood flowing") or piles (Latin: "a lump or ball")

FIGURE A: Formation of haemorrhoids



PRESENTATION

ACUTE

External haemorrhoids

With a thrombosed external haemorrhoid the patient, usually young, complains of sudden onset of a painful perianal swelling. Diagnosis is straightforward, as on inspection there is a visible dark blue perianal swelling which is exquisitely tender.

Pain is due to the level of the swelling being in somatically innervated skin. For this reason the sensation of pain is the same as it would be elsewhere on the outside of the body. This explains why banding is not suitable for external haemorrhoids but is very suitable for 2nd degree internal haemorrhoids which are in visceral autonomic innervated territory. My hypothesis is that external haemorrhoidal thrombosis occurs in the normal external haemorrhoidal plexus and is due to damage produced to the intima of the vein and subsequent thrombosis. The damage is produced by the anal sphincter squeezing the vein and producing wall damage. This occurs with activities such as weightlifting, playing sport, digging in the garden and straining at stool. These are normal healthy people without any pre existing external haemorrhoids or anal problems. For most patients this is a one off event but some unfortunately get recurrent problems. In those patients who do get recurrent external haemorrhoidal thrombosis, surgical removal of the external haemorrhoidal plexus prevents further problems.

Women pre or post partum often develop circumferential external haemorrhoidal thrombosis. This is exceedingly painful but usually settles over time leaving external haemorrhoids/tags, which intermittently play up long into the future. A little permanent reminder of the joys of motherhood! A surgical procedure is curative but needs to be warranted by the patient's symptom severity and their wishes. Unfortunately conservative management is unhelpful and banding is definitely contraindicated.

Internal haemorrhoids

Prolapsed thrombosed internal haemorrhoids ("strangulated haemorrhoids") present in a similar fashion but with spectacular anal and perianal swelling in addition to the acute pain. Pain is due to sphincter spasm.

Neither of these diagnoses is clinically difficult but they are not the major causes of anal pain. I will cover the topic of acute anal pain in a later article.

CHRONIC

This is the more frequent presentation of haemorrhoids with the classic symptoms of rectal bleeding, prolapse symptoms, mild discomfort, pruritus ani and difficulty of cleaning after a bowel action. Risk factors play a major role (see Box 1).

BOX 1

Risk Factors

- Straining
- Hard Stools
- Poor Diet
- Childbirth
- Family History

Rectal bleeding is usually bright red and associated with defecation.

A careful history of the nature of the rectal bleeding can help select those patients with alarm symptoms who require colonoscopy (see Box 2)

BOX 2

Alarm Symptoms

- Altered or dark blood
- Blood mixed with the stool
- Change in the normal bowel habit
- Weight loss
- Family history of polyps or bowel cancer
- Abdominal pain and or distention
- Aged over 40 years.

Those patients who are under 40 years who do not have alarm symptoms can be managed without the need for colonoscopy unless they are particularly anxious

EXAMINATION

Careful and gentle perianal examination with a good light and a relaxed patient are vital.

Visible skin tags and external haemorrhoids are noted and any unusual "haemorrhoids" are biopsied or referred.

External Haemorrhoids are not a cause of rectal bleeding and further internal examination is vital.

Proctoscopy, especially with disposable proctoscope, is quite practical and helpful in the GP surgery. During withdrawal of the proctoscope it is clear what degree of prolapse the internal haemorrhoids are (see Box 3).

BOX 3

Treatment of internal haemorrhoids is based on the amount of prolapse (staging or degrees). This can be obtained from the patient history and from proctoscopy.

1st Degree: Piles are internal to the anus and never prolapse.

2nd Degree: Piles prolapse on straining but return to normal spontaneously.

3rd Degree: piles that prolapse on straining and need to be manually replaced after evacuation.

4th Degree: Piles are permanently outside and cannot be replaced manually. Even if they do reduce they come out again on walking or standing.

If squamous metaplasia is visible on the surface of 3rd degree internal haemorrhoids, it is a clue that chronic prolapse has been occurring for years. The normal columnar epithelium on the haemorrhoid is replaced by squamous epithelium as on normal skin.

As mentioned previously, internal haemorrhoids are not palpable with the finger and cannot be diagnosed or staged without proctoscopy.

