Summer 2019

# CPH Pulse

## News & Information from Campbelltown Private Hospital

**DR ANDREW ONG AND THEATRE TEAM**

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Campbelltown
PRIVATE HOSPITAL

# Letter from the General Manager, Christine Profitt

Here we are at the end of another year. 2019 has seen many exciting changes occur at Campbelltown Private Hospital with a focus on working with our public colleagues in ensuring we meet the needs of our community with a comprehensive service provision.

The ongoing development of new services and technology together with a first-class healthcare team means that our residents can readily access important health services in their local area without the extra burden caused by the need to travel to other regions of Sydney.

## Change of ownership

Some of you may already be aware that Healthscope was recently acquired by Brookfield Asset Management. This has been a very positive move for Campbelltown Private and the other hospitals within the Healthscope group, as Brookfield staff bring with them new and innovative ideas that will greatly assist our hospital and healthcare team in providing quality, flexible healthcare to our community.

## How we can keep improving?

As part of the Healthscope group of hospitals, Campbelltown Private employs a variety of strategies to improve our patient experience including:

- Ongoing staff education and provision of resources to ensure that care is person-focused and of the highest standard – including our "back to bedside" initiative
- Hospital management constantly monitoring the rating of overall treatment and care and taking action to address any areas of concern
- Consulting with Healthscope's National Patient Experience Manager to assist us in implementing strategies to enhance patient experience
- Engaging Consumer Consultants who provide feedback from a patient's or carer's perspective involving patients in their care
- Follow-up phone calls to patients after discharge from hospital to ensure they are recovering well
- Keeping relatives informed of the current location of their loved one in hospital via the 'Patient Finder' app
- 'Patient Journeys' – volunteer patients diarising detailed feedback on every part of their hospital experience from pre-admission to post-discharge follow-up
- Focused initiatives to address areas of concern, such as taste testing to improve our menu, or measuring of noise levels within different hospital areas

## Your feedback is important to us

One of the key pieces of information required that allows our hospital healthcare team to continue to improve is feedback from our referring general practitioners and medical specialists. Up to date communication that highlights are areas of success as well as recommendations around updates and changes are a valuable resource in the ongoing development of our service. I very much appreciate any discussion that will allow us to ensure we keep providing our patients with the highest possible level of care and would like to encourage you to contact me for any discussions in this regard.

## What has been accomplished and what lies ahead

The latest technology being used at Campbelltown Private Hospital is the SPY. We are very excited to be utilising this state of the art equipment and bring this service to our patients. Page 4 of this newsletter has an article by Dr Andrew Ong that describes the SPY and the benefits to patients.

## Years Close

As we near the end of the year, I would like to take the opportunity to wish all our specialist doctors, our staff and our loyal referrers a happy, safe and healthy holiday period. I look forward to working with you all as we continue to provide much needed services to our community.

### Important Dates

Campbelltown Private Hospital will close for the holidays from from 20th December 2019 and reopen on 11th January 2020.

# Unsung heroes

**There are so many unsung heroes that make our hospital great. Here are some of them.**

## Helen Pypers

Helen has been a Food Services Team Leader with Campbelltown Private Hospital since November 2008. She makes sure our doctors and nurses are kept fed and watered so they are able to care for our patients.

## Mary Aquilina

Mary has been with Campbelltown Private Hospital from nearly day one and is one of our Environmental Services Assistants. She's part of the reason that the hospital always looks so spick and span when you visit.

## Alice Sienkiewicz & Leonie Quig

Alice and Leonie are Enrolled Nurses in Anaesthetics within our busy operating theatre complex. They are an integral part of our surgical team and work with our doctors to ensure our patients receive the best of care.

## Terry Dickson

Terry is our Food Services Manager and has run our fresh cook kitchen since it opened in December 2013. He's working on Chef Michael's yummy and much loved Lamb and Eggplant Curry, definitely a favourite with our patients.

# Management of Breast Cancer
## A 2020 update

Dr **Andrew Ong**
Dr Andrew Ong – Oncoplastic Breast, Endocrine and General Surgeon

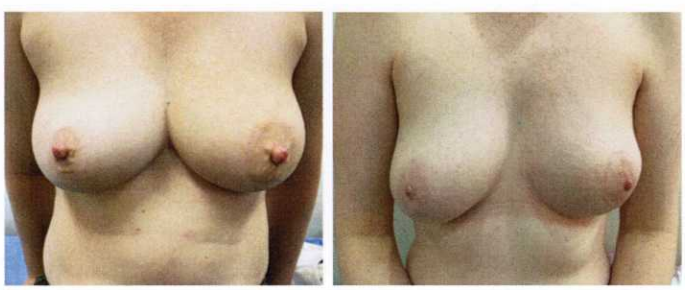
Breast cancer is one of the most common malignancies in Australian women. 1 in 8 women will be diagnosed with breast cancer during their lifetime making the incidence as common as asthma (1). Unlike asthma, the treatment of breast cancer is multidisciplinary and has evolved to the point where modern management is significantly different from a decade ago. This article aims to address these changes with an emphasis on the surgical aspects of the treatment. In Macarthur and Campbelltown Private Hospital, residents are blessed with access to the latest treatments and clinical trials offered in Australia.

