DANDENONG DISTRICT

DIVISION OF GENERAL PRACTICE

Vol. 13 No. 6 NEWSLETTER JULY, 2007

Shaping up for the future

With a new financial year come a whole new set of funding and program development opportunities. Having a number of programs now firmly entrenched with ongoing funding (including the Diabetes Coordination and Assessment Service, Aged Care Panels and Access to Allied Psychology Services) we can look at other possibilities.

One area to which we will be paying particular attention in coming months is Information Management – and specifically finding ways to assist practices in using the enormous amount of information currently stored in your computers in ways that can help you work smarter, not harder.

Among the initiatives we will pursue is that of the **National Primary Care Collaboratives**. This program has been operating across a number of Divisions for a couple of years and has proven to be both popular and successful. The program aims to improve clinical outcomes, reduce lifestyle risk factors and promote a culture of quality improvement in General Practice. It is essentially a 'change management' process, whereby practices are able to identify various activities within the practice and develop and implement structured changes leading to improved quality. Included among the areas that practices have successfully addressed is better patient data management – particularly in relation to chronic diseases – that can enable better reminder systems, more consistent patient care and better SIP rates. We will be inviting practices to get involved over the next few months.

We will also be investigating various information management 'tools' – particularly those that can be of value in data extraction (remembering of course that good data extraction is entirely dependent on good data entry!), and ways of making clinical and business use of that data. An example of such a tool is the **Practice Health Atlas.** This is a methodology that allows you to use practice data as a decision support tool and can inspire general practice teams to reflect on their activities and guide business planning in relation to clinical, financial and workforce aspects of a practice.

While we accept that this sort of information management is not the be all and end all of general practice we do recognise that it is possible to have a greater impact on management of chronic disease in the community through closer attention to data that is often not collected systematically. Some years ago I was involved with an American consulting firm whose mantra was, "If you can't measure it, you can't manage it". Without heading down such a prescriptive road, we look forward to helping members make use of all that technology which, in most instances, sits under-utilised on your desks and which, if managed effectively, can actually give you more time to practice medicine!

Graeme Fletcher, Acting CEO

Dandenong District Division of General Practice

314B Thomas Street, Dandenong, 3175
Phone: 9706 7311 Fax: 9793 4050
Email: dandiv@dddgp.com.au
Website: www.dddgp.com.au
Office hours: 8.00a.m. – 5.00p.m.

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	Dr. Cely Goeltom

To email staff directly: *initial.surname@dddgp.com.au*
pki@dddgp.com.au

Deadline for newsletter articles is 10th of each month. Dandenong District Division of General Practice reserves the right to accept or reject all material submitted for publication. For further information please call the Division.

DISCLAIMER
The views expressed in this newsletter are those of the authors and do not necessarily reflect the official position of the Dandenong District Division of General Practice

Inserts: National Bowel Cancer Screening Program – Information for GPs

Haematology Update

Caring for a person with a disability as you get older

ASTHMA ACTION PLAN 'LIBRARY' LAUNCHED

A comprehensive on-line library of downloadable Written Asthma Action Plans has been launched by the National Asthma Council Australia (NACA).

The new library, located on the NACA's website www.nationalasthma.org.au/html/management/actionplans/ap005.asp provides quick access to a selection of the most reputable plans currently available in Australia today, as well as links to several international options.

All plans can be accessed directly from the website enabling health professionals to select the most appropriate plan for their patients and eliminating the need to stockpile hard copies.

According to National Asthma Council Australia chairman, Prof John Wilson, a written asthma action plan should be an integral part of asthma management.

"Research shows that written action plans keep people with asthma in control of their condition," Prof Wilson said. "They are better equipped to recognise deterioration of their symptoms and can respond appropriately."

"Different action plans suit different people and this new one-stop shop will allow doctors and other health professionals to select and adapt the format that is most appropriate for them and their patients," Prof Wilson explained.

The new Written Asthma Action Plan mini-site, within the National Asthma Council Australia website, features the:

- National Asthma Council Australia's popular Action Plan template;
- Department of Health and Ageing Action Plan developed as part of the Asthma Cycle of Care 2007 initiative;
- Symbicort SMART Asthma Action Plan;
- Every Day Asthma Action Plan developed by the Spencer Gulf Rural Health School, Pika Wiya Health Service and Asthma SA for remote indigenous Australians. This plan may also be useful for other people who are not comfortable with complex written English.