MANAGEMENT

The absolute basis of management of most patients is to reduce risk factors (see Box 1) and to rule out serious pathology higher up. It is not uncommon to have obvious symptomatic haemorrhoids associated with other more serious pathology higher up (even in the right colon) eg polyps or colon cancer.

Colonoscopy is indicated if any alarm symptoms are present (see Box 2).

All patients should have dietary advice and increased fibre intake but surgical procedures have a role for patients with more severe degrees of haemorrhoids (eg some 2nd degree, all 3rd/4th degree).

TREATMENT

Conservative

Avoid straining ie minimal time in toilet, less than 2 minutes. No reading or escaping from the hurly burly of family life!

Increased fibre intake especially breakfast cereal. Make patients aware of the fibre content of well known cereals ie 1 standard bowl of Sultana Bran = 15 bowls of cornflakes! Very high fibre cereals can taste like the packet ("cardboard") so eat what you enjoy. Snack on cereal later in the day (or at bed time). Arrange to eat cereal at work if you are anorexic at 5am when you get up (?to drive to Sydney). Add psyllium husks/unprocessed bran and try bulking agents such as Metamucil, Agiofibe, Normafibe etc. Eat more vegetables and fresh, tinned or dried fruits. Adequate hydration is also important. Over the counter preparations may be helpful for minor symptoms eg Scheriproct, Proctosedyl, Anusol.

A specialist opinion is required if topical preparations are unhelpful and a sinister cause needs to be excluded (see Box 2).

Surgical

1. **Injection sclerotherapy, cryotherapy and infra red coagulation** are used by colleagues for the treatment of milder degrees of haemorrhoids ie 1st/2nd degree. I do not use these techniques but favour conservative treatment for the majority of patients in this group.
2. **Rubber band ligation**
   I favour this technique for those patients who wish to be free of bleeding and who have 1st or 2nd degree haemorrhoids. Many patients, once reassured their rectal bleeding is not due to a serious cause, are quite happy to live with occasional bleeding. The technique is to apply the band to the base of the internal haemorrhoid. It is done in the rooms without anaesthetic. There is no pain if properly applied well above the dentate line (in visceral autonomic territory). It is like a "spot weld" and reduces prolapse. It does not produce a cure for internal haemorrhoids but stops bleeding for a varying period of time.
3. **Haemorrhoidectomy** for 3rd and 4th degree haemorrhoids or patients with more severe symptomatic external haemorrhoids. This is very effective and produces long term cure.
   a. The traditional operation is either "open" or "closed". In the open procedure, the wounds are left open whilst in the closed procedure the wounds are sutured after removal of the haemorrhoidal complexes but preserving good mucocutaneous bridges (ie not removing all the haemorrhoids as this can produce anal stenosis). The main problem with the operation is severe post op pain which often requires narcotic analgesia.
   b. **Carbon dioxide laser haemorrhoidectomy**
      This is a traditional open haemorrhoidectomy using a CO2 laser. This state of the art technology is now available at Berkeley Vale Private Hospital. Studies overseas and personal (Burke A 1996 Day Case Laser Haemorrhoidectomy. International Journal of Colorectal Diseases. 11 (3): 150) have shown a great reduction in post op pain where the patient is often discharged within 2 hours of the procedure and oral analgesics such as NSAIDS and paracetamol suffice. Narcotic opiates are not required. This allows the patient to feel confident about having the operation when previously they avoided surgery and suffered in silence.
      Benefits of the laser
      - Day case
      - GA not required – LA / sedation
      - Home within 2 hours
      - Minimal pain
      - No opiates required
   c. **Stapled Haemorrhoidectomy**
   d. **Haemorrhoidal artery ligation & recto anal repair** – HAL RAR
      Techniques c & d are popular with some surgeons but I have no personal experience.

SUMMARY

The vast majority of patients can be managed with simple measures – diet, avoiding straining etc – once sinister pathology has been ruled out.

Some patients are happy with intermittent banding for 2nd degree haemorrhoids, particularly the elderly where haemorrhoidectomy is seen as major surgery.

Haemorrhoidectomy cures haemorrhoids and is the treatment of choice for patients with chronic symptomatic 3rd/4th degree severe external haemorrhoids.

