wellnews

Volume 15 Number 3

The newsletter of Wellness on Wellington

Summer 2013-14

Social media is a great boon and a wonderful way of keeping in touch with communities, including our patients. Rather than just put out this newsletter every three months (or six months in the case of this edition—sorry about that!) we now try to provide a regular stream of articles and information of interest via our social media channels. Sometimes they are general interest stories, sometimes matters of importance. For example, those who follow us via social media found out about the problem with baby Panadol syringes 48 hours before the mainstream press broke the story.

So we cheerfully confess that we've cheated a bit in this issue of our newsletter. Most of the articles have previously appeared on our **blog (wellonwell.wordpress.com)** with links from our **Twitter feed (@wellonwell)** and **Facebook pages (wellonwell)**. We think that they are of ongoing interest and we hope that if you find them worthwhile that you will Like us, and subscribe to one of those social media channels. We believe that the more often we can communicate with you, the better for you and your family's health and well being.

Summer skin

As you may know, Australia has one of the highest rates of skin cancer in the world and the highest rates of the deadliest skin cancer – melanoma. Many people can relate to the days of sunbaking on the beach and coming home resembling a bright red lobster or spending hours outside working in the garden with a top off and no sunscreen – "working on the tan".

Whilst our knowledge of sun protection has come a long way and we have embraced the need to "Slip, slop, slap", many people are still at risk of developing skin cancer, either due to past exposure to the sun, their family history or simply because of their skin type. And to make matters worse, some skin cancers, particularly melanoma, may even occur in areas that don't get much sun exposure.

So if you are over 50, have a history of high sun exposure, a family history of skin cancer, are worried about a new or changing skin spot, or you would simply like a thorough skin check up, then we suggest seeing one of our doctors for a dedicated skin examination. Now often we are asked at the end of a consultation "Hey Doc, could you take a look at this spot?" and whilst sometimes we may be able to give reassurance that that spot is not cancer, there may be other spots that are hidden from your view (eg. your back and scalp) or spots that *you* are not concerned about but *we* are! So do yourself a favour and book in for a dedicated skin check with your doctor.

Some skin cancers, particularly melanoma, may even occur in areas that don't get much sun exposure.

Whilst all GPs can do a thorough skin check, several doctors at our clinic have undertaken special training in this area and are now running skin clinics. Just ask our friendly reception staff to make a booking. If any suspicious spots are noted, your doctor may do a small skin biopsy on the day and then if a skin cancer is confirmed, they will talk with you about the options for treatment, which may include non surgical treatments like creams or freezing treatment or taking the skin cancer out in our surgery. Most skin cancers can be treated completely by your GP at our clinic, saving you time and money. However for more complex cases, you may be referred for specialist treatment. Just a note about our skin clinics: these appointments are for skin checks only and if you have any other issues you wish to discuss, we encourage you to make a separate booking with your GP.

So don't delay, make your appointment for a skin check today! It could just save your life.

Wellness on Wellington
1101 Wellington Rd, Rowville
9780 8900 - all hours, every day.
www.wellonwell.com.au

We are open every day of the year:

Monday - Friday	8.00 am - 9.00 pm
Saturday - Sunday	9.00 am - 5.00 pm
Public Holidays	9.00 am - 1.00 pm
(Christmas & New Year Day	10.00 am -12.00 noon)

For patients of this practice with urgent problems after hours, a doctor from the clinic can be contacted by calling the surgery and following the instructions on the answering machine.

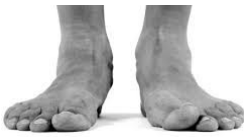
Save a life—
your own or your family's!
Update your home phone, work phone, mobile phone and address at reception!

Does my child have flat feet?

Our podiatrist, Michelle Davies has a special interest in children's feet, and is able to provide assessment, advice and treatment for a range of childhood foot problems, including flat foot. She has written the following in response to a common question asked of podiatrists—"Does my child have flat feet?"

Whilst the answer may be "yes", it doesn't necessarily mean your child will have foot pain or need treatment.

The sole of a normally developed foot has an arch, called the medial arch, formed by muscles and ligaments. For the first two years, your child's feet will seem to have fallen arches. Flat feet are normal in a young child due to weak muscle tone in the foot, a generous padding of fat, and loose ankle ligaments that let the foot lean inwards. As your child masters walking, the ligaments and muscles will strengthen and the fat pads in the arch area won't be so noticeable. By age five your child should have normal arches in both feet.