(Taken from NACA media release July 2007)

information about recent gp items:

Check out our division web site home page under "Hot resources" for a link to the DoHA website to get quick information about new item numbers relevant to general practice. www.dddgp.com.au

The National Bowel Cancer Screening Program

You may see patients or have queries from patients who have turned 55 **or** 65 between 1st May 2006 and 30th June 2007 and have received a bowel cancer screening kit (Faecal Occult Blood Test - FOBT) in the mail. Ideally patients will complete the test and send it back to the pathology lab in the pre paid envelopes provided. Patients are asked to nominate a GP or Practice for the test results to be sent to, as well as being sent to themselves and the Medicare register.

Upon receiving a positive FOBT result patients are encouraged to make an appointment with their GP to discuss the results. Depending on the patients circumstances you may need to refer them for a colonoscopy and manage them according to your practice policies and procedures.

All practices should have received a National Bowel Cancer Screening – Information Kit – Please contact the **Information Line** on: **1800 118 868** if you didn't receive a kit.

NB: Non PIP registered practices won't have received a kit as their details aren't on the Medicare database used for this program, these practices are still eligible for this program but will need to call the info line to get a kit)

The kit contains all the information you need to know about this program as well as the forms that you need to fill out for payment and sending results back to the Medicare register.

Information covered in kit that may be of interest:

- Your role in this program
- The screening pathway
- Your duty of care (if a patient with a positive FOBT doesn't contact the clinic and you know that they have a positive result as you have received a copy of the results)
- Payment arrangements

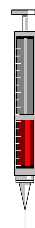
Important to know:

- If you want to receive payment for the program you must fill out a "Payment Account Details for Service Provider Form" and fax to: 03 6281 0554. If this isn't filled out you will not receive any payments associated with this program. If you require a form please phone the National Bowel Cancer Screening Program **Information Line** on: **1800 118 868.**
- You must notify the register (on the forms provided) of the outcomes for all patients that attend as a part of the program. Even if you are not referring the patient on for a colonoscopy please advise the register of the outcome. A payment to you of $6.60 (GST inclusive) applies. Forms can be faxed to the register on **free fax** number: **1800 115 062**
- When referring your patient for colonoscopy, please attach a National Bowel Cancer Screening Program Participant sticker (provided in the kit) to the colonoscopy referral letter. This sticker will identify your patient as a program participant.
- Concerns have been raised about colonoscopy waiting times for public patients, especially if they have received a positive FOBT result, patients will be anxious to find out the results of their colonoscopy and waiting 4 months isn't ideal. An arrangement has been made with DHS for some hospitals to provide a colonoscopy to patients referred through this program within 30 days of receiving the referral. Two hospitals that have agreed to this are: Dandenong and Monash Clayton. This is why it is important that you put the stickers on the referral letter to identify the patients as a part of this program.

For more information:

- See attached info sheet.
- Visits www.cancervic.org.au/generalpractice and click on the National Bowel Cancer Screening Program and General Practice Link
- Contact Michelle Guille at the Division on: 9706 7311.

Immunisation Tip



There have been reported cases of chickenpox around Melbourne, remember that all children born since May 1st 2004 are eligible for funded chickenpox vaccine once they are 18months old. There is also a catch up program for children in Year 7. Sometimes they just need a reminder.

End of 2005 – 2007 Triennium

As the end of the 2005 – 2007 triennium approaches, now is a good time to check that you have met your minimum QA & CPD requirements. GPs need to gain an overall minimum of 130 points, of these 2 activities completed need to be Category 1. Current credit point statements are due to be sent out soon otherwise it is available to participating GPs on the RACGP website or copies can be faxed or posted by contacting the RACGP QA&CPD Unit on 8699 0488.

Quality Use of Medicine News

It's frightening out there! QUM News started out in pharmacy as a delivery boy and has done just about everything in pharmacy but act as a consumer. So it was a bit of a shock when I got my first consumer experience a few weeks ago. A friend from the country asked me to pick up some medication at our local pharmacy for him. He was leaving for Canada the next Monday, the pharmacy had already given him some medication but was short a couple of boxes of Zocor® and out of stock of Coversyl Plus®, they promised these for the next day. As I was to see him that evening he asked me to pick these up.

Next day they did have the Zocor® but not the Coversyl Plus® and I was told to go to another pharmacy down the road to pick this up. At this stage with everything in hand I decided to check to see that nothing was missing and for the first time actually read the script. **Six** health professionals had been involved - 4 pharmacists (2 at each pharmacy, one took the script in and another handed it out) plus the prescriber (a locum - repeating these medications) plus my friend's regular GP (the original prescriber).

