INSIDE:  The New Technology  The Diagnosis  The Advances  The Innovation

Artificial Cervical Disc Replacement  Familial Breast Cancer  Lymphoedema Services  Allergy Clinic  Knee Surgery  FibroScanning in Assessing Liver Fibrosis  Scarless Surgery  Flat Feet  London Rheumatology Centre  GP Liaison Team Information
Dear everyone,

I am delighted to introduce this new edition of Health Matters and to update you on the new services and staff available for the care of your patients.

London Bridge Hospital has, for the first time, brought a number of procedures to the private sector. Our cardiac specialists have undertaken eight Transcatheter Aortic Valve Implantations (TAVI) to date, inserting valves to patients who were previously considered to be inoperable. I am delighted to say that these procedures have gone extremely well. We have also undertaken our first case of left atrial appendage closure using the WATCHMAN® Closure Device for prevention of stroke in patients with atrial fibrillation. This is a new technology that has recently been developed and used as an alternative to long-term Warfarin therapy. Finally, one of our ENT specialists, Mr David Bowdler, has successfully carried out the first procedure in this country to surgically implant a completely invisible middle ear implant (Esteem Hearing Implant) developed specifically for patients with sensorineural deafness. I am pleased to report that since the first case, two more have successfully been implanted and a few more have already been booked.

I am delighted to say that we continue to open new units and purchase new equipment. We have funding to build a state-of-the-art Critical Care Unit into the atrium of the main hospital. This will be a 14-bedded unit and with it will come a further 10 inpatient beds. We will be opening a hybrid angiography laboratory later in the year, which will mean upgrading the laboratory environment to enhance the clinical surroundings and facilities in one of the angiography laboratories. We will also be opening our first two integrated operating theatres at the end of June. In addition to these, we have a new dialysis unit and we will be opening, very close to the hospital, a ‘Back2Normal’ physiotherapy service for our spinal patients. This will be a holistic Spinal Therapy Unit supported by our spinal physicians and surgeons and managed by our own Physiotherapy Manager, Katie Lovegrove.

I am also delighted to say that there have been many developments in cancer care. HCA International, our parent company in London, operates a cancer care network from our six sites. Essentially, our cancer patients have access to the best equipped service in Europe and we are the only private operator in the country who can deal with patients of all ages. Through our sister hospital, The Harley Street Clinic, our patients will be able to access the latest developments in IMRC, CyberKnife and Gamma Knife Radiation Therapy.

It would not be right to mention all of these things without celebrating our staff. We continue to hire more Clinical Nurse Specialists. Every time we add a nurse specialist to our service, the investment pays dividends and services improve. They act as great coordinators between departments, clinicians and patients, providing continuity of care long after the patient has been discharged from the hospital, as well as helping them before they are even admitted. We continue to hire more Cardiac Physiologists and effectively have become a training ground for newly qualified Physiologists who, by the time they leave us, are employable anywhere in the world. We have a department of 17, all of them at different stages of development, and we fully accept they will move on to work in specialist roles for the equipment companies and elsewhere around the globe. Every time one leaves, they are replaced by another candidate eager to build on their career. These developments are reflected in all other areas of the hospital. For instance, our Clinical Perfusion Scientists are developing point of care testing facilities and coagulation profiling for all specialties, where previously this profession tended to focus solely on cardiac and liver work.

Our doctors are also teaming up to market the subspecialties that they excel in, with the same profile that they offer in their NHS teaching sites. For instance, in Oncology, we will be presenting a complete multispecialty team of medical and clinical Oncologists who work with their differing multidisciplinary colleagues in Surgery, Radiology and Pathology as well as their supporting nurse specialists. Service line development in every area is paying off many times over.

Finally, a huge thank you to you for your support and trust in the hospital; we appreciate that you have entrusted the care of your patients to us and we continue to work hard to merit that trust.

I wish you a very long and enjoyable summer.

With kind regards and best wishes,

John Reay
Chief Executive Officer
The mobile cervical spine is particularly prone to degenerative change. Degenerative Cervical Spondylosis is a common disorder in late middle age and may cause spinal cord or nerve root compression, resulting in a variety of neurological symptoms.

Approximately half of the population over 50 years of age will show changes of degenerative changes in the cervical spine. 20% of these patients will develop symptoms such as neck pain or discomfort and a ‘clicking’ noise upon neck movements. Nerve root compression causes pain radiating into the arm and the hand (Brachialgia) and/or altered sensation (numbness) and/or motor weakness. Compression of the spinal cord causes Myelopathy, with progressive weakness and spasticity of the arms and legs, difficulty with fine motor function of the hands, unsteady gait and poor balance. MRI of the cervical spine is the investigation of choice to demonstrate the anatomy of the vertebral column, discs, spinal cord and nerve roots. Confirmation of nerve root dysfunction may be clarified with an EMG test.

Traditionally, neurosurgeons have replaced the resected disc with bone graft or cages to achieve fusion and stability. However, new technology is being pioneered which avoids the potential problems caused by unphysiological fusion. Disc replacement restores the biomechanical movements of the spinal segment using artificial disc implantation.

Neurosurgical management
Almost 70-80% of patients with cervical nerve root compression usually settle spontaneously with conservative measures, such as physiotherapy, analgesics, acupuncture etc.

Failure of symptoms to improve (persisting symptoms) or recurrent symptoms, requires referral to a neurosurgeon. In most cases, anterior compression of nerve roots and/or the spinal cord necessitates surgery via an anterior approach, using a right-sided transverse cervical incision, with microscopic removal of the intervertebral disc(s) and posterior bony osteophytes. It is traditional for the resulting interspace to be ‘fused’ using techniques such as an iliac crest, synthetic bone graft or cage system with or without anterior cervical plate and screws.
Why is artificial disc technology the future?

