GP INTELLIGENCE
THE QUARTERLY MAGAZINE FROM THE HOSPITAL OF ST JOHN & ST ELIZABETH
WINTER 2012

GPi

INTRODUCING OUR NEW GYNAE UNIT

A comprehensive service for assessment and treatment

DEDICATED REFERRAL HOTLINE FOR GPS

Our education programme and annual symposium

PIONEERING NEW IMAGING EQUIPMENT

The first private London Hospital to offer a 256-slice CT scanner

ST JOHN'S HONOURED

Hospice receives prestigious Hospice@Home award

OUR NEW KNEE UNIT

Instant access to some of the finest specialists in this field

FOCUS ON PAEDIATRIC CARE

Looking at eczema and cardiology problems in children

ABNORMAL UTERINE BLEEDING

Often the cause of post-natal discomfort for the new mother

Hospital of
St John & St Elizabeth
150 years of compassion and excellence supporting St John's Hospice

OUR MANAGEMENT TEAM

DR DAVID GRANT
Medical Director

MRS CHRISTINE MALCOLMSON
Matron

DR CHRIS FARNHAM
Hospice Medical Director

MR GEOFF GREEN
Financial Director

FORGING AHEAD INTO 2013 INSPIRED BY A VERY SUCCESSFUL 2012

Happy New Year and welcome to the Winter edition of GPi. Just before Christmas we completed the installation of a new 256-slice state-of-the-art CT scanner, which offers the very best quality images and more advanced clinical applications. This £1.2million investment in our Imaging Department comes less than a year after we became the first private hospital in the UK to have a 3T MRI scanner.

As the official medical facility of UK Athletics, we were delighted at the success of the 2012 GB Olympic team after many of the medal-winning track and field athletes were treated at the Hospital.

Our reputation is growing. A record 293 GPs attended our Annual Symposium to hear lectures from 15 of our leading consultants. We plan to build on this success and the extremely positive feedback by hosting a special Hot Topics Annual Symposium on March 23 (see Pages 6 and 7 for full details). Meanwhile, 266 healthcare professionals attended our Hypermobility Seminar. The Hypermobility Unit, led by Professor Rodney Grahame, is the UK's only private specialist unit and is already attracting international interest.

We are launching a new GP hotline to ensure all referrals are dealt with immediately and also a new Knee Unit and Gynaecology Unit. This will complement our wide range of world-class services – we have hundreds of specialist consultants and boast Spine and Shoulder Units and the fast-growing London Urology, as well as the world-renowned London Foot and Ankle Centre.

Our walk-in private urgent care centre has proved to be such a success – with 10,000 patients already treated – that we are now expanding the service. Casualty First is unique in being able to treat adults and children from the age of one for all minor accidents, illnesses and injuries.

The success of the Hospital allows us to fund our on-site hospice, St Johns, which recently launched London's first palliative care ambulance service. Our Hospice@Home service scooped the prestigious Domiciliary/Home Healthcare Provider 2012 at the Laing Buisson Independent Healthcare Awards, beating hundreds of rivals.

I thank you for your support last year and look forward to a successful 2013.
Kind regards,

DAVID MARSHALL CHIEF EXECUTIVE

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Carol singers at the St John's Christmas Fayre which helped to raise £15,000 for the Hospice

AT THE HEART OF THE LOCAL COMMUNITY **OFFERING FIRST CLASS HEALTHCARE**

The Hospital of St John & St Elizabeth is truly unique. As an independent charity, we are proud to deliver ultimate standards of private care to our patients. But while doing this, all of our profits help fund our on-site Hospice.

St John's Hospice provides vital palliative medicine services free of charge to the local community and beyond.

This unique combination has put the Hospital and the Hospice at the heart of the area.

Our Easter, Summer and Christmas Fayres partner with local schools, groups and businesses to raise money to support St John's.

More than 7,000 local residents attended the St John's Christmas Fayre on St John's Wood High Street, raising £15,000 for the Hospice.

Our self-pay, walk-in urgent care centre, Casualty First, is proud to sponsor the fayres.

In 2013, the Hospital has a range of exciting expansion plans – starting with Casualty First. Our urgent care centre, able to deal with any minor illness or accident, has already treated 10,000 patients. Now we are expanding Casualty First to keep up with demand, ensuring patients enjoy a truly walk-in service without the waiting times of NHS A&Es.

We are also launching new units in 2013, including the Knee Unit and our new gynaecological London Wellwoman Clinic.

All these are designed to help the Hospital continue to flourish, allowing us to meet the ever growing demand for support from the Hospice, which cares for 2,000 terminally ill patients and their families for free every year.

We are extremely grateful to all those who contributed to our success in 2012.

For full details of all the services provided by the the Hospital please visit www.hje.org.uk.

Alternatively, to find out how you can support our Hospice visit www.stjohnshospice.org.uk.

AMAZING PROGRESS OF CASUALTY FIRST AND OUR EXPANSION PLANS - PAGES 4 & 5

CASUALTY FIRST HAS NOW PATIENTS AND EXPANSION

CASUALTY FIRST
Hospital of St John & St Elizabeth

Due to its phenomenal success our urgent care centre, Casualty First, is currently undergoing expansion. A third consulting room will be created by converting part of the Grove End Road reception. Work is due to commence early this year. Meanwhile, a third full-time consultant is being recruited as we further boost staff numbers to cope with demand.

Since the start of our autumn marketing campaign offering flu vaccinations and health screenings, there has been an average of over 30 patients a day.

Despite this growth, waiting times have been kept to an absolute minimum and the urgent care centre is winning widespread praise from the local community and beyond.

Following the great success of our first year we can confidently offer instant treatment to all of the following immediately on arrival...

- Acute illness
- Sports injuries
- Fractures, soft-tissue injuries, sprains and strains
- Wounds, wound closure and burns
- Cuts and grazes
- Ear, nose and throat conditions
- Gynaecological conditions
- Respiratory and chest complaints
- Stomach, bowel and bladder problems
- Eye conditions
- Ear consultation and ear syringing
- Flu vaccines
- Travel vaccinations and advice

HEALTH SCREENING BENEFITS INCLUDE EARLY DIAGNOSIS

DR YUMNAH RAS
Urgent Care Centre doctor

It is well known that the absence of disease does not define wellness. Wellness, or wellbeing, is the feeling that physically, psychologically, emotionally and spiritually, a person is in a state of harmony and balance.

Health screening can identify problems before they become more advanced, and before a patient even becomes aware that there is something wrong, such as detecting high blood pressure, early cancers, or giving advice about cardiovascular health and the prevention of heart attacks and strokes.

A health-screening consultation can be an extremely rewarding process for both the patient and the doctor. A doctor is in the very privileged position of being able to ask the patient about many aspects of their lives, and discuss their lifestyle in an open and frank manner.

