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NOMINATION PROCESS



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Top Doctors[®], the world's largest and most prestigious medical team, operates on an exclusive peer-nomination system.

We personally ask our doctors who they would go to in times of ill health, or which specialist they would recommend to friends and family. Their suggestions are made on the basis of their professional experience, and are then used as the first stage in our rigorous 4-step selection process.

Once a doctor has passed our selection process and has joined us, she or he will then become a member of a global team of over 60,000 doctors, from the **USA, Latin America, Europe** and the **UK**. This allows them exclusive services such as being an active member of **topdoctors.co.uk**, appearing in our magazine, as well as participating in the on and offline publicity we create.

Doctors cannot nominate themselves, and therefore personal details are required to nominate a medical professional. Any details are treated with the strictest of confidentiality at all times.

If you would like to nominate one of your peers, please visit topdoctors.co.uk/nominations

Many thanks.

We do not publish doctor's details and we do not share with third parties. Recommendations are subject to scrutiny, and any falsified or fraudulent nominations will be disqualified.

editorial



Alberto E. Porciani

CEO Top Doctors®

Welcome to the first edition of our **Top Doctors UK magazine**, representing the work of a selection of London's very finest medical professionals. **Top Doctors®** is a leading global company, unique in its mission to help patients connect to the very best healthcare available, and the right doctor for their needs.

Within these pages, you will find cutting-edge research, technological advances, family, lifestyle and wellness advice, and medical innovation. We only work with the top doctors, so you can be sure that each and every one is the best in their field.

Here at **Top Doctors®**, we know that the future of healthcare will reflect the choice and flexibility that we are coming to expect in all areas of our lives; we are already developing intelligent technology that works alongside our top physicians to get the very best results for both patient and doctor.

While technology will never be able to completely replace the traditional face-to-face consultation, the benefits of eHealth are undeniable. We are already at a place where we use apps to check which doctor is best for us based on our symptoms, have initial or follow up meetings with our doctors from the comfort of our home or desk, use telemedicine to communicate our medical history more effectively, and chat with our doctors using our smartphones. In the near future, digital health-monitoring devices will alert us to imbalances in our health, remind us of check-ups, and give us real-time reports and advice on maintaining a healthy body and mind.

In this future, access to the best doctors will know no borders. With over 60,000 of the world's best professionals already signed up to **Top Doctors®**, patients using our technology will have instant connection to the right doctor for their condition, whether they be in the same city, or halfway across the globe. This will change the way you manage your health.

We would like to thank the doctors that have started the UK chapter of our adventure with us, who represent the cutting-edge face of healthcare. We would also like to thank the patients that have already signed up to use our services. Last but not least, we would like to thank the Top Doctors UK team, who through dedicated hard work and professionalism are actively improving the healthcare environment for both patients and doctors in the UK and across the globe.

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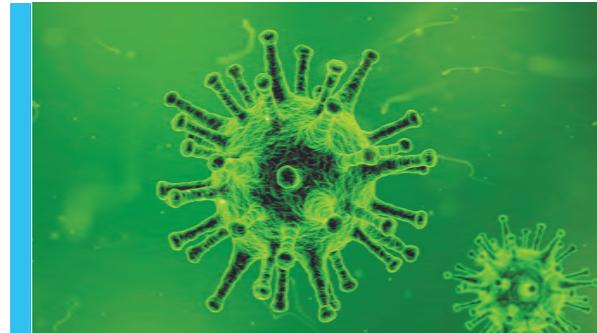
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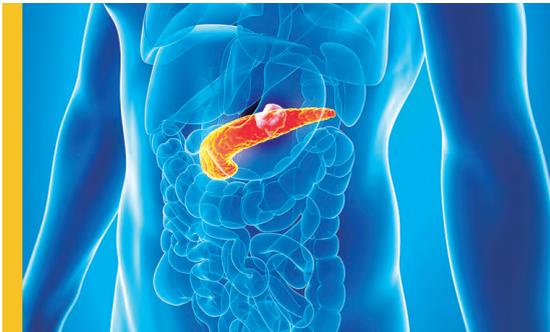
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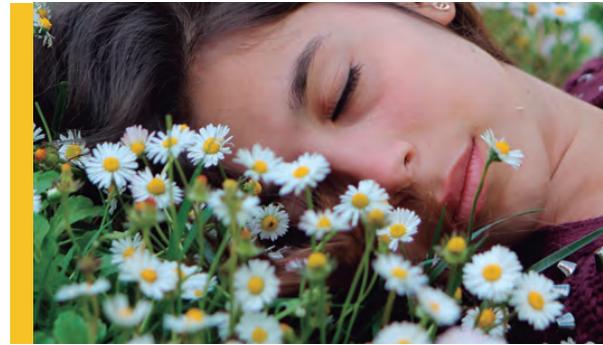
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2017-2018's Best Specialists

110 Guide to all of our top doctors

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Robotic-assisted head and neck surgery

How pioneering technology can help patients

Robotic-assisted head and neck surgery has opened the door to new surgical possibilities, meaning shorter recovery times and the avoidance of scars.



What is robotic-assisted head and neck surgery?

Robotic-assisted head and neck surgery is one of the latest advances in medicine. This innovative technology helps overcome technical restrictions associated with conventional surgical techniques.

Robotic-assisted technology helps the surgeon access otherwise hard-to-reach areas and provides a high-resolution 3D view of the operating field. It removes line-of-sight problems associated with conventional endoscopic techniques as well as surgical tremor by employing the algorithm of tremor

filtration. Small endowristed instruments permit precise, agile and dextrous interaction with the patient.

Where is robotic-assisted surgery used?

Robotic-assisted techniques are used to treat cancers of the tongue base, tonsils and other selective areas of the head and neck. Scars in the neck can be avoided for thyroid and parathyroid surgery and when performing selective neck dissections for benign or malignant conditions.

Selected patients suffering from obstructive sleep apnoea may also be helped by robotic-assisted surgery. Patients who have a

BMI of less than 30 and a history of non-compliance or failure to use a CPAP machine can be considered. If investigations show obstruction at the tongue base or epiglottis, robotic-assisted techniques can be an ideal approach to access these areas. Long-term success rates of 70% have been reported.



SURGERY THAT WOULD HAVE REQUIRED LONG INCISIONS IN THE NECK CAN NOW BE PERFORMED THROUGH THE MOUTH

What are the benefits of using this procedure?

- Operating on hard-to-reach areas, such as the tongue base and tonsils where conventional methods such as the laser are extremely difficult if not impossible to use accurately. Tonsil cancer due to an association with the HPV-16 virus has increased 3 fold in the last 10 years. These have an equal sex incidence and are more prevalent in the middle-aged working population.
- Trans Oral Robotic Assisted (TORS) avoids the need for free-tissue flaps that often is an all-day operation requiring two surgical teams. In-patient stay can be reduced from 3 weeks to 5-7 days. This significantly reduces hospital costs at the same time

as enhancing the patient experience in a very positive way. Finally, it increasingly facilitates use of a de-escalation protocol where radiotherapy and chemotherapy can be reduced or avoided altogether.

- Selected thyroids can be removed via a trans-axillary technique avoiding a visible scar in the neck. This is particularly indicated in those patients who scar poorly. Rarely, parathyroid surgery can also be performed using a similar technique again with an intention to avoid a neck scar.
- Because of being able to operate on small, precise and previously unreachable areas, it reduces the need for chemotherapy and radiotherapy when treating cancer.

Are there any complications?

There are no additional complications that occur as a result of using robotic-assisted techniques within the head and neck.

Professor Neil Tolley has an international reputation as a leading thyroid, parathyroid and head and neck surgeon. He pioneered head and neck robotic-assisted surgery in the UK and was the first surgeon in the UK to use the da Vinci robot for head and neck cancer, obstructive sleep apnoea and thyroidectomy. He was the first surgeon in the world to perform a successful robotic-assisted parathyroidectomy. 🌟



OTOLARYNGOLOGY - HEAD & NECK SURGERY/ENT

Professor Neil Tolley MD FRCS DLO

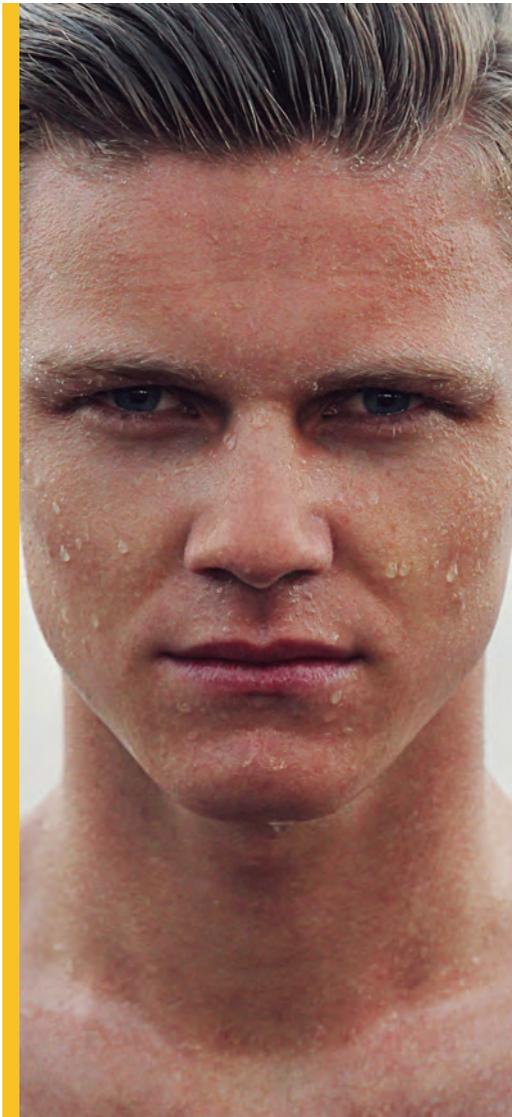
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How common are jaw problems?

TMJ: a form of jaw replacement surgery

Leading oral and maxillofacial surgeon Mr Luke Cascarini discusses jaw surgery, and what patients should expect from a TMJ replacement.



Jaw problems are relatively common; these range from mild jaw clicking to more serious jaw locking and joint degeneration or traumatic damage. The range of problems can be as extensive as with any joint in the body, and whereas hip and knee replacement surgery has been perfected over many years, being confident of success with jaw joint procedures has only been possible in the last 10-15 years.



BEING CONFIDENT OF SUCCESS WITH **JAW JOINT PROCEDURES** HAS ONLY BEEN POSSIBLE IN THE LAST **10-15 YEARS**

One procedure that we use to correct certain jaw issues is temporomandibular joint replacement surgery, known as TMJ replacement surgery.

Do I need TMJ jaw replacement surgery?

TMJ jaw replacement surgery is usually required in patients who have:

- Jaw damage through osteoarthritis
- Damage due to an accident
- Had part of the jaw bone removed due to a cancerous tumour, bone infection, rheumatoid or psoriatic arthritis.

Jaw replacement surgery is not required for all kinds of jaw problems, some can be solved by looking inside the joint with a scope and washing the joint out.

Our practice uses the very latest tiny scopes, which are just over 1mm in diameter and can be used to examine the inside of the joint directly.

Injections are also offered to relieve inflammation and pain, which may provide enough relief for the patient.

Patients who have a seriously damaged TMJ experience limited movement and pain that can be debilitating. With severe TMJ disorder the patient usually can't talk or swallow their own saliva without severe pain. A TMJ replacement can be a huge benefit to these patients.

What does the TMJ replacement surgery consist of?

To replace the TMJ, the knuckle of the joint has to be cut off and a titanium replacement installed. A little of the bone at the base of the skull is sometimes removed, and replaced with a high-density type of plastic that screws onto the side of the skull. The titanium knuckle sits into the plastic and allows the jaw its full range of movements.

How long does the procedure take?

The planning and custom manufacture for joint replacement is complex and takes approximately 3 months. This stage begins with the patient undertaking a CT scan, which is then used to create draft designs by the

implant manufacturer. These designs will be discussed and amended until they are perfect. A date is then booked at the hospital, and once payment is agreed between the hospital and the insurance company, the 6-week process of the building of the joint can begin.

The surgery takes approximately 1.5 hours per side. The patient usually remains in hospital as an inpatient for one week and will require some recovery time before returning to work. The patient will be regularly reviewed and patients with chronic pain may require longer admissions.

What are the risks of the procedure?

- As with any joint replacement procedure one of the main risks is of infection
- Allergic reaction to implant components
- Facial swelling and facial nerve weakness
- Heterotopic bone formation (bone found in an abnormal place)
- Neuroma formation (abnormal growth of nerve tissue)
- Ear problems
- Dislocation
- Replacement of one joint can cause detrimental effects to the opposite joint
- Misalignment of the teeth after surgery is possible
- Patients with long term pain prior to surgery may continue to experience pain. In this case, the patient will be referred to a chronic pain specialist

TMJ surgery is one of **Mr Luke Cascarini's** specialties. He is a leading oral and maxillofacial surgeon who is known for using techniques and methods which are at the forefront of his field. 🦷



ORAL & MAXILLOFACIAL SURGERY

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A safer technique for spine surgery

The latest minimally invasive technique

Leading orthopaedic surgeon Mr Sean Molloy, specialist in spinal surgery, explains how minimally invasive surgery is an ideal technique.



What is minimally invasive surgery?

Minimally invasive surgery is an ideal technique in spinal surgery. What is meant by minimally invasive surgery is smaller incisions rather than larger and more invasive incisions.

The benefit of the minimally invasive technique is that recovery time for the patient is reduced, there is less tissue trauma, the patient does not lose as much blood, and there is less chance of complications. What is meant by less tissue trauma is the

use of a muscle splitting, rather than muscle cutting approach. There are different ways in which the surgeon can choose to approach minimally invasive surgery.

Anterior minimally invasive spinal surgery

Using the anterior minimally invasive technique, the spine can be approached surgically from the front.

If the spine is approached from the front (also called the anterior approach), then the



THE BENEFIT OF THE **MINIMALLY INVASIVE** TECHNIQUE IS THAT **RECOVERY TIME** FOR THE PATIENT IS REDUCED

abdominal wall muscles can be split, the damaged discs can then be removed and replaced with metal blocks that cause the bones to fuse. There is no damage to the muscle that has been split and retracted for the minimally invasive anterior procedure.

Posterior minimally invasive spinal surgery

The posterior procedure can once again be performed by operating between muscles, rather than cutting through the muscles themselves.

Implants can be inserted via computer navigation, which enables us to get a complete visualisation of the bone and spinal cord on a monitor throughout the entire operation. This means that large retractors are not needed, as was the case in the past, and there is less tissue trauma as a result. This surgical approach is safer, as it allows easy insertion of screws and application of rods, to once again ensure a good fusion.

Spinal navigation has been a significant advance for the facilitation of minimally invasive spinal surgery.

Reduced recovery time

Because minimally invasive techniques do not disturb soft tissue and muscles in the way that traditional spine surgery does, generally these procedures can reduce post-operative discomfort, and the amount of time spent in post-operative recovery.



THERE IS **NO LONG-TERM DAMAGE** TO THE MUSCLE THAT HAS BEEN SPLIT FOR THE **MINIMALLY INVASIVE PROCEDURE**

Returning to normal activity is a process which varies in each individual case. After spinal fusion, it takes time for the fusion to take and it is important to keep the spine straight. Patients will be shown how to move and reposition to aid this.

After surgery, a patient is monitored to ensure recovery is progressing as it should.

Mr Sean Molloy specialises in complex orthopaedic surgery, with particular interest in spinal deformities. He is a pioneer in minimally invasive surgery. This type of surgery can significantly improve quality of life and reduce hospital time for the patient. 🌐



ORTHOPAEDIC SPINAL SURGERY

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Modern innovations in cataract surgery

Intraocular lenses and the femtosecond laser

Cataracts affect millions of people, usually occurring as people get older. Find out how modern techniques can provide a solution.

What are cataracts?

The natural crystalline lens of the eye focuses light onto the retina, allowing us to see and focus on things close to us. With ageing, this lens can become cloudy or opaque, impairing vision. This is called cataract formation. In some people this reduction in vision will not be serious, but for most people, the cataract could severely affect their sight and their activities.

How do you treat cataracts?

When cataracts are causing sight problems, compromising one's ability to drive, read or work, surgery is recommended. Cataract surgery involves replacing the natural lens

with a synthetic replacement called an IOL (intraocular lens), which can also fix other vision problems, such as long or short-sightedness, presbyopia and astigmatism. Cataract surgery is the most common elective surgical procedure in the UK, with around one in three people over 65 requiring it.

What is an intraocular lens?

An intraocular lens is an artificial lens made of a plastic-like material, which is implanted to replace the natural lens of the eye. The original lens is liquefied by means of high-frequency ultrasound (this process is called phacoemulsification), and then washed out of the eye. The IOL is then inserted through a small incision, and unfolds within the lens



capsule. IOLs are unlikely to deteriorate, making them a permanent solution. There are two categories of IOL: monofocal and multifocal. Multifocal and monofocal IOLs can also correct astigmatisms and these are called toric IOLs.



IOLS ARE UNLIKELY TO DETERIORATE, MAKING THEM A PERMANENT SOLUTION

Monofocal IOLs

While monofocal IOLs have proved successful, they only offer improved vision at a certain range – usually long-distance, meaning patients need glasses for short distance, e.g. for reading. Some patients have one eye fitted with a lens for seeing long distances, and the other for short-distance sight (micro-monovision), but still may need glasses for a few tasks and also may need to adapt to the difference between the two eyes.

Multifocal IOLs

Multifocal IOLs spread vision focus between short, middle and long distance, with the aim of reducing dependency on glasses. Although they offer a wider range of focus than monofocal IOLs, occasionally some patients experience light scatter problems, e.g. glare. Clinical trials on new multifocal IOLs continue to be carried out, and as a result, this technology is improving, and has

a real potential to provide a replacement lens that leaves patients free from dependence on glasses in almost 90% of cases.

Innovative surgery

The latest cataract surgical technique involves using a femtosecond laser. A 'femtosecond' is one quadrillionth of a second, and the energy of the laser is released in a few hundredths of these, over a diameter of a hundredth of a millimetre. This offers extreme precision in making delicate incisions in the eye tissue. This procedure is often referred to as 'femtophako', and is constantly monitored via high-resolution images of the cornea, iris and lens provided by Optical Coherence Tomography (OCT).

What to look out for

Cataracts are very common, and can be dealt with if diagnosed and treated properly. Some people's lenses never deteriorate to the point where surgery is necessary. However, if you experience symptoms such as blurry vision, faded colours, haloes around light and trouble seeing at night, you should consult your doctor or a specialist, who will advise you on the best course of action.

Mr Vincenzo Maurino is recognised internationally as an expert in refractive cataract surgery, and using IOLs (intraocular lenses) to replace the affected natural lens. He has pioneered the use of femtosecond laser-assisted cataract surgery and multifocal lenses, and is regarded as an authority on this technique. 



OPHTHALMOLOGY

Mr Vincenzo Maurino MD BQOphth AM-RCOphth

Consultant Ophthalmic Surgeon Corneal Transplant & Refractive Surgery / Director Cataract Surgical Services / Moorfields Eye Hospital NHS Foundation Trust / Visiting Professor Corneal Transplant Surgery University of Rome - Tor Vergata / **02039342077**

Metabolic surgery: a solution for type 2 diabetes

Changing how blood sugar is regulated

Many people in the UK now suffer from type 2 diabetes – a serious health condition. However, there are ways it can be put into remission.

Type 2 diabetes is a very common and serious disease that, in many cases, can lead to complications including heart attacks, strokes and reduced life expectancy. Conventionally, type 2 diabetes is treated using insulin and oral drugs. Unfortunately, up to 50% of patients who take medication, especially patients with associated obesity, are not able to achieve adequate control of their blood sugar levels.

For many patients with type 2 diabetes, metabolic surgery could be a solution. It can achieve adequate control of blood sugar levels and can even result in a complete disease remission.

Metabolic surgery

Bariatric surgery was developed in the 1950s as a surgical approach to reduce the size stomach, or to bypass a segment of intestine to reduce the absorption of nutrients, with the





IT IMMEDIATELY CHANGES THE WAY BLOOD SUGAR LEVELS ARE REGULATED, ACTING AS A SOLUTION FOR TYPE 2 DIABETES

aim of achieving weight loss. We now know the original mechanical idea behind bariatric surgery is actually wrong. In fact, when you change the anatomy of the gut or reduce the size of the stomach, you're basically changing the physiology that regulates satiety/appetite and sugar metabolism.

Patients do not eat as much because they simply feel less hungry, and, very importantly, their metabolism is made more efficient by the changes in gastrointestinal physiology. This is an excellent physiological way to tackle obesity. However, it is not mechanical as we first thought, and we now understand the full implications of bariatric surgery. In fact, when we change the anatomy of the intestines, we also change physiological mechanisms (i.e gut hormones, bile acids etc) that powerfully regulate insulin secretion and blood sugar levels. This explains why GI surgery rapidly and dramatically improves type 2 diabetes.

Tailored treatment

There are a number of procedures available for the treatment of severe obesity or type 2 diabetes which can be offered by a bariatric surgeon. These include sleeve gastrectomy,

gastric bypass, biliopancreatic diversion, gastric banding, and also new procedures that can be performed endoscopically. All these operations can be offered using a minimally invasive or laparoscopic approach that reduces post-operative pain and allows for an early recovery and a return to daily activities. These procedures can now be performed with the same safety as common operations such as gall bladder surgery and hysterectomy.

The important thing is that we now know how these procedures work and that each operation has a distinct mechanism of action. Therefore, it is important to decide on the right surgical procedure based on the individual patient's needs. There is no one procedure that fits all, but different procedures with different mechanisms of action and effects that suit different types of patient. The challenge is, therefore, to identify the patient's characteristics that may require one or another mechanism of action and therefore one or another procedure.

Professor Rubino has been at the forefront of developing metabolic surgery as a cure for type 2 diabetes for many years. His interest in the topic began in 1999 when he was working as a junior doctor. After observing that patients' diabetes seemed to disappear quickly after weight loss operations he began carrying out research and found a crucial link between the anatomy of the gut and the way blood sugar levels are regulated. Since then, Professor Rubino has been awarded numerous awards and prizes for his research and work in this area. 🌟



BARIATRIC SURGERY

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Recent advances in weight loss surgery

Surgical techniques to help with weight loss

Leading surgeon Mr Ahmed R. Ahmed talks Top Doctors through a number of advances in weight loss surgery over the years.

Obesity worldwide is reaching epidemic proportions. In the UK, it is estimated that 24.9% of the population is overweight, giving reason as to why the country has been dubbed one of “the fattest nations in Europe”. Nowadays, however, there are a number of surgical techniques and other therapies available that aim to curb the problem before it gets out of hand.

The intragastric balloon

The intragastric balloon aims to improve weight loss by limiting the intake of food so the patient feels fuller more quickly. It remains in the stomach for 6 months, encouraging the body to adapt to healthier portion sizes at mealtimes. Weight loss during this time averages 10-15 kgs.

New drug therapies

Drugs previously used in the treatment of type 2 diabetes can now be prescribed off label for weight loss purposes. These come from a family of drugs called glucagon-like peptide-1 (GLP-1), which is a gut hormone released following the intake of food. This hormone stimulates the increase of insulin, while inhibiting the release of glucagon, ultimately decreasing the amount of food consumed through increased satiety, which refers to the feeling of being full after eating. Weight loss has been shown to be effective



in both diabetic patients, and patients who do not have the condition.

The Apollo OverStitch device for endoscopic sleeve gastroplasty

This endoscopic suturing system allows surgeons to place sutures (a surgical stitch used to hold tissue together) in the stomach through a flexible endoscope.

The stitches, which are placed using the Apollo OverStitch, essentially shrink the size of the stomach. The implantation of these sutures ultimately leads to the patient adapting a healthier way of eating as their appetite is reduced.

Mini gastric bypass (MGB)

The mini gastric bypass works by restricting the amount of food that can be eaten at any one time, and also causes malabsorption, which limits the absorption of foods in the intestinal tracts. In the first part of the operation, a small tube of stomach is created which becomes the pouch. This is the restrictive part of the procedure and means that only a small amount of food can be taken at any one time.

Next, the surgeon brings up a loop of bowel (about 200-300cm long) and joins this to the lower part of the stomach pouch. This means that food passes from the small pouch into the small bowel where it meets the digestive juices which have moved downwards from the main part of the stomach. In effect,



BARIATRIC SURGERY REMAINS THE ONLY SCIENTIFICALLY PROVEN TECHNIQUE FOR LONG-TERM WEIGHTLOSS

therefore, about 2-3 metres of small bowel has been bypassed before absorption of food (and calories) can take place. Fewer calories absorbed translates to weight loss.

The future of weight loss surgery

Bariatric surgeons are trying to develop less invasive techniques such as the ones mentioned previously, and are aiming to avoid scars altogether. However, for now, mainstream operations such as the laparoscopic sleeve gastrectomy and gastric bypass procedures are still the most effective, scientifically proven means for significant long-term weight loss.

Who needs it and how much does it cost?

If you have a BMI over 27 you may be eligible for endoscopic therapies and BMI 30 and over, you may be eligible for weight loss surgery. Prices start at around £5,500, depending on the type of treatment chosen.

Ahmed R. Ahmed is a leading bariatric surgeon. He runs his own research team which investigates mechanisms of weight loss and he has won numerous prizes for his work in this area. 🌟



SURGERY

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B-Lites: the lighter breast implant

A revolutionary implant in breast surgery

Drooping of the breast is a very common reason why women have their breast implants changed or opt for further breast surgery.

B-Lite implants are a third lighter than traditional silicone implants, resulting in less drag on the breast tissue. Helping to reduce the weight of the implant significantly reduces the risk of having to have an operation later on in life.

What are B-Lites breast implants?

The implant is filled with a microsphere enhanced silicone gel. The shell is standard industry silicone, and the gel allows for a weight reduction of 30%. The microspheres, made from high purity and biocompatible



borosilicate, are fixed into the cohesive gel which allows for the weight reduction compared to normal implants.



SINCE THE 1980s, THERE HAS BEEN A GROWING DEMAND FOR BIGGER BREAST IMPLANTS

What are the advantages to the patient?

Since the 1980s, there has been a growing demand for bigger breast implants and the size of implants has been steadily increasing as a result. However, the weight of the implants has also increased and with that came problems including breast tissue atrophy, breakdown, deformity of the breast, traction rippling, visibility of implants through breast tissue, back and shoulder or neck pain, skin atrophy, stretch marks and sagging. With these problems in mind the B-lite was developed and it is able to:

- Reduce the effects of gravity
- Reduce the detrimental effects on the breasts in the long term
- Maintain optimum results for longer
- Make movement more comfortable

Safety first

The breast implant is very safe. The highest quality silicone gel is used and a microsphere is added to reduce the weight of the implant. The implants are the result of nearly ten years of research, development and testing. The

shell is designed by a market leader based in Germany who has over 25 years of experience, and a well-documented safety record. The pre-clinical mechanical, chemical and biological tests showed that there was superior product safety over standard implants. They are used in orthopaedic surgery and neurosurgery without any risk of reaction in the body. B-Lites, like all high-quality breast implants, are guaranteed for life. In the event of rupture they are replaced free of charge. The microspheres used within the silicone gel have a very low reaction within the tissue so there would be no risk if the implants were to rupture.

The procedure

The actual surgical procedure for inserting a B-Lite is exactly the same as any other breast implant. The implants come in all shapes and sizes, with smooth or textured surfaces. The only difference that we see from a surgical point of view is a slightly longer incision to insert the implants, half a centimetre to a centimetre longer. The scars heal very well so the length of the scar is of no concern to patients. Patients describe the feel of the implants as very natural. They feel light and don't have that sensation of heaviness that other implants have. The long-term results have been very good.

Mr Christopher Inglefield is at the forefront of cutting-edge breast surgery and has performed thousands of procedures. In 2012, he was accredited with a Lifetime Achievement Award at the Aesthetic Awards for his work and dedication to innovation within the field. 🌟



PLASTIC SURGERY

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Varicose veins: a new surgical approach

Modern methods to eradicate varicose veins

Expert consultant vascular surgeon, Mr Philip Coleridge Smith talks about the latest technological advances in vascular surgery.