Techniques continually advance and rigid fusion after discectomy in the cervical spine itself may cause further problems. By immobilising a previously dynamic structure, fusion causes an increase in Intradiscal Pressures (IDPs), intersegmental motion and facet joint stresses above and below the fusion. This may cause the development of accelerated degeneration at other disc levels. Studies quote varying degrees of Adjacent Level Spondylosis (ALS) after cervical fusion, between 9-32% at a mean of 7 years after surgery, or 26% of patients developing symptomatic ALS 10 years later. In contrast, implantation of an artificial cervical disc has been shown to preserve adjacent IDPs and operative level kinematics. The disc prosthesis is engineered to preserve range of movements. By preserving motion in the cervical spine and helping to prevent ALS, disc arthroplasty may have the additional benefit of reducing the symptoms of neck pain that may be unchanged after fusion operations.

Surgical technique and results

Relief of nerve root compression and/or spinal cord compression still relies upon expert and meticulous neurosurgical technique. However, the insertion of the disc prosthesis requires new training and techniques. The disc space must be prepared precisely to fit the shape and size of the suitable disc prosthesis. Most patients stay in hospital for only two or three nights.

In our series of over 60 cases of cervical disc replacement, more than 95% of patients have improvement or resolution of symptoms. In addition, there has been encouraging improvement in neck pain symptoms indicating possible additional advantages of the disc replacement over fusion surgery.

Conclusions

Cervical disc arthroplasty with the artificial disc system after anterior cervical discectomy offers the ability to preserve physiological spinal dynamics and to prevent the future development of adjacent level degenerative changes. For the patient, this may mean better long-term outcomes without the need for further complex surgery and the possibility of improvement of the neck pain symptoms in comparison with rigid fusion techniques. Cervical fusion might become an outdated concept, with the realisation of preserving cervical spinal motion and function.

Mr Habib Elamushi is a Consultant Neurosurgeon at London Bridge Hospital and St Bartholomew’s and the Royal London Hospitals and Honorary Senior Lecturer at the Queen Mary’s Medical College, University of London.

Mr Elamushi had higher specialist training in Neurosurgery in the National Hospital, Queen Square, Charing Cross Hospital and Great Ormond Street. He completed his research into Neuroimaging of brain tumours, cerebral aneurysms and epilepsy. He furthered his neurosurgery subspecialty training in the USA, Canada and France. He leads multidisciplinary teams in minimal access spinal surgery, craniofacial surgery and neurostimulation.

Mr Elamushi’s neurosurgery practice includes cranial and spinal neurosurgery with particular interest in minimal access (keyhole) spinal surgery, brain and spinal tumours, Gamma Knife and CyberKnife Stereotactic Radiosurgery and Neurostimulation.

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Nipple Discharge: Is it Commonly a Sign of Breast Cancer?

Often patients of mine experiencing nipple discharge will come to me with concerns regarding the correlation between nipple discharge and breast cancer.

The breasts are developmentally modified sweat glands. In addition to their predominant function of milk production at the end of pregnancy, breasts can produce secretions of various colours and consistencies which are considered a part of their physiological function. However, nipple discharge could also occur as a result of local breast changes or underlying pathology. Women will often seek consultation for nipple discharge for a variety of reasons, including inconvenience or embarrassment, as a part of other breast problems such as pain or a lump, and, most significantly, through a fear of breast cancer.

Nipple discharge constitutes about 7% of all cases referred to breast clinics. In over half of these cases, women become aware of the discharge as a result of expressing the breast (non-spontaneous) and with others awareness occurs spontaneously. In addition, nipple discharge can be unilateral or bilateral and from one or multiple ducts.

There are several types of nipple discharge:
• Galactorrhoea
• Pseudo Galactorrhoea
• Opalescent
• Blood-related nipple discharge: serous, sero-sanguinous, sanguinous and watery.

Although nipple discharge is a common breast symptom it is not usually a manifestation of breast cancer. Only spontaneous blood-related nipple discharge is found to be associated with breast cancer albeit in a minority of these cases, amounting to approximately 10% with wider range in relation to age at presentation. The correlation of blood-related nipple discharge and breast cancer increases with age. Nipple discharge is considered pathological when it is spontaneous, blood-related and from a single duct from one breast. Clinical examination rarely reveals any other physical findings and therefore further investigations are required to exclude underlying breast cancer.

Over 50% of cases are Carcinoma In-Situ (CIS) with the presence of a breast lump in association with blood-related nipple discharge increasing the probability of an underlying invasive disease.

Several investigative methods have been used in determining a prognosis. Cytological examination of the discharge has proven unhelpful, with frequent false negative and false positive results. Imaging of the breast using ultrasound scan and mammography are frequently employed, where appropriate, with ultrasound scan helpful in identifying retroareolar intraduct pathology, such as a papilloma. Mammography is usually used in women 35 years and over to visualise non-palpable soft tissue masses or microcalcifications that require preoperative tissue diagnosis. The new technology of intraduct microendoscopy is still in its infancy and it is too early to rely upon.

Diagnosis of underlying pathology is unequivocally achieved by surgical excision of the offending duct, Microdochectomy. Benign Intraduct Papillomata are the most frequently encountered pathology. Duct-ectasia and Fibrocystic changes are common, however, breast cancer represents a small percentage of the cases treated.

