Coccydynia is a painful condition that is often exacerbated by sitting for prolonged periods of time especially on firm hard surfaces. It is more common in females and accounts for 2000 admissions per year in the US health system. Patients will often complain of pain deep between the buttock cheeks on sitting for long periods of time and especially worse on harder surfaces. A good discriminatory question for simple coccydynia is the patient will often not have it while sitting on the toilet seat as this has no pressure on the coccyx. Bearing down to pass a bowel motion can exacerbate the pain commonly. First described by Simpson in 1859, causative aetiological factors have included trauma, repetitive injury, local tumours, degenerative disc disease and idiopathic causes. Fractures of the coccyx are in fact quite rare and commonly x-rays of suspected injuries are misinterpreted as this rather than the normal morphological variation that is present. Continued on p2

Area: Orthopaedics. Article written by: Mr Jonathon L. Richards, Orthopaedic and Spinal Surgeon, ph (04) 464 0035

Bony destruction of sacrum/coccyx suggesting a pathological cause

What’s inside
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Bowen and Wakefield Hospitals

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Message from Acurity Health

Chief Operating Officer’s Message
Paul Quayle, Chief Operating Officer, ph (04) 920 0146

With the cooler weather setting in it seems fitting to give a warm welcome to Edition 18 of Health Matters.

Inside this issue you will find interesting and informative articles from our specialists along with a feature on the Acurity GP Conference: Connect 2017 held mid-May. We also have a number of new consultants to introduce to you who have recently joined our hospitals.

Wakefield Hospital New General Manager
It is my pleasure to introduce Marg Jenner as Wakefield Hospital’s new General Manager. Marg is well known to those within Wakefield, and in the broader market following her extensive experience across Wakefield – most recently as the Practice Manager at Wakefield’s Specialist Medical Centre. Marg is a great leader and I have no doubt in my mind that she will confidently lead Wakefield Hospital into the future.

With Marg moving into the General Manager role Lee White, formerly the ICU/HDU Specialist medical Centre. Lee is always available and happy to hear from you and will assist you with any queries you may have.

I wish both Marg and Lee all the best in their new roles.

GP Conference 2017
It was fantastic to see so many new faces in the conference this year along with a strong contingent of returning delegates. I enjoyed the opportunity to chat with a number of you over the course of the conference and appreciated the positive feedback about our event. As I mentioned at the opening of each day, your feedback is very important to us, and is used to form the following year’s programme and to continually improve the event.

I’d like to thank all of the speakers, sponsors and exhibitors who travelled from across the country to be a part of the event. Without their strong support it certainly wouldn’t have been the overwheming success that it was. Congratulations to all of our prize winners and my sincerest thanks to the sponsors and exhibitors for providing these prizes. The Acurity Health Group Practice Prize this year was won by Dr Reshmi Goyal, who takes back to Upper Hutt Health Centre a surgical treatment bed.

CME (Educational Events)
Our CME sessions continue to be well attended. The purpose of these meetings is to introduce you to new consultants and to update you on any new developments in their specialties. Our next CME meeting will be advertised in the coming issue of Health Matters.

Save the Date
Next year is a very special year for the GP Conference as we will be celebrating its 20th year running. Please lock the date in your diaries for Friday 25th and Saturday 26th May 2018, at The PAPA, Wellington. We already have lots of great ideas for the conference but we would appreciate if you have any suggestions that you share them with us so we can do our best to include them. Keep an eye out in future editions for Health Matters and on our website www.acurity.co.nz for details.

Bowen Icon Cancer Centre
The Bowen Icon Cancer Centre is the first private cancer care facility in the Wellington region and is the result of a partnership between Acurity and the Icon Group (a specialist provider of cancer care in the AsiaPacific region). The new centre will initially focus on chemotheraphy, with radiation oncology expected in 2018. The Centre is a Southern Cross affiliated provider and will be accepting referrals from late July.

A long sugar corn with significant angulation of the sacro-coccygeal articulation

Coccydynia – A Right Old Pain in the Butt!

