



'Capsule endoscopy: complete endoscopic examination of the small intestine has not been possible until now.'

Dr Chris Fraser and Dr Brian Saunders, Consultant Gastroenterologists, assess its implications.

theNotes

Fast Track for New Hypertension Guidance

GPs are set to receive new guidance on the treatment of hypertension by June 2006

The review, by the National Institute for Clinical Excellence (NICE) in conjunction with the British Hypertension Society (BHS) and the National Centre for Clinical Guidance, has been prompted by the results of the ASCOT study announced at the end of last year.

The ASCOT study included more than 19,000 men and women with high blood pressure who were at a moderate risk of strokes and heart attacks. To control their blood pressure, they received either newer drugs - a calcium channel blocker; amlodipine and the ACE inhibitor; perindopril - or a traditional combination of a beta-blocker; atenolol and a diuretic. The final results of ASCOT, which was conducted in the UK, Ireland and Scandinavia, showed that the combination of newer blood pressure lowering drugs reduced the risk of strokes by about 25%, coronaries by 15% and new cases of diabetes by 30%, compared with the standard treatment.

Current guidelines recommend therapy should normally begin with a low dose thiazide-type diuretic. If necessary at second line a beta-blocker should be added, unless the patient is at raised risk of new onset diabetes, in which case an ACE-inhibitor should be added instead. At third line, a calcium-channel blocker should be added. However the results of the ASCOT study have brought this into question, suggesting that calcium channel blockers and ACE inhibitors should be used earlier in the treatment pathway.

Under normal circumstances NICE only reviews its guidance four yearly but the significance of the ASCOT data has prompted it to launch a new review only a year after the last guidance was issued. The review is also unusual in terms of its collaborative nature - until now BHS and NICE have issued separate guidance on the treatment of hypertension but in this case the two bodies have agreed to conduct a joint review simplifying the process and making the guidance more consistent for GPs.

Professor Peter Littlejohns, NICE Clinical and Public Health Director, said: "The new data considered by the Hypertension Expert Advisory Committee are, in their view, likely to have a significant impact on the recommendations in the existing NICE guideline and also in the BHS guideline relating to pharmacological therapy to manage hypertension. Accordingly, we have asked the National Collaborating Centre for Chronic Conditions to work with the BHS to begin the review process immediately so that we are in a position to provide GPs with clear guidance as soon as possible."

The new guidance will be welcomed by many GPs. The number of drugs on offer for the treatment of hypertension and recent new evidence about the best medications for hypertension has left many GPs feeling that current guidance is not adequate.

Dr Paul Ettlinger, Private GP and Family Physician at the London General Practice comments: "The current NICE guidance is based on the use of older drugs but we need new guidelines as there are better and newer drugs available that are not necessarily recommended. Current NICE guidance is based on financial considerations whereas private practitioners may be in a position to offer newer more expensive treatments - new guidelines will help private and NHS GPs to offer the best treatment for their purposes from an-evidence based perspective."



Dr Paul Ettlinger
Private GP and Family Physician at the London General Practice



The London Clinic
Newsletter
Spring 2006

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'Our plan is to provide you with a varied and interesting newsletter that gives our readers a quick way to keep up to date with news at The London Clinic.'
Karen Bullivant



'I am looking forward to my term as chairman. I see the Group as a vital link between the primary care sector and the Clinic.'
Dr Paul Ettlinger

Noted

New Chairman General Practitioners Group!

Welcome

'theNotes' – the new name for our newsletter; is full of clinical articles and news items that have been written to give you valuable information in 'bite-size' pieces. This edition looks at the impact of the ASCOT study that has led to the revision of blood pressure guidelines and the implications for doctors. We have a variety of clinical articles – Professor Ajay Kakkar and Professor John Pasi provide an insight into thrombosis conditions and Dr Chris Jenner offers advice on the diagnosis of neuropathic pain.

You may have seen on the BBC programme 'Newsnight' a documentary on two Iraqi torture victims who had been sponsored to receive treatment in the UK. Mr David Ross, Consultant Plastic Surgeon tells us about his involvement and the surgery he performed.

Under new services, Dr Chris Fraser highlights the advantages of capsule endoscopy as a diagnostic tool and Lisa Cheshire, our Hepatobiliary Nurse Specialist talks about her pivotal role in our new Hepatobiliary Unit.