London Bridge Hospital’s GP Liaison website went live early in 2010 providing another useful resource for GPs. The site provides information on upcoming GP Seminars and on members of the GP Liaison Team.

London Bridge Hospital’s Marketing and GP Liaison Manager, Manuela Bernhard, says, “The launch of the GP Liaison website will play an important role in continuing to make information and seminar details as accessible as possible for GPs. We are constantly looking for new ways to make life as easy as possible for GPs, given their busy schedules, and now we have another channel through which to do that.”

If you would like to visit the GP Liaison website, please go to: www.gpseminar.co.uk
Since the identifications of breast cancer genes, BRCA1 & 2 in 1994 and 1995 respectively, a lot has been known about the inheritance of breast cancer. However, this is only relevant to an even smaller number of Familial Breast Cancer. BRCA1 & 2 mutations only explain about one fifth of those with familial disease and there are many other unknown genes involved in the development of breast cancer.

This indicates that the majority of women with a family history of breast cancer fall in the category of either those with an average risk of developing the disease, that is to say a similar risk of women with no family history of breast cancer, or only have a moderately increased risk of the disease.

Women with an average risk of breast cancer have about a 10% lifetime risk. Such a risk is about 2-3 times higher for those who are considered at moderately increased risk. In view of this, these women are recommended to have annual mammographic screening from the age of 40 to the age of national screening. Subsequently, these women will join the NHS Breast Screening Programme which offers mammography every three years.

The level of risk is very different for women with a strong family history or those who are proven to be carriers of BRCA1 & 2 mutations. These women have a high lifetime risk of developing breast cancer, up to 80%. The highest risk is incurred by the BRCA carriers.

Age remains the most significant risk factor for sporadic breast cancer. However, nearly 50% of breast cancer in carriers develops under the age of 50. Furthermore, data has shown that such a risk starts to rise from the age of 30 and remains higher than that in the general population for the rest of these women’s lives.

It is not surprising that these women experience high levels of anxiety and, consequently, have tough and difficult decisions to make in their attempt to deal with the fear of developing breast cancer. These women have limited options, ranging from surveillance to risk-reducing mastectomy. Changes in lifestyle and use of endocrine therapy may have a role to play, however, they provide a limited level of risk reduction. These women are also at a significantly increased risk of ovarian cancer. Bilateral risk reducing salpingo-oophorectomy in premenopausal women has consistently been shown to reduce the risk of breast cancer by about 50%. Mastectomy, however, provides the maximum risk reduction and data has shown risk reduction in the order of 90% or more.

These women need the full support of a multidisciplinary team involving geneticists, breast surgeons, oncologists, reconstructive surgeons, psychologists and breast care nurses, all of whom have special interest in Familial Breast Cancer. At London Bridge Hospital, we are able to provide such specialised care to these patients, who undoubtedly present a challenging and complicated medical problem. This has a significant impact on these women, both physically and psychologically, and such a team is fundamental in assisting these women to restore a good quality of life.
Breast Reconstruction

Every woman facing breast cancer has a right to breast reconstruction.

The Plastic Surgeons of the London Breast Reconstruction Associates are a dedicated team of Consultants specialised in breast restoration. Alongside their consultancy at Guy’s and St Thomas’ NHS Foundation Trust, they offer the most advanced breast reconstruction techniques at London Bridge Hospital. These include implant-based reconstruction and microvascular autologous reconstruction from the abdomen, the buttocks or the inner thigh. All five Consultants are actively involved in the development of new techniques in breast reconstruction, and strong links with King’s College have been established.

The team has worked closely together for a number of years and are well-established within the multidisciplinary team. In order to provide the highest standard of care to patients, all microvascular procedures are performed by two Consultants. One of the Consultants is available to patients 7 days a week.

Patients will experience clinical care that goes beyond their expectations. From initial consultation to full recovery, the dedicated team at London Bridge Hospital provides support at every stage.

Mr Jian Farhadi
MD PD FMN (Plast) EBOPRAS
Consultant Plastic Surgeon

Lymphoedema Services at London Bridge Hospital

In January 2009, a Lymphoedema Service was established at London Bridge Hospital to augment the existing Breast Care Service.

The service offers support to all patients who develop secondary lymphoedema due to any cancer-related treatment, and appointments are available from early morning to late evening to provide flexibility for patients. Referrals can be made by Consultant Breast Surgeons, Oncologists, Breast Care CNS, Ward Nurses or Physiotherapists.

London Bridge Hospital is the only hospital to provide a dedicated Lymphoedema Nurse.

Some insurance companies will pay for lymphoedema management; however, there is a package available when treatment is self-funded.

The nurse will initially see a patient during a Consultant appointment. Subsequent visits will coincide with either surgical or chemotherapy admissions.

By providing education and advice to patients from an early stage, the nurse aims to increase awareness of the condition and the management options available. For patients with existing lymphoedema, the nurse aims to reassure them that the condition can be controlled and that use of the affected limb will be regained.

Due to the service growing rapidly, there are plans to increase the number of staff trained in lymphoedema management, thus improving availability for patient consultations.

The service provides:

• Post operative assessment and education for all patients who have had breast-related surgery and removal of lymph nodes.
• Advice on skincare.
• Manual Lymphatic Drainage (MLD) for uncomplicated lymphoedema of both arms and legs.
• Initial hosiery fitting and six-monthly reviews.
• Education and support for patients and relatives who are predisposed to develop lymphoedema.
• Bandaging or MLD for palliative conditions.
• Flight and travel information.
Unparalleled premium healthcare services on your doorstep

Docklands Healthcare is conveniently located on the ground floor of the Clifford Chance Building, Upper Bank Street, next to Canary Wharf tube station (east exit).