High Fibre Diet

Dietary fibre means food which passes all the way through the gastrointestinal tract (i.e. "roughage" such as breakfast cereal, fruit, vegetables and wholemeal bread).

The fibre content of the Australian diet has fallen dramatically since the turn of the century. In tandem with this, there has been a rise in the incidence of bowel cancer, haemorrhoids and diverticular disease. These diseases are very rare in the population of countries that take a high fibre diet. In rural Africa, the average weight of faeces produced per day is about 400gms or more; a typical Australian produces 100gms or less! Urban Afro-Americans who take a diet similar to Australians, and not their African cousins, have a similar high risk of the diseases mentioned above.

The ideal start to the day is a bowl of high fibre cereal e.g. All-Bran, Sultana Bran, Shredded Wheat, Fibre Plus. Unfortunately many traditional breakfast cereals, although tasty, are not satisfactory from the fibre point of view eg Corn Flakes, Special K, Rice Bubbles, Nutragrain, Honey Smacks, Fruit Loops and Coco Pops. There is no reason why "breakfast" cereal cannot be taken at afternoon tea, as well as in the morning. It is important to like the taste of a cereal as it is difficult to eat food as "medicine"! Keep trying different varieties until you find one (or more) that you like. A major source of fibre is fruit, both fresh and dried fruit. All vegetables are excellent, cooked and uncooked. All bread is good but particularly wholemeal bread.

When starting on a high fibre diet it is important not to take too much initially, as the under-used bowel has got used to a quiet life and will object to the increase work load! It is a bit like a jogger being asked to run a 45km marathon when previously they had only run the occasional 1 or 2 km! It is suggested that a slow build-up over a period of weeks or months is appropriate. It is advisable to take more fluids than usual since some fibre is soluble. Other supplements that can help increase fibre intake are bulking agents such as psyllium husks, Metamucil, Granocol, Normacol, Easyfibe, and Agiofibe. A new agent called Normafibe is particularly recommended. These can be obtained at all pharmacies.

An easy way to greatly increase your dietary fibre is to have a high fibre breakfast cereal, such as Sultana Bran, twice a day (eg breakfast and tea-time) as well as two teaspoons of Metamucil at night.

If you are taking adequate amounts of fibre, your stools will float in the toilet bowl. The low fibre stool sinks.

Please see information below regarding the fibre content of most breakfast cereals.

Dr Adrian Burke

Good Fibre Websites

1. ww.mydr.com.au
2. www.en.wikipedia.org/wiki/Dietary_fiber
3. www.nestle.com.au
4. www.mayoclinic.com

High-fibre foods

Fruits	Serving size	Total fibre (grams)*
Raspberries	1 cup	8.0
Pear, with skin	1 medium	5.5
Apple, with skin	1 medium	4.4
Strawberries (halves)	1 1/4 cup	3.8
Banana	1 medium	3.1
Orange	1 medium	3.1
Figs, dried	2 medium	1.6
Raisins	2 tablespoons	1.0
Grains, cereal & pasta	**Serving size**	**Total fibre (grams)***
Spaghetti, whole-wheat, cooked	1 cup	6.2
Barley, pearled, cooked	1 cup	6.0
Bran flakes	3/4 cup	5.3
Oat bran muffin	1 medium	5.2
Oatmeal, quick, regular or instant, cooked	1 cup	4.0
Popcorn, air-popped	3 cups	3.5
Brown rice, cooked	1 cup	3.5
Bread, rye	1 slice	1.9
Bread, whole-wheat or multigrain	1 slice	1.9
Legumes, nuts & seeds	**Serving size**	**Total fibre (grams)***
Split peas, cooked	1 cup	16.3
Lentils, cooked	1 cup	15.6
Black beans, cooked	1 cup	15.0
Lima beans, cooked	1 cup	13.2
Baked beans, vegetarian, canned, cooked	1 cup	10.4
Sunflower seed kernels	1/4 cup	3.9
Almonds	1 ounce (23 nuts)	3.5
Pistachio nuts	1 ounce (49 nuts)	2.9
Pecans	1 ounce (19 halves)	2.7
Vegetables	**Serving size**	**Total fibre (grams)***
Artichoke, cooked	1 medium	10.3
Peas, cooked	1 cup	8.8
Broccoli, boiled	1 cup	5.1
Turnip greens, boiled	1 cup	5.0
Sweet corn, cooked	1 cup	4.2
Brussels sprouts, cooked	1 cup	4.1
Potato, with skin, baked	1 medium	2.9
Tomato paste	1/4 cup	2.7
Carrot, raw	1 medium	1.7

**Fiber content can vary between brands*

Introducing...