What these 6 all missed was one of the most publicised and potentially dangerous drug interactions – the infamous "triple whammy". It's been publicised in the MJA, NPS and by ADRAC to mention just a few sources. This was my friend's script - Coversyl Plus®, Celebrex®, and Zocor® which, translated into drug classes, is a diuretic + an ACE inhibitor + a COX2 NSAID (the "triple whammy") and a statin. The doses were all in the moderate range and my friend is in his mid 60s. He also has a great cellar (after visiting his place I've sometimes suffered a bit of volume depletion) so he does have renal risk factors.

I have advised my friend to lay off the Celebrex® and have a chat with his GP re alternate medication when he returns. And what was so frightening? Well none of the 4 pharmacists picked up this common drug interaction and queried it with either of the GPs involved. And neither of the GPs discussed the use of the much safer alternative of paracetamol with him, disappointing to say the least, as the short chat that I did have with him indicated that this may have had a fair chance of success. Below is the latest ADRAC bulletin re the triple whammy.

Beware the triple Whammy. *ADRAC has previously warned prescribers about the 'triple whammy' - the combination of an ACE inhibitor (ACEI) or an angiotensin II receptor antagonist (A2RA), a diuretic and an NSAID (including a COX-2 selective NSAID), which may predispose vulnerable patients to renal failure.*[1,2,3] *Risk factors include advanced age, pre-existing renal impairment and dehydration. In 2005, ADRAC received 21 reports of renal failure in patients who were exposed to the triple whammy. In a number of cases, precipitating factors included an acute illness, dehydration, digoxin toxicity or the recent addition of an NSAID to a patient already on an ACEI or an A2RA and a diuretic.*

The National Prescribing Service (NPS) has recently released Indicators of Quality Prescribing in Australian General Practice: a manual for users, available from the NPS website. One of the process indicators is entitled Good prescribing (avoiding the 'triple whammy') and reinforces the message that risk of the triple whammy should be avoided if possible and extreme caution should be taken with ACEIs or A2RAs and NSAIDs in patients with renal impairment.

It should be remembered that there are now many combination products available that contain both an ACEI or an A2RA and a diuretic. Some of the more commonly used combinations are shown in the Table. ADRAC advises that prescribers avoid the triple whammy where possible. However, if these drugs are necessary, prescribers should be alert for situations such as illness, dehydration or initiation of an NSAID, which may predispose patients on this combination to renal failure, and advise patients to seek medical advice during such episodes.

ACEI or A2RA/diuretic combination	***Product name/s***
Perindopril/indapamide	*Coversyl Plus*
*Fosinopril/HCT**	*Monoplus*
*Enalapril/HCT**	*Renitec Plus*
*Quinapril/HCT**	*Accuretic*
*Captopril/HCT**	*Capozide; Coverex Plus*
*Irbesartan/HCT**	*Avapro HCT; Karvezide*
*Telmisartan/HCT**	*Micardis Plus; Pritor Plus*
*Eprosartan/HCT**	*Teveten Plus*

**HCT - hydrochlorothiazide*

1. *ADRAC, Thomas M. Diuretics, ACE inhibitors and NSAIDs - the triple whammy. MJA 2000; 172: 184-5.*
2. *Boyd IW, Mathew TH, Thomas MC. COX-2 inhibitors and renal failure: the triple whammy revisited. MJA 2000; 173: 274 (corr. MJA 2000; 173: 504).*
3. *ADRAC. ACE inhibitor, diuretic and NSAID: a dangerous combination. Aust Adv Drug React Bull 2003; 22: 14-15.*

Quick Quiz.

1. The strength of the association between hip fracture and PPI therapy increases with increasing duration of PPI therapy. True or false?
2. Strontium ranelate has just been approved for the initial treatment (as the sole anti-resorptive agent) of established postmenopausal osteoporosis in women with fracture due to minimal trauma. Trials have shown superiority to, equivalence with or lesser effectiveness than other drugs currently used for this indication?
3. Drug-induced QT prolongation may be caused by blockade of cardiac potassium channels, and can lead to a life-threatening polymorphic ventricular tachycardia known as torsade de pointes. Name an antibiotic that has been implicated in producing this tachycardia.
4. Drug-induced interstitial nephritis is dose dependent and may not always recur with rechallenge. True or False?
5. Treatment of aggression and agitation in those with dementia with atypical antipsychotic medications is also associated with a reduction in death rates. True or false?