Docklands Healthcare on your doorstep

Designed to meet the fast-paced demands of the Canary Wharf and Docklands community, Docklands Healthcare offers an unparalleled range of premium diagnostic imaging services and healthcare.

Our imaging centre offers a convenient location and minimal waiting times so any medical concern can be swiftly addressed and the highest quality treatment offered.

Diagnostic Imaging

We have a team of fully qualified and experienced radiographers on hand with results assessed by leading consultants from London’s top hospitals. Diagnostic imaging services include:

- General X-ray
- MRI scanning
- Ultrasound scanning

Orthopaedics

Our team of orthopaedic consultants specialise in the following:

- Arthritis
- Cartilage repair/replacement
- Cartilage tears inside a joint
- High performance hip and knee replacements
- Management of ligament tears
- Surgical ligament reconstruction
- Tendonitis

If onward referral is required, London Bridge Hospital ensures convenient access to consultants from a wide range of other specialties.

For further information on Docklands Healthcare please call 0844 800 0636 or visit www.docklandshealthcare.com
Consultant Allergy Clinic Opens its Doors

A new Consultant-led Allergy Clinic has opened at London Bridge Hospital. The clinic is treating patients with airborne, food, medicine (drug) and wasp allergies.

The Allergy Clinic is led by one of Europe’s most distinguished Consultants, Dr Pierre Dugué, who trained and practised for many years in Paris and on the Côte d’Azur.

The growing demand for the treatment of allergies has long outstripped the capacity of the very few specialist Allergy Clinics in the UK.

“Most allergic reactions occur as a result of environmental and individual genetic reasons, but our research has shown that we can now effectively treat the vast majority of conditions,” said Dr Dugué.

Whilst the incidence of asthma has now reached a plateau, there is a steady increase in the incidence of allergic reactions in adults as well as children. Desensitisation is an increasing area of our work. Essentially, this is a vaccination with varying concentrations of allergen, once that allergen has been identified.

We use either sub-cutaneous immunotherapy by repeated injections or sub-lingual immunotherapy with daily drops under the tongue.

The second main area of the clinic’s work is a new procedure for the diagnosis and treatment of drug (medicine) hypersensitivity. Drug challenge is the ‘gold standard’ of diagnosing drug allergic hypersensitivity when conventional allergy tests are negative or not available.

Patients undergo this diagnosis as a day procedure and the drug challenge involves a cautious and graded re-introduction of the suspected drug under strict medical control. This begins with the ingestion of a tiny dose, followed by incremental increases of dosage up to the normal therapeutic dose. The challenge is stopped if an allergic reaction occurs and the patient is immediately treated. However, because of the low doses administered, any reactions are almost always very mild.

“We have achieved remarkable success in helping patients with this technique, allowing many of them to resume and benefit from treatment otherwise excluded. We have also been able to identify people who have been wrongly suspected of having tolerances to drugs such as penicillin, from their childhood,” said Dr Dugué.

Dr Pierre Dugué
MD A. Practicien Hospitalier Chef de Service ACC-AH AIH
Consultant in Allergy and Asthma

For further information about the new Allergy Clinic, please call 020 7234 2163
Meniscal Transplantation: Donors make a difference in sports injuries

Cartilage tears in the knee are one of the most common but most debilitating sports injuries facing active people today. The knee cartilages are two elastic shock absorbers inside the joint that can often tear during heavy twisting on a bent knee or from innocuous sports injuries. Knee cartilage tears cause pain, swelling and clicking and can cause the knee to give way or to lock up.

Up until relatively recently, cartilage tears in the knee had to simply be ‘chopped out’ – removing the torn tissue but leaving the knee with either a reduced, or even no, shock absorber. Thankfully, nowadays, some cartilage tears can be repaired successfully.

Mr Ian McDermott, Consultant Orthopaedic Surgeon at London Bridge Hospital states, “Knee cartilages naturally have a very poor blood supply and therefore only about 25% of tears can actually be repaired, and that is in the most expert hands.”

For those patients who have lost a meniscal cartilage in the knee, sadly the long-term consequences can be quite grave, with an increased risk of future arthritis of up to 1500%.

Fortunately, groundbreaking research is ongoing with attempts to introduce methods of replacing missing cartilage tissue, to improve patients’ symptoms and to try and reduce the risk of arthritis. Various artificial scaffolds are being developed whereby new cartilage tissue grows into the implant. However, these scaffolds are delicate and as yet can only be used to replace relatively small amounts of missing tissue. For those patients who have lost large amounts of cartilage tissue or even a whole meniscal cartilage in its entirety, a small group of surgeons in the UK are leading the way in the technique of Meniscal Transplantation.

During Meniscal Transplantation, whole meniscal cartilages are taken from donors and tested, sterilized and stored. These frozen cartilages can then be provided to patients and transplanted into a knee to replace missing tissue. The technique is complex and is currently only being undertaken by about half a dozen surgeons in the UK.

Mr Paul Barralough, a 39-year-old banker from London, had had terrible trouble with his knee, with a series of operations relating to injuries from football. Paul had previously undergone an anterior cruciate ligament reconstruction in his knee, but this had failed and he had ended up with severe tears of one of the cartilages in his knee. Mr Ian McDermott, Paul’s knee specialist, stated, “When I met Paul, he had no ACL in his knee, and after a series of cartilage tears also ended up with no meniscal cartilage. Paul was young and determined to stay active and healthy and wanted me to get his knee as close to normal as possible.”