Flat feet, if present, are normally flexible. This means you can see an arch when the feet are off the ground, or when the child stands on tip-toes. It's important to note that not all flat feet will be painful, and most adults who have flat feet have no long term problems or pain. Flat feet can also be present in multiple family members.

If a normal arch has not developed by the age of five, or your child is experiencing foot pain, it's a good idea to see your podiatrist for a thorough assessment. Treatment for flat foot can include; advice on wearing supportive shoes, close monitoring only, stretching, in shoe padding and orthotics (shoe inserts).

The government's "good idea"

The promise of a personal medical record accessible to everyone involved in a patient's health care sounds like a wonderful idea. And if the system actually worked – it would be! Tests wouldn't be duplicated, hospitals would know the full list of diseases that the GP was treating and GPs would know all the medication changes that hospitals and specialists instigated.

Of course the more complex a system, the bigger the chances that something will go wrong. So the development of the PCEHR (Personally Controlled Electronic Health Record) was always going to be difficult. Medical groups were worried whether the information on the file would be accurate; IT experts were worried about whether the security levels would be robust enough; consumer groups wanted patients to be able to control who could and couldn't have access to any aspect of the record.

Simply put most GPs don't trust the system

But when a committee designs a horse it tends to look like a camel. Although the government invested close to a billion dollars developing the PCEHR, nobody involved has been really happy with the outcome. Though several hundred-thousand people have registered to enrol in the system, less than 5000 GP-written health care summaries have been created across Australia.

Simply put most GPs don't trust the system. We are worried about the security, we are worried about the implications of relying on the information in the record when there is no certainty as to who is able to amend notes, and we are worried about the time involved in creating a health summary when Medicare will not fund it as an exercise other than letting us count the time towards a consultation.

A few of our patients have asked our thoughts on PCEHRs and the answer our doctors give is pretty consistent – a good idea that we think has a long way to go before it's useful and therefore we won't get involved just yet.

Our view was justified when the entire expert group introducing the PCEHR resigned because they feel that the concerns of doctors about the usefulness of the system is being completely ignored. This confirms our view that the system simply isn't fit for its intended purpose.

Our practice has always been forward-thinking in the use of technology for medical care. Dr Peter Tribe was one of the first doctors in Victoria to write electronic scripts, and we converted to electronic medical records years before most practices. But we will never adopt a technology just because it's new. There is nothing quite as dangerous as "a good idea".

2 is worse than 1

Medical students (and by extension doctors and then their patients) are taught that Type 1 Diabetes (T1D) is worse than Type 2 (T2D). Turns out, at least some of the time, that's wrong.

T1D – also called Insulin Dependant diabetes or "juvenile onset diabetes" – is what young kids get. They develop antibodies which attach to their own pancreas, the insulin-producing cells stop working, they produce no insulin and they get very sick. Before the discovery of insulin in 1921, T1D was an early death sentence. Now, it commits the patient to a lifetime of sugar testing and insulin injections.

T2D – Non-Insulin Dependant diabetes or "adult onset diabetes" – is classically associated with overweight, inactive middle-aged patients. In fact we see a wide variety of people with T2D and not all fit that mould, though it is true that lack of exercise and excess weight do make the likelihood of developing diabetes much greater. However there is probably also a gene which makes the condition more likely, though not inevitable, in many patients.

With the progressive increase in obesity in society we are seeing increasing numbers of diabetics, and in particular T2D at younger and younger ages. Whereas even a generation ago, we never saw T2D in teenagers or children, now about 1/3 of kids who develop diabetes have type 2.

Frighteningly – and against traditional teachings – it turns out T2D is much more dangerous in kids than T1D. Research in Sydney shows the death rate for teens with T2D is double that of those with T1D. They also develop more severe complications, develop them sooner and do so even if their sugar control after diagnosis is the same as the T1D patients. There are lots of theories as to why that might be – perhaps the genetic predisposition that allowed T2D to develop might be the cause of the complications, or perhaps the lifestyle issues which triggered the diabetes are the cause.

The medications typically used to prevent complications of diabetes are not normally given to kids because most research excludes children from drug trials. But something needs to be done to help these kids. And foremost, is trying to prevent diabetes in the first place.

Whilst we can't do anything about the genetic factors, it's critical for parents, doctors and society at large to look at the lifestyle choices and behaviours that may cause diabetes and that can be altered to improve our kids' overall health.

From the medical press

Each issue we bring you a few interesting developments in the world of medicine with references so you can read more.