Previous surgical methods

In recent years, there has been a considerable change in surgical practice in the field of varicose vein surgery. The basis of treatment used to be varicose vein stripping, in which the diseased veins were removed in their entirety. These treatments were performed under general anaesthesia and led to significant post-operative pain and a recovery period of about 1 month.

New approaches: thermal ablation

In recent years, new methods of treatment have been introduced which are performed under local anaesthesia. The veins may be successfully destroyed by thermal ablation (heating) methods, where a tube is passed along the diseased vein for a distance of 20 – 50cm.



**VEIN STRIPPING LED TO
SIGNIFICANT POST-OPERATIVE
PAIN AND A RECOVERY PERIOD
OF ABOUT 1 MONTH**

The tube contains either a laser optical fibre, an electrically heated catheter or a tube delivering super-heated steam. Local anaesthetic is applied to the vein, and the heat is used to destroy it without removing it. Side effects are mild, and complications are rarely experienced.



This procedure also helps to alleviate related symptoms such as swelling, aching, and irritation caused by varicose veins.

Ultrasound guided foam sclerotherapy

An improved method of injecting varicose veins known as ultrasound guided foam sclerotherapy has become popular. In this method, injections of foam are made into the diseased saphenous veins and associated varices under ultrasound guidance. The vein then hardens and is eventually blocked. The term 'sclerotherapy' comes from the Greek word 'sclero', which means 'to make hard'.

Local anaesthesia is not required for this treatment. The treatment is quick and can be performed as a day case walk-in procedure, meaning there is no overnight stay in hospital required. Each session of treatment lasts about half an hour. This method is much safer than traditional surgery, improves the appearance of the veins, and is more comfortable for the patient, which explains why it is a popular choice for surgeons these days.

It is suitable for patients with small or moderate size varicose veins, and patients who have had previous surgery on veins can still be treated using foam sclerotherapy.

How effective are these treatments?

These treatments are both equally effective – neither stands out from the other in particular,

and the treatments are comparable to the ability of surgery to treat varicose veins. The main difference compared with the previous methods is that these treatments have a greatly reduced post-operative recovery time, with most patients experiencing little post-treatment discomfort.



MODERN METHODS ALLOW
VARICOSE VEIN TREATMENT TO
BE DONE SWIFTLY, EFFECTIVELY
AND WITH LITTLE DISCOMFORT

Return to work is usually within 1-3 days, in contrast to a much longer period of recovery following traditional varicose veins surgery. Modern methods of treatment allow varicose veins treatment to be done swiftly, effectively and with little discomfort for the patient.

Mr Coleridge Smith is a prominent vascular surgeon and a member of the Venous Forum of the Royal Society of Medicine. He operates at the British Vein Institute, and is an expert in the treatment of varicose veins. He is current president of the British Association of Sclerotherapists, and one of the UK's leading experts on ultrasound guided foam sclerotherapy. He is acknowledged as an international authority and expert in venous disease, including the management of vein problems using modern methods of vein ablation. 🌟



VASCULAR SURGERY

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Living with life-threatening arrhythmias

What the ICD can do for you

An implantable cardioverter defibrillator allows people at risk of dying from an arrhythmia to lead a normal life.



Due to the advances in treatment and prevention of heart problems, most patients with cardiac conditions such as arrhythmias are not at a substantially increased risk of dying suddenly from an arrhythmia. However, some people do have an increased risk. For

example, people who have survived large heart attacks in the past, people who have previously had a dangerous arrhythmia, or some people who have an inherited cardiac condition.

Sometimes, heart specialists may recommend an implantable cardioverter defibrillator (ICD)

or a subcutaneous implantable cardioverter defibrillator (sICD).

What is an ICD and how does it work?

An ICD consists of a generator that is implanted under the skin of the upper chest. One or more leads are connected and these are positioned in the heart. The ICD monitors the heart rhythm.

If dangerous rhythms are detected then the ICD is able to deliver a shock to the heart. This resets the heart rhythm and can save the person's life. Some patients need leads that go to their heart in order that the ICD can 'pace' the heart (like a pacemaker). However, this is not always necessary and then a subcutaneous sICD may be appropriate. This uses leads which pass under the skin around the outside of the chest wall and do not need to enter the heart.

How are ICDs implanted and how long until patients can go home?

For any particular patient, the treating cardiologist will discuss the best type of device and lead configuration depending on their needs. Implantation of ICDs is done either with local anaesthetic and sedation or with general anaesthetic. The operation usually takes between one to three hours and the patient can go home within 24 hours.



IF **DANGEROUS RHYTHMS**
ARE DETECTED THEN THE **ICD**
IS ABLE TO DELIVER A
SHOCK TO THE HEART

What can people expect after ICD surgery?

After ICD surgery certain lifestyle changes may be required. However, many patients are able to lead full and active lifestyles with devices in place. The device is monitored periodically and generator changes are required at intervals in order to replenish the battery. Further information is available on the British Heart Foundation website.

Dr Nick Linton is a leading consultant cardiologist who, having obtained a Master's degree in Engineering, Economics, and Management at Oxford University, decided to go into medicine and, specifically, cardiology. He is one of London's top specialists in general cardiology, the treatment of irregular heart rhythms and the use of implantable cardioverter defibrillators. Working alongside other specialists at Imperial College, and employing the use of his engineering background, he invented a new and innovative mapping system, and now continues to focus his research on atrial and ventricular arrhythmias. 🧑‍⚕️



CARDIOLOGY

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Heart murmur in babies and children

A common worry for parents of young children

Unusual noises from a child's heart can be a cause for concern for parents, but are all heart murmurs a serious problem?

Heart murmurs are very common in children. They are extra noises from the heart, heard with a stethoscope. They may represent an underlying heart problem or may be a normal finding (innocent). They are frequently heard incidentally when a child is taken to the GP or another doctor for a different reason e.g. a fever. A child with a heart murmur is usually assessed with a clinical examination followed by an echocardiogram (heart ultrasound) and an electrocardiogram (ECG).

Innocent heart murmurs

Sometimes in our homes we hear the sounds of water in our radiators and water pipes without there being a problem. Similarly, extra noises may be heard from the heart without there being a problem. These are the commonest murmurs in children and affect up to 1 in 3 children at some time in their life. They may be present one day and not on another day and are often louder when a child is unwell e.g. with a fever. They are a normal finding and do not mean that there is any problem with the heart. They are caused by normal blood flow in the heart and the surrounding blood vessels. The diagnosis is made after an assessment by a paediatric cardiologist. If your child has an innocent heart murmur, they are within the normal range and do not require any medical follow



up or treatment and no restrictions should be put on their activities. In some children, the murmur disappears as they get older and in others it persists throughout life.

Pathological heart murmurs

Other heart murmurs may be due to a problem with the heart. Such problems include holes in the heart, narrow or leaking heart valves, and problems with cardiac structure and function. Even if your child has a pathological heart murmur they may not necessarily require treatment. Mild conditions which cause heart murmurs can be monitored. Management will depend on the underlying condition which can usually be diagnosed with an echocardiogram (heart ultrasound).

What is an echocardiogram?

An echocardiogram, or ECHO, is a scan of the heart using ultrasound. Ultrasound uses very high-frequency sound waves to create accurate images of structures within the body – in this case within the heart, including the heart muscle, chambers and valves. These sound waves are too high frequency for people to hear, but they can be created and detected by special machines. The machine used for echocardiograms is similar to that used for scanning pregnant ladies.

The child needs to be undressed above the waist and lie on the couch. Teenage girls can cover themselves throughout with a sheet and should ideally wear a sports bra.



EXTRA NOISES MAY BE HEARD FROM THE HEART WITHOUT THERE BEING A PROBLEM

Parents usually sit next to their child during the echo. It is a good idea to bring a tablet or mobile phone so children can watch a favourite show or song during the test.

The lights in the room will be dimmed like in the cinema. This makes the pictures on the screen easier to see.

A scanning probe and a special ultrasound gel is put on the child's chest and tummy. Ultrasound waves are sent from the probe towards the heart and then echo ('bounce back') to the machine, creating a moving black and white picture of the heart. The monitor shows colours, which represent blood flow.

Your child may be asked to lie at the end of a pillow and look up while a few images are taken in the neck area, usually at the end of the test.

The result of the echocardiogram is usually given to parents as soon as the scan is completed.

Dr Nitha Naqvi is an award-winning paediatric cardiologist, who specialises in echocardiography and aortopathy, and offers expertise in diagnosis and treating all kinds of heart conditions in children, from congenital heart disease to heart murmurs in babies. 🌟



PAEDIATRIC CARDIOLOGY

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Should I freeze my eggs?

The new treatment revolutionising fertility

Thanks to vitrification, storing eggs for future use is now an option for women all over the world.



Women generally used to get pregnant at an earlier age, but nowadays, as many women delay starting a family, we are seeing an older age group attending fertility clinics for help in getting pregnant. Unfortunately, there is little we can do to help them as the underlying reason for not getting pregnant is poor egg quality due to age. Although lifestyles have changed over the years, unfortunately the human biological

clock has not. This can put pressure on a woman, as they only have so much time before they can no longer have babies.

A common misconception of why many women freeze their eggs is because they want to focus on their career and do not have time to raise a family. This is not always the case, however. Many women freeze their eggs as they do not have a partner, or they have not found the right one with whom they want to settle down and start a family. By

freezing their eggs, they therefore ease the burden of having to find somebody before their biological clock runs out. Not having a partner is one of the main reasons that women choose to have their eggs frozen.



ALTHOUGH LIFESTYLES HAVE CHANGED OVER THE YEARS, UNFORTUNATELY THE HUMAN BIOLOGICAL CLOCK HAS NOT

A woman is born with all her eggs and these are used up every month during menstruation even when she is not trying to get pregnant. At age 33, around 30% of the embryos women create will have chromosomal abnormalities. This has a negative impact on attempts at pregnancy as most of these embryos do not implant, and those that do usually miscarry. By the time women reach 40 years of age, almost 90% of their embryos are abnormal. Their chances of having a successful pregnancy, therefore, are significantly reduced.

Is it, therefore, worth considering freezing eggs in your early 30s to give yourself the best chance of having a baby? Many women will not need to use them because they will most likely meet somebody with whom they want to have a child before they are too old to do so. Consider egg freezing as an insurance policy, and like all insurance policies you hope you will never have to use them. If the necessity

should arise, however, you can be thankful you took out the policy in the first place.

Age is an important factor to take into account when contemplating whether you want to freeze your eggs or not. If you freeze your eggs before you reach 33, you have an 85% chance of getting pregnant when you want to use them. If you wait until 38, the chance of conceiving with your frozen eggs falls to less than 20%. This is a substantial difference, hence the reason specialists recommend that it is best to freeze your eggs sooner rather than later to increase your chances of success.

Egg freezing is not cheap and costs around £4,000 TO £5,000 per cycle, but there are very few risks, and for women who can afford to do so, it is a sensible precaution.

Take home message

Freezing eggs is best done early, preferably before 35, for the procedure to be more effective.

Unfortunately, freezing eggs does not always guarantee a pregnancy.

It is recommended for women who know they will be unable to try to conceive until they are older.

Mr Adrian Lower is one of London's leading consultant gynaecologists and surgeons who specialises in fertility and egg freezing. In 2005 he featured in Tatler's best 150 private doctors in the UK. 



OBSTETRICS & GYNAECOLOGY

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Five lifestyle tips to improve male fertility

“Of course you can improve your chances!”

There is a growing body of evidence that lifestyle is very important to reproductive health for both men and women.

A healthy man is much more likely to have healthy sperm; fertility is the canary in the coalmine of human biology. If there is an underlying health problem it is likely to have an effect on fertility. Thankfully, the quality of your sperm improves as your health does. The first thing a man should do is to make lifestyle changes in order to improve the quality of his sperm.

Five tips which can help you to improve your chances of fertility:

1) Lose weight

Losing weight increases testosterone levels, and some studies show that this alone can improve sperm production.

2) A Mediterranean-type diet

Ensuring an intake of vegetables with antioxidant properties, improves sperm quality.

3) Remember that sperm require lower temperatures to thrive

As you increase your exercise regimes to try to lose weight, remember that wearing lycra, cycling, using a sauna or steam room, or exercising strenuously for longer than 30 mins at a time could be counter-productive.

4) Don't smoke or vape

Smoking definitely, and probably even vaping affects sperm quality. We are now able to look more closely at the DNA in sperm, so that we are beginning to understand what damages sperm, and therefore how to improve sperm quality.

5) Avoid recreational drugs, steroids and some body-building supplements

These suppress sperm production. Many men may have had minor, non-specific, and seemingly irrelevant urethral or other infections, and often these asymptomatic and undetected conditions can be treated with consequent improvement in male fertility.

Male fertility testing

We always like to have more than one semen analysis. This is because there is much biological variation in sperm production, and we cannot be sure that one or even two semen analyses reflect the real situation. Appropriate testing and accurate interpretation of semen analysis results are vital to achieve a reliable diagnosis for male factor infertility. A fully comprehensive semen analysis is performed by an experienced embryologist with a fertility background.

The tests support diagnosis and determining the best course of treatment by providing a detailed description of the overall appearance including:



FERTILITY IS THE CANARY IN THE COALMINE OF HUMAN BIOLOGY



FAMILY

• **The number of sperm present.**

This is important as sperm have to travel an exceptionally long and convoluted distance from the vagina into the Fallopian tubes to meet the egg. If the count is too low, the chances of even one sperm finding the egg is going to be very much reduced.

• **The percentage of sperm that are moving** and analysis of how progressively motile these sperm are (motility). Sperm have to be good swimmers, moving rapidly and in straight lines if they are to be successful in reaching the egg.

• **The shape of the sperm** (morphology) with a detailed breakdown of defects. If sperm

are an abnormal shape this can decrease their ability to fertilise an egg.

• **MAR antibody test (IgA/IgG).** If antibodies are present this can cause the sperm to stick together and reduce the ability of the sperm to fertilise an egg.

• **Presence of other cells** as a marker of inflammation or infection as this may reduce fertility.

• **The quality of the DNA in the sperm**

Never just accept that nothing can be done! See an expert urologist if have any more questions or are worried about your fertility. 🙏

Mr Jonathan Ramsay is a male fertility expert who treats male fertility complaints using a range of new diagnostic tests and surgical procedures, including microsurgical retrieval and testicular mapping.



UROLOGY

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All you need to know about the menopause

Moving on to a new chapter in a woman's life

The menopause usually occurs in a woman's middle age, when her periods stop. It brings a number of physical and emotional changes.

As women live longer, management of the menopause is important to enhance quality of life and minimise the effects of prolonged low oestrogen levels.

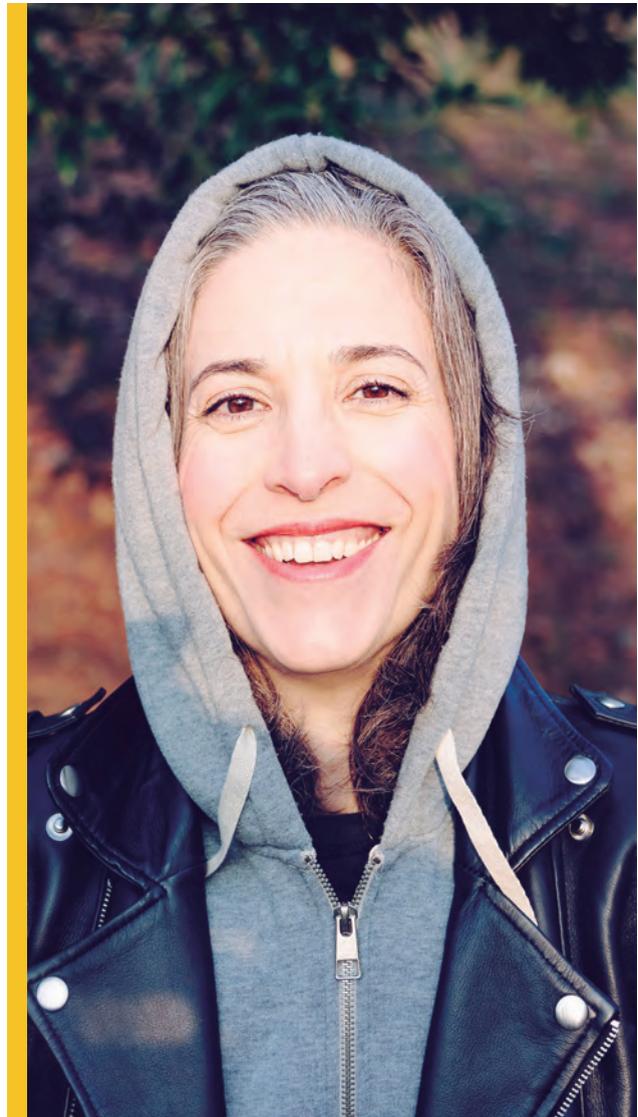
Different terms associated with the menopause

The **menopause** itself is when the last natural period (LNP) has occurred, usually at about age 51. At this time ovarian hormone production has fallen dramatically, but rarely, ovulation can occur. Contraception is advised for one year after the last period if the patient is over 50, or two years if under 50.

Premature menopause is when the LNP occurs under age 45, although those under 40 may have premature ovarian insufficiency (POI). Ovarian damage, e.g. by chemotherapy, radiotherapy, or surgical removal can induce the menopause.

Post menopause is defined as 12 months or more from the LNP.

Symptoms start in the **perimenopause**, i.e. the time leading up to the LNP, and for one year after it. Most suffer with some mix of menstrual changes, hot flushes and sweats, vaginal dryness, low mood or sexual difficulties, but there may be other symptoms. On average, hot flushes and sweats last seven years.



Diagnosis of the menopause is based on age and symptomology for women over 45. Blood follicle stimulating hormone (FSH) is needed for women under 45 and further tests are needed if POI is suspected.

Menopause treatments

Hormone Replacement Therapy (HRT) is the most effective treatment for symptoms and has longer-term benefits, such as maintenance of bone strength. It usually incorporates oestrogen and progesterone, and is available in different forms, e.g. patches, gels, tablets, pessaries and the Mirena coil. Oestrogen can be applied topically to the vagina to relieve dryness. It is important to spend time with each patient, listening to concerns and questions. A review of medical and family history is vital. The gynaecologist should go through the benefits and risks of HRT, enabling and supporting each patient to make a plan for her path through the menopause in an informed way. For many, the benefits of HRT outweigh the risks, but not for all.

Current thinking is that cardiovascular problems may not be as much of a contraindication to HRT as previously thought, thus opening up access to HRT for more women. The risk of breast cancer in patients taking HRT with oestrogen and progesterone goes up with length of use, and gradually reduces after stopping. If using oestrogen alone, there is probably no increased risk. Whatever path is chosen by the patient, support and monitoring (e.g. mammography) should be put in place.

Patients should preferably be seen three months after starting to take HRT, and if all is well, less often thereafter, but always with an open door if issues occur.



WOMEN TAKE HRT TO RELIEVE SYMPTOMS AND FOR LONGER-TERM HEALTH BENEFITS, E.G. OSTEOPOROSIS PREVENTION

Non-hormonal prescription preparations can help, e.g. venlafaxine for hot flushes. Other therapies have some effect, e.g. red leaf clover, but their safety profile is still under review. CBT may also help.

Lifestyle changes, such as a healthy diet, stopping smoking, cutting down on caffeine, and increasing exercise can help.

Menopause management must be individualised and personalised. It should be delivered in an inclusive, empathetic and supportive way, by an expert in menopause medicine and contraception, so that the contraceptive aspect of the menopausal transition is seamlessly incorporated.

Ms Christine Robinson is a consultant community gynaecologist, who is an expert in menopause and contraception as well as the medical management of menstrual and hormone conditions. She was the President of the Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists. 



OBSTETRICS & GYNAECOLOGY

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What are the risks of HRT?

HRT - does it come with complications?

HRT is used to manage menopausal symptoms, but has been associated in recent years with bad press. How true are the stories?



How effective is HRT?

Oestrogen therapy is effective in the treatment of hot flushes in 90% of women, and is considered the gold standard of treatment.

Menopausal HRT is primarily used for the treatment of vasomotor symptoms (those relating to the dilation and constriction of blood vessels), such as hot flushes, sweats, and for the prevention of osteoporosis.

Hormone replacement therapy has received some bad publicity in recent years regarding the risks associated with this treatment. However, recent NICE (The National Institute for Health and Care Excellence) guidelines provide recommendations on the use of HRT, and



HRT CAN PREVENT THE RISK OF FRACTURES TO THE HIP, AND OTHER AREAS, ASSOCIATED WITH OSTEOPOROSIS

distinguish between oestrogen-alone therapy and combined oestrogen and progesterone therapy.

The guidelines also endorse the need for HRT in women with premature ovarian dysfunction (menopause before the age of 40).

Why is HRT needed?

HRT is used in the short term management of the symptoms associated with menopause.

These include hot flushes, night sweats, and the prevention of osteoporosis.

HRT treatment can prevent the risk of fractures to the hip, vertebrae and other bones as a result of osteoporosis.

However, long-term use should be discouraged in women who do not suffer vasomotor symptoms (night sweats, hot flushes) and non-hormonal methods should be used for the prevention of osteoporosis.

What are possible risks associated with HRT?

A Women's Health Initiative (WHI) study showed that HRT treatment can lead to an increased risk of coronary heart disease, stroke, venous thromboembolism and breast cancer in postmenopausal women. Different types of HRT, the mode of application (oral or transdermal) and most likely the dose have different risks attached.

The risk of breast cancer with combined oestrogen/progesterone HRT was related to the duration of the treatment – that is to say, a significant increase in the incidence of invasive breast cancer among HRT users was reported to show after 4 years of use.

Oestrogen alone does not increase the risk of coronary heart disease or breast cancer. Oestrogen which is given via transdermal route (delivered through application to the

skin) is not associated with an increased risk of venous thromboembolism, which is a combination of either deep vein thrombosis or pulmonary embolism (when blood clot blocks an artery in the lungs.)

The risks and benefits of HRT use in an individual woman depend primarily on her age and her individual risk factors. The benefit of taking HRT outweighs the risk in women aged early to mid-50s. After the age of 60 the risk becomes greater than the benefit. The use of HRT should be actively discouraged in women older than 65.

HRT for women with an early menopause

Younger women with premature menopause (before the age of 40) or early menopause (before the age of 45) should take HRT up to the age of natural menopause, which in the UK is around the age of 51.

HRT recommendations

HRT should only be prescribed for the short-term relief of menopausal symptoms and for the prevention of osteoporosis, and should be part of an overall strategy to encourage healthy lifestyle, increase exercise, decrease alcohol intake, decrease smoking and fight obesity.

Hormone replacement therapy is one of **Professor Gordana Prelevic's** main areas of expertise, she is a leading authority on the matter and has a longstanding commitment to patient education through her involvement in patient support groups. 🌱



ENDOCRINOLOGY, DIABETES & METABOLISM

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Facing The World...

...with the hands of a top plastic surgeon

As a trustee of the charity 'Facing the World', Mr Niall Kirkpatrick treats children worldwide who suffer with facial deformities.

Craniofacial plastic surgeons treat a very wide range of conditions in children such as complex facial clefts, abnormalities of skull growth, and a complex range of facial deformities and childhood facial tumours.

Throughout the world children with facial disfigurement find themselves excluded from normal interaction in society. Similar conditions are seen in children everywhere in the world but in developed countries, like the UK, children have access to the treatment that they need.

Facing The World was set up in 2002 so that children with severe facial disfigurement living in countries where they cannot receive help due to lack of training, resources or infrastructure can have access to the quality treatment that they need.

The occurrence of severe facial birth defects is ten times higher in Vietnam than in neighbouring countries and the charity has been sending medical training missions to Da Nang and Hanoi in Vietnam for the past nine years to establish craniofacial centres. These missions consist of teams of expert craniofacial surgeons all of whom donate their time, as do all the Vietnamese doctors.

In May 2017, Mr Kirkpatrick was part of the team in Hanoi treating a 6-year-old girl born with abnormal skull growth and part



of her brain dropping down into her face. Her eye sockets were very wide apart and at different heights so that her eyes looked in different directions. It took ten hours to reshape her skull and to move her brain and eye sockets to the normal, correct position. Now she should be able to grow up without the difficulties that a child with severe facial deformity faces in society.

More about Facing the World

The international charity is also involved in a training program, working with specialist medical teams in Danang General Hospital in Vietnam. Why Vietnam? The country has the

highest incidence of congenital birth defects in the world. These are thought to be due to the use of genotoxic dioxone compounds during the Vietnam War in the 1970s.

The charity also supports surgeons and other medical staff to come to the UK for training. For the past nine years, the UK team has been travelling to Danang General Hospital and Viet Duc Hospital in Hanoi to provide local training and to also treat patients who are not able to be transferred to the UK for medical care. The aim is to provide the training and support necessary to establish a craniofacial unit at the hospital in Danang. This enables the medical teams there to provide specialist treatment for the children and adults of Vietnam who have severe facial deformity and disfigurement.

Within the next five years, the charity aims to establish a series of craniofacial centres in Vietnam, sponsor training missions to hospitals across Vietnam and to train 60 doctors. It is estimated that 18,000 life-changing operations will be performed.

Mr Niall Kirkpatrick is the Chairman, Medical Director and a trustee of the international charity organisation Facing The World. Mr Kirkpatrick is a consultant plastic surgeon at The Consulting Suite and was previously the head of the Craniofacial Unit at Chelsea and Westminster Hospital. He is highly recognised for his specialisation in techniques such as craniofacial reconstruction, craniomaxillofacial trauma, head and neck reconstruction as well as cosmetic surgery, among many others. 🌍



MANY CHILDREN HAVE BEEN TREATED FROM AROUND THE WORLD BY THE FACING THE WORLD TEAM



FAMILY



PLASTIC SURGERY

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Water in the kidney – what does it mean for babies?

The condition affects around 1/500 pregnancies

Hydronephrosis occurs when one or both kidneys stretch and swell because of a build-up in urine.

What is hydronephrosis and how is it diagnosed?

The term 'hydronephrosis' derives from 'hydro' (water) and 'nephro' (kidney) and in medical terms, means 'water in the kidney'. It is a term used to describe the appearance of the kidney on an ultrasound scan, but is not a diagnosis. Hydronephrosis is most commonly seen on antenatal scans in pregnancy, affecting around 1 in 500 pregnancies, or on kidney scans done when babies or children are investigated following a urine infection.

What causes hydronephrosis?

The most common causes of prenatally-diagnosed renal tract abnormalities are:

- A transient, self-limiting swelling due to the increased fetal urine output in the third trimester of gestation.
- A blockage at the level of the kidney (pelvi-ureteric junction obstruction) or bladder (vesico-ureteric junction obstruction).
- A blockage to the outflow of the bladder (posterior urethral valves).
- A backflow of urine up into the kidney (vesicoureteral reflux).

Occasionally hydronephrosis is seen in 'duplex' systems, where the kidney has two parts to it and two ureters, and may also drain into a bladder cyst (ureterocoele). Hydronephrosis discovered following a



urine infection may also be caused by these conditions.

Does it cause symptoms?

Mild, self-limiting hydronephrosis is not an infection risk and does not cause symptoms. Hydronephrosis caused by a blockage or reflux may result in urine infections, pain in the flank, or a poor urinary stream.

How is it treated?

In cases which are prenatally-diagnosed, the newborn babies are usually started on a very low dose of prophylactic (preventative) antibiotic every evening. The antibiotic protects the baby against urinary tract infections (UTI) until necessary investigations are carried out. It is not a treatment, and the dose given will not harm the baby, affect its immunity, or give it any side effects.

On the other hand, a urine infection in a newborn, when the kidneys are still developing, can be very serious. The timing and type of scans organised will depend on whether the swelling affects one or both kidneys, and whether it affects the ureters (tubes leading from the kidneys to the bladder) and the bladder itself.

In the majority of cases, the babies are discharged home and brought back for their scans at 1-2 weeks of age. In a few cases, in particular in boys with swelling of both kidneys and bladder, the baby will require admission for a few days until the scans are done.



HYDRONEPHROSIS IS MOST COMMONLY SEEN ON ANTENATAL SCANS IN PREGNANCY

The most common investigations requested are a cystogram (to look for kidney reflux or a blockage) or a nuclear medicine scan to check the function of the affected kidney. Once a diagnosis is made, your doctor will advise what happens next. Most cases will not require surgery, however, the minority that do will be discussed with you in detail and the surgery is usually straight-forward when carried out by an experienced paediatric urologist.