New in NPS RADAR for July. A couple of significant changes took place at the Pharmaceutical Benefits Branch of the Department of Health and Ageing last year. Consequently, the PBS is now updated monthly rather than quarterly and the PBAC is responsible for making recommendations about funding of vaccines under the National Immunisation Program. See the complete review on the *NPS RADAR* website (www.npsradar.org.au) also in this issue:

• **The human papillomavirus (HPV) vaccine (Gardasil),** has received widespread media coverage for both its anticipated public health benefits and for its adverse effects. The latest issue of *NPS RADAR* considers both of these aspects of the vaccine. The quadrivalent HPV vaccine is intended to protect against HPV types 6, 11, 16 and 18, which are responsible for 70–80% of cervical cancers. The vaccine does not protect against all HPV types that cause cervical cancer, or cervical cancer caused by HPV infection acquired before vaccination. The vaccine is available under the National Immunisation Program to females aged 12–26 years. All girls and women who have been vaccinated must continue to have regular Pap smears because the vaccine does not protect against all HPV types that cause cervical cancer, or cervical cancer caused by HPV infection acquired before vaccination.

• **Strontium ranelate (Protos) for secondary prevention in postmenopausal osteoporosis:** *NPS RADAR* explains its place in therapy for postmenopausal women with a previous fracture. The article highlights its differences in mechanism of action and method of administration, compared with other antiresorptive medications.

• **Atomoxetine (Strattera) for attention deficit hyperactivity disorder (ADHD):** *NPS RADAR* explains the place in therapy of atomoxetine as second line after psychostimulants for the treatment of ADHD. Safety issues, including suicidal tendencies in children, are considered.

• **Rotavirus vaccines (Rotarix and RotaTeq) for prevention of rotavirus gastroenteritis:** *NPS RADAR* examines the efficacy of these two oral vaccines that are listed on the National Immunisation Program. Although equivalent in efficacy, they are not interchangeable.

Amlodipine taken at twice the dose ordered, alendronate regularly forgotten and thyroxine taken after food. This was found in a Home Medicine Review reported to QUM News recently and is typical of the types of situations uncovered. With this patient it is probable that the higher dose of amlodipine was causing the fluid retention for which frusemide 20mg d had been ordered and may also have been responsible for the GORD for which pantoprazole had been prescribed. Additionally before food thyroxine instead of after food thyroxine could be just enough to repair the patients slightly depressed thyroid function results. And perhaps the alendronate may now get to be taken as "directed". Do you have patients that may be getting their medications a bit out of whack? Perhaps a HMR might help. If you are not sure what is involved give Graham Sweet at the Division a call on 9706 7311.

Current NPS topic - "Selective use of antibiotics". Booking are now being taken (Graham will ring regular NPS clients over the next few weeks) and this qualifies for the NPS QPI and the PIP - don't miss out, call Graham Sweet at the Division on 9706 7311.

NPS Clinical audits for GPs for QPI/PIP year 1 May 2007 – 30 April 2008. Topic* Updates

Targeted use of antibiotics* More than 1000 GPs participated. *Feedback reports* and *Review phase packs* will be received in October 2007.

Optimising drug use in ischaemic heart disease (Clinical e-Audit)*

Submission of initial data collection closed on 1 June 2007. GPs will be able to start the Review phase 12 weeks after submitting their initial data collection (from 27 June onwards).

Management of hypertension* Enrolment forms will be distributed to GPs with *Prescribing Practice Review* (PPR) 38 in June. Audit packs will be available in July 2007.

Management of osteoporosis* Enrolment forms will be distributed to GPs with *Prescribing Practice Review* (PPR) 39 in September 2007. However, audit packs will be available in August 2007.

Management of hypertension (Clinical e-Audit) Available in October 2007.

*These clinical audits are included in the 2005–2007 triennium of the RACGP QA&CPD Program and ACRRM PD Program. Clinical audits qualify as an activity for the Quality Prescribing Initiative. Activities completed before 30 April 2008 will qualify for QPI cycle May 2007 – April 2008. NPS applies for 30 (category 1) points in the RACGP QA&CPD program and 27 (including 20 mandatory) points in the ACRRM Professional Development Program.

Quick Quiz Answers.