Our plan is to provide you with a varied and interesting newsletter that gives our readers a quick way to keep up to date with news at The London Clinic. Feedback on the newsletter is always appreciated, so please feel free to send us an email to info@thelondonclinic.co.uk with your thoughts!

Karen Bullivant
Marketing Director, The London Clinic



The General Practitioners Group was set up at The London Clinic to ensure the views and advice of GPs were understood when considering clinical decisions and changes in practice. The group consists of a mixture of GPs and members of the Clinic's senior management team including Malcolm Miller, CEO and Amanda Hallums, Matron.

Amanda Hallums says "GPs provide a valuable perspective to patient care. The Group's advice helps to ensure that all aspects have been considered when making changes to specific areas of clinical practice".

At the last meeting, Dr Paul Ettlinger; (The London General Practice) was appointed as the new chairman of the General Practitioners Group. Dr Ettlinger comments "I am looking forward to my term as chairman. I see the Group as a vital link between the primary care sector and the Clinic. It provides the opportunity to discuss clinical governance matters, provide opinions on service development concepts and suggest day-to-day operational improvements".

The London Clinic would like to take this opportunity to express their great thanks to Dr H Rowbotham (147 Harley Street) for his hard work and commitment during his time as chairman.

Mr David Ross treats Iraqi torture victims



Khalid and his friend Adel, both from Basra and in their early twenties, had refused to join Saddam Hussein's army. As a consequence, they were arrested, imprisoned and had their left ears severed as punishment.

Mr David Ross, consultant plastic surgeon at The London Clinic, talks to us about his involvement in the pioneering technique to replace Khalid and Adel's ears:

How did your involvement with the Iraqi torture victims come about?

I was initially approached by a Swedish charity - The International Rehabilitation Council for Torture Victims. They had raised the funds to pay for two Iraqi torture victims to travel to the UK for pioneering reconstructive surgery to replace their ears.

They had also agreed to fund three Iraqi surgeons to accompany the men so that they could learn the technique. Khalid and Adel aren't alone in their plight – hundreds of men in Iraq have suffered the same fate and are in desperate need of surgery.

What did the surgery involve?

I worked closely with my consultant colleague Walid Sabbagh. I removed a small part of Khalid's rib, which was to be used to form the skeleton of the new ear. With this section removed, Walid spent a number of hours carefully sculpturing this piece of cartilage into the shape of an ear. He then attached this new 'framework' to the remaining section and moulded the excess skin over the top. Extra skin was also taken from the scalp to provide a good blood supply to help ensure that the graft 'took'.

How did the surgery affect the men's hearing?

Both men still had a degree of hearing as the internal drum of the ear remained unaffected. But the new ears will help improve their hearing.

What impact did the surgery have on the men?

Since their ordeal, the men have had to live with the humiliation and a constant reminder of their experience. Naturally, they were both deeply traumatised by the event and even shunned by Iraqi society.

The surgery has given them a sense of closure – both physically and emotionally.

'Capsule endoscopy provides excellent visualisation of the entire small intestine using a pill-sized, video imaging, wireless capsule that is swallowed by the patient.'
Dr Chris Fraser and Dr Brian Saunders



The arrival of Capsule Endoscopy

Capsule Endoscopy is an exciting new addition to the existing Gastro-Intestinal services provided by the Clinic. It will significantly enhance our ability to treat patients with known or suspected gastroenterological disorders.

What is Capsule Endoscopy?

Complete endoscopic examination of the small intestine has not been possible until now. Capsule endoscopy provides excellent visualisation of the entire small intestine using a pill-sized, video imaging, wireless capsule that is swallowed by the patient. Each capsule contains a camera, light emitting diodes, batteries and transmitter. During the procedure the patient can move freely around and over 50,000 colour images are recorded onto a data-recorder worn on a belt around the patient's waist. The capsule passes through the small intestine as peristalsis occurs and is excreted naturally.

What are the benefits of Capsule Endoscopy?