Mr McDermott performed a new ACL reconstruction and a new meniscal transplant in Paul’s left knee. Paul stated, “Before this surgery I couldn’t run or even manage a light jog without pain and clicking in my knee. The operation went well and afterwards I had a lot of rehab, gradually building up the knee. Now I can jog, ride a bike, I row four times a week and also conduct football training for my son’s football team. I would definitely recommend the operation and am grateful for the outcome and the continued support I received from Mr McDermott.”

Mr McDermott stated, “Meniscal Transplantation is a complex and involved procedure with very specific indications that are not suitable for every patient. However, those of us who have pioneered the technique in the UK are seeing very encouraging results, it can give patients greatly improved function with the hope of reduced risks of arthritis when they get older. Also, as techniques improve and technology develops, we are all looking forward to the day when patients will be able to ‘grow their own’ replacement tissues. The future does look very exciting.”

Meniscal Transplantation is just one of the reconstructive techniques available from Mr Ian McDermott and the team of specialist surgeons at London Bridge Hospital.
Laparoscopic or keyhole surgery has now entered a new dimension. Many of the traditional operations originally requiring unsightly incisions on the stomach can now be performed without visible scars.

Traditional laparoscopic surgery has improved the cosmetic appearance and healing rate of surgical procedures, which required substantial and painful incisions. The introduction of a single scar, concealed within the umbilicus, has taken keyhole surgery to the next level. Patients have been delighted with their rapid return to function and minimised discomforts afforded by keyhole surgery, but were still looking to avoid the telltale marks of surgery. Traditional laparoscopic surgery requires multiple incisions across the abdomen that can be unsightly and painful whilst healing.

By placing the scar deep within the umbilicus, it is virtually impossible to identify the incision required to perform the surgery. Patients have been delighted with their rapid return to function and minimised discomforts afforded by keyhole surgery, but were still looking to avoid the telltale marks of surgery. Traditional laparoscopic surgery requires multiple incisions across the abdomen that can be unsightly and painful whilst healing.

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Advantages
- Non-invasive, risk-free and painless.
- No anaesthetic or injections.
- Changes to liver may be picked up in just a few minutes during an outpatient consultation, which means no hospital admission.
- Patients are able to return home or to work straight afterwards.
- Real time result print-out supports treatment option decision making with a specialist liver doctor.
- Easy to repeat regularly to assess the effect of treatment or changes to lifestyle.

Disadvantages of FibroScan®
- May underestimate fibrosis in some patients with advanced fibrosis or macronodular cirrhosis.
- May overestimate fibrosis in patients with extrahepatic cholestasis or acute hepatocellular injury, due to the effects of these conditions on liver stiffness.

Medical Insurance Cover
London Bridge Hospital works with all major private insurance companies. Patients are advised to contact their insurance provider and advise them of their planned consultation. FibroScan® may or may not be covered, depending on individual policy.

Reference Sources:

Mr Nick Marshall
Consultant Laparoscopic and Upper GI Surgeon
Concerns about flat feet are a very common reason for a consultation with a GP. A normal foot has a longitudinal arch on the inner side of the foot. A person with a flat foot has little or no arch, the heel tilts outwards (valgus) and the forefoot may rotate outwards (abduction) when they stand or walk. Many people will never have any problems caused by their flat feet, but if a patient starts to experience discomfort they should be investigated thoroughly.

There are various conditions that can cause flat feet, some are congenital, others acquired. The most common pathology linked to the development of flat feet is a dysfunction of the tibialis posterior tendon.

This tendon runs behind the medial malleolus and is essential for the ankle/foot alignment. Pain behind the postero-medial aspect of the ankle associated with a flat foot is always a strong indication of a tibialis posterior tendon dysfunction.

There is a spectrum of problems caused by flat feet, ranging from tendon inflammation through to irreversible tendon and joint damage with increasing pain and flat foot deformity.

If detected and treated at an early stage, conservative treatment including physiotherapy, insoles and brace with relative rest may lead to a full recovery. At a later stage, one has to consider a surgical procedure including osteotomies and a tendon transfer. Thereby, one can still achieve a full recovery and good function. At the final stage, one has to fuse joints to realign the foot and eliminate the pain.

In order to prevent this happening and to make sure that the correct treatment is initiated at the right time, all patients with flat feet and discomfort should be seen by a foot and ankle specialist.

**Flat Feet - When Should a Patient be Referred to a Foot Specialist?**

Martin Klinke  
Consultant Orthopaedic Surgeon  
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Describe your foot problem
As a teenager, I was diagnosed with enlarged big toe joints, which meant I would be prone to developing bunions at a later stage. By my twenties, I was also diagnosed with flat feet. So I knew that at some point, I was likely to need foot surgery. It was something I kept at the back of my mind until gradually, my feet became increasingly painful and uncomfortable. I did develop bunions and having both bunions and flat feet made it very difficult to find shoes because my feet were so wide. Eventually, even trainers became uncomfortable after I had been wearing them for a while. It wasn’t just my feet which were affected. If I did much walking, I would get a lot of aching in my lower back and in the base of my neck and develop dreadful headaches. There was no cushioning in my feet as I moved, so all the impact as I walked was being transferred to other parts of my body.

Why did you choose surgery?
I was first diagnosed by a consultant at a London teaching hospital. He said I had severe bunions and recommended surgery to correct them. I had a further assessment by Mr Klinke as a second opinion and he thought my foot problem was more complex. He suggested that my flat feet were the precipitating factor behind my bunions, because they led to uneven weight distribution as I walked.