The old-style family doctor was someone who knew the entire family, their health concerns and personal problems, and was available in times of crisis to provide counselling and advice on many issues, not all of them medical. Unfortunately, with the pressures of time in which we live, we are not able to do all of this for our patients, as much as we do genuinely wish to make a difference to people's lives. We often have no time to get to know patients and establish a rapport, much less win their trust enough to discuss personal matters.

Patients don't always see the same doctor in their local practice. Many times people do not deem certain issues as being significant enough to 'bother' their GP about. Yet it might be something that has enough of a negative impact on their lives that they really wish to change but feel powerless to do so.

For example, erectile dysfunction in men, loss of libido in either sex, urinary incontinence or the discomfort of a vaginal posterocoele might be at the root of relationship breakdowns and cause real unhappiness.

Personality issues may be the reason that a patient struggles at work and at home, and might need to be gently brought to their attention. It might be that someone may want to lose weight, get fit, or just wish to change their lifestyle.

I have worked in both general practice and health-screening centres, and have been in the privileged position to combine the two and offer health screening to my GP patients.

The process begins with a health questionnaire completed by the patient which asks about any medical problem ever encountered, about stress and sleep, as well as details of family medical problems, diet, exercise, sexual problems and psychological issues.

This has the advantage of getting the patient to think about all of these details before the consultation, and allows the clinician to hone in on problem areas, while at the same time, a consultation of 30-45 minutes helps to build a feeling of trust, and of getting to know each other.

After coming for a health screening, a nurse or health care assistant starts by doing fasting bloods tests for comprehensive haematology and biochemistry testing, as well as urine test, body measurements, visual and hearing tests, stool tests if needed, blood pressure and ECG.

The client is given a light breakfast then sees the doctor to discuss the questionnaire, results of the tests, have a full physical examination which is age appropriate and includes smear testing, prostate examination, as well as discussing breast and testicular self-examination if needed. Any issues can be discussed, whether it is a cholesterol-lowering or weight-loss plan or referral to a specialist.

At the Hospital of St John & St Elizabeth we have an onsite lab for rapid results to blood tests, onsite imaging department for same-day chest X-rays, mammograms, or scans such as ultrasound, CT or MRI. There is also a large physiotherapy department, dietician, a cardiology and respiratory department where lung function tests and stress ECGs take place, as well as echocardiograms. We also have onsite allergy testing and can arrange for someone with high blood pressure readings to be fitted with a 24-hour BP monitor on the same day.

There is a distinct advantage to have rapid access to so many resources in the same place, and the hospital is so well known for its friendly atmosphere that health screening at the Hospital of St John & St Elizabeth is a natural choice for many.

Some of the best job satisfaction I have enjoyed is helping someone map their route to optimal health and wellbeing. It is even more satisfying knowing that downstairs in the Hospice is the evidence of the charity we all contribute to with our association with the Hospital.

TREATED MORE THAN 10,000 PLANS FORGE AHEAD

Capable of detecting possible problems, health screening also provides a safety net for the patient and helps the general practitioner

Tel: 020 7432 8300 casualtyfirst@hje.org.uk www.casualtyfirst.co.uk

DEDICATED REFERRAL HOTLINE FOR GPS

We are delighted to announce our new dedicated referral hotline for GPs. For urgent referrals and admissions call 07736 223344 and one of our team will be on hand to assist you.

GPs now have just one number to call to access fast-track appointments with HJE consultants and clinics for both adults and children.

This service is available 24 hours a day, 7 days a week, 365 days a year.

The Hospital of St John & St Elizabeth's GP education programme continues to grow. More and more GPs are turning to our lecture and seminar series to help them keep up-to-date with the latest developments in secondary care.

All those involved in primary care are advised to attend our lectures to hear from our consultants on the latest hot topics. We ask our speakers to include referral red flags, case studies and Q&A sessions in their talks to ensure that GPs get the most out of our lectures.

We have now confirmed the agenda for our short lecture and seminar series in 2013. Please see our January-March calendar for further information. Our consultants are also happy to make personal appearances to lecture at local GP surgeries. If you would like to hear about a topic not included in our series, please contact us to discuss booking a talk at your practice.

ANNUAL SYMPOSIUM BECOMES BI-ANNUAL

Last year's day-long symposium was held at the Royal College of Physicians in October and provided a fantastic opportunity for GPs to gain essential CPD points and enhance their knowledge of conditions they treat everyday at a primary care level. It gave them the opportunity to meet leading experts from an array of specialities and network with other GPs throughout the capital.

Due to the continued success and popularity of our symposia, we now plan to hold two a year from 2013 onwards, with events taking place in both March and October (please see the calendar for dates and times). Booking is essential, so why not get in early and reserve your place at these great educational events today?

The feedback we received from the last symposium was fantastic with GP delegates offering warm endorsements such as:

- 'Seeing different consultants and specialities and learning about what they think is important for GPs'
- 'Sessions were really good and relevant to GPs'
- 'Excellent and well organised symposium'
- 'Dietary advice for renal stones – the clearest I have ever heard – fabulous!'
- 'Clinically very relevant and useful for everyday practice'
- 'Poster of abnormal LFT algorithms will be placed on my office wall tomorrow'
- 'From many of the talks I have two or three skills to take away from the day'
- 'Excellent lectures and very useful. Please arrange another symposium, maybe two per year?'

Thank you to all who attended. The symposium proved to be our biggest and best yet with over 290 attendees enjoying a range of topics from kidney stones to cancer management given by 15 of our expert consultants.

WHY CHOOSE OUR EDUCATION SERVICE

We have a reputation for providing relevant and high-quality education and we welcome all members of the Primary Care teams to attend our varied programme.
We offer:

- Topics of modern-day relevance given by our world-renowned consultants
- Convenient times for GPs to attend the lectures, with morning, evening, lunchtime and weekend lectures provided
- Lectures that are completely FREE OF CHARGE to primary care teams
- Certificates of Attendance to count towards your Continuing Professional Development (CPD)
- The opportunity to network with fellow London GPs

OUTREACH LECTURES

For flexibility we're happy to provide free lectures at your practice at a time that suits you. Our outreach lecture programme has been designed especially for those healthcare professionals with exceptionally busy schedules.

These sessions will be arranged completely for the convenience of you and your colleagues, including practice nurses and registrars.

All the lectures are of modern-day relevance and are given by our own consultants, who are leaders in their field.

HOW TO ARRANGE A LECTURE

You can contact us on 020 7806 4047 or email education@hje.org.uk to discuss your preferred topic and available dates. We will do the rest and even bring catering along to your practice. Available to GPs in London only.

JANUARY 2013 – MARCH 2013

All seminars and lectures take place in the Conference Room, 3rd Floor, Brampton House at the Hospital of St John & Elizabeth (60 Grove End Road, NW8 9NH) unless otherwise stated.