Learning points

- Coccydynia is commonly relieved by sitting on the toilet seat as no pressure on the sacro-coccygeal junction is present.
- It is more common on women who have a longer sacrum putting them in a vulnerable position to pressure.
- Good regular analgesic regime and activity/sitting modification is the first line.
- Coccygectomy is rarely needed if patients are carefully selected satisfaction rates are approximately 75%.

P: (04) 464 0035, F: (04) 479 2217
E: admin@woss.co.nz, Healthlink: bownorth
www.orthopaedics.co.nz

Mr Jonathan L. Richards

Mr Jonathon Richards is an Orthopaedic and Spinal Surgeon who is consulting at Wellington Orthopaedic and Sports Surgeons, Bowen Specialist Medical Centre and also has a public consultant position at CCDHB, Wellington Hospital.

Wellington Orthopaedic & Sports Surgeons, 98 Churchill Drive (based at Wellington Hospital), Crofton Downs, Wellington

Mr John A. Downes, Diana, Irvine, Kirsten, Frances, Stuart, Janet and Jeremy.

Plan x-rays and bloods to rule out infection should always be performed if ongoing symptoms are encountered. I would commonly give this patient management six months duration before proceeding to the next level of treatment. Routinely I will MRI the coccyx and the lumbar spine on referral, looking for any of the rare causes of coccyxia that may have been missed on the plain x-rays. Ongoing lumbar pathology will be found that can contribute to the overall disability but the vast majority of the time the MRI will be normal.

If the patient has ongoing disabling symptoms despite maximal non-operative therapies then we would perform an EIM and steroid injection under GA. This allows me to assess the mobility of the sacro-coccygeal articulation and then provide an injection of local anaesthetic and corticosteroid. This is used as both a therapeutic and diagnostic injection. It helps me confirm the pain generator is a sacro-coccygeal articulation.

If the pain is relieved with the injection and returns and is disabling despite maximal non-operative treatment the final treatment option is a sacro-coccygeal articulation.

This procedure involves removing the coccyx and rounding off the distal end of the spine through a small incision in the natal cleft. Results of this procedure can be summarised in a series, I analysed while away on fellowship of one surgeon’s results over a 40 year career. By condensing the satisfaction rates into those with an excellent, good, fair, poor prognosis into two groups those satisfied and those unsatisfied 32/39 were satisfied with the outcome and 7/39 were unsatisfied5. There was one revision case in the unsatisfied group. This equated to only one coccyxectomy per year out of his average 600 cases per year. The complication rate was 8% with wound infection being the only complication encountered.

Coccyx implants are 3D printed and used as a surgical treatment bed. They are made from medical grade polyetheretherketone (PEEK) and then are coated with hydroxyapatite 6.

There is also an associated higher incidence of coccygeal morphologies have notiptyline or amitriptyline. This has the effect of placing the sacro-coccygeal junction in the natal cleft.

References

8. Images are authors own.

Mr John A. Downes, Diana, Irvine, Kirsten, Frances, Stuart, Janet and Jeremy.
Lymphoedema in Breast Cancer

When lymph stasis prevails, inflammation and fibrosis cause entrapment of the superficial vessels and accelerate insufficiency of lymphatic channels. During lymph stasis, activated macrophages respond to accumulations of lipoperoxidase caused by free radicals not absorbed by compromised lymphatics and cause further inflammation and fibrosis.

Lymphoedema is swelling caused when protein-rich fluid accumulates in the interstitial tissue due to impaired function of lymphatic tissues.

Lymphoedema in Breast Cancer

### Table 1: Stages of Lymphoedema

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Latency stage&lt;br&gt;Reduced lymphatic transport and functional capacity. No visible, palpable oedema, subjective complaints</td>
</tr>
<tr>
<td>1</td>
<td>Reversible&lt;br&gt;Reduces with elevation, pitting when present, no fibrosis</td>
</tr>
<tr>
<td>2</td>
<td>Spontaneously irreversible&lt;br&gt;No resolution, may fluctuate, pitting more difficult, fibrosis present</td>
</tr>
<tr>
<td>3</td>
<td>Lymphostatic&lt;br&gt;Dermal hardening, non-pitting, papillomas, hypertelorism, extreme girth</td>
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### Table 2: Symptoms and Characteristics of Lymphoedema