Therefore, if the bunions were treated in isolation, the problem would certainly come back and it would be a case of treating the symptoms rather than the cause. Mr Klinke carefully explained that surgery to correct flat feet is complex and involves a long recovery. He suggested I took some time to consider before making up my mind and I was grateful to have that advice and the opportunity to think it all through. Mr Klinke also explained that recovery is better if surgery takes place on one foot at a time, so I knew I would be looking at a long period of operations and rehabilitation. It was quite a daunting prospect, but it was clearly the right decision for my overall quality of life.
How did you feel straight after surgery?
To be honest, immediately after surgery my first feeling was one of immense relief. I had been brave enough to finally go ahead with surgery and I wasn’t in any significant amount of pain. I spent three nights in hospital after the first operation because I wanted to be sure that I could manage with crutches before going home. I was more confident after the second operation and spent two nights in hospital. The first two weeks after surgery I wore a plaster cast for the first two weeks. You are instructed to stay off your foot completely and keep it elevated as much as possible. I took a full three weeks off work and my boyfriend fretted about looking after me. It is so important in those early days to have help at home. Carrying things while you are using crutches is very difficult, so just getting food and drinks for yourself is a challenge.

The first two months after surgery
I had to avoid weight-bearing on my foot for a full six weeks after surgery. I started work again after three weeks, but was working from home. Fortunately, my employer was really supportive and flexible. Physiotherapy started pretty quickly; two weeks after surgery. You start with exercises to move your toes around. It’s amazing really that at such an early stage, your feet are already healing and you are able to move a little. At first, I went to physiotherapy once a week for four weeks, then every other week after that. The physiotherapists at the London Bridge Hospital Sports Clinic were great and it was so important to have physiotherapy in the same place as the London Foot and Ankle Centre. It was very reassuring – you have a long recovery and if I had any worries about how well I was getting on, they would explain exactly what was happening and what to expect.

Three months to six months after surgery
By the three-month stage, I was able to walk around in a pair of trainers for a short time and started travelling on the tube again. I was starting to feel like my old self and it was tempting to overdo it, but my foot would swell if I spent too long on my feet. You have to be guided by how you feel – if your feet become painful and swollen, it’s time to rest. You feel like you are starting to get your life back, but don’t do too much too soon.

Six months and beyond
It was back to business as usual by the six-month stage. It took slightly longer to fully recover from my first operation than from my second, as there was slightly more swelling in my right foot than left. But for both feet, by six months, I was getting back to normal activities, including lots of walking and light running. However, with this type of foot surgery, it takes up to a year before you can say that you are fully recovered.

There is now a massive visual difference with my feet. I didn’t have surgery for cosmetic purposes and it shouldn’t be undertaken for cosmetic purposes. But I can now fit into normal shoes without any pain or discomfort. I can walk around for a long time without getting pain in my back or headaches. That is a real achievement after being in pain for so long and is life-changing. Simple things like just being able to rise up on your toes seem almost impossible six to eight weeks after surgery, so by six months, being able to rise up on your toes and jump feels like a major milestone.

What would your advice be to anyone considering this type of surgery?
First of all, I would say that anyone considering this type of surgery needs to think very carefully about their reasons for having it. This surgery is a big commitment and a major undertaking, both physically and psychologically. Even though I had already had one operation, by day three after surgery on my second foot, I was feeling really grumpy and frustrated. It’s a natural psychological state, when you consider the long recovery that lies ahead.

My second piece of advice is to follow the instructions from your surgeon and physiotherapist to the letter. I wanted the best possible long-term recovery and so I didn’t cut any corners and start leaping around too soon. My final advice would be to check your surgeon is a very experienced foot and ankle specialist. I did my own research and was confident that, with Mr Klinke, I was in very capable hands and stood the best chance of a complete recovery.
London Bridge Hospital Adopts e-Qit for Cleanliness

Two years ago, HCA launched an initiative with Infection Control Services Ltd, a company formed by six Consultant Microbiologists from University College London Hospital.

As part of a drive to raise hospital hygiene standards even higher, HCA partnered the development of a new state-of-the-art computerised system called e-Qit, which will dramatically change the way that cleanliness inspections and follow-up actions are carried out in hospitals.

The e-Qit system enables us to audit the cleanliness of every part of our hospitals, both on a regular and on a spot-check basis, and to identify where immediate and longer term action needs to be taken. The e-Qit system uses special hand-held computers loaded with the floor plan of our hospitals and its software details every area of potential risk. The machines are also equipped with a camera which can record areas in need of attention. Once the data collected is downloaded, a report is generated automatically and managers are given the responsibility for fixing any problem that may have been identified within a set timeframe.

HCA is the first hospital group to achieve the five-star cleanliness rating, the highest level of cleanliness a hospital can achieve.

Michael Neerb, CEO, HCA International said, “We are very proud to be the first hospital group to achieve the five-star cleanliness rating, but it doesn’t end there. Each and every day, our team is committed to improving the quality of patient care in a safe and clean environment.

“It is an important and objective rating that the independent public can look to to ensure that the facility they choose is a clean and safe environment for their care.

“The entire team is committed to providing the highest quality patient care available, plus the benefits you get from the private hospital setting of being treated by your Consultant in a safe and clean hospital environment.”
London Bridge Hospital Completes UK Private Hospital First

London Bridge Hospital’s Cardiology Department has completed the first ever WATCHMAN® case in a private hospital in the UK, with Professor Richard Schilling performing the procedure.