- **Email education@hje.org.uk to book your place at any of the events below.**

GP SEMINARS

Saturday, February 2
9am-1pm Urology Seminar

GP SHORT LECTURES

Evening lectures 7.15pm-8.15pm
(A buffet dinner is served from 6.45pm)

Wednesday, February 6
Evening
Gynaecology Lecture
Friday, February 8
International Conference on Breast Cancer, Lord's Cricket Ground
9am-1.20pm
Wednesday, February 27
Evening
tbc
Wednesday, March 6
Evening
Paediatrics Lecture
Wednesday, March 13
Evening
Ophthalmology Lecture

ANNUAL SYMPOSIA

Saturday, March 23
9am-3.30pm
Royal College of Physicians
Saturday, October 12
9am-3.30pm
Royal College of Physicians

INTRODUCING OUR NEW GYNAE UNIT

The Gynaecology Unit – London Wellwoman Clinic offers a comprehensive assessment and treatment under one roof. Appointments are offered to patients within 24 hours, with clinics available Monday to Saturday.

The London Wellwoman Clinic covers general gynaecology checks, abnormal smears, colposcopy, abnormal menstruation clinics, early pregnancy, pelvic pain, infection, continence, HRT and all general gynaecology.

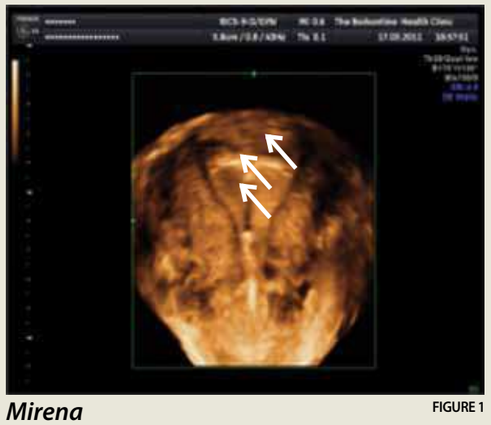
Our world-renowned consultants also treat obstetric conditions such as fibroids, recurrent miscarriage, infertility, problems following childbirth and maternal medical disorders.

Supported by state-of-the-art imaging facilities and theatres, the multi-disciplinary team at the London Wellwoman Clinic is dedicated to offering the very best in private healthcare. Patients can rest assured that they will receive the utmost care and attention.

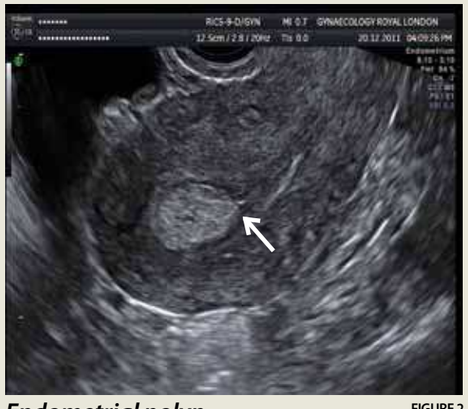
We have recently invested in our inpatient and outpatient facilities, so that we can offer as comfortable and relaxing an environment as possible.

BEATING ABNORMAL UTERINE BLEEDING

- **30% of all gynaecological outpatient attendances are due to menorraghia**
- **25% of women feel that their menstrual loss is excessive**
- **Up to 10% take time off work**



Mirena FIGURE 1



Endometrial polyp FIGURE 2

MR EMEKA OKARO
MBBS MRCOG
Consultant Gynaecologist

It is often difficult to know if the menstrual loss is normal or heavy compared to other women. By definition, menorraghia is the loss of 80mls of blood or more which clinically can be difficult to quantify.

A detailed history, pelvic examination and ultrasound scan are essential to establish a diagnosis. In 60% of women no abnormality will be found and thus a diagnosis of dysfunction uterine bleeding is made. 60% of women with menorraghia will be anaemic.

This is treated with oral medication such as mefenamic and/or tranexamic acid, the oral contraceptive pill or progesterone tablets. The intrauterine system (Figure 1) is also a good first choice in women also requiring contraception irrespective of parity. Should these be unsuccessful, removal of the lining of the womb (endometrial ablation) should be considered in women whose family is complete.

In the remaining 40%, conditions such as polyps (Figure 2), fibroids and adnenomyosis are also amenable to medical treatment. In some cases focal lesions such as polyps and fibroids are removed by hysteroscopy.

Hysterectomy is reserved for cases that do not respond to the treatments above in women whose family is complete. Should menorrhagia be accompanied by inter-menstrual and/or post-coital bleeding it is important to exclude a pelvic infection and ensure that the cervical cytology is normal.

Post menopausal bleeding accounts for 5% of all gynaecological outpatient attendances. In 90% of cases the underlying cause is benign and in 10% malignant. The commonest finding being atrophic vaginitis, endometrial or cervical polyps.

Treatment is usually a six-week course of topical oestrogen therapy or removal of the focal lesion. An endometrial thickness of 4mm or less on ultrasound reduces the pre-test probability of endometrial cancer from 10% to 1%. Overall, an endometrial thickness of 4mm will detect 96% of endometrial cancers and 92% of endometrial disease (polyps, hyperplasia, fibroids). It is also essential to visualise the cervix and obtain a normal cervical smear.

020 7806 4060 info@hje.org.uk www.londonwellwomanclinic.co.uk

Gynaecology

THE GP AND HIGH RISK PREGNANCY COUNSELLING

MISS AMMA KYEI-MENSAH
MRCP FRCOG
Consultant Gynaecologist

The 2006-2008 UK Confidential Enquiry reported 261 maternal deaths. 154 deaths were indirect, i.e. due to coexistent medical or psychiatric illness. Many of these women received no pre-pregnancy counselling (PPC) therefore opportunities for closer surveillance, change in medications etc were missed leading to suboptimal care.

Pre-pregnancy counselling is a "Top ten" recommendation in the report, requiring a nationwide multi-disciplinary response from all stakeholders involved in maternity service provision.

COMMON CONDITIONS REQUIRING PRE-PREGNANCY COUNSELLING

- **Obesity (BMI>30 kg/m^2)**
- **Diabetes**
- **Epilepsy**
- **Asthma**
- **Congenital or known acquired heart disease**
- **Renal or liver disease**
- **Autoimmune disorders**
- **Severe pre-existing or past mental illness**
- **HIV infection**

WHEN SHOULD PRE-PREGNANCY COUNSELLING (PPC) BE PROVIDED?

Half of pregnancies are unplanned so it is vital that women with pre-existing medical conditions are proactively offered PPC referral whenever they access NHS services.