- Slow, gradual progression
- Pitting in early stages
- Distal to proximal advancement (may spare the hand)
- Loss of bony contours
- Dorsal “buffalo hump” if hand involved
- Normal skin colour
- History of infection
- Ulcerations are rare
- Rarely painful
- Asymmetric if bilateral

Treatment consists of:
1. Manual lymphatic drainage/massage
2. Compression bandaging/garments
3. Exercise
4. Skin and nail hygiene
5. Low level laser therapy

Low level Laser Therapy is also used for treatment of scars and contractures as well as muscle injuries. Some practitioners also use it to minimise post-operative pain related to muscle tightness. There are no reported complications from LLLT.

Lymphoedema is a chronic and incurable condition. Early identification and management will improve quality of life and minimise all complications including cosmetic, functional, psycho-emotional and potentially life threatening.

References
2. Omar MTA, Morsey AM, El-Gyaed AA. J surg research 2010: 1-8
3. Treatment of Post-Mastectomy Lymphoedema with Laser Therapy: Double Blinded Placebo Control Randomised Study
4. Carol CI, Anderson SH, Garrett BJ &- Ait-Ai-Nab C. Cancer, 86: 1164-22
5. Kozarek E, Bauer S, Pandy S, Sarpal T. Clin Rehabil 20(2) 175-74
7. A randomised controlled trial
9. Images supplied by RianCorp Pty Ltd

Wakefield Hospital

Area: General Surgery

Article written by: Dr. Alex Posadzki, Endocrine, Breast & General Surgeon, ph (04) 381 8120

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Upcoming CME Meetings

Acurity Health Group host a variety of Continuing Medical Education (CME) sessions for GPs throughout the year. Each session is formatted to give you an opportunity to meet consultant physicians and surgeons, receive expert feedback and discuss topics in an interactive environment. We aim to deliver practical sessions with a primary healthcare focus and learning outcomes based on general practice diagnosis, management and investigation.

Consultants are often able to provide updates on the latest research and cutting edge treatments and procedures. Our sessions are endorsed for CME and MOPS purposes by the RNZCGP. If you would like to suggest a topic of interest or require more information please contact Sarah Malone, Business Development Manager, P: (04) 920 0158, sarah.malone@acurity.co.nz

To register, please email events@acurity.co.nz

For updated information, visit www.acurity.co.nz

Upcoming CME Meetings – 2017

<table>
<thead>
<tr>
<th>Date</th>
<th>Speaker</th>
<th>Speciality</th>
<th>Topic/Details</th>
<th>Venue</th>
<th>CME endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 July</td>
<td>Mr John Groom, Gastrointestinal and Colorectal Surgeon/Endoscopist</td>
<td>Gastrointestinal and Colorectal Surgery</td>
<td>Gastroenterology 101 Top and Bottom: A Surgeons Perspective</td>
<td>The Dowse, James Coe 2 Room, Lower Hutt</td>
<td>2 credits</td>
</tr>
<tr>
<td>26 July</td>
<td>Dr Ken Romeni, Dr Anup George, Haematologists</td>
<td>Haematology</td>
<td>Topic to be confirmed</td>
<td>Wakefield Hospital, Education Centre</td>
<td>2 credits</td>
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<tr>
<td>3 August</td>
<td>Wakefield Heart Centre, Speakers to be confirmed</td>
<td>Cardiology</td>
<td>Cardiology Update 2017</td>
<td>Kapiti Lindale, Conference Centre, Kapiti Coast</td>
<td>2 credits</td>
</tr>
<tr>
<td>8 August</td>
<td>Dr Lupe Taumoepeau and Mr JK Wicks, Vascular and Endovascular Surgeons</td>
<td>Vascular</td>
<td>Topic to be confirmed</td>
<td>Wakefield Hospital, Education Centre</td>
<td>2 credits</td>
</tr>
<tr>
<td>15 August</td>
<td>Dr Lupe Taumoepeau and Mr JK Wicks, Vascular and Endovascular Surgeons</td>
<td>Vascular</td>
<td>Topic to be confirmed</td>
<td>Kapiti Lindale, Conference Centre, Kapiti Coast</td>
<td>2 credits</td>
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<tr>
<td>16 August</td>
<td>Wakefield Heart Centre, Speakers to be confirmed</td>
<td>Cardiology</td>
<td>Cardiology Update 2017</td>
<td>Wakefield Hospital, Education Centre</td>
<td>2 credits</td>
</tr>
<tr>
<td>22 August</td>
<td>Mr Grant Broadhurst, General Surgeon</td>
<td>General Surgery</td>
<td>General Surgery Update: Colonic Problems, Thyroid Nodules, Melanoma in General Practice, Benign Breast Disease</td>
<td>East Pier Hotel, Napier</td>
<td>2 credits</td>
</tr>
<tr>
<td>29 August</td>
<td>Mr Grant Broadhurst, General Surgeon</td>
<td>General Surgery</td>
<td>General Surgery Update: Colonic Problems, Thyroid Nodules, Melanoma in General Practice, Benign Breast Disease</td>
<td>Rosston Centre, Hastings</td>
<td>2 credits</td>
</tr>
<tr>
<td>13 September</td>
<td>To be advised</td>
<td>Musculoskeletal</td>
<td>Manual Musculoskeletal Diagnosis Techniques (practical session)</td>
<td>Wakefield Hospital, Education Centre</td>
<td>2 credits</td>
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</tbody>
</table>