Does it affect kidney function?

In the majority of cases, the child's kidney function is completely normal. Occasionally, the affected kidney has reduced function, and this can usually be preserved with appropriate treatment. If the condition affects both kidneys, or a solitary kidney, then the kidney function may be reduced and will require long-term follow-up: this is commonly seen in boys with posterior urethral valves.

Miss Marie-Klaire Farrugia is a consultant paediatric urologist in Chelsea & Westminster and the BUPA Cromwell Hospital. She is specialised in fetal and perinatal urology and runs prenatal-counselling and postnatal clinics covering the North West London network of hospitals. 🌟



PAEDIATRIC UROLOGY

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Seeking help for mild memory problems

What to do when you can't quite recall

Forgetfulness as time goes by is common amongst many of us, but sometimes it is necessary to seek professional medical help



There has been a dramatic increase in dementia awareness over recent years, with more and more research being done into this often tragic condition as scientists try to find a cure. They are still a long way off, however, despite the progress being made in understanding how the human brain works.

The emphasis from government initiatives has been on early diagnosis, although available treatments have only a small effect on symptoms. Due to this raised awareness, conditions involving forgetfulness are more ingrained in the collective consciousness of the general public. People in their middle ages and beyond are increasingly aware of even minor changes in their memory and are often concerned that they might have

early signs of dementia, but do not know how or when to seek help.

Dementia is a broad term describing a syndrome of problems with memory and thinking that impair a person's ability to perform their normal daily activities. There are many brain diseases that cause dementia; the most common is Alzheimer's disease. The pathological brain changes of Alzheimer's disease begin 10 to 15 years before a person shows any symptoms, the earliest of which are usually problems with short-term memory. Perhaps it starts with them not remembering where they left their keys, or what they had for breakfast.



PERHAPS IT STARTS WITH NOT REMEMBERING WHERE THEY LEFT THEIR KEYS, OR WHAT THEY HAD FOR BREAKFAST

Over time, other areas of memory and thinking and day to day activities are affected to the point that sufferers in the advanced stages are no longer able to remember names or even recognise those most close to them much to the dismay of friends and family. Nobody wants to witness this happening to their loved ones, or notice the first signs of it happening to themselves. General signs of more serious memory problems to watch out for are when somebody gets lost in a familiar place, is unable to follow directions, asks the same question again and again, and no longer knows how to look after themselves.

People with mild memory problems without dementia are often diagnosed as having Mild Cognitive Impairment (MCI) and are not actively treated; current convention is that Alzheimer's disease is diagnosed only when a person develops dementia. However, practice is shifting to include 'Alzheimer's disease without dementia' – identifying people with MCI due to early Alzheimer's disease pathology. New brain scanning techniques also allow us to identify Alzheimer's disease brain changes even before memory difficulties are present. Although people with MCI are more likely to develop memory conditions such as Alzheimer's, a bit of mild forgetfulness here and there isn't always necessarily a sign of a more serious problem.

There are a number of things people with mild memory problems can do to try and improve their memory. Things such as learning a new skill, spending time with friends and family, resting well and avoiding excess alcohol are all ways one can help their memory.

Anyone concerned about their memory can tell their doctor and may be referred to a memory clinic for assessment. If you are told that there is no cause for concern or that you have MCI, you may be able to access further in-depth assessment and to take part in clinical trials of potential new disease-modifying treatments targeting the earliest stages of Alzheimer's disease.

Dr Emer MacSweeney has a special interest in neuroradiology of cognitive impairment disorders, including dementia. She is a leading authority in this area, heading an expert team at Re:Cognition Health. 



NEURORADIOLOGY

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Cervical cerclage to prevent pre-term delivery

How can doctors prevent early birth?

In pregnancy, a woman's cervix can shorten or open too early, causing miscarriage or pre-term birth. How can this be corrected?

What is cervical cerclage?

Cervical cerclage is a surgical procedure to insert a stitch to the cervix (neck of the womb) to try and keep it closed. It can be either performed at about 12-15 weeks into the pregnancy, when there is history of previous preterm deliveries or late miscarriages, or later in pregnancy when there is shortening of the cervical length on scan or cervical dilation. There are occasions when we perform cervical cerclage before pregnancy.



THE **CERVIX** SHOULD REMAIN CLOSED UNTIL LABOUR OCCURS AT OR **AFTER 37 WEEKS OF PREGNANCY**

There are 2 main types of cerclage and usually one type will be recommended to you depending on your specific needs. Transvaginal cerclage (Macdonald and Shirodkar cerclage) is performed by operating from the vagina, whereas transabdominal cerclage involves a bikini-line cut to the abdomen. An occlusion stitch is sometimes inserted vaginally and offered to some women undergoing cervical cerclage.

Why do it?

The cervix should remain closed until labour occurs at or after 37 weeks of pregnancy. In

some women it opens early and, depending on the number of weeks of pregnancy, this may result in a late miscarriage or premature birth.

How do I know if I should have cervical cerclage?

If you have had a previous pregnancy which has resulted in the loss of a baby, a premature birth or if you have had significant cervical surgery in the past, you will be assessed by your doctor, who will look at the length of your cervix and whether or not it is open. They will discuss whether you require a cervical cerclage or whether the cervical length needs to be monitored with scans.

How is it done?

An anaesthetist will discuss pain relief for the operation. This is usually a spinal anaesthetic for transvaginal cerclage and a general anaesthetic for transabdominal cerclage.

A spinal anaesthetic involves the injection of a local anaesthetic into the middle of your back and means you feel no pain in the lower half of your body. You are awake for the operation, will be unable to move your legs much for approximately 4 hours afterwards and will have a catheter inserted for the duration of this time.

What are the risks?

There is often a small amount of bleeding from the vagina at the time of the operation

and for several days afterwards. The risk of infection is lowered by giving you a dose of antibiotics during the operation.

A more serious risk is that the pregnancy membranes are ruptured by the stitch needle and if this happens the pregnancy is likely to miscarry. This is rare when cervical cerclage operations are done as planned operations (risk is probably less than 1%). There is also a very small risk of bladder injury at the time of the operation.

It is important to remember, that despite a stitch, some women still go on to deliver their babies early, which may result in premature birth or miscarriage.

What happens afterwards?

Your follow up will be arranged in the antenatal clinic. If your waters break, you

develop an offensive discharge from the vagina or if you have regular contractions or severe abdominal pain you should tell your midwife, or call the labour ward. If there is infection inside your womb, or you are in labour, the stitch will normally be removed.

If everything goes well and you have a transvaginal stitch, this will be removed through the vagina at 36-37 weeks. After the stitch is removed, women may go into labour after hours, days, or even weeks. If you have an abdominal stitch you will need a caesarian section. The stitch can be removed at that time if you are not planning any further pregnancies.

Dr Vasso Terzidou heads a specialised prematurity clinic, providing support and highly-skilled obstetric monitoring for women at risk to deliver preterm. She is known for offering the highest level of care. 🌟



OBSTETRICS AND GYNAECOLOGY

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HPV: what is the human papilloma virus?

We find out how an infection can be detected

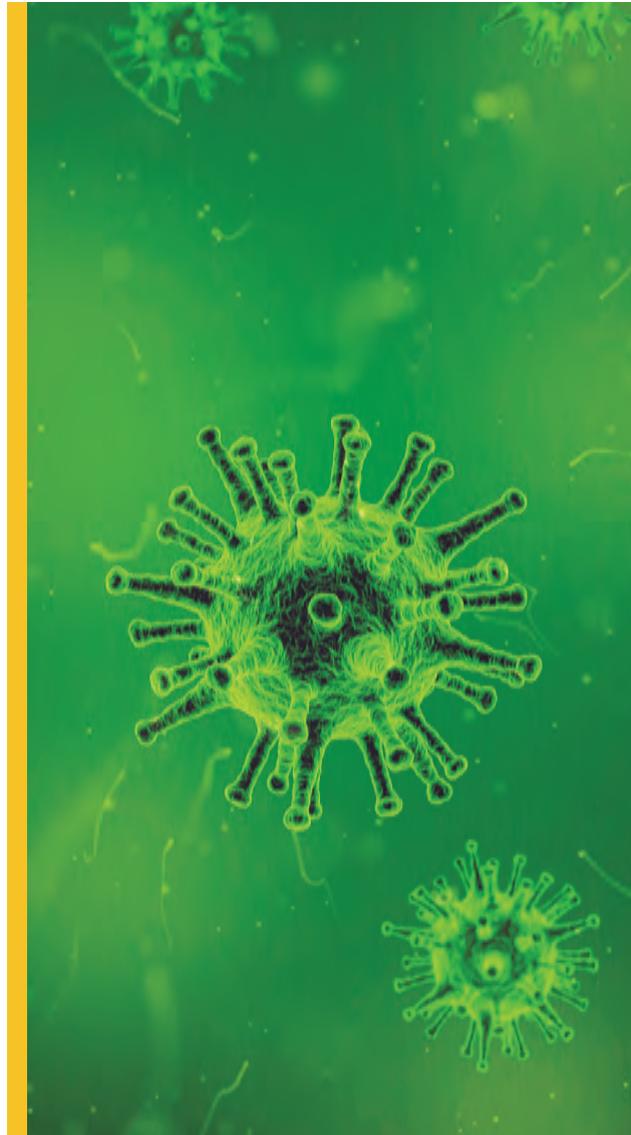
HPV often shows no symptoms, which is why awareness and regular check-ups are important

The human papilloma virus, or HPV, is a family of common viruses that, in addition to causing warts on the feet, hands, and genitals, can cause pre-cancerous and cancerous changes of the cervix, vagina, vulval and anal skin. Many don't display symptoms if they have it, and the body can even rid itself of certain types of HPV, but it is important to be aware of the causes and risks. Mr Rahul Nath, a leading London gynaecologist, tells us more.

How is HPV caused?

HPV lives in cells found on the skin's surface, called epithelial cells. There are many types of HPV which can be classified into types that affect humans, or animals. The types that can affect humans are divided into low risk types that are associated with skin wart formation, and higher risk subtypes that can lead to pre-cancerous or cancerous change. In women, HPV infection most commonly causes wart formation on the vulva or precancerous changes of the cervix, but less commonly warts can be found on the vagina, cervix or anus and pre-cancerous changes can be found on the vulva, vagina, or, rarely, the anus. In men the commonest presentation of HPV infection is with warts on the head of the penis.

Infections of the genital area are extremely contagious, which is why genital warts are the most common sexually transmitted viral infection in the UK.





HPV INFECTIONS OF THE GENITALS ARE EXTREMELY COMMON AND ARE TRANSMITTED THROUGH SKIN CONTACT

What are the symptoms of HPV?

The HPV infection may not display any symptoms at all, and many people do not know that they carry the virus. However, the most common sign of the HPV infection is warts, in many different shapes and sizes. They could be flat, or raised, a singular wart, or a collection of warts together. They can be large or small, and grow in various places on the body, as mentioned above. Women may be identified as having the HPV infection when they have a cervical smear performed.

Can HPV lead to cancer?

There are some types of HPV that are linked to cancer. These high-risk types last longer, and can cause abnormal tissue growth or changes in cells that may lead to them becoming cancerous. Nearly all cases of cervical cancer are caused by HPV.

How can this be prevented?

Teenage girls (age 12-13) are now being offered a vaccination against HPV, which helps protect against cervical cancer as a result of HPV. Women are offered cervical screening to check for abnormal tissue or cells in the cervix.

In men, HPV infection is usually transient and is cleared naturally by the immune system. Men who have an impairment of their immune system - such as those who have HIV infection, or have had an organ transplant are at risk of persistent HPV infection that can lead to HPV related cancer formation. It is very difficult to diagnose high-risk HPV, as it does not carry any symptoms.

The use of condoms cannot eliminate the risk of contracting an HPV infection, but it decreases the chance of passing it on during vaginal, anal, and oral sex.

Is there a cure for HPV?

There is currently no cure for the infection, but warts, growths, and cell changes (e.g pre-cancerous changes) can be treated. Your doctor may choose to treat the warts using various methods such as topical application of a cream, cryotherapy (freezing the cells with liquid nitrogen), or burning the area with an electrical current. Pre-cancerous changes of the cervix can be treated easily and simply, often as an outpatient.

Remember to get regular check-ups, especially if you are sexually active, and visit your doctor if you are worried and would like a test for HPV.

Dr Rahul Nath is a leading authority on the HPV virus, which is just one of his areas of expertise. He is widely published on the topic and has won numerous awards for his research. 🌟



GYNAECOLOGY

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Everything you need to know about dental implants

Substituting your natural teeth

The treatment that can restore your smile and confidence in just a few months.

An implant is a substitute for a natural tooth that cannot be saved. Implants are made up of three parts:

- **The implant fixture** - this is like a tooth root replacement
- **The abutment** - joining piece between implant fixture and restoration
- **The restoration** - crown, bridge or denture

Implants provide a solid foundation for fixed or removable replacement teeth.

How long does the process take?

The process for a single tooth implant usually takes three to four months.

Do you have to live with a gap during the process?

There is no need to worry about your appearance during the process. Temporary teeth can be fitted so no one will know you have a missing tooth. If the implant is not in a noticeable place or you don't want to



temporarily fill the gap, the titanium implant is not visible as it is usually below the gum line.

How long do implants last?

Well-maintained implants, like your natural teeth, will last for many years with good home care and regular check-ups. They are as vulnerable to gum disease as your own teeth so attending regular hygiene appointments may be necessary. As always, it is very important to maintain your own dental hygiene to avoid any oral problems.

Are implants always possible and suitable?

If you still have a viable tooth, it is preferable to save the natural tooth whenever it is possible. However, if the tooth cannot be saved, an implant can offer a lasting fixed-in solution. We always like to look at the full range of options when replacing a missing tooth as no single approach is a panacea. For some people, a bridge, where a tooth is attached to adjacent teeth, can offer a better solution than having a dental implant put in. Other people will find that accepting a gap or wearing a denture is better suited to their overall needs. It is always a question of finding the right solution for any individual.

What are the advantages of dental implants?

There are many advantages to benefit from by having dental implants put in. Firstly, having dental implants can greatly improve



TEMPORARY TEETH CAN BE FITTED SO NO ONE WILL KNOW YOU HAVE A MISSING TOOTH

one's appearance. The fact that they feel like your own natural teeth is an added bonus. As the implants eventually fuse with the jaw bone, essentially becoming a part of you, they fit as comfortably in your mouth as your own teeth. Other types of dentures can make eating difficult. Implants, however, allow you to eat as normal; with confidence and without pain. Also unlike dentures, implants are designed to be durable and can last many, many years. As well as improving your self-esteem, implants can also improve dental health, as nearby teeth are left intact.

To find out whether dental implants are the right choice for you, get in touch with a specialist.

Mr Greg Finn is a specialist prosthodontist based in London. He offers the full range of dental care from preventive care to full mouth reconstructions. Outside of his practice, Mr Finn is dedicated to passing on his knowledge to other dentists and student dentists, lecturing and speaking at both national and international conferences and meetings. 🌍



DENTISTRY

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Heart failure – what is it, and what does it mean?

The causes and symptoms of heart failure

Dr Duncan Dymond, leading London cardiologist talks to Top Doctors about heart failure, what it is, and how it can be treated.

The term 'heart failure' refers to the heart not being able to meet the demands of blood circulation, due to the heart muscle failing to contract properly. It is a condition where congestion occurs in the lungs and tissues because of improper heart function. A more recently discovered type of heart failure is diastolic heart failure, which is a reduction in performance of one or more of the heart's ventricles.

It is not the same as a heart attack (cardiac arrest), which is a rhythm disorder, and it is possible to have a heart attack without having heart failure.

What are the symptoms of heart failure?

The symptoms of heart failure are related to the formation of a build-up in pressure due to the heart not being able to pump sufficiently.

With failure of the left side of the heart, the lungs can become congested with fluid, like a wet sponge, making it more difficult to move. The first symptom is usually breathlessness, which can be present when climbing stairs or walking up an incline and as it gets worse, it can cause breathlessness while walking on just a flat area, or doing regular tasks. As the lungs become increasingly congested, the patient will have difficulty lying flat, as this causes the lungs to fill with fluid, and they will have to sleep sitting up.



THE FIRST SYMPTOM IS USUALLY **BREATHLESSNESS** WHICH CAN BE PRESENT WHEN **CLIMBING STAIRS**



When the right side of the heart fails, the peripheral tissues become congested. The most common symptoms are swollen ankles, swollen abdomen due to enlarged liver, and fluid at the base of the spine. The patient may also become very fatigued and lethargic, feeling completely without energy.

What are the causes of heart failure?

There are a number of conditions that damage the heart muscle and can lead to heart failure:

- Blocked coronary arteries, which supply the heart with blood
- Disease of the heart valves
- Abnormalities of the heart muscle, known as cardiomyopathy
- Drinking too much alcohol, and the use of certain drugs
- Some viruses can damage the heart muscle
- Underlying causes such as anaemia can require the heart to do more work or can affect the heart rhythm
- Atrial fibrillation, in which the upper chambers of the heart go out of rhythm
- Long-standing untreated high blood pressure can cause heart failure if not treated properly

What are the available treatments for heart failure?

There are several different options available to treat heart failure. Firstly, it's important

to correct the underlying causes such as anaemia, rhythm disorder and high blood pressure, and it's important for the patient to reduce salt intake.

Drugs known as diuretics, more commonly known as water tablets, which cause the kidneys to remove excess liquid and clear congestion, can be taken orally or intravenously.

Several groups of drugs like ACE inhibitors, beta blockers and nitrates, can have beneficial effects and ease the load on the strained heart.

There are also some devices that can be used to improve the function of the heart:

- A special kind of pacemaker called a resynchronisation pacemaker forces the chambers of the heart to beat more synchronously and improve function.
- The pacemaker can often be combined with a defibrillator device which will administer a life-saving electric shock if a patient goes into an unstable life-threatening rhythm.
- In certain circumstances, surgery may be the best choice to correct an abnormal valve or to bypass the coronary arteries.

Mr Duncan Dymond has carried out pioneering research in the field of cardiovascular disease, including publications on heart failure. He performs a variety of invasive and noninvasive surgeries to treat heart conditions. 🏥



CARDIOLOGY

Dr Duncan Dymond MD FRCP FACC FESC

Consultant Cardiologist, Wellington Hospital

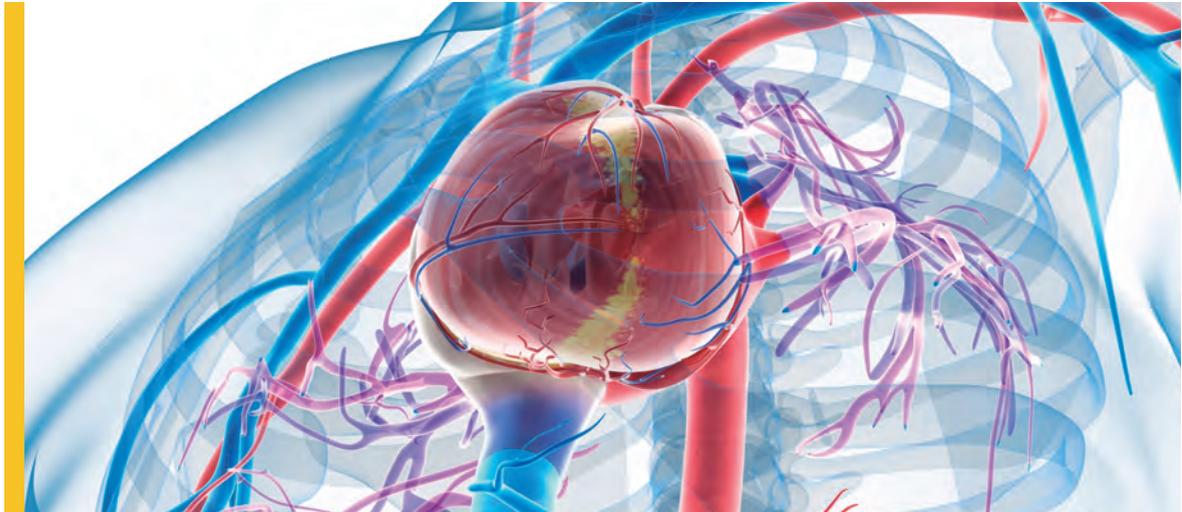
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Correcting abnormal heart rhythms

Cardiac ablation surgery: what is it?

Dr Martin Lowe, leading consultant cardiologist, talks us through what cardiac ablation surgery consists of.



The heart has its own inbuilt electrical system, which sends signals throughout its upper and lower chambers, and helps it to beat in a regular rhythm. Sometimes the conduction pathway becomes blocked or damaged, which can cause the heart to beat too quickly, slowly, or at an irregular rhythm.

Cardiac ablation surgery is used to correct abnormal rhythm problems by treating abnormal electrical tissue in the heart by burning or freezing the tissue to restore a normal heart rhythm. Cardiac ablation surgery is sometimes an option for patients who have taken medication without any effect.



**CARDIAC ABLATION SURGERY
CAN BE AN OPTION FOR PATIENTS
WHO HAVE TAKEN
MEDICATION WITHOUT EFFECT**

What does the cardiac ablation procedure consist of?

The procedure consists of gently passing electrodes through a vein at the top of the leg (the groin area) until they reach the correct position in the heart. The problem area of the heart where irregular signals are being emitted will have been identified prior to the procedure, and once the abnormal electrical circuit is

found, the ablation electrode or catheter is used to burn or freeze the tissue inside the heart. Either heat energy is applied (radiofrequency), or cold (cryo), through a catheter, which is a very thin flexible wire that can be placed directly onto the area responsible for the arrhythmia in the heart. This modifies the abnormal tissues in the heart to prevent irregular signals.



THE PROCEDURE GENTLY PASSES ELECTRODES THROUGH A VEIN AT THE TOP OF THE LEG TO THE HEART

The surgery usually takes between one and four hours, depending on the type of procedure. It is carried out under local or general anaesthetic, which means the patient is not awake during the procedure. The procedure is often carried out as a day case, but it can sometimes be a short stay procedure, where the patient stays in the hospital overnight afterwards

Which conditions are treated with cardiac ablation?

Cardiac ablation can be used to treat a full range of heart rhythm problems, the main ones being atrial fibrillation, heart flutter (otherwise known as heart palpitations, where you feel your heart is beating too hard, or too fast), supraventricular tachycardia (SVT) and ventricular tachycardia.

What are the risks of cardiac ablation?

There is a small amount of risk associated with cardiac ablation which will be explained

by the doctor prior to surgery. Small risks include bleeding where the catheter is inserted, bruising, and the possibility of blood collecting under the skin (haematoma).

In some cases, it is possible that a pacemaker is needed if the heart goes too slowly following ablation surgery.

Patients will most likely feel tired following surgery, but most people will be back to normal after a couple of days.

Although there are some small risks, the benefits of surgery outweigh the risks associated with heart rhythm irregularities.

What happens after the procedure?

Quality of life is generally improved for patients who have undergone a cardiac ablation procedure. It is an effective procedure which can successfully stop abnormal heart rhythm, or prevent it from recurring.

After the procedure, it's important for the patient to lie flat on their back for a few hours – an overnight hospital stay may be advised. After a few days, the patient can expect to start feeling normal again, and commence daily tasks without trouble. The doctor or specialist will advise aftercare, and what precautions should be taken. Recovery from the procedure is normally fairly quick and painless.

Dr Martin Lowe specialises in using cardiac ablation surgery to treat arrhythmias in adults and children, he is also committed to ongoing research in this area. 🌐



CARDIOLOGY

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Practical tips to tackle indigestion

Acid reflux is avoidable

Indigestion has many different interpretations including heartburn, reflux, and discomfort in the chest and upper belly.

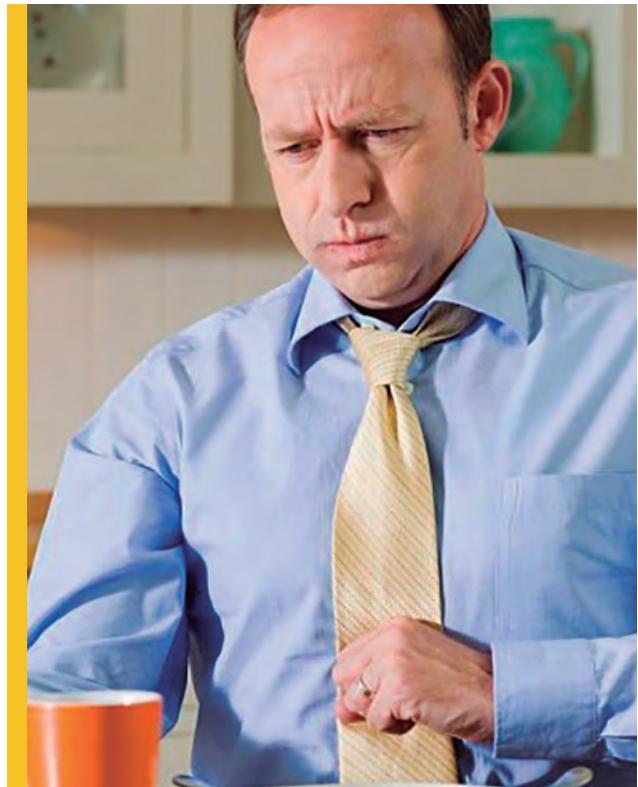
The symptoms include chest pain, heartburn, belching and regurgitation. It may be caused by acid reflux (regurgitation of acid from the stomach into the gullet) or other rarer oesophageal or stomach (gastric) problems. It is very common but it's rarely dangerous. At least one in three people suffer from one of these symptoms. Heartburn occurs due to a poorly functioning valve at the bottom of the gullet often related to a hiatus hernia (movement of the stomach into the chest cavity).

Acid reflux can cause Barrett's oesophagus, a condition which can lead to cancer of the oesophagus. It is caused by the oesophagus being regularly exposed to regurgitating stomach acid, which damages it, causing the normal pink lining to be replaced by a salmon coloured intestinal-type.

Five lifestyle tips to avoid indigestion

1) Avoid eating late

Leave at least 4 hours before going to bed if you have had a heavy meal. Eating at night substantially raises your risk of acid reflux. You produce more stomach acid after a meal and the valve between your stomach and your oesophagus also relaxes. If you're lying down relatively soon afterwards, acid is more likely to get into your gullet.



CUT DOWN ON OR CUT OUT
CAFFEINATED DRINKS,
DECAFFEINATED OPTIONS ARE
NOW WIDELY AVAILABLE

2) Avoid large, heavy meals

High-fat meals delay stomach emptying and increase reflux

3) Avoid irritating foods

Such as those high in spices (chilli), vinegar and citrus fruits/juices as they increase the amount of acid in your gut

4) Avoid caffeine

Cut down on or cut out caffeinated drinks, decaffeinated options are now widely available. Both coffee and tea relax the lower oesophageal sphincter, which prevents the backward flow of stomach contents that causes reflux.

5) Reduce alcohol consumption

Alcohol, like caffeine, relaxes the lower oesophageal sphincter, allowing stomach contents to reflux back up into the oesophagus, it also increases the production of stomach acid.

Medicines to treat indigestion

Antacids can reduce symptoms rapidly. Take them when your symptoms are most common, for example after food or before bed. Medicines which reduce acid production include ranitidine (an H2 antagonist) and omeprazole (a proton pump inhibitor or

Dr Matthew Banks is a consultant gastroenterologist at University College London Hospitals (UCLH) where he leads the largest Barrett's oesophagus centre in the UK which undertakes ground-breaking

PPI). These are best taken 30-60 minutes before food for the best effect. They can be bought in low dose in pharmacies but need a prescription for higher doses. If any of your symptoms persist despite treatment, or you are older than 40 and the symptoms are new, we would suggest seeing your doctor, and, if necessary, a specialist gastroenterologist.

Anti-reflux surgery

Anti-reflux surgery appears to be most effective for patients who respond well to the proton pump inhibitor. It is therefore ideal for patients who do not want to take tablets or are unable to tolerate tablets. It is also useful for symptoms not responding to PPI therapy such as regurgitation, acid brash and belching. There are, however, side effects after surgery and, rarely, some serious complications – however, this is true of many surgical procedures and your doctor will always discuss possibilities before any operation.

research. He is a faculty member on the largest live endoscopy conferences in the UK (London Live Endoscopy) and frequently facilitates endoscopy courses for consultants. 🌐



LEAVE AT LEAST **4 HOURS**
BEFORE GOING TO BED IF YOU
HAVE HAD A **HEAVY MEAL**



GASTROENTEROLOGY

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Wear and tear and rotator cuff injuries

Symptoms, causes, and treatments explained

A painful injury to the shoulder caused by overuse, arthritis, or age. Find out why it happens and how it can be treated.