In patients with back pain, distinguishing between those that have fractures or cancer and those that have uncomplicated pain which will settle is both difficult and vital. Many experts suggest looking for "red flags" that warn of more serious conditions. But a meta-analysis of 14 studies examining 53 possible red flags showed little predictive value unless there was damage to the skin (for fracture) or a history of cancer (for bone cancer).
bmj.com/content/347/bmj.f7095

The banning of Vioxx because of it's risk in heart attack reopened the debate on safety of all anti-inflammatory drugs (NSAIDs).
A meta-analysis in the UK shows that all NSAIDs increase the risk of stomach ulcers and heart attacks though new drugs like Celebrex and high doses of old drugs like Voltaren are probably the riskiest medications whilst Naproxen is probably safest.
thelancet.com/journals/lancet/article/PIIS0140-6736(13)60900-9/abstract

Much is made about the dangers of caring for patients when tired, and there is a strong push in the medical world to cap working hours to "safe levels". However a Canadian study showed that removal of gallbladders by surgeons who had performed other operations between midnight and 7am the night before surgery caused no more complications than operations done by well-rested surgeons.
jama.jamanetwork.com/article.aspx?articleid=1764050

Catalyst and Cholesterol

TV shows love a good controversy and where there isn't one available it's always handy to be able to generate one.
So TV show *Catalyst* did an excellent job recently running a two part episode on how statins – a family of tablets used to treat high cholesterol – are overprescribed, not very useful and that doctors don't adequately think about (or warn patients about) their side effects.
There is enough truth in those claims that they can't be rejected out of hand. But there is enough about the claims which bends, distorts or maims the truth that they have to be clearly refuted.
So what's true and what's not. Well …..it's complicated.
Nobody ever died of high cholesterol. People die of heart attacks and strokes. The controversy is whether cholesterol is a cause of those fatal conditions, and whether lowering cholesterol with tablets is worthwhile.
We know FOR CERTAIN—high cholesterol is associated with heart attacks.
We know ALMOST CERTAINLY that cholesterol is a risk factor.
We know FOR CERTAIN that statins lower cholesterol in most people.
We know FOR CERTAIN that people who have already had a heart attack, on average live longer if they are put on statins.
We are REASONABLY CERTAIN that people who have not had a heart attack but have high cholesterol are, on average, less likely to have one if they take statins.
We are REASONABLY CERTAIN we can calculate how likely it is that statins will reduce the risk.
We are REASONABLY CERTAIN that in most individual people, taking a statin will not help – because most people will not have a heart attack, and statins don't always work in people who do.
We have NO IDEA in a large group of people, which ones will be helped by the statins and who won't.
We know FOR CERTAIN that a small number of people will get major side effects from statins and a moderate number will get mild side effects.
We have NO IDEA in a large group of people who will get the side effects till they've had them.
So ….should you take (or keep taking) statins?
Perhaps the most important concept to help understand whether statins are useful for you is an idea called Number Needed to Treat (NNT for short). This tells us how likely it is that a statin will help. And then YOU need to decide what degree of risk you are willing to accept.

TV shows, like research, deal with statistics, not each patients individual concerns. For that you need your GP.

In the following examples it's not important to understand the individual risk factor numbers – it's the overall risks that matter:
Imagine a 50 year old male, non-smoker, non-diabetic, with a blood pressure of 140/85 and a cholesterol ratio (Total cholesterol/HDL) of 6.
His chance of a heart attack in the next 5 years is 5-10%. A statin might reduce that risk by about a quarter. Whether the patient thinks the statin is helpful depends on how his doctor presents the figures:
Doctor 1: If you take a statin, we can reduce your risk of a heart attack by 25% (ie from say 7.5% to 5.7%)
Patient 1: Wow Doc, that's great … gimme a script
OR
Doctor 2: If you take a statin we can reduce your risk of heart attack by 1 or maybe 2% (ie from say 7.5% to 5.7%)
Patient 2: And run the risk of side effects? Why would I bother?
OR
Doctor 3: If we cloned 100 of you and we gave none of you statins, about 93 of you would not have a heart attack in the next 5 years, 7 of you would. If we gave you all statins – 95 would not have heart attacks, 5 would. So we can prevent one heart attack for every fifty people who take the tablet. For the other 49 – about 46 WON"T have a heart attack whether or not they take a tablet. Three WILL have a heart attack whether or not they take a tablet and about 1 of you will prevent a heart attack by taking a statin tablet for five years.
Patient 3: Well….I don't want to take a tablet that's useless, but the idea of a heart attack is pretty scary and I'd want to do whatever is reasonable to reduce the risk. Let me think about it……
Another example – a 60 year old diabetic woman who smokes and has a blood pressure of 160/100 and Cholesterol Ratio of 6. Now the NNT to prevent a heart attack is about 13 …ie 12 women out of 13 will get no benefit from the tablet but the 13th will avoid a heart attack.
For some patients, that screams "take the tablet". For others, that's still not enough of a sure thing for them to want to take medication.
The problem with shows like *Catalyst* is that they suffer from the same deficiency as medical research – they deal with statistics, not the individual concerns of each patient and their own views on what they want for their health.
For that you need to see your GP.
We strongly urge patients already on statins NOT to stop taking them till they have had a proper discussion with their family doctor. We know FOR CERTAIN that is a worthwhile exercise!
PS … we cheerfully note that losing weight, controlling blood pressure and especially stopping smoking are usually more important than controlling cholesterol. Those issues are subjects for another day!