Unlike more traditional investigations, capsule endoscopy avoids exposure to potentially harmful radiation. It is also comfortable and sedation free, as the capsule is easily swallowed by the patient. During the procedure the patient can walk about and relax. Importantly the key findings of multiple clinical trials show that capsule endoscopy is significantly superior for examination of the small intestine for a broad range of indications compared to small bowel enteroclysis and barium follow through, CT, MRI, push enteroscopy and ileoscopy.

What are the indications for Capsule Endoscopy?

The main indications for capsule endoscopy include the investigation of iron deficiency anaemia when obscure gastrointestinal bleeding is suspected, and the diagnosis of

early or suspected Crohn's disease of the small intestine. In addition, capsule endoscopy has a high level of sensitivity for detection of benign and malignant small intestinal tumours; it is helpful in the evaluation of Coeliac disease (particularly refractory cases) and other malabsorption disorders that may lead to chronic diarrhoea and weight loss; it can identify medication (e.g. NSAID) related small bowel injury and it provides an additional diagnostic facility for small bowel abnormalities requiring further investigation.

What investigations are normally performed before Capsule Endoscopy?

Generally patients will have undergone a gastroscopy and colonoscopy prior to capsule endoscopy as many conditions commonly affect the stomach and/or colon. If these prove unhelpful than a capsule endoscopy may be considered. Should the patient's symptoms include significant abdominal pain, distension and/or vomiting it may be necessary to arrange a Patency Capsule or a barium examination before capsule endoscopy to exclude possible obstruction.

What are the contra-indications for Capsule Endoscopy?

Capsule endoscopy is contra-indicated in patients with known or suspected gastrointestinal obstruction, strictures, or fistulas; when swallowing disorders are present (although the capsule can be placed endoscopically), for certain cardiac pacemakers and other implanted electro-medical devices, and during pregnancy.

What are the side effects of Capsule Endoscopy?

Capsule endoscopy is a well tolerated and safe procedure and side-effects are rare. To date, more than 300,000 examinations have been performed worldwide. The main risk is capsule retention which is estimated to occur in less than 0.75% of cases. In the rare instances when this occurs, an endoscopy or an operation may be required to remove the capsule. Should there be any doubts about using the capsule, a bio-degradable Patency Capsule (which dissolves away should it get stuck) or a barium examination will be performed first.

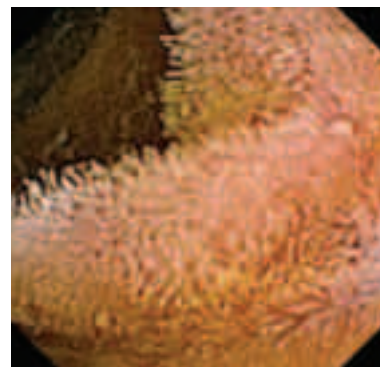
What preparation is required by the patient prior to Capsule Endoscopy?

Capsule endoscopy is patient friendly and preparation usually involves dietary modification only. On the day before the procedure, lunch is followed by clear fluids and then an overnight fast. The capsule is swallowed by the patient with some water in the morning. Unlike conventional endoscopy, no sedation or analgesia is necessary. The Capsule Endoscopy Nurse will ensure that patients are fully informed in advance of the procedure. Doctors notes and patient information on capsule endoscopy is also available on the Clinic's web site: www.thelondonclinic.co.uk under Medical Professionals.

For referrals to our endoscopy unit, please contact 020 7616 7760.

Dr Chris Fraser MB ChB MD MRCP
Consultant Gastroenterologist

Dr Brian Saunders MB BS MD FRCP
Consultant Gastroenterologist



Top: The Olympus EndoCapsule.
Bottom: View of the Small Intestine with the EndoCapsule.

Venous thromboembolism remains one of the most common avoidable causes of hospital mortality. A recent enquiry by the House of Commons health select committee estimated that some 25,000 patients a year die of pulmonary embolism during or after hospital discharge.

Implications of venous thromboembolic disease

Venous thromboembolism remains one of the most common avoidable causes of hospital mortality. A recent enquiry by the House of Commons health select committee estimated that some 25,000 patients a year die of pulmonary embolism during or after hospital discharge. Despite the fact that it is possible to recognise patient populations at high risk for the development of venous thromboembolism and that effective and safe methods for its prevention are readily available, too many patients pass through the hospital systems without the benefit of appropriate thromboprophylaxis.