Thanks to everyone who participated in the Acurity GP Conference Connect 2017. We are truly appreciative of your support, and with more of you attending than ever before, this conference continues to grow in popularity. The event which was held over a fabulous two days at Te Papa, explored four main themes: Health Challenges in our Communities; Health for the Over Fifties; Oncology Update and Management of Long Term Conditions.

Themes were structured around topics you wanted us to present and started with Dr David Graham motivating the audience to tackle childhood obesity through practical tools and approaches. The Oncology Update session on Saturday morning was another highlight covering new treatment and therapies within this fast moving field.

Over thirty speakers and a variety of plenary and concurrent sessions to attend, delegates were spoilt for choice. Lighting talks continued to be a highly regarded part of the conference programme and many enjoyed the important message behind Nigel Latta’s witty, light hearted talk on Communicating with Humans. Within the busy programme there was also plenty of time to relax and catch up with colleagues, presenters and sponsors and it was great to see familiar faces and to meet those attending for the first time.

We hope to see you again next year, 25th – 26th May 2018 at Te Papa.

Our sponsors and exhibitors help make this conference possible each year and we are especially grateful for their ongoing support. Equally important is your feedback which helps to shape future conferences and we appreciate the time you take to share this with us.

“We have been one of the best run high quality conferences I’ve been to”
Special thanks to the following speakers

- Dr Joe Feltham
  Diagnostic & Interventional Radiologist
- Dr Cathy Ferguson
  Otolaryngologist
- Dr Jesse Gale
  Ophthalmologist
- Dr David Graham
  Paediatrician
- Dr Justine Lancaster
  Cancer Pathway Clinical Editor, CCDHB
- Nigel Latta
  Psychologist
- Dr Phillip Matsis
  Interventional Cardiologist
- Dr Lynn McBain
  GP, Director at Compass Health, Senior Lecturer, University of Otago, Wellington
- Mr Bernard McEntee
  General Surgeon
- Darien Montgomery
  Oncology Site Manager, Bowen Icon Cancer Centre
- Dr Anne O’Donnell
  Clinical Leader Medical Oncology, Wellington Blood and Cancer Centre, CCDHB
- Jake Pearson
  Sports and Exercise Medicine Specialist
- Mr Fred Phillips
  Orthopaedic Surgeon
- Dr Jessica Povall
  Physiotherapist
- Adj. Professor Alex Sasse
  Cardiologist
- Anna Sisley
  Cancer Information Nurse
- Dr Nicola Smith
  Respiratory Physician
- Mr Rod Studd
  Urologist
- Dr Lupe Taumoepeau
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  Podiatrist
- Dr Richard Trendle
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  Gastroenterologist

Winner of the Practice Prize
Congratulations to Dr Reshmi Gounder of Upper Hutt Health Centre, winner of the Acurity GP Conference Practice Prize. Above: Dr Reshmi Gounder and Maire Mackle, Nurse Manager, enjoying the Amtech E327T Jago 2 Section Treatment Table.