Dr Jenson Mak

Geriatrician, General Physician & Rehabilitation Physician

MBBS (UNSW) FRACP FAFRM(RACP) BMedSc JP

At the commencement of September Dr Jenson Mak joined our progressive and professional rehabilitation team. This now brings together a total of three Rehabilitation Specialists to manage our 34 bed inpatient rehabilitation unit, Day rehabilitation program and Outpatient rehabilitation program. They include:

Dr Michael Smith (Director of Rehabilitation Services)

Dr Edward Lassau-Wray (Rehabilitation Specialist)

Clinical Interests Dr Mak has an active interest in disorders of the elderly including psychogeriatrics, osteoporosis, falls, cognitive disorders, post operative care following elective joint replacement and general surgery. He is an Australasian expert in hip and knee disorders especially hip fractures and iliotibial band pain syndrome and is co-author for several Cochrane reviews.

In addition to these special interests, Dr Mak offers a wide range of rehabilitation services including stroke, chronic pain and preventative cardiology.

Academic Background Dr Mak is a graduate of the University of New South Wales having completed his MBBS in 2000. He undertook extensive geriatric, rehabilitation medicine and general medical training at Royal Prince Alfred, Concord, Westmead and Prince of Wales Hospitals.

Dr Mak went on to attain a double specialty Fellowship in rehabilitation medicine (FAFRM) and internal medicine (FRACP) and is a PhD candidate with the University of Sydney and conjoint associated lecturer with the University of Newcastle, including periods at Gosford, Wyong, and Woy Woy Hospitals.

As a Rehabilitation consultant at Berkeley Vale Private Hospital, Dr Jenson Mak is looking forward to providing his services to the local Central Coast population.

Contact Details

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Berkeley Vale Private Hospital *Welcomes The Following New Staff*

New Nurse Unit Manager Surgical Ward – Sue Taylor

In August, Sue Taylor joined our hospital team as the new Nurse Unit manager (Surgical ward) Sue has a diverse background of clinical and management experience. Sue joins us from The Mater Women's and Children's Hospital Hyde Park in Townsville, Queensland where she held the position of Director of Nursing for two year. Prior to that Sue was the Nurse Unit manager of the medical/surgical, oncology and paediatric/Day Surgery Units at the Mater.

Sue is also well know to Berkeley Vale Hospital, our staff and visiting medical officers having worked here as a registered nurse in recovery prior to moving to Queensland approximately ten (10) years ago.

NEW OCCUPATIONAL THERAPY STAFF

Rebecca Auld

Rebecca Auld joins our hospital team as the new Occupational Therapy Manager. Rebecca has over thirteen years work experience in a variety of health settings throughout Australia, New Zealand and the United Kingdom. Rebecca recently joined us from the Central Coast Local Health District as Team Leader Community Occupational Therapy. She has completed a four year degree course in Occupational Therapy at the University of Newcastle and holds the qualification of Bachelor of Health Science (Occupational Therapy).

Rebecca has had a varied and complex caseloads comprising of clients with such diagnoses or medical conditions as spinal cord injury, multiple sclerosis, CVA, muscular dystrophy, lower limb amputation, joint replacements, spina bifida, renal failure, COPD and cancer. Rebecca will be a valuable highly competent clinical professional to our rehabilitation, medical and surgical patients.

Lauren Bolton

Lauren Bolton has commenced part time as an Occupational Therapist. Lauren graduated with a Bachelor of Applied Science (Occupational Therapy) at the University of Sydney in March 2012 where she graduated with a Distinction. Lauren has come to Berkeley Vale Private from the ACT Health (Community Care Team), where she was responsible for own client case load which comprised aged clients and clients with complex and varying care needs. Lauren will also be a valuable team member to the hospital supporting both medical/ rehabilitation patients, Day patient programs and surgical inpatients.

Berkeley Vale Private Hospital

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