The rotator cuff refers to a group of muscles and tendons surrounding the shoulder joint, which keep your upper arm bone in the socket of the shoulder. An injury to the rotator cuff often causes an ache in the arm, which can get worse with stretching, such as when sleeping on the injured side, or when reaching out to pick up an object. Mr Simon Lambert, top orthopaedic surgeon based in London, and specialist in

shoulder and elbow surgery, talks to Top Doctors about rotator cuff injuries.

What are the causes of rotator cuff injury?

The rotator cuff often wears out over time: most people over the age of 60 have some degeneration of the tendons of the cuff. Injury, through overhead exertion or over-reaching, is more common as we get older. However, the tendons can be damaged by repetitive or excessive over-loading at any age.



Rotator cuff pain and symptoms of injury

If you suffer a rotator cuff injury you may experience an aching pain in the side of the upper arm which continues throughout the day, and makes certain activities difficult and painful, such as reaching behind your back, or brushing your hair. You may also feel that your arm is weaker than usual. Commonly your sleep may be disturbed by a similar pain, which has a burning quality. It is not easy to make a diagnosis of a rotator cuff tear simply by considering the symptoms: if your pain lasts longer than a couple of weeks even with simple painkillers and rest, you should see a shoulder specialist (physiotherapist or doctor). They will suggest investigations and consider a management plan with you to reduce the chance of progression of the rotator cuff problem.

Rotator cuff surgery and treatments

Most problems with the rotator cuff can be treated without surgery, but ideally they should be treated as soon as possible after the onset of symptoms. Treatment such as medication, guided injections, and physical therapy are the mainstay of management. In some cases symptoms do not improve, and the doctor or specialist may send you for tests such as an MRI or ultrasound scan to see if a rotator cuff tear is present, and if so where and how big it is.

Surgery can often be useful to help recover from a rotator cuff tear. Surgery can be useful in providing pain relief, strength, and better function at any age. Surgery is generally advised for those who have a



IF YOU SUFFER A ROTATOR CUFF INJURY, YOU MAY EXPERIENCE A CONTINUOUS PAIN IN THE SIDE OF THE UPPER ARM

rotator cuff tear caused by sudden injury, or when non-operative treatment has been tried for at least 3 months without success.

The outcomes of surgery are slightly more favourable in younger people, whose tendons are more elastic and healthy. As the rotator cuff gets older it becomes stiffer and the tendons are not so healthy, and so the outcomes for surgery to get the tendon tear to heal are not quite so good. However, much can be done to gain pain relief, even if the tendon does not eventually heal.

The recovery from surgery takes time, whether the operation is done with key-hole (arthroscopic) or open surgery: the tendon heals in the same way and over the same time whichever technique is used. A period of up to three months graded rehabilitation is needed before the tendon tear heals sufficiently for normal activities to resume, although this varies depending on the size and position of the original tear.

Rotator cuff injuries are one of **Mr Simon Lambert's** main areas of interest. He has played an integral role into developing the reputable specialist shoulder rehabilitation service which forms part of University College London Hospital. 🏥



ORTHOPAEDIC SURGERY

Mr Simon Lambert FRCS FRCSEd BSc FRCSEdOrth

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Adhesive capsulitis– frozen shoulder

What is frozen shoulder? How is it treated?

Mr Steven Corbett, one of London's top orthopaedic surgeons, explains everything you need to know about frozen shoulder.

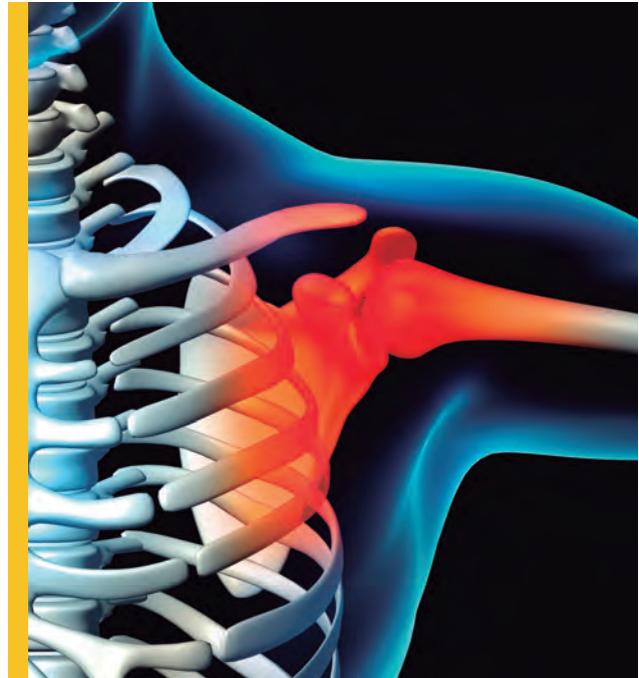
Adhesive capsulitis is a condition in which the body forms scar tissue about the shoulder ball and socket joint capsule (glenohumeral joint). This results in a painful, stiff shoulder with limited function.

The condition can either be:

- primary, whereby there is a progressive loss of motion without any specific trauma or inciting event
- secondary, where it is acquired as a result of an obvious stimulus e.g. following trauma, surgery or systemic illness.

Adhesive capsulitis can be associated with a number of conditions including prolonged immobilisation of the joint, diabetes, neurological conditions, heart disease and lung disease. Both type 1 and type 2 diabetic patients are at increased risk of developing adhesive capsulitis, and they have worse functional outcomes compared to their non-diabetic counterparts.

The condition is more common in women, in the age range between 40 and 60 years, and there may be a genetic predisposition. The condition is usually self-limiting, meaning it will eventually go away by itself, and in many cases frozen shoulder resolves after between one and three years have passed. However, up to 50% of patients may develop longer lasting symptoms.



Traditionally the condition is described in three phases.

- Stage 1 : freezing phase
- Stage 2 : frozen phase
- Stage 3 : thawing phase

In the freezing phase, the shoulder becomes increasingly painful, particularly at night, with progressive restriction in movement.

In the frozen phase, the pain symptoms generally begin to improve but stiffness is maintained.

In the thawing phase, the range of movement is gradually restored to the shoulder.

The treatment of adhesive capsulitis is dependent on the stage, the timing and the patient. That decision may change during the duration of the disease.

Most clinicians would not recommend physiotherapy during the painful freezing stage. However physiotherapy is very important in phase two, the frozen stage, and three, the thawing phase. Anti-inflammatory medication may improve some symptoms but seldom provides satisfactory relief.

Corticosteroid intra-articular injections are often used, particularly during the painful phase. These injections can significantly reduce pain, although there may be a lag period before range of movement improves.

An injection may be combined with a hydrodilatation technique, whereby a large volume of saline (water) is injected with the steroid. The aim of this technique is to stretch the lining of the shoulder.

Surgery can be performed, but this is usually reserved for cases when there are progressive symptoms which go on for longer than three months, or symptoms which are hard to control or deal with lasting more than six months, and where other treatment options have failed.



THE CONDITION IS MORE COMMON IN **WOMEN** BETWEEN **40 AND 60**, AND THERE MAY BE A **GENETIC PRE-DISPOSITION**

Surgical options include an arthroscopic capsular release (otherwise known as keyhole surgery) or a manipulation under anaesthesia.

It should be remembered that whatever treatment is employed, the majority of patients get better, although time scales can be long and variable.

The doctor may also give certain exercises to do once the frozen shoulder is less painful, or refer the patient to a physiotherapist. It should be noted it is not a good idea for the patient to make up their own exercises or strain themselves too much.

With a case of frozen shoulder, it is always important to seek medical opinion.

Adhesive capsulitis is one of the orthopaedic conditions which **Mr Steven Corbett** specialises in. A keen sportsman himself, he helps professional athletes return to top level sport after sustaining upper limb injury. 🙌



ORTHOPAEDIC SURGERY

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Watching your waistline is not just about vanity

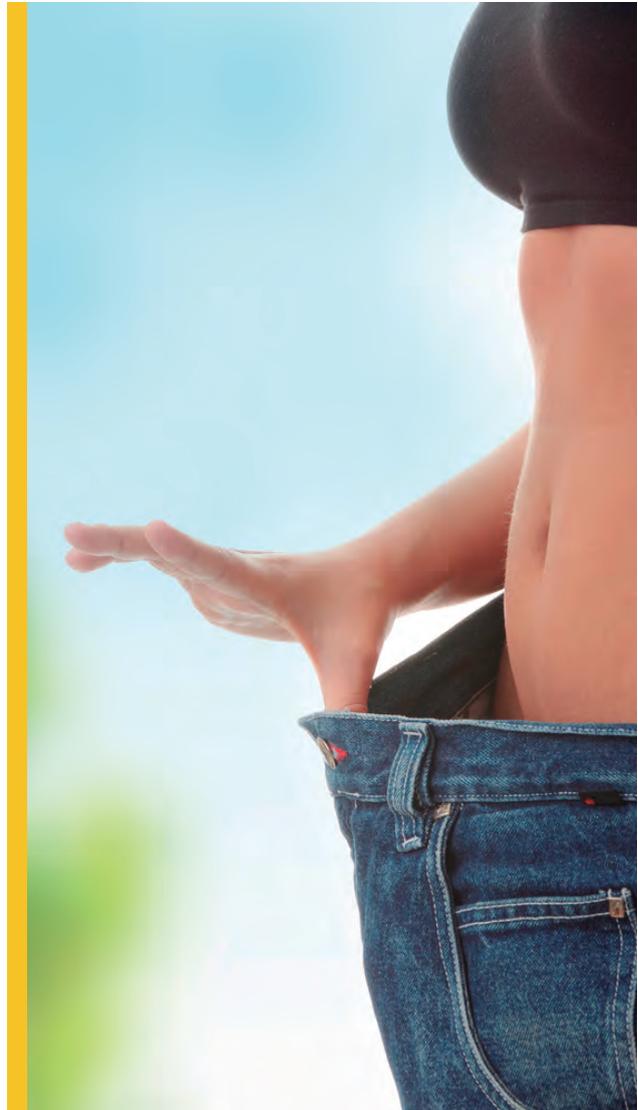
...it's about health too!

The term 'prediabetes' has only been officially recognised relatively recently despite the increased concern about our nation's obesity.

Type 2 diabetes has tripled over the last 20 to 30 years, a worrying statistic. Prediabetes is effectively a pre-diagnosis of diabetes when your blood sugar level is higher than it should be but not yet high enough to be considered to be within the diabetes range. You may also hear this condition being described as IGT (Impaired Glucose Tolerance) which is higher than normal blood sugar after a meal or IFG (Impaired Fasting Glucose) which is higher than normal blood sugar in the morning before eating. Not only will 10% to 20% of those with prediabetes go on to develop type 2 diabetes within 10 years, the risk of heart disease is also doubled.

What causes prediabetes?

People with obesity are five times more likely to be diagnosed with type 2 diabetes, according to a study by Public Health England. If you're overweight, especially if you carry fat centrally around your abdomen, your body is likely to be more insulin-resistant, meaning that it either doesn't make enough insulin or it doesn't use it well. For European men, this applies when the waist is greater than 102cm (40 inches) and for women and Asian men when it's more than 88cm (34.5 inches). And I'm loath to tell you this, but most people actually believe their waist line to be at least 7.5 cm (3 inches) less than it actually is. Sorry!



How is it diagnosed?

Usually diagnosed between the ages of 40 and 70, prediabetes is when your blood sugar level is higher than it should be but not high enough to be considered as being within the diabetes range. It is possible to see that this has happened through a fasting blood test (which is usually taken 10 to 12 hours after your last meal, or when you last ate).

- Ideally your levels should be in the low 5 mmol/L (mmol/L is the measurement used for blood sugar levels, or blood glucose levels)
- If they measure 6-7 mmol/L you are in the stage called 'prediabetes'
- At 7 mmol/L and over you will be diagnosed with type 2 diabetes

Increasingly, a blood test called glycosylated haemoglobin (HbA1c) is now being used to help classify patients with prediabetes or diabetes. This test is the main long-term marker for blood sugar control and assesses blood sugar levels over the preceding three months. It's easier to measure as it's not dependent on whether or not you have fasted. A HbA1c between 42 and 47 mmol/mol (6.0-6.4%) is within the prediabetes range and 6.5% or greater is diagnostic of diabetes.



MOST PEOPLE ACTUALLY BELIEVE THEIR **WAIST LINE TO BE LEAST 7.5 CM (3 INCHES) LESS THAN IT ACTUALLY IS!**

Take control if you have been diagnosed with prediabetes

Fortunately, around 80% of cases can be delayed or prevented by actively pursuing a healthier lifestyle, which entails:

- losing weight. This can be challenging, but making dietary change and sticking to a new exercise routine is normally enough to achieve this
- a low salt, sugar and fat diet which is rich in fruit and vegetables
- being more physically active and taking moderate exercise, such as walking 30 minutes per day for 5 days a week

Dr Mark Vanderpump has clinics at The Physicians' Clinic, BUPA Cromwell Hospital, Wellington Hospital, and Chelsea Out-Patient Centre in London. He has published widely in his main area of expertise of thyroid disease but his clinical practice includes all aspects of diabetes and endocrinology. 



ENDOCRINOLOGY, DIABETES & METABOLISM

Dr Mark Vanderpump MD FRCP

Consultant Physician and Endocrinologist, The Physicians' Clinic
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Alcoholic liver disease and alcohol dependency

The effects of excessive drinking over time

New government guidelines recommend that both men and women should not drink more than 14 units of alcohol per week.



The risks of excessive drinking

The risks associated with drinking alcohol excessively over a sustained period of time include the development of alcoholic liver disease, increased risk of cardiovascular disease, high blood pressure, strokes, chronic pancreatitis, pancreatic cancer, as well as a doubling of the risk of developing breast cancer, and a five-fold higher risk of developing throat cancer. It is estimated that 9% of men and 3% of women are alcohol dependent,

though many more have alcohol related issues and may be classed as an alcoholic. If you have an alcohol addiction you may find that drinking has become an important, or perhaps the most important, factor in your life and you may feel unable to function without drinking.

Who is at risk?

In general it is only people who drink excessive alcohol regularly for many years that develop alcohol-related liver disease, but everyone is

different. Some people drink vast amounts of alcohol and have an unscathed liver, while others develop alcohol-related cirrhosis after a few years of less heavy alcohol consumption. The risk factors seem to lie in our genes, as well as our sex (women are more susceptible to alcoholic liver disease than men).

Good news!

The good news is that if you stop drinking early enough, your liver shows an immense capacity to recover. Studies have shown that people who drink an average of 35 units per week, who then go on a one-month alcohol detox, such as 'Dry January' or 'Sober October', experience improved blood pressure, cholesterol, blood glucose, liver function tests and liver stiffness, as assessed by Fibroscan. Importantly their sleep and concentration also improve, and they also lose weight. If there was a drug that could do all of this it would make a fortune! It is highly beneficial for anyone who drinks regularly to give up alcohol for a one month period, it also helps in controlling, and being aware of, the amount one drinks.

NHS Guidelines – alcohol units

It is advised that we shouldn't drink more than 14 units a week on a regular basis. It is also advised that these units should be spread over three or more days (as opposed to binge drinking) and that we should have a few drink-free days a week



IF YOU STOP DRINKING EARLY ENOUGH, YOUR LIVER SHOWS AN IMMENSE CAPACITY TO RECOVER

One unit equals 10ml of pure alcohol, which is the amount the average adult can process in an hour. The number of units in a drink is based on the strength of the alcohol and the size of the drink. Knowing your units will help you stay in control of your drinking. Fourteen units is equivalent to six pints of average-strength beer or 10 small glasses of low-strength wine. A bottle of 13.5% wine contains 10 units.

If you are worried about your liver, you should seek medical help. Professor Moore offers a full liver check-up: 'The Liver Health Screen' and he works closely with a team of therapists who can provide one-to-one counselling to help you deal with any alcohol dependency issues.

Professor Moore is a leading liver specialist, serving as a professor of hepatology at University College London (UCL). He currently leads the Alcohol Care Team at the Royal Free London NHS Foundation Trust and treats patients with alcohol dependency and alcohol-related liver problems such as abnormal liver function, and advanced cirrhosis. 



HEPATOLOGY

Professor Kevin Moore MB BS FRCP BSc PhD

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Skin cancer signs to watch out for

Increasing chances of survival

Skin cancer is the most common type of cancer worldwide. With early detection and appropriate treatment, it can be cured in most cases.

The main types of skin cancer include melanoma, the deadliest type, and non-melanoma which accounts for about 100,000 cases of the disease each year.

Skin cancer rates in the United Kingdom are increasing, with more people dying from the disease here than in Australia. There are an estimated 12,000 cases of melanoma each year, and around 2,000 deaths. It has become the most common form of skin cancer among people in the age bracket of 15 to 34.

Knowing what to watch out for can greatly increase one's chances of survival if it so happens that they develop skin cancer. For this reason, even if you do all you can to stay safe in the sun, it's important to be on the lookout for the early signs of skin cancer. It is worth bearing in mind that around 80% of all cases of skin cancer are caused by over-exposure to dangerous UV radiation from the sun or sunbeds.

As fair-skinned people are much more susceptible to sun damage and therefore skin cancer, it is imperative they know



what to look out for, especially if they have been spending a lot of time on sunbeds or in the sun.

The ABCDE skin cancer guide

It is important to watch out for changes in moles or for the formation of new moles. The earlier skin cancer is detected, the higher the likelihood of cure. The ABCDE guide is helpful, easy to remember, and stands for:

Asymmetry - if the mole is not symmetrical it's best to get it checked out.

Border becoming irregular - benign moles have smooth borders. The borders of early melanoma are usually uneven.

Colour changes - especially uneven and abnormal colour. Most benign moles are just one colour.

Diameter greater than 6mm - benign moles are usually smaller.

Enlargement or elevation - a general sign of melanoma is if a mole changes size over time.

Other signs to keep an eye out for

Melanoma tends to appear as a new lesion more often than developing from a pre-existing mole. A new mole or one which is different to the rest of the surrounding moles should be scrutinised more carefully. Moles which become itchy or bleed may also need to be examined. It is also important to be aware that most skin cancers do not appear as



IT IS IMPORTANT TO WATCH OUT FOR CHANGES IN MOLES OR FOR THE FORMATION OF NEW MOLES

'moles'. Basal cell carcinoma often appears as a pearly pink or red spot, a red scaly patch or an ulcer. Squamous cell carcinoma appears as a scaly or crusty area of skin or a lump with a red, inflamed base. They may feel sensitive to touch and bleed when rubbed. As we get older we develop scaly, rough patches predominantly in areas exposed to the sun. These are known as actinic keratoses and they become more common with advancing age, especially in fair-skinned people. These occasionally develop into squamous cell carcinoma and so can also be considered to be pre-cancerous.

Fortunately, most skin lesions are harmless and we are more likely to develop benign lesions as we grow older. However, it is difficult for an untrained eye to tell the difference, so if you are concerned about skin cancer it is best to seek your GP's opinion and if necessary refer to a dermatologist.

As always, it's better to be safe than sorry. If in doubt get it checked out!

Dr Raj Mallipeddi is a consultant dermatologist and dermatological surgeon based in London. He is Clinical Lead for skin cancer at the St John's Institute of Dermatology, and is recognised nationally and internationally as a leader in his field. 🌟



DERMATOLOGY

Dr Raj Mallipeddi BSc (Hons) MD FRCP FACMS

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When voice problems affect your job

...and when to seek help

Humans are unique amongst the animal kingdom in that they possess the ability to communicate through their speaking and singing voices.



In professions like singing, teaching, law and customer care, where you need your voice for your living, the voice's absence can mean loss of earnings or even the end of a career.

The larynx contains the vocal folds which open to let you breathe and close to vibrate to make the sounds of your voice. We have all experienced voice loss or hoarse voice (dysphonia) when we have had laryngitis in association with a 'cold' or 'flu'. Otherwise, dysphonia is usually due to something (a lesion) on the vocal folds impairing normal vibration or weakness of a nerve supplying the larynx.

Symptoms associated with vocal cord problems

Having a problem with your vocal cords most commonly results in hoarseness, loss of voice, discomfort on speaking and poor control of pitch and loudness. Hoarse voice for more than three weeks, especially if associated with pain, swallowing or breathing problems needs urgent attention.

Persistent problem? Seek professional advice

Persistent voice problems should always be assessed by a laryngologist (an ENT surgeon



THE VOICE'S ABSENCE CAN MEAN LOSS OF EARNINGS OR EVEN THE END OF A CAREER

with an interest in voice). Examination of the larynx is usually painless and can be performed in a clinic with a small camera that inserts either in the mouth or the nose.

If you use your voice excessively or shout frequently you can end up with vocal nodules. These are swellings always in the middle of both vocal folds, due to voice trauma. Treatment is resting the voice and guidance from a speech therapist who will help improve your vocal technique.

Smokers should be vigilant

Anyone can develop a voice problem, but some people are more prone to problems than others. Professions that use the voice a lot, such as teachers and singers, have a greater chance of developing problems with the voice. If you talk loudly or shout a lot your chances increase, and aging can also increase the risk of problems. If you have been a smoker then dysphonia for more than two or three weeks should always be assessed by a laryngologist. One has to be concerned about small precancerous or cancerous lesions on the folds. Laryngeal

cancers can also be associated with pain or present with a lump in the neck. Quite often small cancers can be eliminated using a laser but sometimes radiotherapy treatment may be indicated. With small laryngeal cancers, cure rates are very high. Radiation therapy uses high-energy x-rays, gamma rays, or particles to kill cancer cells.

Laryngoscopy is a medical procedure that is used to obtain a view of the vocal cords and the glottis. Laryngoscopy is most commonly performed in clinic by an ENT specialist using local anaesthesia and a flexible nasal endoscope. This helps to look for laryngeal problems. Direct laryngoscopy or microlaryngoscopy is performed under a short general anaesthesia and allows for surgery on the vocal cords, using a laser if indicated.

If you notice changes with your voice, or if you have persistent voice problems, it's worthwhile making an appointment with a specialist laryngologist.

Mr Guri Sandhu has a special interest in voice, airway and swallowing problems, as well as minimally invasive techniques for the management of head and neck tumours. He has a large practice managing the problems experienced by professional voice users from stage, music and media, and is ENT surgeon to the Royal Society of Musicians. 🎤



OTOLARYNGOLOGY / ENT

Mr Guri Sandhu MBBS MD FRCS FRCS(ORL-HNS)

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How to diagnose & treat long-lasting throat problems

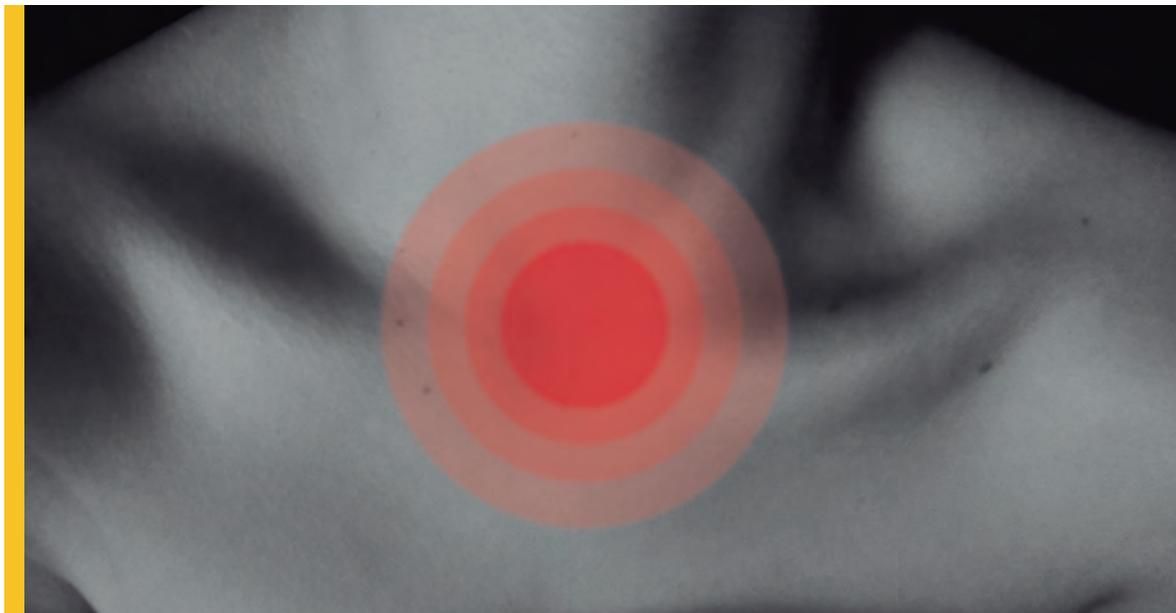
A tailored approach

With colds and at other times, such as after a night out, we all get strange sensations in our throats.

The feeling of a lump, or odd pains, tightness or throat clearing, hoarseness or a dry cough are commonplace and are generally of no great concern. These throat problems normally pass quickly. However, sometimes the sensations can hang around for weeks, months or even years, causing anxiety that something serious and harmful might be going on, or just causing a real nuisance in life. These problems need specialist attention and can be tricky to diagnose, but with the right approach there is usually a solution.

Rule out sinister underlying conditions

These throat problems are grouped by ENT specialists under the name 'globus' ('globus pharyngeus' or 'globus hystericus'), and our first goal is to rule out anything sinister, such as throat cancer, something quickly achieved from taking a history and looking at the throat with a small telescope passed into the nose under local anaesthesia. 99.9% of the time the cause is completely benign, but identifying what exactly it is and how to treat it takes a little longer.



Detailed inspection

It is important to take a detailed history and explore various possible avenues of thought, and also add into the diagnostic mix a slightly wider and longer telescope called a 'transnasal oesophagoscope'. This makes it possible to check beyond the vision of a standard nasendoscope, down into the oesophagus (gullet) and check for signs of acid reflux, spasms, infections and inflammations. The whole procedure takes about seven minutes.



99.9% OF THE TIME THE CAUSE IS COMPLETELY BENIGN

Tailored treatment

A tailored course of treatment can then be given to tackle a combination of aggravating factors and underlying conditions. This may mean managing reflux, increasingly concentrating on diet and lifestyle rather than medicines, at least for 'globus'. It may include speech and swallowing therapy from highly specialised colleagues, and treatment for muscle tightness or incoordination. Some patients with particularly ingrained symptoms of throat clearing and chronic cough may also benefit from a course of cognitive behaviour therapy (CBT). New diagnostic measures for persistent symptoms, especially working with specialist



SOMETIMES THE SENSATIONS CAN HANG AROUND FOR WEEKS, MONTHS OR EVEN YEARS, CAUSING ANXIETY

gastrointestinal and respiratory physiology units, and new drug-based approaches mean that these days, thankfully, very few people have to continue to live with those niggling and worrying persistent throat problems.

Professor Martin Birchall diagnoses and manages people who have problems with their voice, swallowing or breathing, as well as those with lumps in the neck. Additionally he has a particular interest in the management of an uncommon condition causing dysphagia (swallowing difficulties) called pharyngeal pouch, with more than 50% of his practice being 'tertiary referrals' (referrals from other consultants). He co-led the first team that used stem cell-based organ transplants, an achievement for which he won the 'Great Briton' award in science and technology from the Daily Telegraph, and continues to dedicate himself to pioneering life-altering techniques via his active research and presence in the field. He is currently the principal investigator on four clinical trials, including one which is exploring a new way to restore voice functions using the drive from unaffected nerves. 🧠



OTOLARYNGOLOGY / ENT

Professor Martin Anthony Birchall MA MB BChir MD FRCS

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Neck lumps: when are they a cause for concern?

Mostly benign but worth checking out

Neck lumps are a common condition; most of the time there is no need to worry but it's always better to be on the safe side.