1. True. Proton pump inhibitor (PPI) therapy is linked to an increased risk for hip fractures, with the highest risk in those receiving high-dose PPI therapy, according to the results of a case-control study reported in the December 27 issue of *JAMA*. The adjusted odds ratio (AOR) for hip fracture associated with more than 1 year of PPI therapy was 1.44 (95% confidence interval [CI], 1.30 - 1.59); this risk was further increased in patients prescribed long-term high-dose PPIs (AOR, 2.65; 95% CI, 1.80 - 3.90; *P* < .001). The strength of the association between hip fracture and PPI therapy increased with increasing duration of PPI therapy (AOR for 1 year, 1.22 [95% CI, 1.15 - 1.30]; 2 years, 1.41 [95% CI, 1.28 - 1.56]; 3 years, 1.54 [95% CI, 1.37 - 1.73]; and 4 years, 1.59 [95% CI, 1.39 - 1.80]; *P* < .001 for all comparisons).

2. Equivalent effectiveness. There have not been head to head trials but indirect comparison reveals no statistical difference. For more detail see the current NPS RADAR on www.radar.org.au .

3. From the ADRAC bulletin on December 2005 the most commonly implicated antibiotic was erythromycin. Also there were reports on clarithromycin, azithromycin, roxithromycin, metronidazole and moxifloxacin.

4. False. From the Australian Prescriber June 2007. Acute interstitial nephritis is due to a hypersensitivity reaction and is typically associated with reversible acute renal failure. Drugs account for 71% of cases of acute interstitial nephritis.[1] Medicines commonly implicated include non-steroidal anti-inflammatory drugs (NSAIDs), penicillins, cephalosporins, sulfonamides and proton pump inhibitors. Drug-induced interstitial nephritis is not dose dependent and can recur with rechallenge. The classic triad for interstitial nephritis of fever, rash and eosinophilia occurs in less than 10% of cases.[2] Urine examination including microscopy may show haematuria, proteinuria, white cells, casts and eosinophiluria, but may be unremarkable.

5. False. In a meta analysis of 15 placebo controlled trials published in JAMA (2005; 294:1934-1943) atypical antipsychotics increased the occurrence of death OR 1.54 (95% CI, 1.06-2.23). However other drugs also used for this indication also carry risks. The NPS advises caution with these patients when there is a known history of CV disease.

Patient Feedback – new requirements from the RACGP

The RACGP **Standards Liaison Committee** has mandated new requirements regarding patient feedback. As from 1st May 2007 the **"minimum number of surveys to be performed are 30 surveys per EFT GP per triennium, if a practice chooses to perform patient surveys."**

Minimum Requirements:

· 30 surveys/1 EFT GP

· 60 surveys/2 EFT GP's

· 90 surveys/3 EFT GP's

· 100 surveys if more than 3 EFT GP's.

This is mandated for all practices who will be conducting their patient surveys from 1st May 2007. For further information go to the RACGP Fact Sheet on Patient Feedback at http://www.racgp.org.au/standards/212

Feedback surveys in plain English and languages other than English are available free to download from the Dandenong Division website - look under Practice Accreditation Resources.

ASTHMA TIP

The NACA website link can be found on the division website or go to www.nationalasthma.org.au for resources, updates, general asthma information and links are also provided to international resources from the United States, Canada, New Zealand and the United Kingdom.

PAIRS

Parent and Infant Relationship Support group

- Free 8-10 week **treatment group**, run at least annually
- Collaboration between Dandenong Child & Adolescent Mental Health Services and Maternal Child Health Services
- Long-standing, well researched and run Australia-wide
- For the **early intervention** of potential later-life mental health difficulties
- Targets the **parent-child relationship** in the first 18 months of life
- Common presentations around which referrals might be made:

  Bonding difficulties

  Perinatal depression and anxiety

  Parental mental illness

  Failure to thrive

  Trauma or marked coping difficulties (medical or psychological)

  Abuse and/or neglect concerns

  Sleeping and/or feeding difficulties

All queries and correspondence to:

Dr Dion Rudzki, Psychologist,
Dandenong CAMHS
145-151 Cleeland Street, Dandenong 3175
Ph: 9767 8274
Fax: 9767 8244
Email: dion.rudzki@southernhealth.org.au

PREVENTING CRISIS – AGEING CARERS OF PEOPLE WITH A DISABILITY

Ageing carers 65 years and over who live with and care for a son, daughter or grandchild with a disability, i.e., an ABI, an intellectual or physical disability or a degenerative neurological condition, can now be funded through the Commonwealth Carer Respite & Carelink Centre (CCRCC), Southern Metropolitan Region (**Freecall 1800 059 059**) to take a break from their caring role. Indigenous carers are eligible for this respite program at the age of 45 years and over.