The WATCHMAN® is a device-based solution designed to close off the left atrial appendage. The technology provides a solution for patients with atrial fibrillation who require blood thinning medications to reduce their risk of stroke.

The device is introduced into the heart via a catheter through a vein in the groin. The device has been designed to capture any clots that may form in the appendage, potentially reducing the risk of stroke and eliminating the need for long-term use of blood thinning medications.

Professor Schilling said, “We are ideally placed to do this kind of procedure because crossing into the left side of the heart and entering the pocket where a clot occurs (the left atrial appendage) is something we do every day as part of the catheter ablation procedures to eliminate atrial fibrillation. This experience makes a complex procedure very simple.”

Docklands Healthcare

As part of London Bridge Hospital’s ongoing commitment to offering the best in diagnostic and treatment facilities, we are proud to have expanded the consulting services available at our satellite centre in Canary Wharf, Docklands Healthcare.

Docklands Healthcare is convenient and well resourced, providing patients living and working in the Canary Wharf area with diagnostic imaging and orthopaedic specialists on their doorstep.

In most cases, we are able to offer a same or next-day appointment for general X-rays, state-of-the-art MRI scanning and ultrasound scanning, as well as clinics held by leading specialist orthopaedic Consultants, including a Consultant Sports Physician.

Docklands Healthcare is able to provide patients with results on CD following their scan. The results are assessed by leading Consultants from some of London’s top hospitals, and the centre will fax their reports to referring GPs or Consultants within 24-48 hours.

For more information on the services offered by Docklands Healthcare, contact GP Liaison on 020 7234 2009, or visit www.docklandshealthcare.com
Refurbishments Continue at London Bridge Hospital

Refurbishment works continue across London Bridge Hospital with theatre building works well underway – the stakeholders have all had input in the design/layout and chosen the medical equipment. We are currently choosing the colour scheme and finishes. Building works are nearing completion, with new equipment soon to be installed. The completion of these works will be followed by commissioning and Healthcare Commission approval, and the theatres are scheduled to open in July. Furthermore, the new dialysis unit has recently been completed and is now up and running in St Olaf House.

The planned move from the 2nd floor main hospital will commence now that dialysis has moved into its new unit. The builders will begin work in the vacated unit to turn that space into inpatient beds. In addition to the new dialysis unit in St Olaf House, Audrey Kerr, Angiography Manager, now has a new administration office and a fully compliant recovery bay for the cath lab.

The new ICU, to be built out into the atrium, is waiting on listed building consent. This takes between 10 and 12 weeks, and work will commence once the hospital receives approval. ICU will be located on 3rd floor north, while further work will take place in the atrium to expand inpatient bedroom capacity on the 4th and 5th floors.

The London Rheumatology Centre

A Consultant Rheumatology Opinion Within 48 Hours

London Bridge Hospital is pleased to introduce the addition of a Rheumatology Centre to its services. It is becoming increasingly evident that incisive diagnosis leading to early treatment is vital. Whether it be the management of acute shoulder pain, back pain, knee problems or more general problems, such as stiffness or widespread aches and pains, referral to the appropriate specialist is critical.

Current treatment options for the patient with aches and pains can involve a GP visit, referral to a hospital or, in some cases, an operation or X-ray. However, these solutions can take up valuable time.

The London Rheumatology Centre, led by our team of dedicated Consultant Rheumatologists, offers full medical examinations and appropriate investigations. Where appropriate, treatment in the Rheumatology, Orthopaedic or Physiotherapy Departments can also be arranged.

At London Bridge Hospital and our satellite centre, 31 Old Broad Street, we have over 20 orthopaedic surgeons, sports medicine specialists, osteoporosis consultants, physiotherapists and full acute medicine services at our disposal. On site, we have a range of comprehensive X-ray, MRI, DEXA and other diagnostic facilities available.

To avoid delay, we can offer an initial appointment within 48 hours in most cases. To make an appointment, please call 020 7234 2060. For further information, please visit www.londonrheumatologycentre.com or email londonrheumatology@hcahealthcare.co.uk.

For those patients requiring insurance cover, a GP referral letter is advised.
London Bridge Hospital’s GP Liaison Team

For those of you who know us well, you will be aware of how the GP Liaison service can help you. However, for those of you who may be unfamiliar with how we work, our GP Liaison Team offers the following support to our referring General Practitioners:

**GP Liaison Assistant Team**
- A dedicated phone line, 020 7234 2009, open from 8.30am – 5.30pm, Monday to Friday for you, your secretaries and patients.
- A fast, efficient appointments service. We can deal with both named and unnamed referrals (i.e. Dear Consultant Cardiologist).
- A helpful, friendly team ready to deal with any questions that you or your patients may have about the Hospital.
- A promise to help you and your patients as much as we can, even if this means making an appointment with a competitor.

**GP Liaison Officer Team**
A GP Liaison Officer dedicated to your area offers the following:
- Organising educational events on areas of interest to primary care. These can be both large scale and bespoke smaller scale.
- Keeping you in touch with the Hospital and any new developments/services.
- A personal contact point at the Hospital for any issues that may arise.

**Call the GP Liaison Team on:** 020 7234 2009

**Your Feedback:**
We are constantly striving to improve our service offering. We would be delighted to hear from you with any ideas as to how we could do this. Please feel free to contact your GP Liaison Officer.