There are many possible causes of neck lumps and they can be a great source of worry and anxiety, especially before a diagnosis has been made. Although most lumps are benign and not cancerous, all neck lumps that do not settle after a couple of weeks should be checked by a doctor. In some cases it may be necessary to see a head and neck specialist. Also called neck masses, many neck lumps are caused by infections, and the correct treatment will allow a speedy resolution and put people's doubts at ease. Lumps which persist need further investigation using ultrasound and needle aspiration to diagnose.

Lymph nodes

There are a large number of lymph nodes in the neck. Also called lymph glands, they are an important part of the body's immune system. They normally range in size from a few millimetres to a centimetre but they can increase in size for a variety of reasons, and this is the most common reason for neck lumps. The glands usually swell up because of an infection or disease. On some occasions, swollen lymph nodes may be associated with cancer. Malignant causes of enlarged lymph nodes include lymphoma (a cancer of the lymph system) and cancerous cells which have spread from the nose, mouth, throat,

larynx (voice box) or tongue. Investigation of swollen neck glands should therefore always include a clinical examination of these areas in order to make a proper diagnosis. It is always advisable to seek medical help if the swelling has not gone down after a few weeks, or if the lumps are getting bigger. You should also see a doctor if they feel hard and don't move when touched, you have difficulty swallowing, have lost weight for no reason, have a fever, or if you feel as though you have no infection and feel fine.

Thyroid and cysts

In children and young adults, lumps relating to the development of the structures of the neck can develop into cysts which can cause neck lumps that will often require surgical removal. Abnormal swellings of the thyroid gland can cause lumps low in the neck which move when swallowing. These are very often benign but will still require investigation to be on the safe side.

Other causes of neck lumps

There are many different causes of neck lumps, and most of them are not a serious or fatal problem.

Other causes for lumps in the neck include inflamed or infected salivary glands. The submandibular gland in particular can become swollen in response to infection or blockage of the duct by stones. Lumps in the parotid

gland are more often caused by tumours which are usually benign. Surgery is required and is technically challenging because of the presence of the facial nerve running through the gland. This sort of surgery should therefore be undertaken by surgeons with particular expertise in this type of problem. Although all neck lumps in children and adults should be investigated, the probability of throat cancer increases with age. This is particularly true of people who smoke or drink heavily. As with many conditions, cutting down on bad habits, partaking in exercise, and eating healthily can greatly decrease one's chances of this occurring.

If you are worried about a neck lump you should seek professional medical advice from your GP or an otolaryngologist (ENT specialist).

Mr Peter Clarke is a highly-skilled ENT specialist based in London. Practicing at some of the most reputable medical establishments in the capital, his expertise includes neck lumps, neck cancer, skull base tumours, dysphagia, and parotid tumours. 🌐



ALL NECK LUMPS THAT DO NOT SETTLE AFTER A COUPLE OF WEEKS SHOULD BE CHECKED BY A DOCTOR



OTOLARYNGOLOGY / ENT

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All about rhinitis

Causes, types and treatments

Rhinitis is an inflammation of the lining of the nose. It is a very common problem, affecting an estimated one in five people in the UK.

What are the causes of rhinitis?

There are numerous causes of rhinitis, whether environmental, domestic, seasonal, caused by physical obstructions or even medication. They can be broadly categorised as non-allergic or allergic rhinitis.

Allergic rhinitis can either be due to household or pet allergens, or can come and go with the seasons and accompanying increase in pollen count. Common domestic allergens include house dust mites, mould, or animal dander (dead skin cells). When your immune system detects one of these triggers, it acts by releasing histamines as a defence mechanism, which cause the classic rhinitis symptoms, namely a blocked, runny and itchy nose.

Symptoms include:

- Blocked, runny or itchy nose
- Post nasal drip (mucus that drips down the back of the throat)
- Impaired sense of smell
- Sneezing
- Nasal discharge or congestion
- Frequent headaches
- Dry skin or rashes
- In children it can also be a cause of a persistent cough
- Patients with allergic rhinitis often also complain of itchy, watery eyes



Non-allergic rhinitis: This type of rhinitis occurs year round and can be constant, or last for days or weeks at a time. Though the symptoms are much the same, this type of rhinitis does not cause the itchy nose, eyes or throat that are so typical of allergic rhinitis, or hay fever.

Causes of non-allergic rhinitis include:

- Hormonal changes due to pregnancy, thyroid issues or contraceptive pills.
- Occupational or environmental factors like dusty or smoky environments, chemical irritants in the work place can also trigger this condition.
- Extended use of topical decongestants that constrict blood vessels in the lining of the nose may cause a condition known as rhinitis medicamentosa.
- Infection, either bacterial or viral may also cause a bout of rhinitis.
- Other medications like aspirin, ibuprofen, medication for blood pressure and beta blockers can all cause non-allergic rhinitis.

Is rhinitis a serious problem?

The symptoms of rhinitis are similar to symptoms of chronic rhino-sinusitis where there may be other problems including nasal polyps. When the nose is very congested it can also lead to congestion of the ears and fluid in the middle ear. An ENT specialist is able to examine the nose with a fibre-optic endoscope to identify the underlying problem.



**RHINITIS IS A SERIOUS,
UNDERESTIMATED PROBLEM
AS IT SIGNIFICANTLY
AFFECTS QUALITY OF LIFE**

It is responsible for missed days at school and work with data showing poorer performance in examinations in sufferers. This is unfortunate, as with early assessment and treatment it can be managed very well.

How is rhinitis treated?

There is a step-ladder approach to the treatment of rhinitis. The aim is to stabilise the symptoms of the patient with the minimum amount of medication. Treatments can include saline douches, anti-histamines, topical steroid sprays and patients can even need surgery in some cases.

An ear, nose and throat specialist will be able to make an assessment of the nose and symptoms in order to tailor individualised treatment for the patient.

Mr Irfan Syed has a special interest in all aspects of rhinology (nose and sinuses), including rhinitis and sinusitis. He has won numerous awards and has been widely published in this field. 🌍



OTOLARYNGOLOGY / ENT

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The 3 most common types of skin cancer

How to spot them, how to treat them

Whilst there are dozens of different forms of skin cancer, the three most common are melanoma, squamous cell, and basal cell carcinoma.

Different skin cancers present in various ways, so knowing what to look for can help you spot suspicious changes on your skin. Melanomas commonly present as new or changing moles. Squamous cell carcinomas (SCC) tend to present as persistent skin coloured, or red, raised bumps on the skin, often associated with pain or tenderness. Basal cell carcinomas (BCC) may have a more varied appearance.

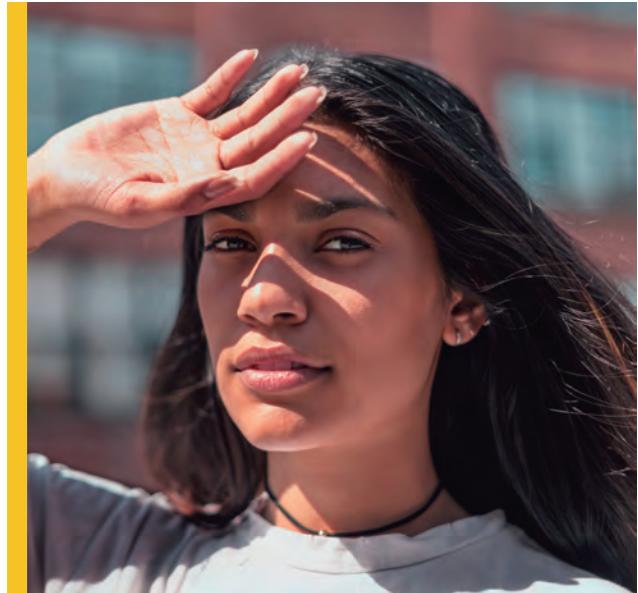
How dangerous are the different forms of skin cancer?

Melanoma

Of the three, melanoma is the most serious type of skin cancer and can spread to other parts of the body. When found early, it can often be treated successfully. The development of a new mole, or change to an existing mole on the skin are common presentations of a melanoma. Suspicious moles may increase in size over a short period of time, become irregular in shape, and develop more than one colour.

Squamous cell carcinoma

Squamous cell carcinomas are not usually life-threatening. They can, however, cause



complications by their growth or by spreading to other parts of the body. Early treatment is often curative.

Squamous cell carcinomas can present as flat red patches with a scaly crust, a firm often tender nodule, a raised ulcerated area, or persistent sore, these can arise in scars. If you have a sore or scab which doesn't heal in the space of one or two months, you should get it checked by a doctor or dermatologist.

Basal cell carcinoma

Basal cell carcinomas (BCCs) tend to cause problems by growing deeper or wider into the surrounding skin and deeper structures. Most basal cell carcinomas develop on the head and neck.

Basal cell carcinoma arises from basal cells, which are found at base of the epidermis, or top layer of skin. Most are thought to be caused by long-term sun exposure and arise in older adults. Rarely, they are seen in patients under the age of 20.

Nodular basal cell carcinomas often appear as a pink, red, or translucent bump on the skin with tiny surface vessels. They may easily bleed or scab. In darker-skinned patients they may be pigmented.

Superficial basal cell carcinomas are often seen on the chest and back, and appear as flat, scaly red-pink patches.

Less commonly, BCCs may present as non-healing sores or ulcers, sometimes with a raised rolled edge. Least commonly, they may present as a white or yellow waxy scar-like area.

How is skin cancer treated?

Skin cancers are most commonly treated surgically, which is often curative when diagnosed early. Options include:



MOST BCCS ARE THOUGHT TO BE CAUSED BY LONG-TERM SUN EXPOSURE

- **Curettage and cautery**, where the skin cancer is scraped from the skin and the exposed surface is then sealed.
- **Surgical excision** where the skin cancer is removed with a margin of normal skin. The wound is then stitched together, but it may require a graft or a flap (tissue being lifted from an adjacent site with an intact blood supply, unlike in a graft, which is skin from a distant site).
- **Mohs surgery** where skin layers are progressively removed and tested under the microscope until no skin cancer cells remain. For some non-melanoma skin cancers this reduces the risk of recurrence and can spare healthy surrounding skin.
- **Radiotherapy** can be used for patients who cannot undergo surgery or who do not want to undergo surgery.
- **Certain creams and ointments** can be effective in treating low-risk basal cell carcinoma.

Dr Kapil Bhargava specialises in skin cancer, he offers a range of evidence-based skin treatments from his Harley Street practice and has received multiple awards for his work in the field. 🌟



DERMATOLOGY

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A guide to pancreatic cancer

Symptoms, risk factors, and treatments

Pancreatic cancer is the fourth biggest killer cancer in the world, but there are ways to reduce risk.

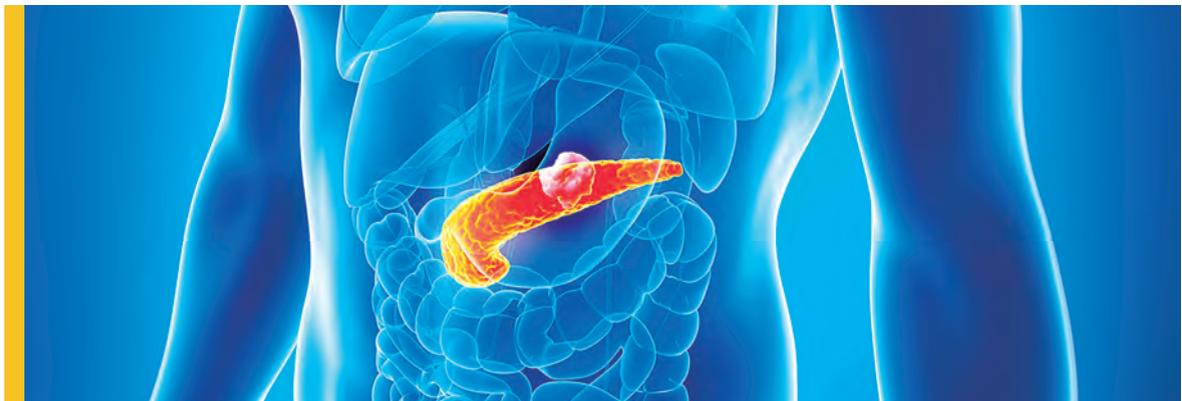
Pancreatic cancer, although a rare form of cancer, is the fifth biggest killer cancer in the UK alone, and fourth in the western world. This is because the symptoms do not show themselves until the cancer has progressed, often affecting parts of the body beyond the pancreas itself. Once this occurs, surgery is no longer a viable option despite being the most effective treatment for pancreatic cancer. Individuals should therefore watch out for early signs of pancreatic cancer symptoms in order to increase their chance of survival.

- Persistent, pain or discomfort in the upper abdomen or upper back
- Back pain
- Sudden loss of weight
- Loss of appetite
- Jaundice (yellow tinge of the eyes and skin, with dark urine, pale stools, often with itching)
- Nausea and vomiting
- Weakness
- Fever
- Chills
- Exceptionally bad smelling and abnormally coloured stools that float

What are the symptoms of pancreatic cancer you should be looking out for?

Symptoms of pancreatic cancer to look out for are:

Although there are other, less deadly conditions that can cause these symptoms, it is recommended that the individual sees a doctor as soon as possible.





INDIVIDUALS SHOULD WATCH OUT FOR EARLY SIGNS OF PANCREATIC CANCER TO INCREASE CHANCE OF SURVIVAL

How to reduce your chances of developing pancreatic cancer

If one wishes to reduce the risk of pancreatic cancer, there are a number of ways to do so, including avoiding smoking and excessive drinking, and trying to maintain a healthy weight. Some individuals are naturally more at risk of developing cancer of the pancreas. Anybody with hereditary pancreatitis, chronic pancreatitis, or a family history of cancer, may benefit from regular screening under GP supervision.

Men are diagnosed more often than women. A bad diet, obesity, and excessive alcohol consumption can also greatly increase one's chances of developing pancreatic cancer.

Pancreatic cancer screening and available treatments

Unlike other cancers, there is no favourable biomarker for pancreatic cancer. In other words, there is no test that demonstrates with clarity that somebody has this form of cancer. Having a reliable biomarker enabling earlier diagnosis could revolutionise treatment of pancreatic cancer.

There are a number of ways a doctor may attempt to make a diagnosis of pancreatic cancer, starting with a physical examination and blood tests.

If a positive diagnosis is made, there are a number of imaging tests available in order to locate the cancer and see if it has spread further than the pancreas. In some cases, the doctor may opt to use a biopsy, wherein a small piece of tissue is removed from the patient and examined to see if cancer is present.

Despite the difficulties pancreatic cancer presents, there has been encouraging progress over the past decade with regard to its treatment and screening, with advances in technology playing a major role. Patients are identified sooner due to the greater ease of access to scanning facilities with CT, MRI or ultrasound. Surgery is now more skilled and precise and surgical results have improved greatly. Although a large percentage of patients may still experience cancer recurrence, drug trials with chemotherapy after pancreatic surgery are generating promising results, which is a further step in the right direction.

Mr Satyajit Bhattacharya is a reputable consultant surgeon whose specialties include pancreatic cancer, gallstones, liver disease, and hernias. 🌐



SURGERY

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Anaemia: reduced oxygen in the blood

The symptoms and causes explained

The WHO state that 2 billion people around the world are anaemic – 30% of the world's population. What is anaemia & how is it spotted?

Anaemia describes a situation in which there is reduced oxygen-carrying capacity in the blood. Usually, oxygen is carried by a red-coloured protein called haemoglobin, which fills our red blood cells. If the haemoglobin level falls below a set reference range, then a person is diagnosed as being anaemic.

What are the symptoms of anaemia?

Anaemia may be very mild and asymptomatic, meaning there may not be any symptoms – perhaps identified only because someone has had a routine full blood count.

Alternatively, anaemia may be severe and associated with tiredness or even shortness of breath. The symptoms are more likely to be severe if the anaemia develops suddenly.

The symptoms can vary between the different types of anaemia, but the common symptoms include feeling tired and weak, dizziness, shortness of breath, and heart palpitations, which is when the heart has an unusual beat or you feel it thumping in your chest.

If anaemia is left untreated and continues to deteriorate then it is possible to develop heart failure with symptoms of profound fatigue and shortness of breath.



SYMPTOMS INCLUDE
FEELING TIRED AND WEAK,
DIZZINESS, SHORTNESS OF
BREATH, AND HEART PALPITATIONS

What are the causes of anaemia?

In some patients, anaemia occurs because blood is being lost from the body – this is not always obvious to the patient and may occur from the gastrointestinal tract, the urine or the uterus.

In other cases anaemia occurs because haemoglobin is not being made properly.

Three important dietary components for normal production of haemoglobin are iron, folate and vitamin B12. If any of these are lacking from the diet then anaemia will occur.

Green leafy vegetables are a good source of folate and meat is a good source of vitamin B12 and iron. Vegetarians can still have a good intake of vitamin B12 and iron, particularly if they eat a varied diet. However vegans are at a higher risk of vitamin B12 deficiency, and may need vitamin supplements.

Other good sources of iron include brown rice, pulses and beans, nuts and seeds, meat, fish, tofu, eggs, and dried fruit.

Haemoglobin production can also be affected by illness. In any patient with a chronic disease, anaemia can ensue and will not be cured until the underlying disease is treated.

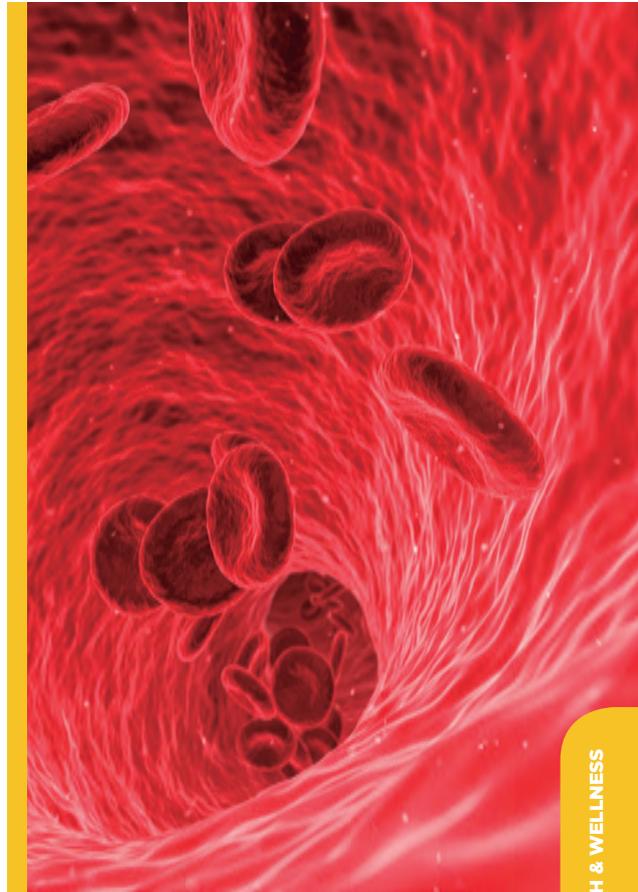
Finally, mild anaemia may be due to inheriting a haemoglobin variant, in which case it may be of minor concern and require no treatment. If two people, both with inherited variants, have children, the child may be at risk of severe anaemia.

If you know that you have an inherited variant of haemoglobin it is good to get some advice from your doctor before embarking on pregnancy so that they can test your partner and discuss any risks with you.

Treatment of anaemia

The treatment of anaemia depends on the cause. If it is due to vitamin deficiency it can be improved either with a change to the diet or by taking supplements to increase the levels. The underlying cause will have to be looked for, however, and corrected to stop the anaemia recurring.

Regular monitoring of the anaemia will be carried out with blood tests every few weeks, with adjustments made to the supplements if needed.



Dr Nina Salooja is a leading haematologist who runs a number of haematology clinics across London, as well as specialist clinics for coagulation and thrombosis (including DVT), bleeding disorders, and pulmonary embolism. She is also passionately involved in education, and is an integral part of numerous professional bodies. 🌐



HAEMATOLOGY

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Colorectal cancer screening

Why early detection is so important

Leading consultant colorectal surgeon, Mr Abhay Chopada explains the symptoms of colorectal cancer and how it can be prevented.

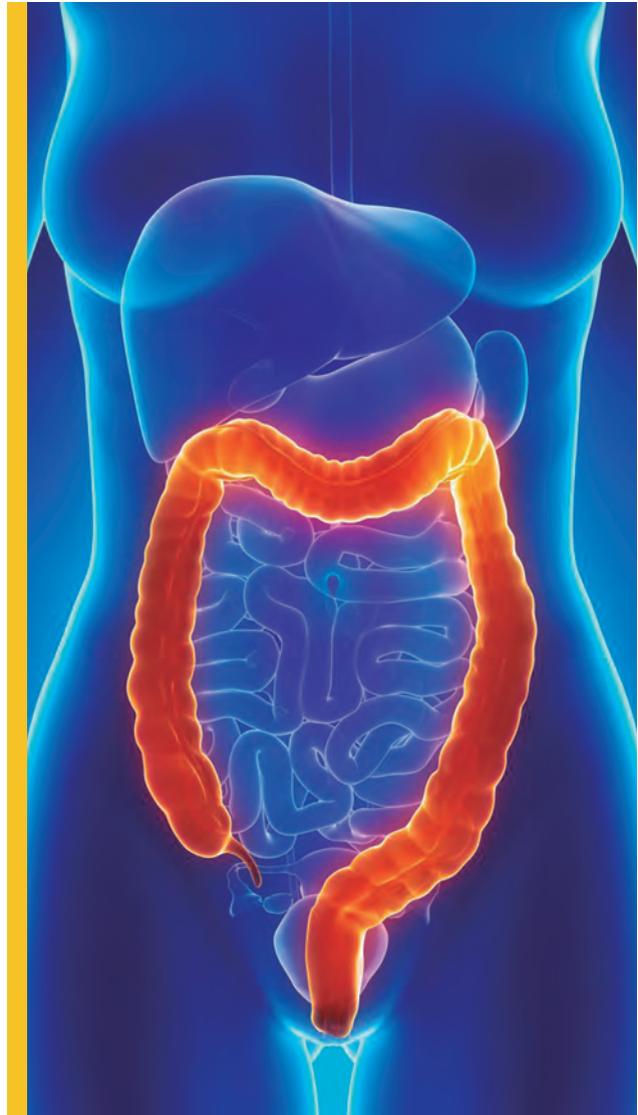
Colorectal cancer, also referred to as bowel cancer, can develop in any section of the colon (large bowel) or in the rectum (back passage). Cancer beginning in these areas is thought to develop slowly over a period of several years. Before the cancer develops, it usually begins as a polyp, which may eventually change into cancer. Early detection for bowel cancer involves screening to find the polyps before they cause symptoms.

What are the symptoms of colorectal cancer?

Colorectal cancer develops in the digestive tract, the system that processes food for energy, and rids the body of solid waste matter. The first part of the large bowel, called the colon acts as a storage place for waste matter. The most common types of polyps can be found in the colon and in the rectum, and can potentially develop into cancer if left undetected.

Symptoms of colorectal cancer can include any of the following:

- A change in bowel habits such as diarrhoea, constipation or a change in the consistency of your stool.
- Rectal bleeding, or blood in your poo.
- A feeling that you haven't completely emptied your bowel.



- Unexplained weight loss.
- Weakness or fatigue.
- Persistent pain and discomfort in your abdomen.

Some colorectal cancers can be found early if patients report any symptoms right away to their doctor. Other conditions such as infections, haemorrhoids, and inflammatory bowel disease can also cause these symptoms. Only a doctor can determine the cause of the same symptoms. It is also possible to have colon cancer and not have any symptoms.

The importance of screening for colorectal cancer

The goal of screening for colorectal cancer is to find polyps and cancers before they cause symptoms. These tests provide the best opportunity to detect the cancer at an early stage, when successful treatment is likely, and to prevent some cancers by detection and removal of polyps. There are several tests used to screen for colorectal cancer and different options for those with an average risk.

Prevention of colorectal cancer

Screening at the age of 50 is recommended even if there are no symptoms. Patients should report any symptoms (such as a change in bowel habits, rectal bleeding and blood in the stool) right away to their doctors. Other conditions such as infections, haemorrhoids, and inflammatory bowel disease can also cause many of these symptoms.



THE RELATIVE FIVE YEAR SURVIVAL RATE FOR **COLORECTAL CANCER**, WHEN DIAGNOSED AT AN EARLY STAGE, IS **90%**

Screening can prevent colorectal cancer by detecting the early polyps. Any polyps that are detected are removed, usually by a colonoscopy and are prevented from turning cancerous.

Talk to your doctor to find out when you should start colon cancer screening.

If the doctor suspects colon cancer, more tests will need to be done. It is important that a patient speaks to their doctor, since finding colorectal cancer early makes successful treatment much more likely.

The relative five-year survival rate for colorectal cancer, when diagnosed at an early stage, is 90% as opposed to an only 65% survival rate when diagnosed after the cancer has spread to involve nearby organs or lymph nodes.

Not only does colorectal cancer screening save lives, but it also reduces health care costs.

Mr Abhay Chopada is one of London's leading surgeons specialising in colonic, hernia, and gallbladder surgery, along with operations for anal conditions. He is known for compassion and ability to put patients at ease. 🌟



COLORECTAL AND GENERAL SURGERY

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Bowel cancer warning signs

Spotting cancer symptoms early can help

Learn what you should be watching for, and how to tell if your symptoms are worth a doctor's visit.

Instances of bowel cancer have been steadily increasing for the past few decades, but perhaps the most concerning trend we are seeing today is the sharp increase among younger adults. This is largely preventable. Cutting down on processed meat and alcohol, stopping smoking, losing weight, increasing fibre intake and exercising regularly, will significantly reduce the risk of developing conditions such as bowel cancer. Secondly, early diagnosis is key. Here are some warning signs to look out for:

Know the warning signs

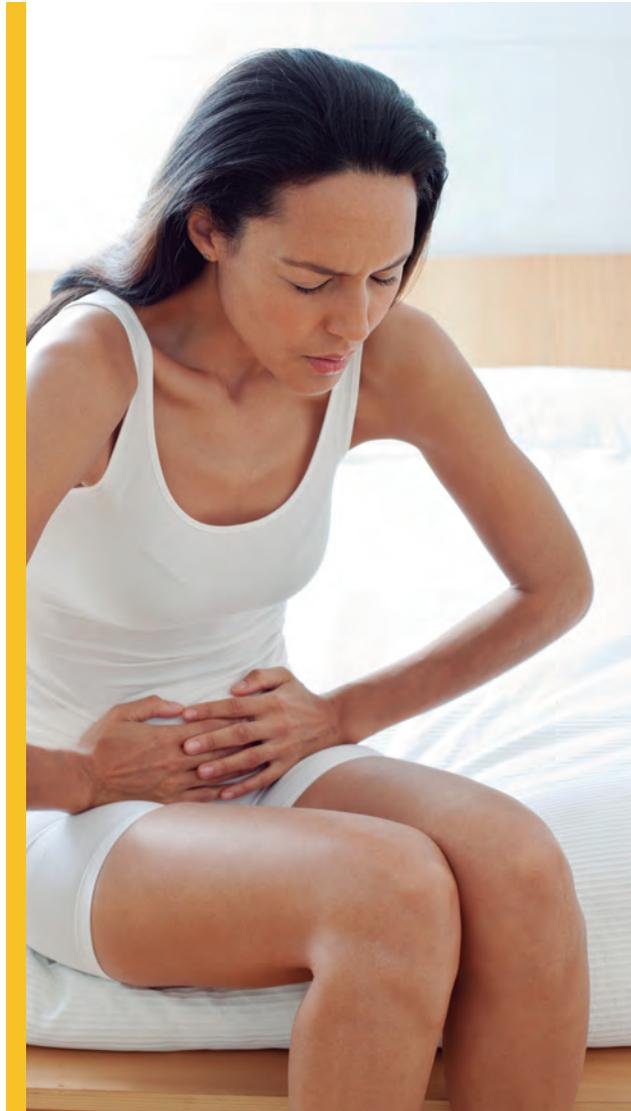
In its early stages bowel cancer may only cause minor symptoms. However, as time goes on, the symptoms worsen, along with the severity of the cancer. For this reason it is important to be aware of the following danger signs.

Blood in the poo

This is a fairly common symptom that many people will experience at some time, especially when wiping. It is often a symptom of haemorrhoids. However, bowel cancer and large polyps can also cause blood in the stool and so any unexplained bleeding is worth mentioning to your doctor.