Contact opportunities include cervical screening and contraception prescribing. Transition from paediatric/adolescent care to an adult clinic for girls with chronic diseases also presents a timely opportunity to promote discussion of future reproductive health.

WHO SHOULD PROVIDE IT?

PPC should be provided by a practitioner with suitable training and expertise in pregnancy management of the medical condition. Specific criteria for conception with regard to optimal disease control and safe effective medication are clarified together with any long-term consequences of pregnancy for the woman. The aim is to develop an individualised prospective pregnancy management plan.

THE FUTURE: A "LIFE-COURSE" APPROACH

These recommendations echo those of a new RCOG Report – High Quality Women's Health Care: A proposal for change (July 2011). It advocates a women's health network with a "life-course" approach to health care. Every contact with the NHS represents a chance to promote healthy living as well as disease prevention. It aspires to reach all women throughout their lives.

This approach may help in tackling obesity. Obesity in women over 16 years in the UK increased from 16% to 24% between 1993 and 2007. 49% of maternal deaths occurred in overweight or obese women. NHS contact opportunities for younger women include rubella screening, HPV vaccination and contraception. Consistent messages to teenagers, encouraging healthy lifestyle choices, have a greater chance of improving long-term health outcomes for future mothers and their babies.

Tel: 020 7806 4060 info@hje.org.uk www.hje.org.uk

Physiotherapy

Research shows that one in four women experience bladder weakness – and even this is thought to be an underestimate. Bladder weakness is a key consequence of weak pelvic-floor muscles and, despite this, 75% of 16 to 24-year-old women have never been shown how to locate or exercise their pelvic floor and one in five women don't know what their pelvic-floor muscles do.

POST NATAL MUMS AND THE PELVIC FLOOR

CLAIRE-ANNE HEAD
Clinical Lead
Women's Health Physiotherapist

The most common form of urinary leakage I see is stress incontinence. This type of incontinence affects up to a third of all new mums and is most common in young women (25-49 years of age). NICE guidelines (2006) recommend that women with urinary stress incontinence undergo a trial of supervised pelvic-floor strengthening for a minimum of three months.

Although mums' and babies' wellbeing should be equally considered postnatally, the focus is often on the baby. GPs are ideally placed to ask postnatal women at their six-week postnatal check about their bladder and bowel function. This helps to identify problems early, prompting women to disclose symptoms that they may have been too embarrassed to discuss, thereby allowing them to seek appropriate treatment.

Research shows that pelvic-floor exercises can strengthen the perivaginal and perianal musculature, helping to improve bladder and bowel control. However, Bo (2001) found that 45% of women doing pelvic-floor exercises were doing them incorrectly and therefore a pelvic-floor assessment should always be undertaken to establish pelvic-floor function and correct technique.

Women's Health Physiotherapists are ideally placed to do this and can individualise pelvic-floor exercise programmes to account for a patient's lifestyle and motivation. This is the key to successful outcomes.

HOW TO EXERCISE THE PELVIC FLOOR

A combination of fast and slow contractions ensures that both types of muscle fibres found within the pelvic floor are exercised equally (Simpson, 2000).

Slow contractions

These work the endurance part of the muscle. The aim is to hold the contraction for 10 seconds. After just a few seconds the muscle may tire and start to let go. The contraction should be relaxed if this happens. The time that the pelvic floor can be held should be increased gradually. These slow contractions should be repeated 10 times.

Fast contractions

These work the powerful component of the muscle. Rather than holding the muscle, the contraction is let go immediately. This should be repeated 10 times.

- **NICE guidelines (2006) recommend exercising the pelvic floor three times a day.**

- Claire-Anne Head is an experienced Women's Health Physiotherapist who specialises in this area. She offers one-to-one sessions for the assessment and treatment of pelvic-floor related issues, as well as post-natal pilates and 'Life After Birth – Postnatal Recovery' classes.

Tel: 020 7806 4010 ext 3330 claire-anne.head@hje.org.uk www.womensphysiotherapy.org.uk

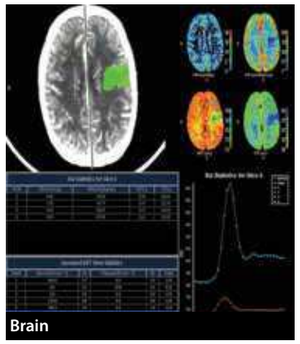
Our celebrated Imaging Department offers patients a 5*service with supreme standards of care and is staffed by some of the UK's leading musculoskeletal Radiologists, Radiographers and Sonographers. Walk-in appointments are available and in our latest audit we had zero cases of MRSA.

It's no wonder so many of London's leading consultants choose to hold their clinics here and why the country's top athletes and sportsmen trust the Hospital of St John & St Elizabeth with their diagnosis and treatment. We are the medical base for UK Athletics and were proud to support many of our gold-medal-winning Olympians this summer.

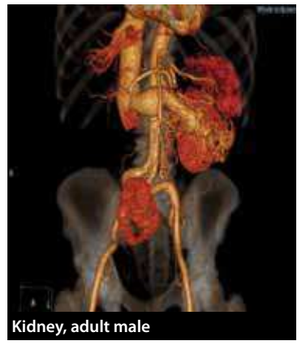
OUR FULLY EQUIPPED IMAGING DEPARTMENT

The department is fully digital with an integrated PACS system for all imaging modalities which allows consultants to instantly view images in their consulting rooms or at any terminal in the hospital.

★ We offer a full range of imaging, including 3T MRI scanner, digital mammography, ultrasound machines and interventional radiology facilities.



Brain



Kidney, adult male

PIONEERING NEW EQUIPMENT

The quality of imaging results is excellent with the new 3T MRI scanner

The Hospital of St John & St Elizabeth has a reputation for embracing the latest medical technologies which goes back more than 150 years. As such we have continued to invest in our Imaging Department to ensure that we remain one of the leading imaging facilities in the UK.

We are pleased to announce that we have become the first private hospital in London to install an iCT TVI 256 slice CT scanner.

In addition to our state-of-the-art, whole-body 3T MRI scanner, which was installed in 2011, we now have the very best in CT scanning technology. This innovative new equipment is perfectly adapted to performing the full range of CT examinations and provides a unique approach to managing important factors in patient care – a new era in low-energy, low-dose and low-injected-contrast imaging.

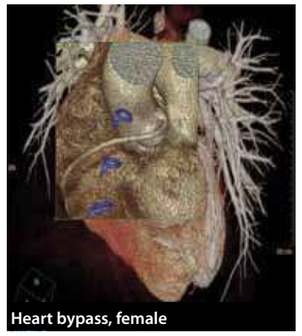
What the iCT TVI scanner means for our services

Head and neck imaging, abdominal imaging including CT Virtual colonoscopy and musculo-skeletal imaging is now available in greater detail and at faster speeds than previously.