Both medical and surgical patients being admitted to hospital are at high-risk for the development of venous thromboembolic disease. Professor Ajay K. Kakkar

Recognising the important healthcare implications of venous thromboembolic disease, The London Clinic has decided to proceed with the delivery of a thrombosis service available to all patients admitted to the clinic. The provision of a thrombosis service will ensure that every patient

admitted to the clinic has the opportunity to have their thrombosis risk assessed and where appropriate recommendations for thromboprophylaxis provided.

The thrombosis service forms part of the comprehensive thrombosis unit which has recently been established at The London Clinic under the supervision of Professor Ajay K. Kakkar and Professor John Pasi.

Thrombosis Prevention Service

Both medical and surgical patients being admitted to hospital are at high-risk for the development of venous thromboembolic disease. The risk of thrombosis is driven by both the nature of the procedure, co-morbidities, and intrinsic patient factors. The thrombosis service will provide the opportunity for these to be objectively and routinely assessed in all patients being admitted to the Clinic. On the basis of objective risk assessment recommendations

about appropriate measures for preventing thrombosis, taking into account both the risk of thrombosis and the risk of bleeding in any given clinical scenario, will be provided. It is estimated that the appropriate use of thromboprophylaxis can have an important impact on reducing the frequency of both symptomatic venous thromboembolism (deep vein thrombosis and pulmonary embolism) associated with hospital stay and which may manifest itself after hospital discharge. In addition, symptomatic thrombosis represents only the tip of the iceberg of the total thrombosis burden, which may only manifest itself months or years after hospital admission by way of the late complication of a thromboembolic episode either chronic venous ulceration and the post phlebotic syndrome or chronic pulmonary hypertension.

Diagnosis and Treatment Service

Venous thromboembolic disease is notoriously difficult to diagnose by symptoms alone. Although hospital admission represents a high-risk for the development of venous thromboembolism, spontaneous thromboembolic disease in the community is often a challenging diagnostic conundrum. The thrombosis diagnosis and treatment service will provide 24 hour access to diagnostic facilities for both in-patients and patients referred from the community with a suspected thromboembolic episode. The use of routine ultrasound / duplex scanning and access to CT scanning for the diagnosis of pulmonary embolism will provide the opportunity for rapid diagnosis of suspected venous thromboembolic events. The early management of acute venous thromboembolism has an important impact on the risk of both recurrent venous thrombosis and later complications. With this in mind the thrombosis service will provide the opportunity for both admission of patients with a confirmed thrombotic episode for initial treatment of their venous thromboembolism or the supervision of



CONSULTANT PROFILE

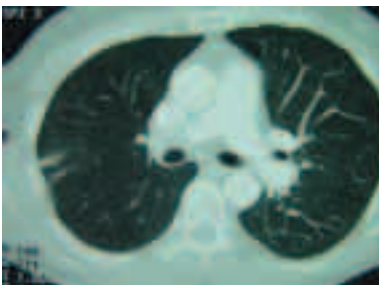
Mr Hugo Henderson attended Oxford University for his preclinical studies, moving on to Guy's Hospital medical school graduating in 1991. He was a specialist registrar and then senior fellow on the adnexal service at Moorfields Eye Hospital, London, before becoming the oculoplastic fellow on the craniofacial unit at The Chelsea and Westminster Hospital, London.

Mr Henderson was appointed consultant ophthalmologic surgeon to the Royal Royal Free Hampstead NHS Trust, and the Whittington Hospital NHS Trust in 2005. His surgical experience includes cataract surgery since 1993, phakoemulsification (small incision surgery) since 1994, and ophthalmic plastic, lacrimal and orbital surgery since 1994.

Mr Henderson's papers and publications have included work on eyelid reconstruction, ptosis surgery, the use of botulinum toxin in the periorbital region, ocular inflammatory disease, glaucoma, and cataract surgery.

Mr Hugo WA Henderson BA, FRCO^{PHTH}
Consultant Ophthalmic Surgeon

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Top: venogram showing venous thrombosis
 Bottom : ct scan showing a pulmonary embolus

outpatient management of thromboembolic disease. In addition, the thrombosis service will provide routine monitoring of anticoagulant therapy and determination of the most appropriate duration for such therapy to prevent recurrent thromboembolic disease and will supervise measures to reduce the potential frequency of the post-phlebotic syndrome.