Longer lasting diarrhoea

Everyone suffers from diarrhoea at one time or another, or have been through periods of



more frequent visits to the bathroom. These periods normally only last a few days, but if it goes on for more than a couple of weeks it is worth telling your doctor.

Being unable to completely empty the bowels

This is known as tenesmus and it can be caused by a build-up of hard impacted stool or by inflammation of the lining of the rectum. However, it can also be caused by a growth in the rectum such as a polyp or a cancer.

Low energy levels

Tiredness is very common and it can be for many reasons. Although it is very rare for it to have a malevolent cause, it is possible. If blood tests show that you have unexplained anaemia (low haemoglobin or blood count) with low iron levels, it is important to see a gastroenterologist.

Unexplained weight loss

All types of cancers can cause unexpected weight loss. If you have been losing weight without really trying, it is important to speak to your GP or a specialist.

An abdominal lump

This is rare. Occasionally, large cancers - especially in the caecum (on the right lower part of your tummy) - can be felt as a mass or lump within the tummy.

Symptoms of bowel obstruction

Advanced bowel cancer can cause a blockage in the colon. This can result in



MANY YOUNGER PEOPLE EXPERIENCING CANCER SYMPTOMS PUT IT DOWN TO IRRITABLE BOWEL SYNDROME

symptoms of severe tummy pain, tummy swelling, vomiting and constipation.

Many younger people experiencing these symptoms put it down to irritable bowel syndrome which is indeed much more common among these generations than bowel cancer. However, always see your doctor if you have any concerns.

Don't be embarrassed

Although younger generations might feel a bit more comfortable talking about the ins and outs of various bodily functions, the fact is that nobody – regardless of age – really likes talking about their bowels, even to a GP. I do think that embarrassment is something that stops people seeking advice when they've got problems. This is because many of the above symptoms of bowel cancer, such as blood in the poo, loose stools or a frequent need to use the bathroom, can be pretty cringe-worthy. But instead of passing it off as probably having a 'simple explanation' it's always best to visit your GP with any changes in bowel movements (they'll have seen it all before, trust me!).

Dr Neil Galletly has over 20 years' experience in investigating bowel cancer, performing over 3,000 colonoscopies. He has been awarded numerous prizes and awards for his work. 🌟



GASTROENTEROLOGY

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Managing the 1 in 5 of us with IBS

How can IBS be tested and treated?

Irritable bowel syndrome (IBS) affects 20% of the population and is the most common reason for referral to a gastroenterologist.

Symptoms of irritable bowel syndrome

IBS is characterised by a variety of gastrointestinal symptoms including disordered bowel habit (constipation, diarrhoea, or both), abdominal pain and bloating. Upper gastrointestinal symptoms manifest as non-ulcer dyspepsia, more commonly known as indigestion.

If the following symptoms persist for a period of around six months or more, testing or referral is usually considered:

- Pain or discomfort in the stomach (abdominal area)
- Feeling bloated, or feeling a sensation of hardness/tension in the stomach
- Discomfort which is only relieved by the act of passing stools
- Changes in how you do pass stools – straining, the feeling of not having properly emptied your bowels, or perhaps urgently needing to go to the bathroom, or with more frequency than usual

On some occasions mucus may be seen in the stools, but if blood is regularly seen, this is usually a symptom of a more serious condition.

Unknown causes

Though the exact causes of irritable bowel syndrome are unknown, most patients with

the condition have some form of digestion problem. Another feature of the condition is visceral hypersensitivity; patients with irritable bowel syndrome have lower pain thresholds for colonic distension induced by inflating balloons placed in the bowel. A proportion of patients develop their IBS symptoms after an episode of gastroenteritis, and emotional stress is another important precipitating factor. Associated psychopathologies, with anxiety and sometimes depression, are common.



THE EXACT CAUSES OF IBS ARE UNKNOWN, BUT MOST PATIENTS HAVE SOME FORM OF DIGESTION PROBLEM

Ruling out other possible conditions

A number of simple non-invasive tests can now be done to rule out other conditions. This can be useful not only for the sake of diagnosis, but to put the patient's mind at ease. These tests include faecal calprotectin (for inflammatory bowel disease), faecal elastase (for pancreatic exocrine insufficiency), lactose breath test (for lactose intolerance), fructose breath test (for fructose intolerance), glucose hydrogen breath test (for small intestinal bacterial overgrowth) and SeHCAT testing (for bile acid

malabsorption, which is a cause of various gut-related problems, including chronic diarrhoea).

Treatment of irritable bowel syndrome

Treatment of IBS will vary according to the symptoms and potential causes. In each case it is important that the patient is reassured of the benign nature of the condition and of the positive prognosis. There is no particular prescribed treatment, and no one-size-fits-all solution for those with the condition.

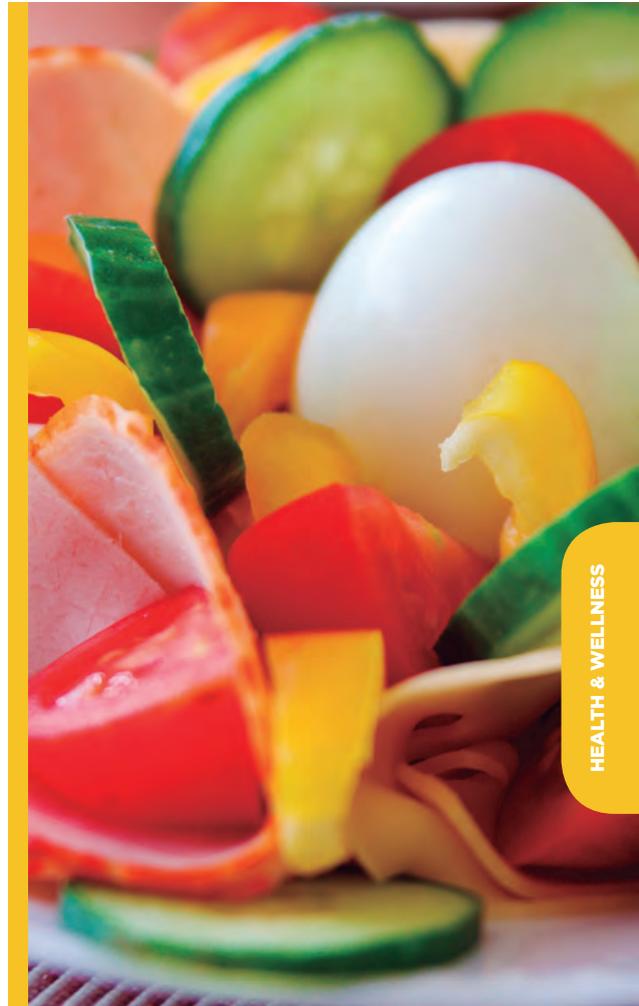
Usually, diet and lifestyle changes are advised for the management of IBS. Those with predominant constipation should be encouraged to increase the fluid and fibre content of their diet. It could also be that certain foods or irregular eating patterns make symptoms of IBS worse.

Medication is occasionally prescribed, in the form of low-dose tricyclic antidepressants, i.e. at doses ineffective as an antidepressant, and antispasmodics are often given for abdominal pain, though there is little objective evidence for their effectiveness. Psychological treatments, in some cases, can also prove helpful for the patient. The body of evidence in this field is complicated by the variable nature of IBS symptoms, the patients who suffer from them, and the high rate of placebo response to this condition.

Dr Devinder Bansal is considered an authority on the topic of IBS, which is just one of his special interests within the field of gastroenterology. Performing over 1,000 gastroscopies and endoscopies annually he has an exceptionally high level of expertise in this area. 🌱



TREATMENT OF IBS WILL VARY ACCORDING TO THE SYMPTOMS AND POTENTIAL CAUSES



GASTROENTEROLOGY

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Can you really die of a broken heart?

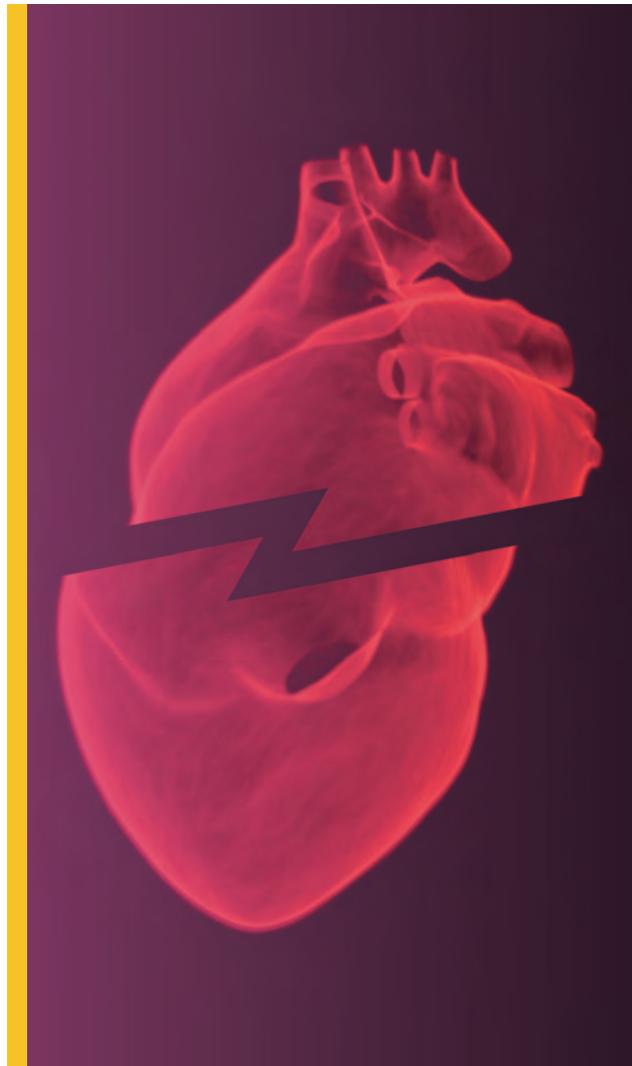
Is dying from a breakup medically possible?

We've likely all experienced the emotional pain of a broken heart, but did you know that a broken heart is a real medical condition?

Putting aside the cartoon image of a heart split into two jagged pieces, broken heart syndrome – or takotsubo syndrome, in medical terms – is a very real thing. Broken heart syndrome occurs when the muscular sections of the heart temporarily weaken. This weakening is connected to traumatic events, such as emotional stress, the death of someone you love, or a relationship break-up. In some cases it can be brought on by joyous events - imagine a big casino payout, an unexpected marriage proposal, or a happy reunion. Broken heart syndrome usually occurs after intense emotional, or even physical stress.

Broken heart syndrome is known more commonly in the medical world as takotsubo syndrome, or takotsubo cardiomyopathy. 'Takotsubo' comes from Japanese, as the condition was first identified in Japan. The word 'takotsubo' refers to a particular type of octopus trap, which looks exactly like the shape of the left ventricle (one of the four chambers of the heart) when this syndrome strikes.

Takotsubo cardiomyopathy occurs when the left ventricle changes shape, and becomes bigger. Symptoms tend to present themselves shortly after emotional stress,



and the syndrome affects women more than it does men. Sometimes no trigger can really be identified.

Takotsubo syndrome is often misdiagnosed as a heart attack, mostly because test results and symptoms look and feel very similar. Symptoms include chest pain and shortness of breath, which comes on suddenly. Some patients also report a sensation of nausea, while some do vomit, or experience heart palpitations. However, with broken heart syndrome, there are no blockages in the coronary arteries (which is the usual cause of a heart attack), but when an area of the heart becomes enlarged, blood is not able to circulate properly around the body.



THE **WEAKENING** IS CONNECTED TO TRAUMATIC EVENTS, SUCH AS **THE DEATH** OF SOMEONE YOU LOVE, OR A **BREAK-UP**

While takotsubo syndrome is a serious illness during the immediate phase, with potential medical complications, most people make a complete recovery within a



TAKOTSUBO SYNDROME IS OFTEN MISDIAGNOSED AS A HEART ATTACK, AS SYMPTOMS ARE VERY SIMILAR

few weeks. However, in a minority of cases, it can recur, and some people are left with permanent heart problems after the initial attack. During the acute episode it can prove fatal, and therefore is taken seriously. Specialist assessment is appropriate to manage and guide treatment, and provide future follow up strategies.

Dr Alexander Lyon has been studying Takotsubo syndrome for over 10 years and is the first author of the professional position statement for the Heart Failure Association (HFA) of the European Society of Cardiology¹ and is the chair of the HFA takotsubo syndrome Study Group. He sees many people who have experienced an episode of takotsubo syndrome, reviewing their current medication and providing a personalised management plan for the future. He has also hosted the first takotsubo syndrome patient workshop to help support people who have suffered from this syndrome. 🧠

1. Lyon AR, Bossone E, Schneider B, Sechtem U, Citro R, Underwood SR, Sheppard MN, Figtree GA, Parodi G, Akashi YJ, Ruschitzka F, Filippatos G, Mebazaa A, Omerovic E. Current state of knowledge on Takotsubo syndrome: a Position Statement from the Taskforce on Takotsubo Syndrome of the Heart Failure Association of the European Society of Cardiology. European journal of heart failure. 2016;18(1):8-27.



CARDIOLOGY

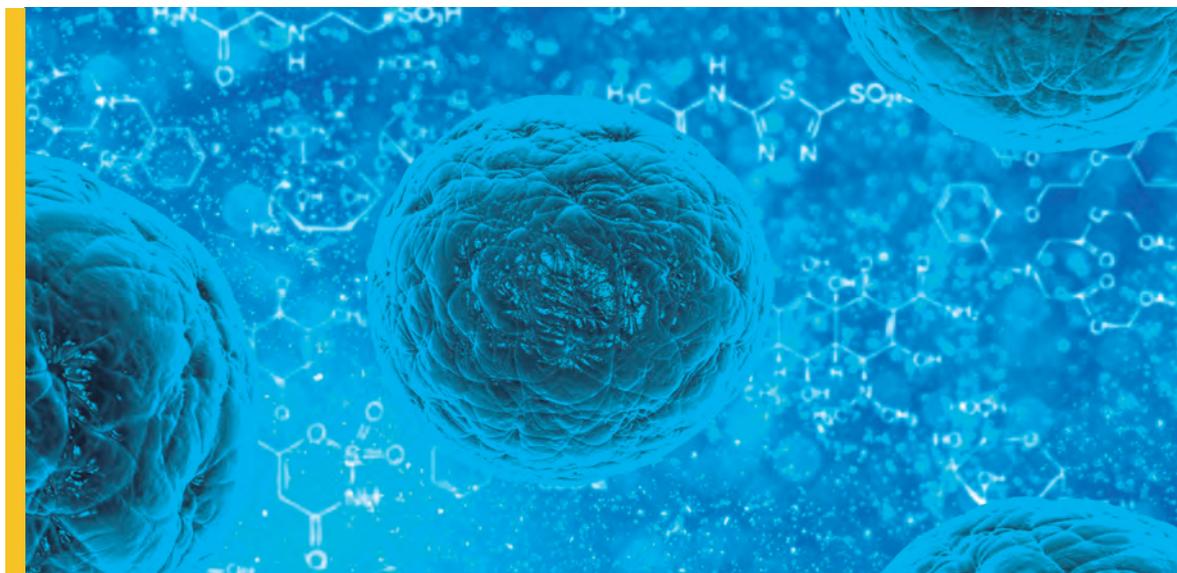
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Using stem cells to cure cancer

The role of allogeneic stem cell transplants

Allogeneic stem cell transplantation is a common procedure for a number of blood and bone marrow disorders.



What is allogeneic stem cell transplantation?

Allogeneic stem cell transplantation is the procedure of a person receiving donated stem cells (the cells responsible for producing all of the cells in the blood) from a genetically similar, but not identical donor. Most of the stem cells in our bodies are found in bone marrow, and some circulate from the marrow into the bloodstream.

The donor is usually a family member with the same tissue type, or if a family member is unavailable, a suitably matched, unrelated donor is searched for and used.

Why is allogeneic stem cell transplantation used?

Patients with conditions such as leukaemia, lymphoma, myeloma, myelodysplastic syndromes, and other rare bone marrow disorders will have unhealthy stem cells due to being damaged by disease or by treatments such as chemotherapy and radiotherapy.

Allogeneic stem cell transplantation is used to cure patients who are at high risk of relapse, or who have relapsed after previously having had successful treatment. There

may also be patients who do not respond fully to treatment, and allogeneic stem cell transplantation may be an option for them.

When a donor transplants their healthy stem cells, the cells of the immune system are also transplanted, and these cells will hopefully attack and destroy the existing disease.

What is the process for stem cell transplantation?

Once a suitable donor is found, the next stage is to collect the stem cells. This is done through a series of injections which stimulate the stem cells to enter the blood stream. The donor is attached to a machine which separates the blood cells, and the cells are removed from the donor. The process is painless for the donor, and they can relax in a chair or a bed while the donation process takes place.



PATIENTS WITH CONDITIONS SUCH AS **LEUKAEMIA** HAVE UNHEALTHY STEM CELLS DUE TO BEING **DAMAGED BY DISEASE**

Prior to the transplantation, the patient will go through conditioning therapy where they will receive high doses of chemotherapy and sometimes radiotherapy, which kills the underlying disease and suppresses the immune system, allowing it to accept

the donated stem cells. Having a stem cell transplant can be very demanding physically for the patient, but the doctor and team working with them will be able to help prepare adequately, and provide them with the care they need.

The donated cells are then placed into the bloodstream through a process similar to a blood transfusion. The cells then travel to the bone marrow where they start to make new blood cells.

What happens after treatment?

New cells are usually produced after 1-3 weeks. Recovery can take some time, and the patient is monitored closely through regular blood tests and doctor's appointments. Blood or platelet transfusions may be administered after the initial transplantation. When the procedure is finished, and recovery begins, the doctor and their team will provide the patient with aftercare advice.

Professor Stephen Mackinnon is one of London's leading haematologists. He leads the bone marrow and stem cell program at University College London, which has world class outcomes for transplants in patients with leukaemia and lymphoma. His research interests include adoptive immunotherapy and immune reconstitution following allogeneic stem cell transplantation. Professor Mackinnon also works with stem cells in the treatment of multiple sclerosis. 🌐



HAEMATOLOGY

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Living with narcolepsy

Understanding a misunderstood condition

Narcolepsy is so much more than falling asleep at inopportune moments. We find out how.

Although we all occasionally nod off or feel sleepy during the day, we can usually clearly differentiate between sleep and wakefulness. Somebody with narcolepsy, however, lives in a perpetual state of never knowing when overwhelming sleepiness may occur, as their brain is incapable of regulating sleep and wake cycles. They struggle to maintain wakefulness during the day, or find themselves randomly falling asleep at inappropriate moments. They also cannot regulate their sleep at night, which is therefore frequently disrupted and disturbed. In addition, the brain cannot regulate dream sleep phenomena.

During dream sleep, our bodies are paralysed so that we don't act out our dreams. People with narcolepsy may have dream sleep intruding into wakefulness, resulting in hallucinations or transient muscle paralysis brought on by strong emotions (usually laughter or anger), termed cataplexy.

How can everyday life be affected by narcolepsy?

Narcolepsy affects at least 25,000 people in the UK. It can seriously interfere with work, studies, and social interactions.

If the sleepiness or cataplexy are not adequately controlled, people with narcolepsy cannot drive or operate machinery, or take part in any number of activities that require concentration and alertness.



Many people with narcolepsy also find that cataplexy (transient muscle weakness) is often triggered at awkward times, such as business meetings or social occasions.

Some individuals may suffer from sleep paralysis, a terrifying experience when they wake up and find themselves unable to speak or move. This may last anywhere from a few seconds to several minutes.

'Sleep attacks' are another common symptom, and can also happen at any moment. Also momentary loss of awareness (microsleeps) can occur leading to people writing, typing or speaking nonsense.

Narcolepsy is a commonly misunderstood neurological condition. For a condition that is mostly associated with falling asleep during the day, it may seem strange to many that poor and disrupted sleep at night is also very common in people with narcolepsy.

People with narcolepsy also commonly put on weight due to a low metabolic rate. Narcolepsy, if poorly controlled, can have a devastating effect on a person's life, resulting in social isolation and depression.

What are the best ways to cope with narcolepsy?

Although there is no known cure for narcolepsy, there are a number of coping strategies an individual can use to improve their quality of life. These include:



PEOPLE WITH NARCOLEPSY MAY FIND IT DIFFICULT TO HOLD DOWN A JOB AND MAINTAIN A HEALTHY SOCIAL LIFE

- Improving sleeping habits by trying to get to sleep at the same time each night
- Educating others about narcolepsy so that they are aware of the condition
- Understanding one's own needs and what might trigger uncontrollable sleepiness and cataplexy so as to minimise the risk of them occurring in embarrassing situations
- Flexibility with social arrangements
- Planned naps in order to replenish energy levels
- Certain medications and stimulants prescribed by a GP or specialist can also help alleviate symptoms and allow many sufferers to lead more or less normal lives

If you or anyone you know is experiencing narcolepsy symptoms, medical advice should be sought.

Professor Matthew Walker is a pioneer in the field of neurology specialising in narcolepsy, epilepsy, and many more neurological disorders. 



NEUROLOGY

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A quick guide to arteriovenous malformations (AVM)

A rare condition that can cause death

Normally present at birth, AVMs cause around 2% of haemorrhagic strokes every year.

What is an arteriovenous malformation?

Normally, blood flows from the heart to the arteries of the body. The arteries branch and get smaller until they become a capillary, which is just a single cell thick. In this way blood pressure drops to very low levels that the thinner walled veins can cope with. In an AVM, usually early in life, arteries connect directly to veins. This is a high-pressure shunt or fistula. Veins are not able to handle the pressure of the blood coming directly from the arteries. The veins stretch and enlarge and create what we call a 'nidus'. Usually, there are multiple feeding vessels in an AVM and many draining veins.

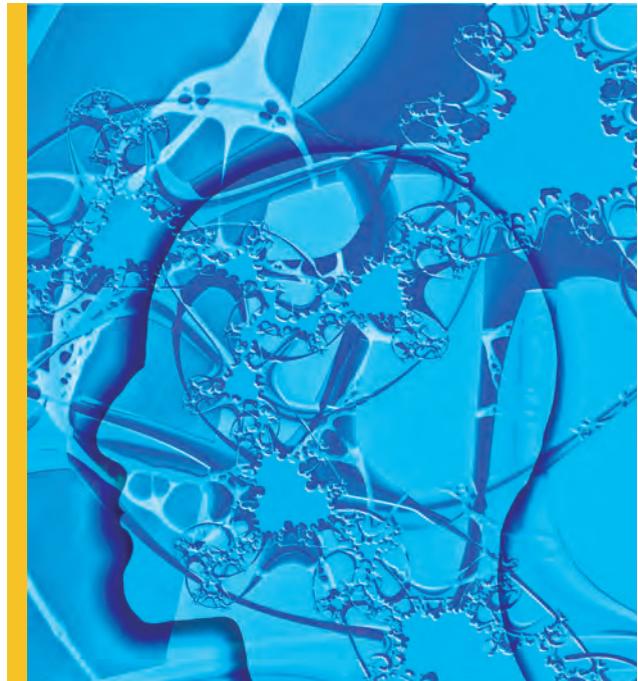
Apart from the typical AVM described above there are other 'vessel abnormalities' routinely seen in scans of the brain (**venous malformation** – abnormal cluster of enlarged veins resembling the spokes of a wheel with no feeding arteries; low pressure, rarely bleed and usually not treated and **capillary telangiectasia** – abnormal capillaries with enlarged areas; very low pressure and usually not treated either).

Brain AVMs can occur on the surface (also called cortical), deep (in the thalamus, basal ganglia, or brainstem), and within the dura (the tough protective covering of the brain). Spinal AVMs can occur on the surface (extramedullary) or within the spinal cord (intramedullary).

What are the symptoms?

The symptoms of AVMs vary depending on their type and location. While migraine-like headaches and seizures are general symptoms, most AVMs do not show symptoms (asymptomatic) until a bleed occurs. Common signs of brain AVMs are:

- Sudden onset of a severe headache, vomiting, stiff neck
- Seizures
- Migraine-like headaches



- Swelling or redness of an eye with a particular type of dural AVM called a **carotid-cavernous fistula** or '**CCF**'
- Noise in the head, called a 'bruit'. A dural AVM can cause a bruit due to the blood flowing through it

AVMs can damage the brain or spinal cord in three basic ways:

1. AVMs can rupture and bleed into the brain—called an intracerebral haemorrhage (ICH), or they can bleed into the space between the brain and skull—called a subarachnoid haemorrhage (SAH). Bleeding is the most serious complication of a vascular malformation, because of the risk of brain damage and so it is treated as an emergency. Sometimes a bleed may be small and produce no symptoms at all.
2. AVMs can exert pressure against the surrounding brain, resulting in seizures or hydrocephalus.
3. AVMs can very rarely reduce the amount of oxygen delivered to nearby tissues and cause neurological symptoms.

Risk of bleeding

The risk of AVM bleeding is 2 to 3% per year. Death from the first haemorrhage is



MIGRAINE-LIKE HEADACHES & SEIZURES ARE SYMPTOMS, BUT MOST AVMS DO NOT SHOW ANY UNTIL A BLEED OCCURS

between 10 to 15%. Once a haemorrhage has occurred, the AVM is more likely to bleed again during the first year (6%). Life time risk is more difficult to calculate in particular for incidental, non ruptured AVMs. For example, a 25-year-old man has an 80% lifetime risk of bleeding (at least once). Many factors affect this percentage, including where the AVM is located and what type of AVM it is. It's best to talk to your doctor about your own individual risk.

Who is affected?

AVMs of the brain and spine are congenital (present at birth) and are relatively rare. They affect both men and women at about the same rate. AVMs account for about 2% of all haemorrhagic strokes each year.

Mr Christos Tolias, the lead neurovascular surgeon at King's College Hospital, has specialist interest in the management of neurovascular conditions, such as AVMs, though his range of expertise is far wider. 🤖



NEUROSURGERY

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Retinal detachment

Causes, symptoms and treatments explained

Leading ophthalmologist, Professor Tom Williamson, explains all about retinal detachment, a condition that can cause blindness if untreated.



Retinal detachment is something that happens when a hole develops in the lining at the back of the eye, known as the retina. Once a hole appears, the retina will peel away from the back of the eye, much like wallpaper peeling off the wall, and cut off blood supply that provides the retina with oxygen and nutrients. If untreated, the condition can lead to blindness.

What is the retina?

The retina is the light-sensitive tissue lining at the back of the eye which allows you to see.

The retina works in much the same way as a film in a camera - information about light on the retina is sent to the visual cortex of the brain through a series of chemical and electrical impulses, and processed into the images you see.

What are the symptoms of a detached retina?

Most people will experience warning signs that the retina is going to detach before it does so. The sudden appearance of floaters in your vision can be a sign of retinal detachment, as with the appearance of black dots or streaks across your field of

vision. You may experience one single large floater, or a cobweb effect of many floaters. Sudden short flashes of light may also be experienced, or blurred and distorted vision.

The vision in the affected eye will gradually deteriorate if nothing is done about it.

If you are concerned about retinal detachment, make an appointment with a consultant ophthalmologist. A detached retina is diagnosed using eye drops to dilate the pupils and an eye examination using a special tool.

How is retinal detachment treated?

The retina can be repaired and reattached in one of two ways:

- A vitrectomy is an operation where the vitreous fluid (the clear gel that fills the eye) is removed and a gas bubble inserted in its place. The gas bubble supports the retina and remains in the eye until it dissolves. The gas bubble is replaced naturally with a watery fluid. The eye does not need the vitreous fluid.

The gas will obscure the view of the patient at first, but over a few weeks a black line will gradually travel down the vision as the gas bubble is dissolved.

- In a few patients a small piece of plastic is sewn into the outside of the eye. This piece of plastic causes a dent in the eyeball, which in turn will cause the hole to close.

It usually takes around two weeks for improvements to be expected following



THE VISION IN THE AFFECTED EYE WILL GRADUALLY DETERIORATE IF NOTHING IS DONE ABOUT IT

surgery, and up to six weeks for vision to improve. It can take up to a year for the retina to fully heal.

What causes retinal detachment?