“Lightning talks are great – to the point and useful”

“Superb conference as usual”

“Very enjoyable and constructive conference”

“Great speakers”

“Excellent and relevant sessions”
But My Sleep Just Isn’t Normal Doc

Sleep is a universal phenomenon. Everybody does it and consequently patients who have sleep disturbance have already had all sorts of advice, some good and some terrible, by the time they seek a medical opinion.

There is a huge variation in what is “normal” sleep and the layperson’s perception of when and how they should sleep is often significantly at odds with biology. The perception of a “normal” sleep pattern being one where you rapidly drift off to a deep and restful uninterrupted sleep, gradually waking to a state of razor sharp alertness eight hours later is grossly incorrect but very pervasive.

The normal sleep latency time (from attempting to sleep to actually falling asleep) is said to be 20 – 40 minutes, the normal sleep duration is said to be five and a half to eight and a half hours, the range of normal is very broad and there are many who happily exist in the extremes of this range although dementia and cardiovascular disease have both been associated with very long and very short sleep durations.

During sleep we cycle through various stages of Non REM (NREM) sleep when our brain is very active but all our muscles except the extraocular muscles and diaphragm are in a state of atonia. It is then common to have a brief period of seldom remembered wakefulness before cycling back through the sleep stages. These cycles last 40 to 90 minutes and we tend to have longer cycle lengths and more REM at the beginning of the night and shorter cycles with more REM towards the end. This REM predominance in the morning, with resultant loss of accessory muscle use, is partly why the calls between three and 5am as house officers on nightshift were so often about decompensating COPD/ Asthma patients.

It is thought that NREM sleep, when the brain is less active, exists so the very metabolically active neurons can clear the buildup of metabolites from the day and NREM sleep has a role in memory processing and retention. Patients who lack the deeper stages of NREM sleep more commonly report fatigue whereas a lack of REM sleep has been linked to cognitive symptoms. The cyclical sleep pattern is probably evolutionary as at any point in the night a small social group of about eight would have one or two individuals who would be easily woken by approaching dangers. Given the cyclical nature of our sleep awareness of two or three awakenings a night is still within the range of normal.

Our sleep phase (the time of day during which we sleep) is as much a social construct as it is biological. Again the range of “normal” is very broad with some societies in the infrequent. Often peoples anxious reaction to a very occasional episode of sleepwalking or sleep paralysis is the problem rather than the symptoms themselves being harmful or abnormal.

Sleep physicians spend a significant amount of time explaining the broad range of normal sleep to patients. Sometimes finding out that their sleep latency of 30 minutes among three awakenings a night with the very occasional hypnic jerk is well within the normal range is all people need to feel less anxious about their sleep.

Area Sleep
Article written by: Dr Andrew Davies, Sleep and Respiratory Physician, ph (04) 479 2019

Dr Andrew Davies consults at the Bowen Specialist Medical Centre and also at Wellington and Hutt Hospitals.

Dr Davies consults at the Bowen Specialist Medical Centre and also at Wellington and Hutt Hospitals.

Contact details: Bowen Specialist Medical Centre, 98 Churchill Drive, Crofton Downs, Wellington P: (04) 479 2019 F: (04) 479 8563 E: spec.centre@bowen.co.nz

A normal Hypnogram from one of our recent PSGs showing the sleep cycles

Mediterranean and Middle East commonly having two sleep periods with one after lunch then staying up late in to the night. In most of the English speaking world we have compressed our opportunity for sleep into a smaller and smaller window interfering with our circadian rhythm with artificial light, bright screens and alarm clocks. Our sleep phase also drifts later during adolescence, commonly returning to its baseline during our mid to late 20s. This may be evolutionary with the most fertile age group being awake later into the night. It also explains why teenagers can be so useless in the morning and why children in their late teens perform better when the school day is shifted back a few hours. As well as being concerned about sleep duration and quality, patients may also want to discuss some of the strange phenomena that occur around sleep. Seemingly bizarre phenomena such as hypnic jerks, hypnopompic hallucinations, sleep paralysis and sleep walking can all affect us very occasionally and are not necessarily a sign of a sleep disorder when they are...
Does Eating Low FODMAP Food Relieve IBS Symptoms?