Risk assessment and thrombophilia screening service

Heightened awareness of the potential risk for thrombosis has resulted in many patients seeking advice about their potential risk of thrombosis and underlying predisposition to thrombotic disease. The London Clinic Thrombosis Unit will provide a service to allow for appropriate risk assessment, including thrombophilia screening, in patients where there is a strong family history or suggestion of the presence of risk factors that might heighten thrombosis risk. This service will also provide appropriate counselling if and when thrombophilic tendencies are identified and advise on how these should be managed over the long-term.

The creation of London's first thrombosis unit in the private sector at The London Clinic is at the forefront of modern thinking on thrombosis management. The ability to provide both opportunities for risk assessment, the availability of appropriate methods for thromboprophylaxis and the timely initiation and long-term supervision for the treatment of established thrombosis has a potential to provide tremendous benefits to patients attending the clinic for this potentially serious condition.

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Consultant Haematologist
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'I've got terrible, severe, sharp, burning pain, doctor...'

Some of the words used by patients to describe their pain. But what is pain? 'An unpleasant sensory and emotional experience associated with actual or potential tissue damage...' (IASP) or a more useful definition 'Pain is what the patient says it is!'

Pain represents a massive socio-economic problem, with up to 1 in 7 of the UK population suffering with chronic pain (>3 months duration) and accounting for up to 40% of GP consultations.

Pain can be divided into nociceptive 'normal' pain, such as fibromyalgia, lower back, shoulder and neck pain; and neuropathic pain, where there is damage and/ or dysfunction of the nervous system, such as post-herpetic neuralgia, diabetic neuropathy and complex regional pain syndrome (CRPS). Cancer pain may be present with a combination of these. Acute pain (<3 months duration) is often due to injuries, such as occupational / sports injuries or post-operative pain.

The management of pain often requires a multi-disciplinary team approach, including pain specialist, physiotherapist, alternative therapist (acupuncture, shiatsu) psychologist and occasionally surgical intervention. The mainstay of treatment is medication, starting with simple analgesics (paracetamol, NSAIDs, COX-2), then adding weak opioids (codeine, tramadol), then strong opioids (morphine, buprenorphine, oxycodone). Neuropathic pain requires anti-neuropathic agents including gabapentin, pregabalin, amitriptylline and capsaicin cream.

With the recent controversies surrounding COX-2 inhibitors and the latest guidelines on the role of opioids in the management of chronic non-malignant pain, opioids are increasingly utilised in pain clinics.

PAIN MANAGEMENT WITHOUT DRUGS

*RICE **
Massage
TENS +
Relaxation
Distraction
Comfort
Acupuncture
Reflexology
Aromatherapy
Hot / Cold

** Rest, Ice, Compression,
Elevation for acute injuries.*

*+ Transcutaneous Electrical
Nerve Stimulation.*

In addition to medication there are a number of nerve block techniques including epidurals and facet joint injections (lower back pain); suprascapular nerve blocks (shoulder pain); stellate blocks (facial pain, CRPS). These are done using local anaesthetic and steroid but increasingly with radiofrequency technology. There are also advanced pain management techniques such as implantable spinal cord stimulators and intrathecal pumps, for severe refractory pain.

Alternative medicine, particularly acupuncture can be beneficial in certain painful conditions, such as musculoskeletal.

The aim is to create a pain-free window to allow physio-based rehabilitation, with gentle mobilisation of painful areas and attention to core stability and aerobic conditioning. Some patients benefit from psychological support including teaching relaxation, motivation and coping strategies. Refractory patients may be suitable for intensive pain management programmes that address all areas of pain and rehabilitation

In summary, pain represents a common clinical problem that may require a multidisciplinary team approach. Pain management aims to relieve pain and rehabilitate.

If you would like further information or to refer patients, please contact:

T: 0845 045 0250

drjenner@satellitesec.co.uk

www.londonpainconsultants.com (from 5/06)

Private: 119 Harley Street, London, W1G
NHS: St Marys Hospital, London, W2
Honorary Clinical Lecturer; Imperial College

Dr C A Jenner MB BS, FRCA
*Consultant in Pain Medicine
and Anaesthesia*



Minimally invasive treatment for Varicose Veins

The way forward

Varicose veins affect 5-10% of men and 25% of women at some stage in their lives. If left untreated, some people will end up with irreversible skin changes and venous ulcers. At the advanced stages, treatment is far less effective than if undertaken earlier in the disease process.