Many types of respite activities for the person with the disability are possible through the program, from supported recreational and leisure activities in the community, to overnight, weekend or holiday breaks in supported residential or camp settings. In-home support for the person with the disability is also offered.

Some of these adults have never stayed away from their parents, or strayed far from the family network. It can be devastating for them if a parent dies suddenly or becomes permanently incapacitated. In addition to the grief of losing their parent, they may lose their home, their familiar networks, even their familiar locality, and be placed in the first available setting for their ongoing care.

Respite activities can assist by familiarising the person with a disability with a range of new experiences, new places, and new people. There is opportunity to learn new skills and to gain confidence in new settings. At the same time, respite may assist the parent to gain peace of mind in knowing there are other options for the care of their son or daughter in the future.

Many older carers have been used to doing everything themselves for a long time, with little public support, and it is difficult for them to consider using a service that is designed to be of benefit to themselves.

GP's, often being the first point of contact for people who may be in distress at a personal level, are well placed to raise awareness about this respite program.
For further information about Ageing Carers Respite, an information brochure and/or poster to inform older carers of the supports available to them please contact the CCRCC Careline, **1800 059 059**, a 24 hour telephone service

Get involved in Hearing Awareness Week

One in six Australians has some form of hearing impairment. It's more common than many people think.

This is a key message that Australian Hearing is highlighting as part of Hearing Awareness Week (HAW).

HAW is a national initiative that raises awareness of hearing issues, including hearing protection and managing a hearing loss.

Deafness Forum of Australia is the coordinator of HAW and this year's theme is "Get the Message".

Australian Hearing uses the entire month of August to promote HAW, although the official week is 19-25 August 20

HAW activities in Dandenong for your clients to get involved in

Australian Hearing is running activities such as like open days and free screenings at each of its centres throughout the country.

Australian Hearing Dandenong plans to run several screening events in the Dandenong, Narre Warren and Springvale areas.

To find out more, your clients can contact 9794-5274.

What you can do

With HAW approaching, Australian Hearing is encouraging GPs to be on the lookout for hearing loss in their patients, particularly those aged over 65.

Australian Hearing Dandenong can help your practice get involved in HAW. If you would like brochures, posters or to organise for audiologists to conduct free screenings, or more information on hearing loss contact District Manager Marc Vandenberg on 9794-5274 or go to www.hearing.com.au

For free posters you can also go to www.hearingawarenessweek.org.au

Specialist Update

Knox Private Hospital is pleased to announce the commencement of their Berwick Specialist Suites

Level 1, Suite 9/50 Kangan Drive Berwick

Dr David Adam, **Cardiologist**
Phone: 9707 3561 or 0401787 743

Dr Danny Chen, **Respiratory /General Physician**
Phone: 9707 3561 or 0412 231 453

Dr Chee Kuan Chew, **(female) Gynaecologist /Obstetrician**
Phone: 9707 3561 or 0408 993 639

Mr Guy Dowling **Plastic Surgeon**
Phone: 9802 3611 or 0433 814 148

Mr Zeev Duieb, **General Surgery**
Phone: 9707 3561 or 0407 825 230

Dr Chris Goods, **Cardiologist**
Phone: 9837 5228 or 0419 893 327

Dr Rafi Huq, **Cardiologist**
Phone: 9707 3561 or 0407 000 996

Mr Alex Rosalion, **Cardiothoracic Surgeon**
Phone: 9457 1837 or 0411 467 395

Mr Adam Skidmore, **General Surgery**
Phone: 9707 3561 or 0400 801 002

City Fertility Centre
Melbourne your partners in life

Dr David Wilkinson
Medical Director

Dr Anne Poliness

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Ovulation induction
Intrauterine insemination
In vitro fertilisation
Intra-cytoplasmic sperm injection (ICSI)
Frozen embryo cycles
Embryo cryopreservation
Semen cryopreservation
Male infertility
Genetic Screening
Infertility Counselling

City Fertility Centre Melbourne
The Avenue Hospital
Level 1 40 The Avenue Windsor Vic 3181
Phone 1300 781 IVF (483)

also consulting at
Suite 4, 228 Cotham Road
Kew Vic 3104
Phone 9816 8100 for an appointment

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