Retinal detachment is usually caused by the vitreous (the gel of the eye) shrinking in middle age. The shrinking gel pulls on the retina causing a retinal hole which then leads to water going under the retina lifting it off. It can also be caused by direct injury to the eye, though this is less common.

A retinal tear can sometimes come before full detachment, and has the same symptoms. A tear can lead to fluid leaking underneath the retina and beginning the process of the retina detaching from its underlying tissue.

Retinal detachment is uncommon, and usually affects people who are aged between 40 and 70 years, and is more common in men than women.

Professor Tom Williamson is one of the most experienced vitreoretinal surgeons in the UK. He has over 25 years' experience treating all kinds of eye conditions, and provides high quality consultancy and surgery. He has an unrivalled clinical academic record in vitreoretinal surgery, which has provided him with a genuine international reputation in his field. 🇬🇧



OPHTHALMOLOGY

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5 ENT tips for parents

Common ear, nose, and throat problems

Sometimes it's hard to know what to do when your child has an ENT problem, but these tips will help.

Young children often get coughs and colds, blocked noses and waxy ears, causing them much discomfort. It can be difficult for first time parents to find the right solution, as they spend another sleepless night trying to comfort their crying child. Mr Samuel Jayaraj gives advice on how to make life easier when your child is suffering from a common ear, nose, or throat problem.

1. Getting a snuffly or blocked nose is part of growing up, and par for the course for

young children still learning their way in the world. If your child has a snuffly or congested blocked nose, try a saline (salt water) nasal spray.

These are drug free and simple and gentle to use, providing relief to your child. They add moisture (counter-acting the effects of central heating, air conditioning and pollution) and help loosen up mucus in the nose and wash away allergens. This simple solution can help clear up your child's problem so that they can carry on with their little adventures.



2. There's always a bug going around at some point or another at school or in the nursery, so it is very likely your child may develop a cough sooner or later. However, if your child has a cough without an obvious bug, it may be due to acid reflux.

Putting a book under the mattress or the feet of the bed at the head end to raise the child's head will help reduce any acid reflux that could be causing the cough. If the cough persists it may be a good idea to get your child checked out by your GP or a specialist. Certain cough medicines may also provide the remedy they need.

3. Ear wax build-ups are also a common part of growing up, and in many cases not much can be done to avoid them occurring. Often, earwax may fall out on its own, but to speed up the process if your child's ears are waxy, use ear wax softening drops to encourage the wax to come out naturally.

Don't use cotton buds in the ears; this may push the wax further in or against the ear drum, and may stop the natural ear canal wax-cleaning process from working or may traumatise the skin of the ear canal. Ear wax only really causes hearing loss if it has been pushed in or compacted in the canal or against the ear drum.

4. Don't give a milk bottle to your child when they are in their cot.

Having a feed may aggravate reflux at night, depriving both child and parents of much needed sleep.



CHILDREN ARE MORE LIKELY TO GROW UP TO BE SMOKERS IF THEIR PARENTS SMOKE

Also the milk may collect in the back of the throat and nose and affect the Eustachian tube increasing the risk of glue ear which causes hearing loss.

5. Don't smoke around children!

We all know about the negative effects of smoking, and how it can give rise to a large number of conditions or diseases, but it is important to bear in mind that children are more susceptible to cigarette smoke. Children of parents who smoke are more likely to develop glue ear and rhinitis. Children are also more likely to grow up to be smokers if their parents smoke, so think twice before lighting up with your child around. If you do need to smoke, do it outside and not in front of your children.

Mr Samuel Jayaraj is a renowned ENT surgeon based in London, with more than 25 years' experience. He has written numerous articles and publications, including textbook chapters and has won numerous prizes and awards, including 'Best Otology Presentation' at the Royal Society of Medicine. At the forefront of his field, he is former Clinical Director at the reputable Bart's Health NHS Trust, and Chairman of the Medical Advisory Committee at the Holly Hospital. 



OTOLARYNGOLOGY/ENT

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Exploring ethnic rhinoplasty

A complete surgery guide

Mr William Townley, leading plastic surgeon, discusses the intricacies of ethnic rhinoplasty, including the kinds of surgery available.

The ideal appearance of the nose is unique to each individual, and is specific to the race and culture of a person. Essentially, all rhinoplasty procedures are ethnic as they consider the nasal shape, skin and facial proportions of the person's ethnicity, whatever it may be.

What is ethnic rhinoplasty?

In the UK, the term ethnic rhinoplasty refers to nose reshaping procedures in non-caucasian patients and therefore encompasses a wide range of ethnicities from Asian, Middle Eastern, Afro-Caribbean and Mediterranean.

Ethnic rhinoplasties are common in a multicultural city such as London, and make up 30-40% of rhinoplasty procedures in Mr Townley's practice.

Why is ethnic rhinoplasty different to standard rhinoplasty procedures?

Although the basic skills required are the same for all kinds of rhinoplasty, including ethnic rhinoplasty, the goals are different between different ethnicities and from one individual to the next.

There is no 'one operation fits all' approach to ethnic rhinoplasty, and it is a niche area of specialisation that requires deep

understanding of different cultures and the different concepts of beauty and elegance. What is considered beautiful to one individual or one culture, may not have the same appeal to another.

What are the different kinds of rhinoplasty procedure?

Each patient presents with a combination of particular features that need to be analysed to help determine the best surgical plan.

These features may include thicker skin type, dorsal bumps (a hump, or bump on the



bridge of the nose), wide nostrils, flat bridges, softer tip cartilages, distinctive tip shape – many of which are common in caucasian rhinoplasty surgery too. A great appreciation and understanding of nasal anatomy is required to analyse the different ethnic-specific anatomical features, and work accurately with the unique characteristics.

What is the procedure for surgery?

Rhinoplasty surgery is performed under general anaesthetic and typically lasts one and a half to three hours. In most cases, an open approach (involving a small incision under the tip) is best as it enables the most accurate manipulation of the structure of the nose.



WHAT IS CONSIDERED BEAUTIFUL TO ONE INDIVIDUAL OR CULTURE MAY NOT HAVE THE SAME APPEAL TO ANOTHER

Some patients go home on the day of the surgery, while others stay in overnight.

Patients are usually advised to take two weeks off work, by which time, most of the swelling and bruising will have resolved,



ETHNIC RHINOPLASTIES ARE COMMON IN A MULTICULTURAL CITY SUCH AS LONDON

and any signs of recent surgery will not be evident at conversational distance.

As with all kinds of rhinoplasty procedures, it may take up to 12 months for the final results to show.

Patients of all kinds of rhinoplasty can expect to experience some side-effects in the weeks following surgery, such as a blocked nose, stiffness and some numbness in the nose, swelling and bruising, soreness, and the possibility of nosebleeds. Patients may also experience an altered sense of smell.

Mr William Townley is a consultant plastic surgeon, running a busy cosmetic practice in London with a special interest in rhinoplasty and all aspects of facial and breast aesthetic surgery. Practising from his two private cosmetic clinics in London, he strives to provide the highest standard of care to his patients, placing great emphasis on quality, safety and innovative techniques to deliver natural and beautiful results. 🙋



PLASTIC SURGERY

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What kind of work does a clinical geneticist do?

Learn more about this little-known specialty

Dr Melita Irving is a clinical geneticist. Here, she explains to Top Doctors what she does & which type of patients she is able to help.

Top Doctors (TD): Not many people have heard of clinical genetics. What is it?

TD: So what exactly does a clinical geneticist do? What kind of patients do you help?

Melita Irving (MI): Clinical genetics is a branch of medicine specialising in the diagnosis and management of genetic disorders. These may encompass chromosome abnormalities, rare diseases and complex genetic syndromes. Individually, these conditions are relatively uncommon, but collectively, 1 in 17 people will be affected by one of these disorders. There are estimated to be up to 7,000 rare diseases. This requires a specialist doctor with the knowledge needed make a diagnosis and advise on future management. Often their relatives need help too.

MI: People seek the help of a clinical geneticist for all sorts of reasons. For instance, someone could be worried that their child might have a genetic syndrome because they have a number of different problems that cannot be readily explained. This might include delay in their development, short stature, an unusual appearance and birth defects. My job is to take into consideration a number of factors about the child and their family. I draw a pedigree to see if there is any important medical history in the family. Then, I assess the child from pregnancy to birth and through



their early childhood, looking for any clues that might point to a recognised genetic syndrome. Physical examination is required to take into consideration the physical signs. Finally, piecing all of this together, I come up with a shortlist of possibilities to explain the child's problems.

TD: Genetic testing is improving rapidly. Does that help you as a doctor in diagnosing genetic conditions?



PROBLEMS MIGHT INCLUDE DELAY IN DEVELOPMENT, SHORT STATURE, AN UNUSUAL APPEAR- ANCE AND BIRTH DEFECTS

MI: Yes, it does. In recent years basic chromosome testing has moved on from being a test where laboratory specialists look down a microscope to becoming a much more detailed, automated analysis of the way someone's genes are arranged all together. And even gene testing has changed from being an expensive, time-consuming, often hit-and-miss exercise in diagnosis to being a simultaneous assessment of many genes relevant to the patient's condition. This produces answers for families much faster and more cheaply than ever before, but it requires specialist knowledge to interpret complicated test results.

TD: Can you give us an example of the kind of patients and families you have helped recently?



GENE TESTING HAS CHANGED FROM BEING AN EXPENSIVE, TIME CONSUMING, HIT-AND-MISS EXERCISE IN DIAGNOSIS

MI: Yes. Recently the mother of a three-and-a-half-year-old boy brought him to see me at The Portland Hospital's Shard Medical Centre, as he was not yet able to walk and talk. He had a number of other unexplained medical problems too. In spite of having many tests and multiple medical opinions, no-one had taken into account all of his issues collectively, so his condition remained undiagnosed. Assessment in my clinic led to a shortlist of possible conditions and genetic testing targeted to his situation. A diagnosis was quickly reached. Now the focus is on the best management for him, such as therapies, and on genetic counselling for his extended family.

Dr Melita Irving works as a consultant in clinical genetics. A paediatrician by training, she now specialises in genetic conditions, including skeletal dysplasia, fetal medicine, and genetic counselling. Dr Irving has established multidisciplinary paediatric clinics in skeletal dysplasia offering a close monitoring and management service, and is an active researcher, working to develop and improve the diagnosis of severe skeletal conditions. 



CLINICAL GENETICS

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The excellent results of Mohs surgery

Minimising damage to healthy tissue

This procedure is the go-to choice for surgeons when treating several types of skin cancer.

Mohs surgery (named after Frederick Mohs 1910-2002) is the gold standard method for treating several types of skin cancer. Also known as Mohs micrographic surgery, it involves testing the skin cancer at the same time that it's removed, to determine if it has been adequately extracted. The main advantages are that the surgical wound matches the size, shape and depth of the cancer, so that no extra tissue is removed unnecessarily.





What does Mohs surgery involve?

In most cases, Mohs surgery is performed under local anaesthetic as a day case, meaning you are awake and can go home the same day. After the anaesthetic is injected, the affected skin can be cut out and sent for laboratory testing. While you wait for the results, a dressing is placed over the wound and typically you would be allowed to eat, drink, read etc. Once the results are available, you may be brought back into the operating room to remove more cancer; this happens repeatedly until the area has been cleared of skin cancer. By removing layer after layer of the skin cancer and some surrounding skin, eventually only cancer-free tissue remains. Subsequently, the wound can be repaired by stitching, a skin graft or flap, or simply allowed to heal by itself with a dressing. Unlike other earlier procedures to remove skin cancer, this technique causes minimal damage to any surrounding healthy and non-cancerous tissue. This increases the chances of curing the cancer, and reduces the necessity of them having to undergo any further, additional treatments.

Mohs micrographic surgery may be used to treat aggressive cancers that have a tendency to recur, cancers located in sensitive areas (such as the face, ears, nose, and around the eyes) where it is important to preserve as much healthy tissue as possible, and cancers where the borders are hard to identify.

As with any surgical procedure, there are certain risks involved. These include the typical risks associated with anaesthesia (such as an allergic reaction) or any other surgical procedure (such as bleeding and infection). Risks specific

MOHS SURGERY IS HIGHLY SUCCESSFUL AND HAS BEEN SHOWN TO REDUCE THE CHANCE OF CANCERS RETURNING.

to Mohs surgery include possible facial nerve injury if operating on the face.

What can be expected post-operation?

Patients can go directly home after most Mohs surgery procedures. Any stitches are typically removed seven days later but this can vary. However, there may be some bruising and swelling, and you may have sports and strenuous activities restricted for a few days after the operation.

Mohs surgery is highly successful and in many studies has been shown to reduce the chance of cancers returning after surgery. It is used for basal cell carcinoma, squamous cell carcinoma, lentigo maligna and other rare skin cancers. If you have any worries regarding skin cancer, see a dermatologist.

Dr Saqib Jawaid Bashir is one of London's most reputable dermatologists, and was named by Tatler's Good Doctor Guide as one of the UK's best 250 doctors. Specialising in Mohs micrographic surgery, skin cancer, and aesthetic surgery, he practices at some of the capital's most reputable hospitals, including Kings College Hospital, The London Clinic and the BMI Sloane Hospital and is Chief Executive of Skin55 Centre in Harley Street. Respected as a leader in his field, he has published extensively on dermatology and is member of the British Association of Dermatologists. 

DERMATOLOGY



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Answering your questions: premature ejaculation

Premature ejaculation has a solution

Leading psychiatrist Dr Andy Zamar answers some of the most common questions that we may sometimes feel too embarrassed to ask.

Premature ejaculation can be an embarrassing topic for people to discuss, and the doubt surrounding it can lead those who experience it to imagine they are one of the only ones with the problem.

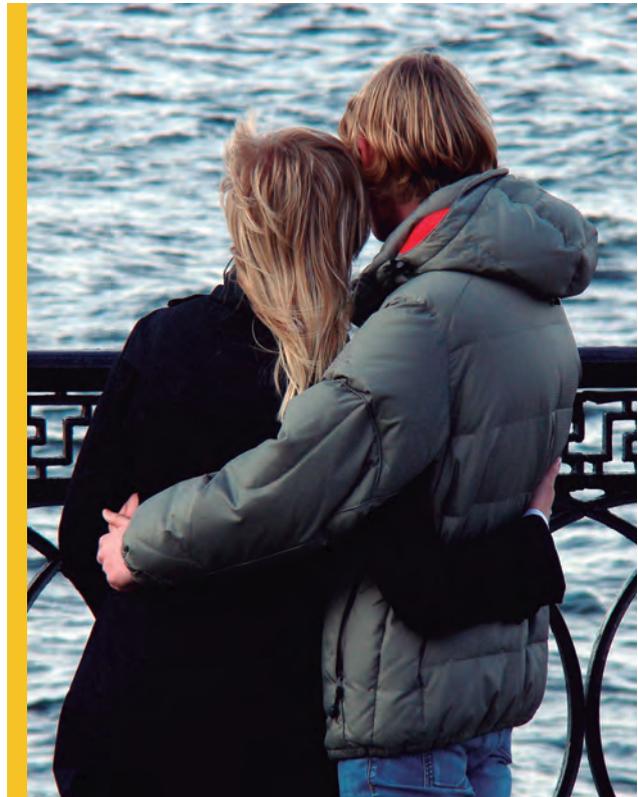
What is premature ejaculation?

People often think that premature ejaculation refers to ejaculating within two minutes of beginning sex, whereas it is usually defined as a lack of control over ejaculation, which results in the man or his partner being dissatisfied with sexual intercourse. This can lead to embarrassment, feelings of self-consciousness, and possible strains on a relationship.

Does premature ejaculation only affect young men?

No. The problem is stable across all age groups and racial groups, and actually affects a slightly larger percentage of older men.

People may often think they are the only one with the problem, but it is thought to affect up to one in three men, so it is not particularly uncommon. Because it can be embarrassing, however, it isn't discussed. This leads people to think that it is much less common than it really is.



Does premature ejaculation affect you every time you have sex?

Premature ejaculation can often be situational, which means that you may experience it at times with your partner, but at other times it doesn't occur. It's also

possible that premature ejaculation may be experienced with some partners, but with others, it does not happen at all.

Is premature ejaculation due to anxiety?

No, in fact it isn't. Studies have actually found that men with premature ejaculation have normal anxiety levels. Premature ejaculation sufferers report double the rates of anxiety and double the rates of stress. It is not caused by these factors but stress and anxiety may be secondary to premature ejaculation. The problem is usually considered to be a physical problem, and one that can be overcome with training. Men who experience premature ejaculation have been found to have more sensitivity to penile stimulation.



YOU MAY THINK YOU ARE THE ONLY ONE WITH THE PROBLEM, BUT IT IS THOUGHT TO AFFECT UP TO 1 IN 3 MEN

Premature ejaculation is an issue that many men face, and a lot will experience it at some point in their lives. Not talking about the issue, or hiding it away can lead to feelings of isolation, but this in itself does not cause premature ejaculation.

Is medication required to cure premature ejaculation?

Medication is not needed as a cure for premature ejaculation. Most medications are unlicensed and should be taken for life, which is unsatisfactory to most sufferers. The problem



MEN WITH PREMATURE EJACULATION HAVE NORMAL ANXIETY LEVELS, BUT AN OVER-SENSITIVITY OF THE PENIS

lies with an over-sensitivity of the penis. Seeing this to be the issue, I developed a device which allows you to train yourself to control ejaculation. The Prolong™ device allows the user to overstimulate the most sensitive areas of the penis, and using a stop-start technique during stimulation, or when using with a partner, the sensitivity felt on the most sensitive areas of the penis can be reduced, meaning that users can control their ejaculation and increase the time to ejaculation by four to eleven times according to studies carried out.

The Prolong™ device means that men can train alone should they wish, meaning the feelings of embarrassment associated with premature ejaculation do not carry over to treatment.

Dr Andy Zamar is an expert consultant psychiatrist and founder of the London Psychiatry Centre. Dr Zamar has special expertise in the treatment and diagnosis of adult ADHD, PTSD, anxiety disorders, and sexual dysfunction. Dr Zamar and his team have introduced several new technologies to the UK, pioneering rTMS (Repetitive Transcranial Magnetic Stimulation) treatment for depression. He is the inventor of the Prolong™ device, a training device which seeks to treat premature or early ejaculation, without the need for any other drug-related treatments. 🌐



PSYCHIATRY

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Hormones and hunger: how hormones affect weight loss

The effect of ghrelin on your appetite

Our hormones control many things in our bodies, including the signals that indicate whether we feel full or empty.

It's estimated that in the UK, at any given time, one in four adults is on a diet. However, of those one in four, most will regain the weight they lost in just a year's time. Why? There are, of course, several reasons, but one of them could be to do with your hormones, and the role that they play in appetite control and weight loss.

Hormones and hunger

The gut-brain axis - which refers to signalling between the central nervous system and the gastrointestinal tract - plays a crucial role in appetite control. Circulating gut hormones send signals to the brain, which inform us whether we feel hungry or full. Ghrelin, our



hunger hormone, is secreted by the stomach just before meal times as a signal that we feel hungry. After meals, satiety hormones such as GLP-1 and PYY are secreted by the intestine to signal to the brain that we feel full. In people with obesity, some of these gut hormone responses are impaired, and this is something which may contribute to their obesity.

The problem with losing weight

When we attempt to lose weight through dieting, our gut-hormone response leads to increases in ghrelin and decreases in our satiety hormones. This is the body's way of telling the brain that we have lost weight and we must fight to regain the calories that we have lost. Furthermore, when we lose weight, our basal metabolic rate, the energy which is required to keep our basic metabolic processes ticking, is lower, which means that we need to eat fewer calories to maintain the new body weight. These lower energy requirements, together with gut hormone response, are some of the reasons which explain the challenges that patients, or indeed dieters in general face when it comes to weight loss maintenance.

Combining lifestyle change and medication

Lifestyle and dietary changes are the cornerstones of any dietary loss programme, but diet alone may not be enough when trying to maintain weight loss long-term. New pharmacotherapies are now available for the treatment of obesity. Certain medication



IN PEOPLE WITH **OBESITY**, SOME **GUT HORMONE RESPONSES** ARE **IMPAIRED**, WHICH MAY **CONTRIBUTE TO THEIR OBESITY**

can mimic the action of the satiety hormone GLP-1 and works by decreasing appetite through its action on the brain. Clinical trial data shows that obese patients can achieve a mean weight loss of 8% in one year, although patients with an early response can achieve more. For patients with prediabetes, medication can reduce the incidence of developing type 2 diabetes over 3 years. These gut-hormone therapies are promising and effective treatments in the fight against obesity and related comorbidities.

Dr Barbara McGowan is an expert in endocrinology, leading the obesity bariatric service at Guy's and St Thomas' Hospital and managing patients with complex obesity problems. Dr McGowan has been awarded a prize by the NIHR/RCP/CRN (National Institute for Health Research, Royal College of Physicians and Clinical Research Network) for outstanding research within the NHS. Her research interests include remission of type 2 diabetes post-bariatric surgery, and hormones in the gut. She was awarded a PhD for her research and investigation surrounding the role of gut hormones in appetite control. 🌟



ENDOCRINOLOGY, DIABETES & METABOLISM

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Cardiology and exercise – what is sports cardiology?

Why athletes need heart specialists

Leading sports cardiologist, Professor Sanjay Sharma, explains how athletes have their own risks associated with practising sport.

We all know that exercise is good for the heart, and is encouraged when it comes to living a healthy life. Regular exercise can help to reduce the risk of a whole host of medical conditions, including diabetes, high blood pressure, heart disease, and even depression.

This said, there are some heart conditions that can be induced through exercise, and

as a cardiologist it is important to work together with those who practise sport, especially athletes, to monitor their health and watch for any indicators of heart problems. It should be noted, however, that the benefits of exercise eclipse the risks by a great degree. Sports medicine works hard to prevent cardiac related death and occurrences are rare.

Exercise related heart problems can affect different people in different ways. In middle



aged adults, the most frequently made association is coronary artery disease, which often is connected to those with a family history of heart attacks, or smokers.

However, in the young, cases are slightly different. Sports cardiology in this age group usually deals with uncommon heart conditions that can cause major complications when exercising. These range from arrhythmia (abnormal heart rhythm), to abnormalities in the heart structure or the heart muscles.



THE BENEFITS OF EXERCISE ECLIPSE THE RISKS BY A GREAT DEGREE

Specialists in sports cardiology work closely with patients, especially athletes, to monitor the heart and check for risk of cardiac complications. Conditions can be diagnosed through looking at family history, medical background, and a combination of tests such as echocardiograph, or measuring the heart rhythm during exercise.

When inherited or congenital heart defects are detected, it doesn't necessarily mean an end to sport and activity for the individual, as in some cases, lifestyle modifications, pharmaceutical remedy, and surgical options can allow a continuation of a relatively active lifestyle. These days, more is being done to identify people who are potentially at risk of heart disease or defects.



THOSE WHO DO SPORT ON AVERAGE LIVE SIX YEARS LONGER THAN THOSE WHO DO NOT

It is important to remember that exercise is not something to be avoided – research shows that those who do sport on average live six years longer than those who do not. Sports and regular exercise have countless beneficial effects on a number of conditions such as diabetes, high blood pressure, depression, and heart disease.

Sports cardiology aims to monitor existing conditions, and work together with athletes to reduce the risk of cardiac complications. Work is being done to ensure that the right steps are taken to ensure the safety of athletes, and to provide all young people participating in sport at any level with cardiac screening, so any defects are identified as soon as possible.

Professor Sanjay Sharma is a highly-reputable consultant cardiologist, with a strong commitment to research and training, holding the position of Professor of Inherited Cardiac Diseases and Sports Cardiology at St George's University. He is currently carrying out research on the impact of long-term ultra-endurance on the heart, amongst other areas. Professor Sharma serves as an expert cardiologist for numerous sporting events and organisations such as the Football Association, the British Lawn Tennis Association, British Rugby League, and the London Marathon and works closely with a number of cardiac charities. 



CARDIOLOGY

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Advances in prostate cancer diagnosis

The problems with the PSA test

Professor Hashim Ahmed explains how the latest advances in prostate cancer diagnosis are leading to better outcomes for men.

The current methods for diagnosing and treating prostate cancer are letting many men down. Advanced imaging, minimally-invasive biopsies and therapies mean men will have fewer and better biopsies and treatments with fewer side-effects. The outlook for men with prostate cancer is already looking better than it did only five years ago.

Conventional biopsy - the PSA test

Men who are concerned about prostate cancer can request a prostate specific antigen (PSA) test. The problems with having a PSA test are that an abnormal level is not specific to prostate cancer and many men will undergo invasive tests unnecessarily. TRUS biopsy is a random process. A needle is used 10-12 times while searching for



cancer of the prostate. It can be harmful – contamination is a risk as the needle passes through the rectum and there are other risks like haematuria (blood in urine), haematospermia (blood in semen) and pain. TRUS biopsies can find tiny cells that look like cancer but do not grow and do not spread in the vast majority of cases, even if left for years. One in three men above the age of 50 actually have these low-risk cancers and may end up having unnecessary treatment as a result. The biopsies can actually also miss important cancers that will grow and spread if left untreated. Studies have shown that TRUS-biopsy has a sensitivity of only 48% for clinically significant cancers.

Conventional treatment - radiotherapy or surgery

Once a man is diagnosed with prostate cancer, the entire prostate is treated with radiotherapy or surgery. Both of these treatments inevitably cause damage to surrounding structures leading to side-effects such as urine incontinence, erectile dysfunction, rectal diarrhoea, bleeding and discomfort. This might be acceptable if the treatment was effective but it only offers a 5% improvement in survival chances over giving no treatment at all.

A new, targeted approach

Thankfully, things are changing for the better. A high-quality MRI is changing how we manage prostate cancer. Firstly, men can avoid a biopsy as a result; the MRI is wrong in 5-10% of cases and the chance of these missed cancers progressing is rare. The accuracy is therefore



THINGS ARE CHANGING FOR THE BETTER. A **HIGH-QUALITY MRI** IS CHANGING HOW WE MANAGE PROSTATE **CANCER**

far superior to the PSA test. Secondly, if they do need a biopsy, they can have a more accurate one with a very low risk of infection called a transperineal MRI-ultrasound fusion biopsy. The needle is guided more accurately through the perineal skin rather than through the rectum. If cancer is found, many men can have a treatment that leads to a dramatically lower risk of side-effects. This is called focal therapy which involves targeting the tumour, rather than the whole prostate, so damage to surrounding structures is reduced along with the side effects. Focal therapy can use a number of energy sources to destroy tissue precisely. The most common are high-intensity, focused ultrasound (HIFU) and cryotherapy. In expert urology hands, the risk of side-effects is relatively small.

Professor Ahmed is best known for his role in the pioneering of ground-breaking changes regarding how men are diagnosed with prostate cancer. He led a study into the benefits of using MRI to diagnose prostate cancer that was described by the BBC as “the biggest leap in diagnosing prostate cancer in decades”. He is dedicated to his research and has won several prestigious awards. He is renowned for the ‘focal therapy’ prostate treatments that he provides which offer a less risky alternative to traditional surgery and radiotherapy and he is a global authority on MRI and minimally invasive diagnosis methods. 🌐



UROLOGY

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Modern developments in spinal surgery

Multi-disciplinary approach improves outcomes

Technological advances in spinal surgery now offer more options and have moved the focus to restoring and preserving.



Once, the only option for many injuries and conditions would be open back surgery involving large incisions, the cutting of muscles and tissues, the use of general anaesthetic, and long recovery times often with little or no movement.

New surgical techniques can mean smaller incisions, smaller scars, reduced blood loss, and reduced hospital stays and less need for medication.

Endoscopic and percutaneous spinal surgery

This involves incisions of less than half a centimeter and, in certain cases, slipped discs can be removed so as to relieve sciatica and fix spinal fractures: true 'surgery without knives'. Day case surgery can be offered and general anaesthesia avoided.

Minimally invasive spine surgery

With minimally invasive surgery, specialised instruments are used which only require

a small incision, often referred to as spinal keyhole surgery. With the use of these tools, there is no need to move and cut muscles. Techniques include:

- **Micro-discectomy** – when the soft tissue acting as a cushion between the intervertebral discs becomes compressed or herniated due to wear and tear, the herniated material can press on the surrounding nerves causing pain. A discectomy procedure can trim or remove the damaged part of the disc.
- **Spinal decompression** – with spinal stenosis (narrowing of the spinal canal), the spinal nerves can become compressed causing limb pain and numbness. It may be possible to remove the damaged bone and soft tissues using a minimally invasive approach.
- **Spinal fusion** – the lower spine can become damaged for a number of reasons like degenerative arthritis, scoliosis, or spondylolisthesis. In more severe cases it may be required to fuse the vertebrae together so there is no longer movement between them. This is done using screws, rods and some form of bone graft.