Varicose veins occur when the valves in the two main superficial veins in the leg begin to leak. These valves are all that ensure that blood only flows from the leg veins to the inferior vena-cava. When the valves fail the blood banks up in the superficial veins causing them to dilate and form varicose veins.

Over the last few years new minimally invasive methods have been evolving to treat varicose veins. The London Clinic now has the latest in vein treatment technology – the Endo Laser-Vein System (ELVeS). Here the incompetent saphenous vein is accessed via a skin puncture at the knee and a laser catheter passed up it to the junction with the deep vein in groin. The laser is activated and pulled down the vein along its length. The laser energy then destroys the inside of the vein wall causing it to block and fibrose, thus preventing the blood from refluxing down it.

This procedure can be done under local anaesthetic (or if the patient prefers, it can be done under general anaesthetic). The advantages over traditional surgery are clear:

- procedure is short - approximately 45 minutes
- no scar in the groin or behind the knee
- less bruising
- more rapid return to normal activity, including driving
- eliminates post operative wound infection
- no need for inpatient hospital stay



Before and after detail of skin of ankle and foot

Early and medium term results of this treatment have been very favourable with success rates as good as or better than conventional surgery¹. Further, the correct dosage of laser energy has now been established². This has been backed up by studies reviewed by NICE.

The London Clinic has three consultants who specialise in the ELVeS treatment.

Mr M Adishesiah MS FRCS FRCP

Consultant Vascular and Endovascular Surgeon
Appointments: 020 7487 4808

Dr Jocelyn Brookes MB BS MRCP FRCR

Interventional Radiologist
Appointments: 020 7616 7693

Mr Neil Browning M Med (Surg) FRCS FCS (SA)

Consultant Endocrine and Vascular Surgeon
Appointments: 020 7616 7693

¹ RJ. Min and N Khilani. Endovenous Laser Ablation of Varicose Veins. J. Cardiovascular Surgery 2005; 46(4): 395-405

² Theivacumar N, Beale R, Mavor R and Gough M J. Factors influencing the effectiveness of Endovenous Laser Treatment (EVL) for saphenofemoral (SF) and long saphenous (LSV) reflux. The Vascular Society Year Book 2005 p.40

There are significant benefits of robotic surgery which were very appealing, in particular the reduced risk of common side effects.

Focus on robotic surgery



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Richard Dodd, was diagnosed with advanced prostate cancer in August last year as part of a routine examination following a previous kidney stone problem. Although his natural reaction was one of shock, Richard quickly decided that he wanted to take control of his treatment choices. After some initial research, Richard was introduced to Professor Roger Kirby, consultant urologist and Professor of Urology at The London Clinic who suggested the possibility of performing the life-saving surgery with robotic assisted-technology.

Richard, a 65 year-old Director of Photography explains: "I felt very strongly

that open surgery was not an option for me.

There are significant benefits of robotic surgery which were very appealing to me, in particular the reduced risk of common side effects such as incontinence and impotence. Fortunately, I felt mentally positive prior

to the operation and had the utmost confidence in Professor Kirby and his team at the Clinic"

In November 2005, Richard was only the second patient to be treated by the Clinic's new da Vinci® Surgical System— one of only a handful available to treat patients in the UK. The 'robot' uses enhanced 3-D visualisation and magnification that allows urologists to perform minimally invasive procedures such as laparoscopic radical prostatectomy.

There are numerous advantages of the world-renowned surgical system over open prostatectomy including faster recovery rates, less post-operative pain and discomfort and less blood loss. Richard experienced many of these benefits, as he explains: "The care I received at the Clinic was fantastic and my recovery since the operation has astounded me. While there have been moments of discomfort, I have not experienced any pain. In terms of 'milestones' for me since the operation, I was able to work within two weeks, maintain a sensible fitness regime within three weeks and am planning to live life to the full on the ski slopes in under three months!"