The traditional treatment model following diagnosis of breast carcinoma involved upfront surgery followed by a combination of chemotherapy and radiation therapy. Surgery offered minimal variation in techniques – either a lumpectomy (wide local excision) or mastectomy. Minimal (if any) options for breast reconstructions were offered. The patient would be handed over to the oncologists for radiotherapy, chemotherapy or biological therapy (Herceptin).

Advances in the last 5-10 years in surgical techniques and chemoradiation have made this traditional progression model obsolete.

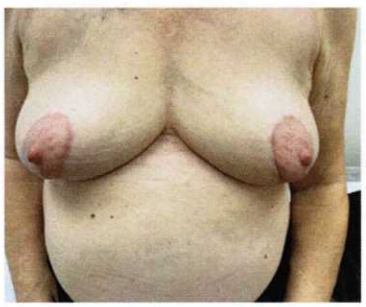
## Advances in Surgery

Breast surgical techniques have grown to include reconstructive options particularly during the index procedure – the rise (and rise) of oncoplastic breast surgery. A good example is a carcinoma located in the upper inner quadrant of the breast. Traditionally, lumpectomy involved an incision directly over the tumour, leaving the woman with an unsightly and obvious incision over the décolletage region. With round-block oncoplastic techniques, tumours are approached via a circumareolar incision with intra-mammarian reconstruction following extirpation of the tumour. The cosmetic results have been shown to be superior while achieving similar oncological outcome (Pictures 1).



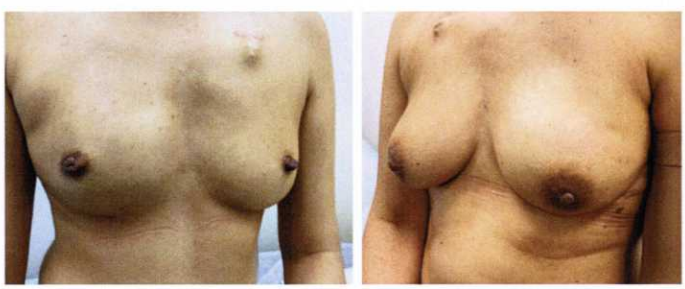
**Pictures 1:** *(examples of round block breast conserving surgery – both women presented with large cancers of the left breast. Post op appearances at 3 months).*

Another example of oncoplastic techniques are for carcinomas located at the upper-outer quadrant of the breast (most common site). Traditionally, a radial incision is used – while effective, extirpation of a bulky or large tumour often results in an indrawn and lateral-pointing nipple over time and/or significant depression of the surgical site. Therapeutic mammaplasty techniques utilising a supero-medial dermoglandular pedicle enables successful extirpation of the cancer with concurrent sentinel node biopsy and at the same time, provides a cosmetic "breast lift" which women find desirable. A contralateral mastopexy (symmetry procedure) can also be performed if the patient so wishes (Picture 2). Other examples in an oncoplastic breast surgeon's armamentarium when aiming for breast conservation include bat-wing excisions, Grisotti flaps, LICAP flaps, etc.



**Pictures 2:** *(this patient had a large cancer upper outer quadrant on the left and underwent a therapeutic mammaplasty with symmetrisation procedure).*

In many circumstances, breast conservation may not be possible (unfavourable breast-tumour ratio, multi-centricity) or the patient desires a mastectomy for "peace of mind". Beginning November 2019, Medicare funded MRI scans of the breast for newly-diagnosed carcinomas have provided oncoplastic surgeons with added tools to more confidently recommend nipple-sparing procedures. Carcinomas shown to be well-away from the surface of the breast envelope gives patients the option of skin and nipple-sparing mastectomy (SNSM) procedures which has been accepted to confer superior cosmetic outcomes with breast reconstruction. SNSM can either be a one stage (i.e. direct-to-implant) reconstructive procedure or if the breast surgeon thinks the patient will likely require radiotherapy, be performed as a staged procedure with insertion of tissue expanders (pictures 3).



**Pictures 3:** *(examples of patients who have undergone skin and nipple sparing mastectomy with expanders in-situ). A swap for definite implant is made following conclusion of adjuvant treatment.*

Immediate or delayed breast reconstruction can either be performed with silicone implants or autologous tissue (L.Dorsi, TRAM or DIEP flaps). Implants and expanders are often supported by the addition of acellular dermal matrices made from human (e.g. FlexHD®) or animal tissue (e.g. Veritas®). Cutting-edge equipment such as the SPY (by Stryker) is utilised to assess intra-operative tissue perfusion (see profile photo). These complex and multi-layered decision-making should be discussed with the patient at the initial surgical consultation and to

underline its importance, has been incorporated into best practice recommendations by Cancer Council Australia (2). If the patient desires breast reconstruction, discussions are made regarding the type of reconstruction desired, balancing oncological priorities with reasonable and realistic expectations of the final cosmetic result.