SO EFFECTIVE THAT **OUR PATIENTS** HAVE BEEN ABLE TO RETURN TO INTERNATIONAL DUTY IN **WORLD CUP RUGBY**



NEUROSURGERY

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TRUE 'SURGERY WITHOUT KNIVES'

Restorative spine surgery

Reconstructive or restorative surgery is a new approach to spinal surgery where the aim is to treat the discs without fusing them, by using artificial disc replacements.

The new generation of total disc replacements now replicate the physiology of a normal disc almost exactly whilst being many times stronger. They are so effective that our patients have been able to return to international duty in world cup rugby, as well as world champion martial arts.

A multi-disciplinary approach means better outcomes for patients

When a patient has a spine problem, there may be a number of different specialists that need to consult with the patient, depending on the condition. They may require a surgical or non-surgical approach and elaborate pain management may be a key element of recovery. The Spine Surgery London gives a truly multi-disciplinary service, where the patient gets the service and treatment that they need under one roof. With the use of a team of highly-skilled members specialising in different areas such as spinal trauma, neurological and orthopaedic surgery, rheumatology, sports medicine, and pain management, the patient will always be the focus, ensuring the best chance of recovery. 🌐



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COLORECTAL SURGERY

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	London, W1G 6BW	02039347418
	London, E1 4NL	02039347418
	London, E14 4HD	02039347418
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	Surrey, SM2 5PT	02084347532
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	Surrey, KT18 7EG	02039342041
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	London, W1G 7HJ	02084347994
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Mr Ranjeev Bhangoo	London, E14 4HD	02084347994
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Mr Christopher Chandler	London, W1G 7HJ	02084347994
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	London, SW5 0TU	02084347994
	London, SE1 9BS	02070348978
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Mr David Peterson	London, W1G 6HL	02084347578
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Mr Richard Selway	Kent, ME5 9PG	02084347994
	Kent, ME14 5FT	02084347994
	London, W1G 7HJ	02084347994
	London, SE5 9RS	02084347994
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	London, W1W 5AH	02037447785
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Mr Adrian Lower	London, W1G 9RQ	02076610816
Dr Shazia Malik	London, W1U 5NY	02039342085
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	London, SE1 9BS	02084347997
Mr David Ogutu	London, W1W 5AH	02039342097
	London, EN2 7PR	02039342097
	London, EN8 9XP	02039342097
Mr Rajendra Rai	London, W2 1NY	02039342065
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	London, W1G 7JX	02038840590
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	London, SW10 9NH	02084347572
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	London, W1G 7JX	02038840516

OPHTHALMOLOGY

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Mr Jonathan Dowler	London, W1G 6AU	02039340009
	London, W1U 5HJ	02039340009
Mr Ahmed El-Amir	London, W1G 7HP	02038840555
Mr Mostafa Elgohary	London, W1G 6AU	02039342059
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	London, EC1V 9EZ	02076610866
	London, W1G 8TL	02076610866
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	London, BR3 5HS	02076610820
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	Essex, IG4 5PZ	02076610852
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	London, EC1V 9LF	02038840611
Mr Brian Little	London, W1G 8TL	02038840534
Mr Vincenzo Maurino	London, W1G 8TL	02039342077
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Mr Mahi Muqit	London, W1G 9HT	02038840511
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Mr Vik Sharma	London, W1G 8HU	02039342057
Mr Kin Sheng Lim	London, W1G 6AU	02038840620
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Mr Alex Shortt	London, W1G 8QN	02038840557
Mr Nicholas Strouthidis	London, EC1V 9LF	02038840540
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	London, BR3 5HS	02076610805
Ms Katherine George	London, W1G 8AQ	02076610859
	London, SE1 9BS	02076610859
	London, W1G 8AG	02076610860
Mr Ashraf Messiha	London, SW1W 8RH	02084347990
	London, SW19 5NX	02084347990
	London, W6 8RF	02084347990
Mr Neil Shah	London, RM7 0AG	02038840569

ORTHOPAEDIC SURGERY

Mr Pramod Achan	London, W1G 6PU	02037447789
Mr Mo Akmal	London, W1G 9QJ	02037447787
Mr Garth Allardice	Hertfordshire, HP2 7YU	02039347401
	London, HA6 2JW	02039347400
	London, HA1 3RX	02039347402
Mr Henry Atkinson	London, EC2N 1HT	02084347574

Mr Henry Atkinson	London, N6 4DJ	02080034590
	London, EN2 8SD	02084347575
	London, NW4 1RP	02084347576
Ms Diane Back	London, W1U 5NY	02076610849
	London, SE1 9RT	02076610849
Mr William Bartlett	London, W1G 6JH	02076610845
	London, N6 4DJ	02084347985
Mr Steven Corbett	London, W1H 6EQ	02038840509
	London, EC4N 7BE	02038840509
	London, SE1 2PR	02038840509
Mr James Donaldson	Hertfordshire, WD23 1RD	02039340005
	London, HA7 4LP	02039340005
Mr Paul Hamilton	London, SM3 9DW	02039342062
	Surrey, KT21 2SB	02039342062
	Surrey, KT18 7EG	02039342062
Professor John Hollingdale	London, HA1 3RX	02076610861
Mr Ian Holloway	London, W1H 6EQ	02038840603
	London, SW5 0TU	02038840603
	London, EC4N 7BE	02038840603
	London, SW3 5AW	02038840603
Mr David Houlihan-Burne	Buckinghamshire, HP16 0EN	02076610834
	Hertfordshire, HP2 7YU	02076610862
	Hertfordshire, WD3 1QB	02076610868
	London, W1H 6EQ	02076610862
	London, EC4N 7BE	02076610862
Mr Simon Jennings	Hertfordshire, WD23 1RD	02039347411
	London, W1G 7ET	02039347419
	London, HA1 3RX	02039347412
Mr Sujith Konan	London, NW8 9NH	02084347531
	London, W1G 6HL	02084347531
	London, W1U 5NY	02084347531
Mr Simon Lambert	Hertfordshire, WD23 1RD	02038840522
Mr Rohit Madhav	London, W1G 6PX	02038840519
Mr Jehangir Mahaluxmivala	Hertfordshire, CM21 0HH	02037442774
Mr Philip Mitchell	London, SW19 5NX	02039347406
	London, SM3 9DW	02039347406
	Surrey, KT21 2SB	02039347406
Mr Sean Molloy (Orthopaedic spinal surgery)	London, HA1 3RX	02084347530
Mr Mark Phillips	London, EC2N 1HT	02038840517
	London, SE3 9UD	02038840559

ORTHOPAEDIC SURGERY

Mr Mark Phillips	London, NW4 1SJ	02038840559
Mr Arun Ranganathan	Essex, IG9 5HX	02085053311
	London, W1G 6BW	02079353721
	London, W1G 6PU	02076610863
Mr David Redfern	East Sussex, BN3 1RD	02038840608
	London, NW8 9NH	02038840610
	London, SW1W 8RH	02038840609
Mr Nashat Siddiqui	London, SW19 5NX	02076610864
	London, KT2 7QB	02038840604
	London, KT2 7EG	02039340006
Mr Ziali Sivardeen	London, W1G 9QP	02038840571
	London, NW8 7JA	02038840571
Mr Matthew Solan	London, NW8 9NH	02084347989
	London, SW19 5NX	02038840624
	Surrey, GU1 3LX	02038840625 ext 3
Mr Manoj Sood (Orthopaedic surgery: hip, knee and sports)	Bedfordshire, MK40 4AW	02084347988
	Hertfordshire, AL5 4BP	02084347988
	London, W1G 9QY	02084347988
	London, NW8 7JA	02084347988
	London, NW4 1RP	02084347988
Mr Vikas Vedi	Berkshire, SL4 3SJ	02039342052
	Buckinghamshire, SL3 6NH	02039342051
	London, HA1 3RX	02039342052
	London, TW8 9DU	02039342052
	London, HA6 2JW	02039342052
Mr Krishna Vemulapalli	Essex, CM15 8EH	02039342056
	Essex, CM13 3LE	02039342056
	London, RM7 0AG	02039342056
	London, IG4 5PZ	02039342056

OTOLARYNGOLOGY / ENT

Mr Zaid Awad	London, W2 1NY	02039342093
	London, W6 8RF	02039342093
Mr Anthony Aymat	London, SE39LF	02038840576
Ms Lydia Badia (Facial plastic surgery)	London, W1G 9QY	02039340008
Mr Jonathan Bernstein	London, SW5 0TU	02037442783
	London, SW3 6JJ	02078118111

OTOLARYNGOLOGY / ENT

Mr Jonathan Bernstein	Surrey, SM2 5PT	02078118111
Professor Martin Anthony Birchall	Bristol, BS8 1BN	02038840558
	London, NW8 7JA	02038840558
Mr David Bowdler	London, SE39LF	02038840576
Mr Paul Chatrath	Essex, CM13 3AD	02076610830
	Essex, CM15 8EH	02076610830
	Essex, IG9 5HX	02076610830
	Essex, IG4 5PZ	02076610830
	London, NW8 9LE	02076610832
	London, W1G 7JZ	02076610832
Mr Peter Clarke	London, SW3 6JJ	02038840581
	London, SW5 0TU	02084347995
	London, W6 8RF	02038840581
Mr Charles East (Facial plastic surgery)	London, W1G 9QY	02039340008
Mr Nicholas Eynon-Lewis (ENT surgeon)	London, EC3N 2JY	02078989993
	London, SE1 9BS	02078989993
	London, NW8 9NH	02078989993
	London, E1 4NL	02038840587
Mr Nicholas Gibbins	London, SE39LF	02038840576
Mr Kambiz Golchin (ENT & facial plastic surgeon)	Ireland, Dublin	02039342073
	London, SW3 1RW	02039342083
Mr William E. Grant	London, SW5 0TU	02039342084
	London, SW1W 8RH	02039342084
	London, W6 8RF	02039342084
Mr Julian Hamann	Kent, TN2 4UL	02039342047
	Kent, TN3 0RD	02039342047
	London, W1G 9QP	02039342047
Mr Tony Jacob	London, SE39LF	02038840576
Mr Samuel Jayaraj	London, IG9 5HX	02038840505
	London, IG4 5PZ	02038840594
Mr Ravinder Singh Natt	Hertfordshire, WD23 1RD	02039342049
	London, NW8 9NH	02039342049
	London, NW3 2QG	02039342049
	London, N6 4DJ	02039342049
	London, EN2 7PR	02039342049
Mr Abhijeet Parikh	London, W2 1NY	02076610865

OTOLARYNGOLOGY / ENT

Mr Abhijeet Parikh	London, SW5 0TG	02076610865
	London, NW8 9NH	02076610865
	London, HA1 3RX	02076610865
Mr Santdeep Paun (Facial plastic surgery)	London, SE1 9BS	02076610806
	London, W1G 9QY	02076610806
Mr Nabil Salama	London, SE39LF	02038840576
Mr Hesham Saleh (Facial plastic surgery / rhinology / otolaryngology / ENT)	London, W1G 6AL	02078989998
	London, W6 8RF	02078989998
Mr Guri Sandhu	London, W1G 7JW	02038840547
	London, W6 8RF	02038840547
Mr David Selvadurai	London, SW1W 8RH	02084347984
	London, SW19 5NX	02084347984
Mr Ricard Simo	London, SE39LF	02038840576
Mr Irfan Syed	London, SE39LF	02038840576
Professor Neil Tolley	London, NW8 9NH	02038840513
	London, HA1 3RX	02084347544

PAEDIATRIC CARDIOLOGY

Dr Nitha Naqvi	London, W1G 9RU	02039342087
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PAEDIATRIC CARDIOTHORACIC SURGERY

Mr Nagarajan Muthialu	London, W1G 8BJ	02076610811
	London, WC1N 3JH	02076610835

PAEDIATRIC ENDOCRINOLOGY, DIABETES & METABOLISM

Dr Helen Spoudeas (Paediatric endocrinology, diabetes & metabolism)	London, W1U 5HJ	02038840515
	London, WC1N 3JH	02084347524

PAEDIATRIC NEPHROLOGY

Dr Richard Trompeter	London, WC1N 3JH	02084347549
	London, W1W 5AH	02084347550

PAEDIATRIC RESPIRATORY MEDICINE

Dr Mark Rosenthal	London, SW5 0TU	02074605700
	London, W1G 9RU	02084347525
	London, W1W 5QT	02076610802
	London, SW3 6NP	02038840518

PAEDIATRICS

Dr Benjamin Jacobs	Hertfordshire, WD6 3BS	02078989985
	Hertfordshire, WD6 3FG	02078989985
	London, W1W 5AQ	02078989985
	London, NW11 9PY	02078989985
Dr Ramnik Mathur	London, HA7 4LP	02078989985
	London, HA1 3RX	02084347996
	London, TW8 9DU	02084347996
	London, TW2 6AN	02084347569

PAIN MEDICINE

Dr Jim Blackburn	London, KT2 7EG	02039340003
	London, SW19 5NX	02039340003
Dr Roman Cregg	London, W1G 6PU	02076610863
Dr Christopher Jenner	London, W1G 9QY	02084347581
Dr Glyn Towleron	London, W1H 6EQ	02039342075

PATHOLOGY

Dr Ashish Chandra	London, SE1 7EH	02070344545
Dr Devaki Nair (Lipidology)	London, NW3 2QG	02076610809
	London, W1G 8TL	02084347538

PLASTIC SURGERY

Mr Mo Akhavani	London, W1G 7LH	02038840574
	London, SW19 5NX	02038840574
Mr Jonathan Britto	Essex, CM15 8EH	02084347583
	Essex, CO4 5XR	02084347585
	London, W1G 6AH	02084347583
Mr Simon Eccles	London, W1W 5QN	02038840614
Mr Christopher Inglefield	London, W1G 8YJ	02038840535
Mr Navid Jallali	London, W1G 8EN	02038840554
Mr Niall Kirkpatrick	London, W1W 5QN	02084347559
Mr Alastair MacKenzie Ross	London, EC2N 1AR	02038840562
	London, NW8 7JA	02038840562
Mr Dan Marsh	London, W1G 7LH	02038840502
Mr Nicholas Parkhouse	London, SW1X 9BW	02039340002
	London, W1G 6QA	02039340002
	West Sussex, RH19 3EB	02039340002

PLASTIC SURGERY

Mr Kieran Power Mr Kieran Power (Reconstructive and plastic surgery)	London, W1G 8BJ	02039347403
	London, SW3 6JJ	02039347404
	London, SW1W 8RH	02039347403
	London, W1G 7ET	02039347403
Mr William Townley	London, W1G 9QY	02076610838
	London, SE1 2PR	02076610838

PSYCHIATRY

Dr Mohamed Abdelghani	London, W1G 9PF	02039340004
Dr Julius Bourke	London, W1G 9RU	02033553536
	London, NW1 6SH	02039342034
Dr Rajeev Dhar	London, NW1 6SH	02039342050
	London, W1G 9PF	02039342050
	London, SE1 9RS	02039342050
Dr Michael Dilley	London, W1G 9RU	02038840575
Dr Dimitrios Paschos	London, W1G 9RU	02038840575
Dr Alberto Pertusa	London, NW1 6SH	02038840580
Dr Justin Sauer	London, SW5 0TU	02037447790
	London, W1G 8TL	02037447790
	London, SW19 5NX	02037447790
Dr Andy Zamar	London, W1G 7HG	02076610817

PULMONOLOGY & RESPIRATORY MEDICINE

Dr Andrew Barlow (Respiratory medicine)	Hertfordshire, WD23 1RD	02038840591
	Hertfordshire, HP2 7YU	02038840591
Dr Sundeep Kaul (Respiratory medicine and critical care)	London, UB9 6JH	02084347567
Dr Anne Mier (Respiratory and general medicine)	London, SW5 0TU	02039342068
	London, EN2 8SD	07947570825
Dr Neal Navani	London, NW1 2BU	02084347992
	London, W1G 7AE	02084347992
	London, W1G 6AA	02084347992
Dr Brian O'Connor	London, SW5 0TU	02039342055
	London, W1G 6AA	02039342055
	London, SW3 5AW	02039342055
Dr Shanthi Paramothayan	London, SM3 9DW	02084347534
	London, CR9 8AB	02038840588
Dr Amit Patel	London, W1G 6AA	02038840606
	London, SE1 2PR	02038840606

PULMONOLOGY & RESPIRATORY MEDICINE

Dr Amit Patel	London, SE5 9RS	02038840606
	London, NW8 9NH	02038840606
	London, N6 4DJ	02038840606
Dr Suveer Singh (Pulmonary, sleep, and critical care)	London, SE1 2PR	02076610801
	London, SW5 0TU	02038840507
	London, SW3 5AW	02076610802

RHEUMATOLOGY

Dr Halina Fitz-Clarence	London, W1G 6HL	02078989999
Dr Gerard Hall	London, SW1W 8RH	02079083722
	London, W1G 6PU	02076610863
	London, EC2M 5TU	02079083722
Dr Dhiya Houssien	London, W1G 9QY	02084347999
Dr Taher Mahmud	Kent, TN2 4UL	02084347999
	London, SE1 9BS	02084347999
	London, W1G 9QY	02084347999
Dr Clarissa Pilkington	London, WC1N 3JH	02037447779 ext 7887

SPORTS MEDICINE

Dr Eleanor Tillett	London, W1G 6PU	2076610863
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SURGERY

Mr Sanjay Agrawal	Essex, CM15 8EH	02084347536
	Hertfordshire, CM21 0HH	02084347536
	London, W1G 6AT	02084347536
	London, NW8 9NH	02084347536
	London, E1 4NL	02084347536
	London, NW8 9LE	02084347536
	London, E14 4HD	02084347536
	London, IG9 5HX	02084347536
Mr Ahmed R. Ahmed	London, IG4 5PZ	02084347536
	London, W1G 6NP	02084347545
	London, W21NY	02084347545
	London, SW1W 8RH	02084347545
	London, W1U 5HJ	02084347545
	London, W1G7ET	02084347545
	London, SW5 0TU	02084347545
	London, W6 8RF	02084347545

SURGERY

Mr Ali Alhamdani	Hertfordshire, WD23 1RD	02076610821
Mr Ali Alhamdani	London, SW5 0TU	02076610821
	London, NW8 9LE	02076610821
Mr Satyajit Bhattacharya	London, W1G 6HL	02038840532
Ms Avril Chang	London, SE1 2PR	02076610839
	London, SE5 9RS	02076610839
Mr Abhay Chopada (Colorectal and general surgery)	London, SW5 0TU	02038840628
	London, TW8 9DU	02084347993
	London, HA1 3RX	02084347993
Ms Christina Choy	London, W1U 5NY	02084347566
Mr Frank Cross	London, W1G 6LF	02076610856
	London, E1 4NL	02076610856
	London, CR9 8AB	02076610856
Mr Maisam Fazel (Plastic and reconstructive surgery)	Berkshire, SL4 3SJ	02084347589
	London, W1G 7HB	02084347589
	London, IG9 5HX	02084347589
	London, EN2 8SD	02084347589
	London, HA1 3RX	02084347589
Mr Pasquale Giordano	Essex, IG9 5HX	02037442776
	Essex, IG4 5PZ	02037442776
	London, W1G 9QT	02037442776
Mr Stuart Gould	London, NW8 9NH	02084347539
	London, HA1 3UJ	02084347527
	London, HA1 3RX	02084347537
Mr David Greenstein (Vascular and venous surgery)	Hertfordshire, WD23 1RD	02039342089
	London, NW8 9NH	02039342089
	London, HA1 3RX	02039342089
Mr Majid Hashemi	London, NW8 9NH	02039342078
Mr Charles Imber	London, W1G 8EA	02039342039
Mr Jeffrey Lordan	London, W1G 7JL	02037442779
	London, NW3 2QG	02037442779
Professor Massimo Malago	London, W1G 8EA	02084347564
Ms Sarah Mills	London, SW1W 8RH	02039340011
	London, W1G 6BW	02039340011
Mr Krishna Moorthy	London, W2 1NY	02084347561
	London, NW8 7JA	02084347561
Professor Muntzer Mughal	London, W1G 8EA	02084347542
	London, W1G 7JL	02084347542
Mr Sakhawat (Zak) Rahman	London, NW3 2QG	02038840560
	London, EN5 5TS	02038840560
Mr Nicholas Reay-Jones (General and colorectal surgery)	Hertfordshire, AL5 4BP	02084347588
	Hertfordshire, SG4 9QZ	02084347588
Professor Francesco Rubino (Bariatric surgery)	London, SE5 9RS	02084347991

Mr Rajiv Vashisht	London, SW5 0TU	02039342094
	London, HA1 3RX	02039342094
	London, TW8 9DU	02039342094
Mr Andrew Wan	London, SW19 5NX	02038840597
	London, SM3 9DW	02076610842
Mr Peter Willson	London, KT2 7QB	02084347998
	London, KT2 7EG	02038840500
	London, SW19 5NX	02038840520

UROLOGY

Mr Hashim Ahmed	London, SW5 0TU	02037447782
	London, W1G 9QJ	02037447782
Mr Christopher Anderson	London, W1U 5LZ	02038840536
	London, SW19 5NX	02038840536
Mr Andrew Ballaro	Essex, CM13 3LE	02084347565
	London, NW8 7JA	02039342054
	London, NW8 9NH	02037442789
Mr Sudhanshu Chitale	London, W1U 5NY	02084347548
	London, E1 4NL	02084347548
	London, W1G 7AF	02084347548
	London, W1G 7JL	02084347548
	London, NW11 9PY	02084347548
	London, N6 4DJ	02084347548
Mr Tamer El-Husseiny	London, EN2 8SD	02084347548
	London, W2 1NY	02076610855
Dr Marie-Klaire Farrugia (Paediatric urology)	London, W6 8RF	02076610855
	London, SW5 0TU	02076610846
Mr David Hrouda	London, SW10 9NH	02078989988
	London, SW5 0TU	02076610846
Mr Rajesh B. C. Kavia	London, W6 8RF	02039347405
	London, W1G 6BW	02037442785
Mr Marc Laniado	London, HA1 3RX	02037442785
	London, HA6 2JW	02037442785
	Berkshire, SL4 3SJ	02039342045
Mr Gordon Muir	Buckinghamshire, SL3 6NH	02039342045
	London, W19 9QJ	02039342045
	Kent, TN13 2JD	02037442772
Professor Anthony Mundy	London, SW1W 8RH	02037442772
	London, SE1 9BS	02037442772
	London, SE5 9RS	02037442772
Mr Keng Jin Ng	London, SE1 9BS	02039342060
	London, W1G 9QY	02076610844
	London, W1U 5NY	02076610844
Ms Jhumur Pati	London, HA6 2JW	02076610844
	London, HA1 3RX	02076610844
	London, NW8 9JA	02038840613
	London, E1 4NL	02038840613

UROLOGY

Ms Jhumur Pati	London, IG4 5PZ	02038840613
	London, EN2 7PR	02038840613
Mr Jonathan Ramsay	Berkshire, SL4 3AA	02038840582
	London, W1G 7AF	02039342043
	London, W1G 6HL	02037447781
Mr Sarb Sandhu	London, KT3 3TX	02038840578
	London, KT2 7QB	02089342875
	London, KT2 7EG	02038840525
	London, SW19 5NX	02038840526
	London, TW8 9DU	02083226000
Mr Ranjan Thilagarajah	Essex, CM1 7GU	02039342091
Mr Mathias Winkler	London, W6 8RF	02038840598
	London, TW8 9DU	02039342074

VASCULAR SURGERY

Mr Paul Baskerville	London, W1G 8GL	02076610810
Mr Philip Coleridge Smith	Berkshire, SL6 8DG	02084347535
	Buckinghamshire, HP7 0HP	02084347535
	London, W1G 6LF	02084347535
	London, SW1W 8RH	02084347535
Professor Alun Davies	London, W2 1NY	02076610846
	London, SW5 0TU	02076610846
	London, SW195NX	02076610846
	London, W6 8RF	02076610846
Mr Ian Franklin	London, W1G 6AA	02076610851
	London, SW1X 9BW	02076610851
	London, SW1W 8RH	02076610851
Ms Sophie Renton	Hertfordshire, WD23 1RD	02076610854
	London, HA1 3RX	02038840623
	London, TW8 9DU	02076610853
Mr Stephen Black	London, W1G 6AA	02039342079
	London, W1G 8BJ	02039342079
	Surrey, KT21 2SB	02039342079
Mr Mark Tyrrell	Kent, TN2 4UL	02037442777
Professor Mark Whiteley	Bristol, BS8 3LS	02084347587
	London, W1G 0BG	02084347584
	Surrey, GU2 7RF	02084347586

DENTISTRY

Dr Anthony Druttman (Endodontics)	London, W1G 6QB	02037442778
Mr Josiah Eyeson	London, W1G 7AF	02038840599
	London, W1G 7LH	02038840602
Mr Greg Finn	London, BR3 3NE	02076610833
Dr Mark Hughes	London, W1G 9PY	02039342031
Dr Tidu Mankoo	Berkshire, SL4 3BA	02039342080

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John K. Castle

Chairman of Castle Connolly Medical Ltd

Former Commissioner and Officer of the Joint Commission (formerly known as JCAHO)



John J. Connolly, Ed.D

President & CEO of Castle Connolly Medical Ltd

Formerly President of New York Medical College

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Dr Devinder Bansi
DM FRCP BM
Gastroenterology



Mr Satyajit Bhattacharya
MB MS MPhil FRCS
Surgery



Professor Martin Birchall
MA MB Bchir MD
FRCS F Med Sci
ENT



Mr Luke Cascarini
BDS MBBCh FDSRCS
FRCS(OMFS)
Oral & Maxillofacial Surgery



Dr Duncan Dymond
MD FRCP FACC FESC
Cardiology



Mr Adrian Lower
BMedSc BM BS FRCOG
Obstetrics & Gynaecology



Professor Stephen MacKinnon
MD MBChB
Haematology



Dr Vincenzo Maurino
MD BQOph AMRCOph
Ophthalmology



Mr Sean Molloy
MB BS FRCS MRCS MSc
Orthopaedic Spinal Surgery



Professor Kevin Peter Moore
MB BS FRCP BSc PhD
Hepatology



Dr Neal Navani
MA MSc PhD FRCP
Respiratory Medicine



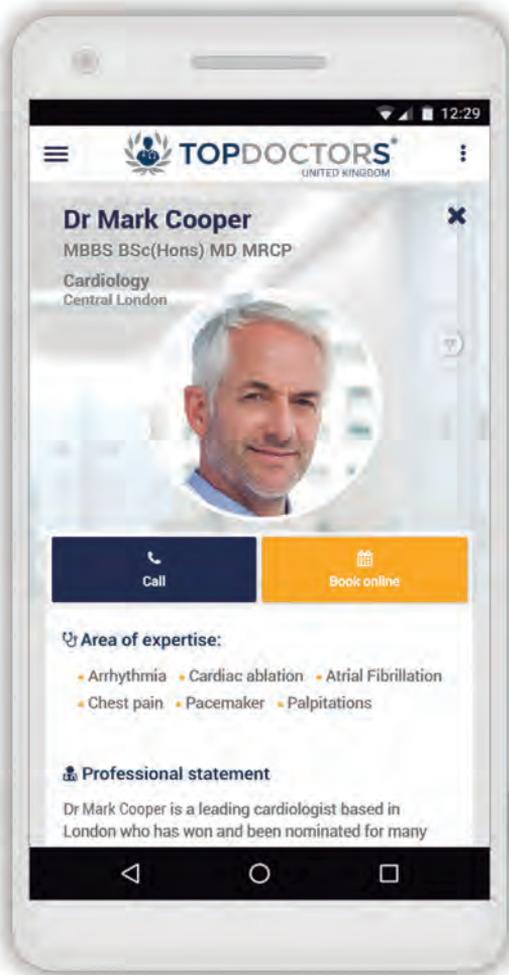
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MD
Bariatric surgery



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ENT - Thyroid



Dr Mark Vanderpump
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