Wellness Whispers

NEW STAFF

We are delighted to welcome our new registrar **Dr Danielle Linden**. "Having moved from Sydney to commence my training in general practice earlier this year I am now very much enjoying my new Melbourne home. I graduated from the UNSW in 2006 and completed three years of post-graduate training at St Vincent's Hospital. I then moved overseas where I worked as an anaesthetics trainee, and upon returning to Australia I spent time at Sydney Children's Hospital where I completed a Diploma of Paediatrics. Having realised I enjoy all aspects of medicine, general practice was the obvious choice for me. In particular my interests include paediatrics, womens' health and internal medicine. In my spare time I enjoy yoga, netball, travel, reading widely and learning foreign languages, good food, good wine and good company!"

We also have been joined by a new receptionist, **Alicia Fletcher**: "Hi—I am the new trainee here at WoW. I'm 19 and love to go out. I finished my VCE at Kambrya College in Berwick. I have two dogs - Gypsy and a Jack Russell cross and Jody is my little puppy . He is miniature pinscher and big fat mumma's boy. I'm very excited to begin my career here and to get to know everyone."

We've also been joined by **Silva Nazaretian** who is an Accredited Practising Dietitian (APD) and a Sports Dietitian. After graduating from Monash University in 2004, she commenced private practice as a Dietitian. In addition to this, she has also worked in the research field, public health promotion and as a University lecturer.

When not active with her own young family, Silva enjoys trying her hand at Armenian cooking, reading and tennis.

Silva is passionate about providing individuals of all ages with the necessary knowledge and tools to empower them to make healthy and informed decisions and achieve a healthy and nutritionally balanced lifestyle. Silva believes that healthy eating leads to a healthy life and, most importantly, enjoy everything in moderation!

NEW SPECIALISTS

One of our aims—and great successes—at Wellness on Wellington, is to continue to add to both the depth and breadth of medical care which we provide at the clinic, including doctors, allied health services, nursing practitioners and medical specialists. Our website lists all of the specialists who practice here but we've recently been joined by several new specialist colleagues.

Dr Rinku Rayoo is a cardiologist who trained and worked at the Austin hospital, with interests in all areas of heart disease, especially cardiac ultrasound and risk assessment for heart attack. He manages a wide variety of adult cardiovascular disease and all areas of cardiac imaging especially echocardiography.

Several other specialists will join our team in the new year—follow us on Twitter and Facebook to hear the news first!

Dr Amit Zutshi is a psychiatrist who is lead consultant at Box Hill Hospital inpatient unit. He has particular interest and expertise in the most difficult psychiatric conditions including bipolar disorder, depression and anxiety, alcohol and drug abuse and adult autism.

Dr Colin Sabau is a specialist obstetrician and gynaecologist who will commence services at WoW on January 23rd. Dr Sabau has extensive training and experience both in Australia and overseas. He offers a wide variety of services in women's health and also manages both low-risk and high-risk pregnancies, with a focus on personalized and comprehensive care of patients.

Several other specialists will join our team in the new year—follow us on Twitter and Facebook to hear the news first!

WELCOME BACK

We are delighted that **Dr Catherine Baccus** has returned from maternity leave. Baby Grace is now 4 months old (born 10.08.2013 at a healthy 3.1 Kg) allowing Cath to return to work each Monday and Friday evening with plans to extend her hours further into 2014. Dr Bacus will also be available for appointments on alternate weekends.