Professor Kirby has performed over 1,000 total prostatectomies for prostate cancer using the traditional open approach. However, he believes that the Da Vinci robot has been a revelation to himself and his team, which includes surgeons Prokar Dasgupta and Christopher Anderson. Professor Kirby comments: "The ten fold magnification allows us to see the nerves which lie alongside the prostate very clearly, and by carefully preserving them we hope to match the latest results from the USA which tell us that up to 90% of men regain their erections and normal sexual function some months after their robotically-assisted operation".

The future looks bright for the Clinic's robot, with exciting opportunities not only for prostate cancer, but also in areas such as gynaecology and general surgery.

Professor Roger Kirby
MA MD FRCS(Urol) FEBU
Professor of Urology
Tel 020 7935 9720



The future looks bright for the Clinic's robot, with exciting opportunities in many areas. **Professor Roger Kirby**

Liver problems linked to a variety of related health issues such as viral hepatitis and alcohol-use are on the increase.

Clinical Nurse Specialist Co-ordinates New Hepatobiliary Unit

Lisa Cheshire (RN, BSc, MSC), Hepatobiliary Clinical Nurse Specialist, is at the very heart of The London Clinic's new Hepatobiliary Unit which it has recently added to its portfolio of services. Ensuring that the specialised unit has an integrated approach to patient care will be one of Lisa's main roles. An experienced nurse, who joins the Clinic from an NHS post at University College London (UCL), Lisa explains:

"There are a number of elements to my role as central co-ordinator of the unit that are key to improving the delivery of care for patients. I believe that by focusing on areas such as education, training, research, professional development and clinical practice, we can provide highly specialised services in a truly patient centred environment."

Patients at The London Clinic have come to expect the highest level of medical care. The new unit will be no exception and the multi-disciplinary team includes some of the UK's leading consultants, many of whom hold teaching posts in London's NHS hospitals. Surgical, medical and radiological specialists are not only supported by a clinical nurse specialist, but by a wider 'support' network including staff nurses, dieticians, physiotherapists and a Macmillan nurse who provides expert advice and emotional support to patients with cancer:

The Clinic is one of the few hospitals in the country to offer patients treatment using a unique MARS® machine (Molecular Adsorbant Re-circulating System). The treatment works on the basis of albumin dialysis and is used for sick patients who have decompensated liver failure. This state-of-

the-art equipment means that we are able to remove toxins from the liver even when it is in failure.

Providing a specialised service for patients with decompensated liver failure is one of The London Clinic's long-term goals. Lisa explains: "From my own experience, the medical management of liver disease is a particular area of interest. Liver problems linked to a variety of related health issues such as viral hepatitis and alcohol-use are on the increase. We believe that there are significant numbers of people who have undiagnosed liver problems and we hope to build a dedicated service to meet the needs of these patients in the future."



TREATMENTS AND PROCEDURES

Diagnostic Services

- Blood tests
- Transjugular biopsies
- Radiological placement of biliary stents and drains
- TIPSS procedure for variceal bleeding and refractory ascites
- Endoscopic investigations and treatments of abnormalities
- Ultrasound and CT scans

Cancer Treatments

- Chemotherapy
- Radio frequency ablation
- Percutaneous ethanol injection
- Embolisation techniques

Surgical Procedures

- Resection of hepatic, biliary and pancreatic tumours
- Management of obstructive jaundice and pancreatitis
- Cholecystectomy
- Whipple's procedure

Transplant Preparation

- Pre-operative assessment
- Post-operative care and follow up

Lisa Cheshire RN, BSc, MSC
Hepatobiliary Clinical Nurse Specialist

Consultants granted admitting /practising privileges

from September 2005
to December 2005

Cardiothoracic surgery

Mr Martin Hayward
MBBS MS FRCS FRCS(CT)
Consultant Cardiothoracic Surgeon
NHS post(s): The Heart Hospital, UCLH
020 7573 8800 ext 6060

Mr David Lawrence
BSc MBBS FRCS MS FRCS(CTH)
Consultant Cardiothoracic Surgeon
NHS post(s): The Heart Hospital
020 7573 8888

Dermatology

Dr Nicholas Lowe
MB ChB MRCP MD FRCP
Consultant Dermatologist
020 7499 3223

Gastroenterology

Professor Alastair Forbes
BSc MBBS MRCP MD FRCP ILTM
Professor of Gastroenterology
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General surgery