Over the past 10-12 years clinical and observational trials have associated low FODMAP eating with a reduction in symptoms, especially abdominal pain, bloating and diarrhoea in up to 75% of those diagnosed with IBS. A low FODMAP diet may also provide relief for those with inflammatory bowel disease and children experiencing IBS, although careful supervision is necessary to mitigate nutritional risks. This article summarises Monash University research shared at an international meeting in 2015 and outlined in the March 2017 Journal of Gastroenterology and Hepatology.

What are FODMAPs?
Oligosaccharides are the longest FODMAP carbohydrate found naturally in wheat, rye, legumes, lentils, and grains known as ‘gas producing’ have long been identified as triggers for gastrointestinal symptoms associated with irritable bowel syndrome (IBS). Researchers at Monash University have classified the problematic components of these foods as slowly absorbed or poorly digested short-chained carbohydrates, now known as FODMAPs or Fermentable, Oligosaccharides, Disaccharides and Monosaccharides and Polyols1.

Table 1: The FODMAP carbohydrates, their action and sources

<table>
<thead>
<tr>
<th>Carbohydrates</th>
<th>Action</th>
<th>Sources</th>
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<tbody>
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<td>Fermentable</td>
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</table>
| Oligosaccharides (longer chain sugars) | Poorly absorbed by humans and highly fermentable. |• Fructans, FOS (chains of fructose) e.g. some fruits, vegetables (onions, garlic), wheat, rye products
• Galactans, GOS (chain of the sugar galactose) e.g. legumes, lentils, some vegetables and nuts |
| Disaccharides (two sugars) | Malabsorbed when the enzyme lactase is deficient. |• Lactose or milk sugar (galactose + glucose) in milk and milk products
• Sucrose or table sugar (fructose + glucose) – rarely causes problems |
| Monosaccharides (single sugar) | Slowly absorbed across the length of the small intestine causing osmotic effects (not necessarily malabsorbed). |• Fructose e.g. apples, pears, watermelon, honey, juice, dried fruit and sweetener, high corn fructose syrup |
| And Polyols (sugar alcohols) | Slowly absorbed along the length of the small bowel causing osmotic effects. |• Sorbitol e.g. apples, nashi, pears, apricots, nectarines, blackberries and some artificial sweeteners in some gums and sweets
• Mannitol e.g. watermelon, cauliflower, snowpeas, mushrooms |

While people of Asian and Mediterranean backgrounds are more likely to be lactase deficient, those with intestinal inflammation such as active Crohn’s disease may also be deficient. Many others will have sufficient lactase and will not require a lactase restriction. Apples, pears, watermelon, mangos, honey, some vegetables and commercial sweeteners (such as high corn fructose syrup) contain the monosaccharide or single sugar, fructose. Polyols, mannitol and sorbitol, are found in apples, pears, stone fruit, cauliflower, mushrooms, snowpeas and artificial sweeteners such as xylitol, an ingredient of some gums and mints. All of the FODMAPs are both poorly absorbed and rapidly fermented. The smaller molecules such as fructose, mannitol and sorbitol are also osmotically active in the small bowel which can lead to fluid changes in the large bowel, excess flatus, altered bowel habit and typical IBS symptoms2.

Implementing the Low FODMAP Diet
A low FODMAP eating pattern is not a one size fits all, nor is it a diet for life or a cure3. Assessment and prescription needs to be individualised based on IBS symptoms, severity, frequency, usual meal pattern, suspected trigger foods and FODMAP and fibre intake. Dietary recommendations need to consider nutrition adequacy especially fibre and calcium, which can be reduced when FODMAPs are restricted. If a low FODMAP diet is deemed necessary and an individual is interested (but not too interested such as being at risk of an eating disorder), then a four to six week restriction is necessary to assess the impact on symptoms.