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**The Referral Process through GP Liaison**

1. **Patient attends GP consultation**
2. **Referral recommended**
3. **Phone call from GP/Sec to GPL**
4. **Fax from GP/Sec to GPL**
5. **Encrypted email from GP/Sec to GPL**
6. **GP directs patient to contact GPL**
7. **GPL call patient for availability**
8. **GPL liaise with consultants/ secretaries**
9. **Call patient to offer appointment**
10. **Appointment made**

Ensure all paperwork with secretary prior to appointment
If you wish, we can inform you when appointment is confirmed

*Please note: To save you time, we only need the minimum details when you contact us: the patient’s name, date of birth, contact telephone number, the specialty to which you are referring them and brief details of their condition.*
# London Bridge Hospital New Consultant List

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>QUALIFICATIONS</th>
<th>DEPARTMENT</th>
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<tbody>
<tr>
<td>Dr Tahzeeb Bhagat</td>
<td>Consultant Anaesthetist</td>
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<tr>
<td>Dr Daniel Horner</td>
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<td>Dr Paul Kelly</td>
<td>Consultant Anaesthetist</td>
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<tr>
<td>Dr Nilesh Nanavati</td>
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<tr>
<td>Dr Mira Razzaque</td>
<td>Consultant Anaesthetist</td>
<td>MBBS FRCA FFRCRA</td>
<td>Anaesthetics</td>
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<tr>
<td>Mr Amir Darakhshan</td>
<td>Consultant General Surgeon</td>
<td>MBBS MD FRCS (Gen)</td>
<td>Colorectal Surgery</td>
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<tr>
<td>Dr Mary Wain</td>
<td>Consultant Dermatologist</td>
<td>BSc (Hons) MBBS (Hons) MD MRCP</td>
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<tr>
<td>Professor Albert Ferro</td>
<td>Consultant in General Medicine</td>
<td>BSc (Hons) MB BS PhD FRCP FBPharmacoS</td>
<td>General Internal Medicine</td>
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<td>Dr Jeremy Harris</td>
<td>Consultant in General Medicine</td>
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<tr>
<td>Dr John Collins</td>
<td>Consultant in General Medicine</td>
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<tr>
<td>Mr Vassilis Hadjianatassiou</td>
<td>Consultant General Surgeon</td>
<td>DM(Oxon) FEBVS (Vasc Surg) FRCS (Gen Surg) BSc</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Mr Hitesh Patel</td>
<td>Consultant Laparoscopic Colorectal and General Surgeon</td>
<td>MB ChB MS FRCS(Eng) FRCS(Eng Surg)</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Dr Christopher Sonnex</td>
<td>Consultant in GU Medicine / Sexual Health</td>
<td>MB BS MA FRCP</td>
<td>Genito-Urinary Medicine / Sexual Health</td>
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<tr>
<td>Miss Nataly Atalla</td>
<td>Consultant Gynaecologist</td>
<td>MRCOG MD</td>
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<tr>
<td>Miss Jemma Johns</td>
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<tr>
<td>Dr Robert Marcus</td>
<td>Consultant Haematologist</td>
<td>MA FRCP FRCPPath</td>
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<tr>
<td>Dr Sawantha Ponsford</td>
<td>Consultant Clinical Neurophysiologist</td>
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<td>Dr Alistair Purves</td>
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<td>Mr Ranjeev Bhangoo</td>
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<td>Dr Padaic Ryan</td>
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<tr>
<td>Dr Rohit Lal</td>
<td>Consultant Oncologist</td>
<td>MRCP PhD</td>
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<tr>
<td>Mr Geoffrey Lane</td>
<td>Consultant Gynaecologist and Gynaecological Oncologist</td>
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</tr>
<tr>
<td>Dr Teresa Guerrero Urbano</td>
<td>Consultant Oncologist</td>
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<tr>
<td>Mr Adel Tavakkolizadeh</td>
<td>Consultant Upper Limb and Orthopaedic Surgeon</td>
<td>MB BS MRCS MSc FRCS (Tr &amp; Orth)</td>
<td>Orthopaedic Surgery</td>
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<tr>
<td>Mr Marc George</td>
<td>Consultant Orthopaedic Surgeon</td>
<td>MB BS FRCS (Eng) FRCS (Tr &amp; Orth)</td>
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<td>Mr Andrew Richards</td>
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<tr>
<td>Mr Jian Farhadi</td>
<td>Consultant Plastic Surgeon</td>
<td>MD PD FMH (Plast) EBOPRAS</td>
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<tr>
<td>Dr Irfan Ahmed</td>
<td>Consultant Interventional Radiologist</td>
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<tr>
<td>Dr Nyree Griffin</td>
<td>Consultant Radiologist</td>
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<tr>
<td>Dr Mamatha Reddy</td>
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<tr>
<td>Dr Ravi Rajakarir</td>
<td>Consultant Renal Physician</td>
<td>BSc (Hons) MBChB (Hons) MRCP</td>
<td>Renal</td>
</tr>
<tr>
<td>Dr Dominic Radford</td>
<td>Sports Medicine Physician</td>
<td>MBChB MRCGP MSc Sports Medicine MFSEM UK</td>
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<tr>
<td>Mr John Pilling</td>
<td>Consultant Thoracic Surgeon</td>
<td>FRCS (CTh)</td>
<td>Thoracic Surgery</td>
</tr>
<tr>
<td>Mr Paul K Hegarty</td>
<td>Consultant Urological Surgeon</td>
<td>MCh MBA FRCS (Urol)</td>
<td>Urology</td>
</tr>
</tbody>
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Note: Please see our website or Referrers’ Guide for contact details of all Consultants featured in this magazine or contact the GP Liaison Department on 020 7234 2009.