Ms Lindsey Barker
BSc (Hons) MBChB FRCS FRCS (Gen Surgery)
Consultant Colorectal Surgeon
NHS post(s): Central Middlesex Hospital
020 8453 2417

Mr Ruben Canelo
MD FRCS
Consultant General Surgeon
NHS post(s): Hammersmith Hospital
020 8383 3937

Mr Shaw Somers
BSc (Hons) MBChB MD FRCS
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Portsmouth, King Edward VII Hospital, Midhurst
01730 811131

Gynaecology

Miss Sara J Matthews
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Consultant Gynaecologist
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020 7403 3363

Haematology

Dr Kirit Ardesbna
MRCP MRCPPath
Consultant Haemato-Oncologist
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Honorary Consultant Haemato-Oncologist Mount
Vernon Cancer Centre
01923 844 413

Professor John Gribben
MB ChB MD FRCP FRCPPath
Consultant Haematologist
NHS post(s): Barts & The London NHS Trust
020 7882 6126

Professor Gareth Morgan
BSc MB BCh MRCP PhD MRCPPath FRCP FRCPPath
Professor of Haematology
NHS post(s): The Royal Marsden Foundation Trust
020 8661 3672

Dr Ketan Patel
BSc (Hons) MBBS MRCP MRCPPath
Consultant Haematologist
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01895 238 282

Immunology

Dr Raul Scott Periera
MB Bchir MRCPPath PhD FRCPPath
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020 7915 1674

Neurophysiology

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Neurosurgery

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Ophthalmology

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Radiology

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Urology

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Sharon Steward
Business Development Manager





In the first of a regular series
Matron discusses some of the
Hot topics that are affecting
the Clinic

Amanda Hallums
Matron, The London Clinic

Notes from Matron

Clostridium difficile

A recent hot topic for infection control over the last couple of months has been the antibiotic associated infection *Clostridium difficile* (*C difficile*) – with new HPA and HCC guidelines being introduced last December.

We're proud to report that we have had a very low incidence of the infection at the Clinic to date due to the well established procedures we have in place. Isolating patients with any infection has been standard practice here for many years. Our staff place particular importance on prevention of cross infection and maintain a high standard of hand hygiene and environmental cleanliness.

In the event of any known or suspected infection, the Clinic has a well rehearsed response process which is implemented immediately by our Infection Control Team.

For diarrhoeal illness, these measures include:

- Source isolating all patients with diarrhoea
- Evaluating patients with diarrhoea for an antibiotic associated problem
- Reviewing antibiotic usage in patients with *C difficile*

In addition, antibiotic usage in all patients is monitored and the policy on antibiotic usage is regularly reviewed.

The Infection Control Team at The London Clinic is always available for advice and Infection Control policies can be accessed on the Infection Control Services website www.infectioncontrolservices.co.uk

Healthcare Commission Inspection

We had our last Healthcare Commission (HCC) inspection on 19th January - with very positive feedback.

The Clinic was complimented on its welcoming, professional and well organised environment that supports the achievement of high standards of clinical care.

The full report is available from the HCC website.
www.healthcarecommission.org.uk

Infection Control at The London Clinic

Our specialist Infection Control Team, comprises a group of expert nurses and microbiologists, amongst others.

Our approach to minimising the spread of infection at the Clinic includes:

- Regular training for all clinical staff on infection control
- Staff decontaminate their hands with an alcoholic handrub or soap and water before and after patient contact
- Clinical staff are discouraged from wearing jewellery whilst on duty which may hamper their ability to clean their hands effectively eg wristwatches
- Where possible, single use disposable equipment is used. If any equipment is re-used, it is cleaned, disinfected and sterilised in accordance with national guidelines
- Wall mounted alcohol gel is provided in every patient room
- Hygienic hand wipes are provided in every patient room
- Visitors are reminded to decontaminate their hands when leaving a patient's room
- Patients are nursed in single rooms (with the exception of certain specialist areas such as the Critical Care Unit)
- All patients admitted to the Clinic for at least one night's stay (with the exception of sleep study patients) have a nose and, if appropriate, wound swab taken to screen for MRSA.



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