The iCT TVI scanner is specifically designed to meet the unique needs of vascular imaging from head to toe, providing high image quality with low dose and less injected contrast.

We will be able to offer stroke imaging as iCT TVI has the lowest dose brain perfusion protocols in the industry and takes a unique approach to symptom and cause for stroke diagnosis.

We will be introducing dedicated Cardiac Imaging with Calcium score analysis. Full field of view, prospective cardiac triggered examinations for coronaries, aortas and pulmonary vessels with Step & Shoot will also be available.



Heart bypass, female

Heart lesion

The new Philips 256-slice CT scanner

The department is equipped and staffed to provide:

- A full range of plain film skeletal radiography using low-dose digital radiography.
- Full field digital mammography, breast ultrasound, fine needle aspiration, breast biopsy and breast MRI.
- Interventional procedures such as biopsy, aspiration, drain insertion and pain-management procedure under X-ray and ultrasound.
- Routine abdominal and pelvic scans, transrectal prostate scanning, transvaginal pelvic scanning, musculoskeletal scan, ultrasound guided biopsy and ultrasound pain management/joint injections.
- Non-invasive vascular assessment (ultrasound) – venous and arterial assessment of the arms and legs, carotids and aorta using colour Doppler ultrasound.

More about our 3T MRI

The incredible detail of the scans achieved by the 3T is particularly valuable in assessing the brain, spine, cardiovascular and musculoskeletal systems.

This state-of-the-art equipment has been designed with the patient's comfort in mind.

Most studies can be performed with the patient positioned with their head outside the scanner providing increased space around the patient.

3T SERVICES AVAILABLE

Cartilage Mapping – detect the earliest signs of joint cartilage changes seen in various degenerative diseases.

Movement Suppression – corrects artefact due to involuntary patient movements, enhancing the quality of the study, even when the patient is unable to co-operate.

3D Imaging – software enables the fast acquisition of 3D data sets. This enables improved quality and faster imaging of the biliary tree (MRCP) and of pelvic diseases.

Vascular Imaging – Capturing multiple arterial and venous phase images virtually anywhere in the body to ensure rapid examination of the vascular system.

Diffusion imaging of the brain – acquisition of data with the potential for earlier and more accurate assessment of patients suffering from dementia.

3T breast coil – enhances the quality and decreases the time taken to acquire breast images.

020 7806 4030 info@hje.org.uk www.londonimaging.co.uk

St John's Hospice
THE HOSPICE OF THE CHARITABLE HOSPITAL OF ST JOHN & ST ELIZABETH

OUR HOSPICE AT THE HEART COMMUNITY PROVIDING

CHRISTMAS FAYRE JOY

● The unrivalled success of this year's Christmas Fayre raised more than £15,000 for St John's Hospice. St John's Wood High Street hosted 60 market stalls, fairground rides and stage performances featuring live entertainment courtesy of The Marylebone Rock Choir, Barrow Hill School, Punch and Judy and Sylvia Young Theatre School. Eastenders actor Sid Owen switched on St John's Wood Christmas lights and he also drew the raffle. Noted attendees included Angela Harvey, the Lord Mayor of Westminster, and Holby City actress Tina Hobley. We are extremely thankful for the support of all local shop owners, schools and our dedicated volunteers.

NEW PALLIATIVE CARE AMBULANCE

A new dedicated Palliative Care Ambulance, the first of its kind in London, has been launched for Hospice patients who can be transferred to and from St John's Hospice. This new ambulance service will run from Monday to Friday between 9am and 5pm and we expect to be able to manage between three and five transfers a day.

Steve Barnes, business manager for the Hospice, says, "The new ambulance will minimise waiting times and hopefully reduce some of the anxiety people feel when coming into the Hospice."

HOSPICE@HOME AWARDS

St John's Hospice's Hospice@Home service has scooped the title of Domiciliary/Home Healthcare Provider 2012 at the Independent Healthcare Awards, beating hundreds of rivals.

Judges for the event, organised by healthcare intelligence provider Laing & Buisson, singled out St John's Hospice, highlighting "its highly tailored approach to the very delicate subject of patients dying in the comfort of their homes".

Hospice@Home service provides support by placing healthcare assistants, experienced in community work and trained in palliative care, in the homes of patients who want to remain in familiar and comforting surroundings during the latter stages of their illness.

Those benefiting from Hospice@Home are often elderly and highly vulnerable members of our community.

The awards recognise outstanding quality and innovation in the independent healthcare sector. Established in 2006, they aim to recognise the achievements within the sector and to praise the efforts of those who have achieved excellence.

OF THE 5* QUALITY

MOVING PROCESSION AT LIGHT UP A LIFE

St John's Hospice's Light Up A Life event brought people together who have lost a loved one or have someone living in the shadow of a terminal illness. They celebrated in a very special way – by remembering their lives and lighting a candle in their honour.

The event also gave those who have lost loved ones, in the Hospice or elsewhere, the chance to come together and celebrate their memory through attending our event and dedicating a star on our Wall of Stars.

This service offers those of different faiths the chance to come together and reflect while listening to testimonials, readings and carols.

PRESCRIBING SYRINGE DRIVERS IN GENERAL PRACTICE

The most common symptoms in patients who are at the end of life are:

- **Pain**
- **Breathing difficulties**
- **Nausea**
- **Agitation**
- **Respiratory secretions**

Therefore, it is usual practice to prescribe the following:

- **Opiate for pain and breathing difficulties**
- **Anxiolytic for agitation and breathing difficulties**
- **Anti-emetic for nausea**
- **Anti-muscarinic for respiratory secretions**

FREE LEAFLET INCLUDED

"One of the areas I'm asked about most often by GPs is the area of prescribing syringe drivers for patients who are no longer able to take oral medication, usually at the end of life. The most common symptoms in patients who are at the end of life are pain, breathing difficulties, nausea, agitation and respiratory secretions. Therefore when I'm prescribing syringe drivers for patients at the end of life, I usually prescribe an opiate for pain and breathing difficulties, an anxiolytic for agitation and breathing difficulties, an anti-emetic for nausea and an anti-muscarinic for respiratory secretions. Initially, patients may not need all four types of drug in their syringe driver, but as symptoms can develop over time it is good practice to prescribe all four types of drugs on the PRN side of the drug chart 'just in case'."

Facts and figures compiled by Dr Samantha Jayasekera, Consultant in Palliative Medicine.
Tel: 020 7806 4050 or 07720 972435 or Dr Chris Farnham (IPU Consultant) 07884 362242.
(Telephone numbers should not be passed on to patients.)

HAIR LOSS IN WOMEN...