## Advances in oncology

Clinical trials in medical oncology have shown benefits in neoadjuvant (i.e. pre-surgery) chemotherapy aimed at downstaging tumour burden and in some cases, opens up new avenues for post-surgical treatments. An example is in women diagnosed with "triple-negative" carcinoma of the breast. Neoadjuvant chemotherapy is sometimes effective at downstaging ("shrinking") these tumours to make breast-conservation possible when originally only a mastectomy was the only option. After surgery, if residual tumour is present, trials have shown a possible benefit with the addition of Capecitabine to adjuvant systemic treatment. A responsible breast surgeon will discuss these patients at an MDT for consideration of neoadjuvant treatment. Another example of the harmony between surgical and systemic treatments is illustrated by a current nationwide clinical trial of which the author has been a major contributor. In the WINPRO study, patients were given double anti-hormone therapy in the immediate two weeks leading up to surgery with early results showing decreased activity of tumour cells which may result in better disease-free survival (reference 3).

Radiation oncology has also made leaps in management with the recent non-inferiority AMAROS trial (reference 4). In selected patients with positive sentinel lymph nodes, axillary radiotherapy is offered as an alternative to axillary clearance.

**Example of decision-making process in a newly-diagnosed breast cancer patient in 2020:**

Jane (not her real name) is a 52 year-old post-menopausal woman, recently diagnosed with a 2-3 cm upper inner quadrant, ER/PR positive, HER2 negative, ductal carcinoma of the breast. She has C-cup breasts and is otherwise well. Axilla clear on ultrasound. Examination revealed the breast to be marginal for breast conservation. The patient's expectations are high and she desires a good cosmetic result and is reluctant to accept an asymmetrical flat chest after surgery. The breast surgeon discusses these clinical findings at an MDT which provided the patient with 3 options: upfront surgery with breast conservation via a round-block oncoplastic technique for the best possible chance of good cosmesis but accepting a chance of 15-20% of positive margins requiring completion mastectomy; consider a trial of neoadjuvant chemotherapy for downsizing of the tumour and providing a higher-chance of negative margins; and the third option, a skin-and-nipple-sparing mastectomy with staged reconstruction with breast tissue expander. Jane opted for a SNSM with tissue expander and was enrolled by the author in the WINPRO clinical trial to maximise benefit. Final histology showing clear margins, lymphovascular invasion, Grade III, a positive sentinel node and Ki-67 15%. She underwent adjuvant chemoradiation and following its conclusion 9 months later, underwent exchange of the tissue expander for a permanent silicone implant. Throughout this period, she was supported by the McGrath breast nurses with counselling and guidance as well as co-ordinated care.

## Conclusion

Modern management of breast cancer is complex and involves a multitude of health care professionals. The responsibility of the Oncoplastic Breast Surgeon as the main point of referral is to discuss all available options with the patient to maximise oncological outcome and long term survival while at the same time, provide satisfactory cosmesis to the breast.

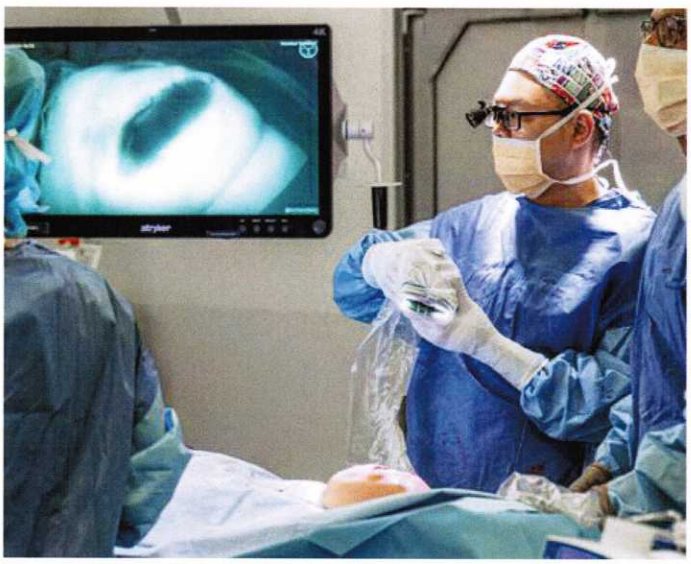

(1) https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Asthma~35

(2) https://thestatement.canceraustralia.gov.au/breastcancer

(3) Chen J, Ong A, et al. Window of opportunity treatment in breast cancer. ANZ J Surg 2019.

(4) https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(14)70460-7/fulltext


# About **Dr Andrew Ong**



**Dr Andrew Ong is a general surgeon subspecialising in Oncoplastic Breast and Endocrine surgery.**

He is the clinical lead surgeon at the Macarthur Cancer Centre which has been voted by patients as the Best Cancer Centre in NSW for the fourth year in a row.

**Dr Ong has recently opened new consulting rooms, please update to the following details:**

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