Re-challenging FODMAPs
Despite the effectiveness of restricting fermentable carbohydrates or FODMAPs on IBS symptoms, this restrictive diet can also negatively impact nutritional adequacy and quality of life. The composition and concentration of bacteria, such as beneficial bifidobacteria can also be altered on the diet, which may impact gut microbiota and health. Consequently, long-term FODMAP restriction is not recommended, necessitating systematic re-introduction of individual FODMAPs to assess tolerance4. The re-challenge will help identify specific dietary triggers. A more relaxed FODMAP regime based on tolerance can continue to support symptom relief but with improved nutritional adequacy and microbiota. Alternatively, those who do not improve are recommended to assess inadvertent intake of FODMAPs, food intolerances or chemicals, or other non-diet-related approaches such as psychyl, antispasmodics, or psychological therapies to alleviate symptoms.

Optimising Success with Low FODMAPs
The implementation of the low FODMAP diet and re-challenging process is complex. To support the success of this strategy, research recommends supervision by a dietitian with expertise in the management of gastrointestinal disorders, along with the use of up-to-date patient resources5. However, with increasing interest in the diet as an IBS therapy but limited understanding of long-term impacts, authors suggest further research and surveillance into its outcomes is needed6.

References
12 Vicki Robinson

Vicki is a NZ trained Dietitian with many years’ experience working with both individuals and on public health approaches to make healthy food choices readily available where we live work and play.

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13. "A low FODMAP eating pattern is not a one size fits all, nor is it a diet for life or a cure"
New Consultants

Dr Brenda Breidenstein
Ophthalmologist
Dr Brenda Breidenstein is an Ophthalmologist consulting at Harbour Eye Specialists in Thorndon, Wellington. I operate at Bowen Hospital.

Dr Andrew Aitken
Interventional Cardiologist
Dr Andrew Aitken is an Interventional Cardiologist with considerable experience in the management of all aspects of coronary heart disease. I consult at the Wakefield Heart Centre, Rintoul Street, Newtown in Wellington.

Mr Simon Harper
Endocrine and General Surgeon
Mr Simon Harper is a newly qualified specialist in intensive care and practices at Wakefield Hospital, Newtown in Wellington.

Dr Kate Tietjens
ICU (Intensivist)
Dr Kate Tietjens is a newly qualified specialist in intensive care and practices at Wakefield Hospital, Newtown in Wellington.

Automated Texting to Royston Patients

Royston Hospital initiated a quality improvement project to improve a very manual and time-consuming process of chasing up outstanding admission forms from patients who had not returned them within the timeframe of a week prior to their admission.

Frequently, admission forms were not received back from patients prior to their admission which lead to delays in relation to both clinical and administration aspects of their admission process. In 2015 Royston successfully implemented texting reminders for patient to follow fasting instructions, which reduced fasting-related postponements and delays by 95%. Following this success, Royston looked to technology to automate the admission form return process to improve patients’ preparedness for surgery and reduce administration anomalies on a patient’s admission.

As the use of mobile phones is now so widespread, testing a messaging functionality with the assistance of staff members proved very helpful. A variety of scenarios were tested using the Acurity Patient Management System, Trak. An indicator field was used to highlight patients who had returned from a paediatric intensive care facility in Brisbane. She also has a diploma in palliative care medicine.

Special interests

Prior to the system change, the rate of documentation ranged from 20 – 25 forms per week equating to 20-25 admissions that may have been missed per week. Acurity Health quality improvements for 2016 and recognised in the Acurity Health Quality Awards. The return rate has improved to an average of only two missing forms per week. The process has significantly reduced the workload for reception and booking staff. This system of texting patients has been well received by patients who have commented positively on receiving a reminder prompt. The admission process for patients has been considerably enhanced since these changes.

Royston is now further testing the system to automate reminders to patients to notify of any recent hospital admissions that may have changed their health status including the possibility of requiring screening for MRSA pre-operatively.

This initiative won the Quality Improvement Award at Royston in 2016 and recognised in the Acurity Health Quality Awards.

The return rate has improved to an average of only two missing forms per week. The process has significantly reduced the workload for reception and booking staff. This system of texting patients has been well received by patients who have commented positively on receiving a reminder prompt. The admission process for patients has been considerably enhanced since these changes.
Earlier this year, in March, we held our annual golf tournament at the Miramar Links Golf Course. Attendees were a mix of GPs, Consultants and Management. Lovely evening had by all.