DR VICKY JOLLIFFE
MBBCHIR, MA (CANTAB), FRCP, FRCS(ED), MRCGP
Consultant Dermatologist

A DIAGNOSTIC AND THERAPEUTIC APPROACH

Help, doctor, I'm losing my hair!' This is a not uncommon cause for consultation in primary care, and a sympathetic and systematic approach needs to be undertaken in managing such patients.

There are several key points in the history which are paramount. A hair fall of short duration may suggest alopecia areata or acute effluvium, whereas gradual thinning with loss of volume is more suggestive of Pattern Hair Loss (FPHL). Ask about trigger factors which may cause an effluvium – recent childbirth, stress, medication, illness, or surgery. How about parents and siblings? Do they have normal hair?

Alopecia Areata (AA) may occur in families and can also be associated with other familial autoimmune conditions. Is the menstrual cycle regular, is there a history of acne or hirsutism which may suggest underlying hyperandrogenaemia, most commonly due to Polycystic Ovary Syndrome? Styling practices may be highly relevant – hair straightening and frequent blow-drying may cause weathering of the hair shaft, making it more prone to breaking.

Examination should be focused on the hair shaft itself and whether there is a scarring or non-scarring process underlying the hair loss. Note the skin type. Patients with Afro-textured hair may have some specific causes of scarring alopecia such as Central Centrifugal Cicatricial Alopecia or Acne Keloidalis Nucheae which are not seen in patients with Fitzpatrick skin types 1-4.

Common non-scarring causes of hair loss include Alopecia areata (annular clearly demarcated non-scarring non-scaly patches of hair loss, with exclamation mark hairs peripherally and very often white regrowth), Telogen Effuvium in which club hairs are shed in increased numbers often resulting in loss of hair volume in a bitemporal distribution, and Female Pattern Hair Loss, in which density is reduced over the crown and preserved at the occiput.

Scarring alopecia is less commonly seen, but the pattern of scarring should be noted alongside other features such a perifollicular erythema and scaling, styling such as corn-row braiding or straightening and pigmentary changes such as hypopigmentation commonly seen with Discoid LE. All cases of scarring alopecia should be referred to a dermatologist as biopsy is usually indicated, and many scarring processes progress rapidly, leaving permanent alopecia.

Investigation in primary care can be helpful, especially for patients with Telogen Effluvium. FBC, ferritin, ANA and TFTs as a baseline are valuable. If FPHL is suspected, SHBG, testosterone, prolactin and occasionally DHEAS may be performed on days 1-5 of the cycle when the patient is off the OC pill. Mycology may be indicated in scaling, and hair plucks as well as scalp scrapings should be sent if possible.

Telogen effluvium should resolve after any correctable factors have been modified, e.g. stopping relevant drugs,correcting ferritin, alleviating stress etc. AA may warrant specialist referral but it is reasonable to start superpotent topical steroid at night for up to six weeks to the affected patch in primary care . FPHL may warrant oral therapy and specialist investigation but topical Minoxidil can reasonably be started pending review by a Dermatologist.

ATRIAL FIBRILLATION

DR PIERS CLIFFORD
BA MBBS MD FRCP
Consultant Cardiologist

What are the medical options open to Consultants and GPs?

Atrial fibrillation is the most common cardiac arrhythmia, affecting more than 10% of patients over the age of 80. It carries a risk of stroke and may lead to heart failure and worsening symptoms of angina. The primary objectives of treatment are to minimise the stroke risk, to control the heart rate or to restore sinus rhythm. The individual's risk of stroke can be estimated using the CHADSVAS score. If the score is zero no anticoagulation is required.

A score of greater than 1 is an indication for oral anticoagulation. Warfarin has been the mainstay of treatment, aiming for an INR between 2 and 3. Newer agents are now available, such as dabigatran or rivaroxiban, which are more effective than warfarin at preventing stroke with a lower bleeding risk.

They are, however, more expensive, have less of a track record in clinical practice and are difficult to reverse if bleeding becomes a problem. Most guidelines now do not advise using aspirin for stroke prevention in AF, as it carries a bleeding risk, especially in elderly patients, but is not nearly as efficacious as oral anticoagulation. The risk of bleeding can be assessed using the HASBLED score and caution is advised if this score exceeds the CHADSVAS score. Restoring sinus rhythm (rhythm control) has never been shown to be more effective than rate control in preventing the major complications of AF. It may achieve better symptom control, but at the cost of a greater number of hospitalisations when patients flick back into AF. Therefore the vast majority of elderly patients can be well controlled using beta-blockers or rate-slowing dihydropyridines (verapamil or diltiazem).

Digoxin can be added to achieve a resting heart rate of 80 beats per minute but should not be used as mono therapy unless the patient is largely sedentary because it does not prevent heart-rate rises on exercise. Achieving rhythm control long term is often difficult and requires the use of powerful anti-arrhythmic drugs such as sotalol, flecainide, dronedarone or amiodarone. All these drugs have significant side-effects, including life-threatening arrhythmias, and should be prescribed only with specialist advice.

Ablation of AF is also a possibility in highly symptomatic patients with paroxysmal AF, with successful cure being achieved in 65-85% of treated patients. Rhythm control in itself is not a substitute for anticoagulation and patients need to remain on warfarin according to their risk score long term in case AF returns unnoticed.

OUR CONSULTANTS:

Our new Knee Unit brings together many of the country's leading lower-limb specialists to provide unparalleled access to top surgeons. Our consultants are available every weekday plus Saturdays, with urgent appointments available on the same day or within 24 hours.

Mr Nimalan Maruthainar
FRCS (Tr & Orth) MBBS BSc (Hons)

He qualified from the Royal Free followed by basic surgical training at Norfolk and Norwich. Further training at RNOH included one year as Clinical Lecturer at the Institute of Orthopaedics, UCL. His fellowships included the Joint Reconstruction Unit, RNOH and Knee Unit, University of Southern California, then consultant at the Royal Free since 2005.

Previously an Honorary Senior Lecturer at UCL, he is Associate Editor Orthopaedics and Trauma Specialist Collection, NHS Evidence & Trust Speciality Training Director for Trauma & Orthopaedic Surgery, Royal Free. He has special interests in hip and knee arthroplasty and the orthopaedic aspects of lysosomal storage diseases.

Mr Robert Marston MBBS FRCS (Eng & Edin), FRCS (Orth)

Obtaining his MD from St Thomas' Hospital, he completed fellowships at the RNOH with Johnson & Johnson as Zimmer Hip Fellow and BOA Travelling Fellow in the United States and Australia.

His main NHS post is at Imperial with honorary positions at St Luke's Hospital and Ravenscourt Park NHS Treatment Centre.

His specific interest and expertise is lower-limb trauma and he runs the 24-hour trauma unit for the elderly at St John & St Elizabeth's.

His orthopaedic subspecialty interests are primary, complex primary and revision hip surgery. He performs knee arthroscopy, anterior cruciate ligament reconstruction, knee replacement and some foot and ankle.

Mr Raj Bhattacharya FRCS (Tr & Orth) MBBS MRCS (Ed) MRCS (Glas) MSc

After starting his medical career in Lanarkshire and the North-East of England, he completed basic surgical training, Masters degree and registrar training.

He undertook Fellowships in Knee Surgery and Trauma in Edinburgh, then Knee Surgery at Southampton Knee Unit before becoming Consultant at Imperial in 2010.

His clinical interests include mainly complex trauma and knee injuries as well as hip and knee joint replacements. He also has active research interests in these areas, is widely published and has presented his work internationally. He is heavily involved in the teaching and training of medical students at Imperial College Medical School.

Mr Nicholas Garlick
MBBS FRCS (Edin) FRCS (Eng) FRCS (Orth)

Having qualified at St Bartholomew's Medical School, he completed registrar training at St George's Hospital, Royal Free and Royal National Orthopaedic Hospital Rotations.

His lower-limb specialist training took place at the Royal National Orthopaedic Hospital and the Charnley Joint Replacement Unit, Redhill. He undertook further specialist training in shoulder surgery at the Royal National Orthopaedic Hospital, a speciality which he maintains.

His main NHS consultancy is at the Royal Free Hampstead where he is Clinical Lead in Orthopaedic Surgery. He teaches students at the Royal Free and University College Medical Schools.

Mr Nicholas Goddard MBBS FRCS

Following graduation from St Bartholomew's Medical School which included further training at the University of Vancouver, he undertook diplomas in Microsurgical Techniques and Surgery of the Hand and Upper Limb at the University of Paris VI.

He started his consultancy at the Royal Free in 1990 where he remains. He is an honorary consultant for several organisations including Surrey County Cricket Club, Dispensaire Français, London and the Royal Ballet School.

He has published over 90 articles and book chapters and 2,000 medicolegal papers. He is an examiner for IMRCS (RCS), European Diploma in Hand Surgery and MB BS (University of London).

Mr James Youngman MBBS FRCS (Tr & Orth)

Graduating from Middlesex and UCL, he worked in major trauma at Whipps Cross and the Royal London before becoming consultant at UCLH, experienced in adult and paediatric trauma.

He has a major interest in treatment of knee problems, including complex trauma, sports injuries and degenerative conditions, and advanced arthroscopic techniques with complex ligament reconstruction using hamstring, patella tendon or allograft.

His deformity work includes correction of long-bone deformity, either by osteotomy or acute correction using Ilizarov or Taylor spatial frames. Performing and teaching knee-replacement techniques including complex knees with severe deformity, he carries out degenerative hip reconstruction and revision arthroplasty.

CONGENITAL HEART DISEASE AND THE GENERAL PRACTITIONER

Heart defects are the most common congenital problem seen in babies, occurring in seven to eight of every 1,000 live births. Congenital Heart Disease comprises of genetic heart disease and structural abnormalities of the heart or great vessels.

DR SHANKAR SRIDHARAN
MRCPCH MBBS BSc
Consultant Paediatric Cardiologist

Why one-third of babies with life-threatening CHD leave UK Hospitals undiagnosed

Limitations in antenatal care	Limited (4-Ch view only) cardiac imaging at 20-week anomaly week scan
Physiological changes at birth	Duct dependent lesions often manifest in neonatal period after arterial duct closes – these lesions missed on one-week checks
Lack of awareness of CHD as a differential	Difficulty in identifying cause of illness in infants due to clinical overlap of signs

Despite advances in fetal medicine, antenatal screening and the implementation of postnatal baby checks in the UK, approximately one-third of infants with life-threatening CHD leave hospital undiagnosed ***(Wren, C et al 2008. Arch Dis Child Fetal Neonatal Ed. Twenty-year trends in diagnosis of life-threatening neonatal cardiovascular malformations).***

These infants then often first present to front-line NHS health services including General Practitioners and A&E departments. An awareness that illness in a young child may be due to cardiac disease is a valuable clinical aid during assessment as, often, clinical signs overlap in young infants and it can be difficult to discern the underlying aeitiology.

Who should be referred?

Patients are often referred to a paediatric cardiologist for assessment following the suspicion of heart disease from either clinical signs such as cyanosis, following the detection of heart murmurs in children, or due to symptoms such as breathlessness and poor weight gain. Chest pain is a common complaint in older children and review can often exclude a cardiac pathology and provide reassurance.

Babies or children with a syndrome, or proven chromosomal problem, are often at much higher risk of having a coexisting heart problem e.g. Downs Syndrome (Trisomy 21) where up to 60% of patients have some form of heart disease.

A family history of heart problems in siblings or relatives, or genetic cardiac conditions should also prompt referral. These include conditions such as:

Cardiomyopathies where there is an underlying problem with the heart muscle.

Connective tissue disorders such as Marfans Syndrome and Ehlers Danlos Syndrome.

Inherited arrhythmic conditions including chanellopathies such as Long QT Syndrome and Brugada Syndrome that may present with tachycardia or syncope.

Common Signs and Symptoms

Clinical history, examination and suspicion that a heart problem may be present are key factors in making a diagnosis.

Presentation with a heart murmur at the 6-8 week check

Approximately 45% of cardiac malformations are detected before a child's first birthday. Around 50% of murmurs heard at the 6-8 week check reflect an underlying structural cardiac issue. Murmurs may not manifest initially as pulmonary pressures but may take a few days to fall following transition from a fetal to postnatal circulation. Urgent referral is warranted if there is associated heart failure (poor feeding, tachypnoea or hepatomegaly) and/or cyanosis, as an emergency if necessary. If a murmur is heard and the baby is otherwise well, review again a week later to assess for ongoing presence. If still present, refer to paediatric cardiology.

Presentation with a murmur in infants and children

Murmurs are a common finding in childhood. Most of these murmurs are innocent murmurs and not due to congenital heart disease. These murmurs are usually generated as a consequence of the blood flowing at speed around tight corners and bends in a relatively smaller heart (as compared to an adult). Innocent murmurs become more apparent during times when the heart works a little harder (producing more turbulence) such as during fever or exertion.

Patients are often referred to a Paediatric Cardiologist for assessment following the finding of a cardiac murmur. Many clinicians feel uncomfortable about classifying a murmur as 'innocent' until formal paediatric cardiac review as they are concerned that an underlying cardiac problem may be missed. This is in part due to the fact that mild defects such as a small VSD produce a loud murmur, whereas larger haemodynamically more important septal defects may give rise only to a very soft gentle murmur as a consequence of the flow characteristics (the diagnosis is always easier with an echo machine!).

Characteristics of an innocent murmur

The murmur is soft with no diastolic component
There is a normal second heart sound
It may vary with position but does not radiate
There are no other signs of symptoms of heart disease

Presentation with heart failure

If a heart defect is undiagnosed and the circulation is insufficient, an infant may present later with symptoms or signs of heart failure. ***These include:***

- Breathlessness, particularly when crying for feeding
- Tachypnoea with or without tachycardia
- Failure to thrive and/or difficulty feeding
- Hepatomegaly
- Weight increase due to fluid retention

The most likely causes of heart failure in neonates include left heart lesions such as severe aortic stenosis and coarctation of the aorta. In older infants and children, large VSDs, patent ductus arteriosus and ASDs may cause heart failure.

Presentation with cyanosis

Cyanosis in babies is uncommon and usually indicates a serious issue. Low oxygen saturations may be difficult to assess in a GP surgery. Later presentation in infancy is mostly due to cases of important pulmonary stenosis or tetralogy of Fallot. Perioral cyanosis can be a common finding in young children and may be due to environmental changes in temperature.

Indications for referral to a Paediatric Cardiologist

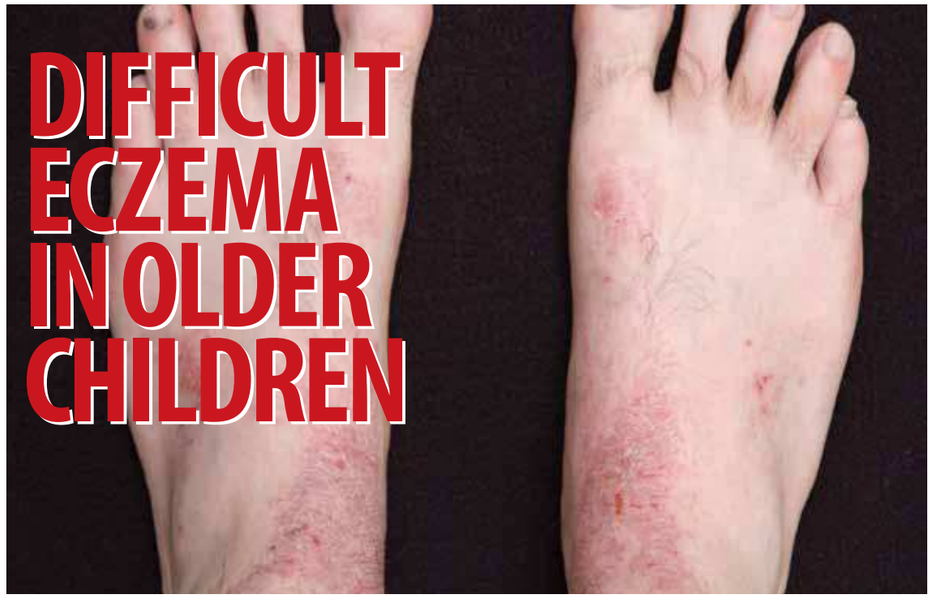
Previous child with congenital heart disease	Background risk of CHD is higher in view of previous affected child	Similar lesions more likely to recur
Family history of heart disease or	A Hx of genetic cardiac disease should prompt referral	Cardiomyopathies Marfans Syndrome
FHx of sudden or early death	This is particular important for arrhythmias or in cases of syncope	Long QT, Brugada syndrome
Dysmorphisms or genetic / chromosomal disease	Down syndrome (T21)	AVSD, VSD, Tetrology
	Turner syndrome (45XO)	Coarctation, bicuspid aortic valve
	Noonan syndrome (Chr 12)	Pulmonary stenosis HOCM
	Williams syndrome (Chr 7) – Elastin gene mutation)	Supravalvar AS and PS
Prematurity	At any gestation	ASD, PDA
Maternal ill health	SLE	Congenital Heart Block
Antenatal Infection	Rubella	Pulmonary Stenosis
Postnatal infection	Viral mediated	Viral myocarditis
	Bacterial	Endocarditis

Signs and symptoms of heart disease in children

Signs	Cyanosis (perioral cyanosis is common in young infants) Murmur Tachycardia Tachypnoea/respiratory distress (young infants) Weak femoral pulse Hypertension
Symptoms	Breathlessness Failure to thrive Chest pain (older children) (check if upon exertion) Exercise intolerance Palpitations or syncope (check FHx)

Is it always awful news?

Confirming that a child has a heart problem is upsetting for any parent. It is important to remember that there is a huge variation in the severity, impact and management of lesions. Congenital heart disease in children may often be managed in the clinic without the need for interventional procedures or child heart surgery. A rapid and accurate diagnosis, together with a kind empathic approach, best serves the child, family and GP.



Treating this distressing problem when traditional steroids are not working

DR LEE NOIMARK
MRCPCH MBBS MSc BSc
Consultant Paediatrician

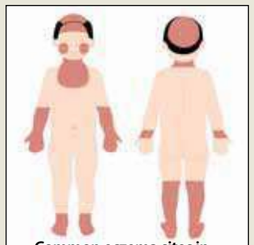
A 12-year-old girl comes to see you with eczema not responding to potent steroids. The distribution affects her arms and legs with general sparing of her body. Her face is also affected. Her eczema treatment has been changed several times with no improvement. The eczema started in the past 18 months. She tells you that the eczema is especially bad in the summer and winter. She has allergic rhinitis but not asthma. The family are convinced that food allergy is causing her eczema.

This remains a common problem that is being increasingly faced in primary care with children with eczema. While there is little doubt that food allergy plays a part in eczema in children under the age of one, with children developing eczema later in life this is less common. It is important here to find out when the eczema may have started, and the older a child is when the eczema started the less likely (but not impossible) it is for food allergy to be related. The eczema treatment needs to be reviewed, making sure that regular moisturising is taking place, a soap substitute and bath emollient are in place and an appropriate steroid has been prescribed. The steroid should be used in a sufficient amount to cover the skin and leave it nicely covered. Too sparing an application is a common problem for treatment failure.

Once the eczema treatment has been reviewed, allergy needs to be considered. A thorough history asking about both immediate and delayed reactions to food is taken and tests taken depending on the history. What is important to recognise in the older age group is the impact of aeroallergens on eczema. The rhinitis history is often helpful and knowing when this causes a problem can help you with likely environmental allergens which are responsible. The distribution of the eczema also only occurring on exposed non-covered areas of skin hints that this may be caused by environmental allergens.

RAST

Skin-prick testing or specific IgE (RAST) testing can be performed and once the allergens are isolated e.g. house dust mite, measures can be put into place above and beyond just the eczema treatment to help the patient's symptoms improve, adopting a more holistic approach. Advice should be given to the patient as to how to minimise the environmental impact of the allergens on their eczema. Rhinitis should be treated symptomatically with nasal douching, anti-histamine and steroid spray as needed.



Common eczema sites in older children

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