WAKEFIELD HEALTH LIMITED

AWAKE

A Wakefield Health Magazine for GPs. Issue 2 Winter 2011

Recent Developments In Cataract Surgery

Area: Ophthalmology
Article written by: Dr Steve Mackey, Bowen Ophthalmologist, phone (04) 499 4940

Dr Steve Mackey

Bowen Hospital performs a significant volume of cataract surgery each year. Recent developments give patients a greater choice in their cataract surgery procedure including customised choices of focus (prescription) after surgery, as well as an easier recovery.

Over the last few years there has been a gradual improvement in a wide variety of aspects affecting the quality and comfort of cataract surgery. Pre-operative assessment assists intra-operative safety and post-operative results due to more sophisticated technology. There is an improved ability to assess visual potential in many eyes by better macular assessment using diagnostic tools such as OCT (Optical Coherence Tomography) and auto fluorescence.

With regard to the cataract pre-operative measurements (biometry), a wide range of diagnostic tools are available to characterise the size and shape of the eye and also software programs to better assist with formulation of the lens implant strength most suited to the eye. Through these methods the predictability of focus of the eye after surgery is becoming closer and closer to the exact desired focal length.

Continued on page 3.

What's inside

Recent Developments in Cataract Surgery > 1 & 3

GP Conference 2012 Update >2

Wellington Cardiac Services >4

Wick Used For Pre-Cataract Surgery Medication >5

Seeing More, Doing More >6

Breast Cancer Treatment >8

Bowen Centre Opening >10

Patient Referrals to Our Hospital >11

Education/Conference Centre >11

BOWEN HOSPITAL

ROYSTON HOSPITAL

WAKEFIELD HOSPITAL

Heart Centre
Wellington cardiac services
Page 4 >

Breast Cancer
Outlining typical courses of treatment
Page 8 >

Seeing More, Doing More
Dr Ian Wilson explores technical advances for gastroenterology
Page 6 >

Chief Executive's Contribution

Andrew Blair, Chief Executive, Wakefield Health Limited,
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It is a pleasure for Wakefield Health Limited to bring this second edition of the AWake magazine to General Practitioners. We received positive feedback from GPs after the first edition earlier this year and we value suggestions on how we can ensure this publication remains topical and of educational value to you.

This is one of the ways for Wakefield Health and our three hospitals (Wakefield and Bowen Hospitals in Wellington and Royston Hospital in Hastings) to thank you for the support that you provide to us and to the consultants who work in our hospitals.

Educational Forums

Another way in which we endeavour to show our appreciation for your support and for referring and entrusting us with the care of your patients is through our programme of educational forums held at each of our hospitals. Over the past 12 months we have provided educational sessions for General Practitioners on bariatric surgery, gynaecology, and orthopaedics at Royston Hospital, gastroenterology at Bowen Hospital, cardiology and gastroenterology at Wakefield Hospital. If you have a particular area of interest that you would like us to arrange a presentation or an educational opportunity, then please let us know. Most of these forums can be structured in a way to ensure GPs receive continuing education points through their attendance.

In this edition of AWake we again bring you interesting contributions across a range of specialties, from all three Wakefield Health Hospitals.

2012 Conference

As a continuation of our support for general practice, Wakefield Health will again be sponsoring the "GP Conference" to be held in Wellington 13-14 April 2012. Please note your diaries with these dates now. The organising committee is making good progress on what is expected to be another extremely stimulating conference, with well respected presenters dealing with topics of particular interest and relevance to your practice. Once again, if you have suggestions about topics you would find valuable, please let us know.

> If your patients believe they have to be referred to a particular hospital because of the insurance cover they have, that is not the case

Health Insurance

Over recent months we have fielded a number of enquiries from GPs on behalf of patients with Southern Cross Health insurance, asking whether it is possible for them to be treated at one of our hospitals, rather than at a Southern Cross owned and branded facility.

As Wakefield, Bowen and Royston Hospitals are not aligned to any particular health insurer, we admit and treat patients regardless of which organisation they have insurance with. You might be interested to know that approximately 65% of patients admitted to our hospitals have health insurance of some form or another. Around 20% of patients are funded by ACC, with the balance either paying out of their own pocket or being treated with funding from District Health Boards. So if your patients believe they have to be referred to a particular hospital because of the insurance cover they have, that is not the case and we encourage you to make your referrals to the specialist and hospital of your choice.

We would appreciate your feedback on the AWake magazine.

Kind regards
Andrew Blair, Chief Executive

GP Conference 2012

The next GP Conference will be held on 13 and 14 April 2012 at Te Papa in Wellington.

The conference programme and registration details will be made available over the coming months.

If you would like to receive further e-updates please email your details to jdarby@acumenrepublic.co.nz

Recent Developments In Cataract Surgery

Continued from front page.

There is now a wide choice of implant options. These include:

- **Monofocal lens – far distance** – allows excellent focus at far distances
- **Monofocal lens – medium distance** – allows excellent focus at medium distances
- **Monofocal lens – near distance** – allows excellent focus close up
- **Toric monofocal lens** – corrects astigmatism and focus at a desired distance
- **Multifocal lens**
- **Toric multifocal lens** – allows a near and distance focus for people with and without astigmatism.

An AcrySof ReSTOR Intraocular Lens

> "Patients get greater choice and an easier recovery"

Anaesthetic options for cataract surgery can also be customised to choice. A very commonly used option is sub-tenons local anaesthetic where the anaesthetic fluid is passed around the eye without the use of a needle. This is associated with mild discomfort only and is an incredibly safe and effective technique (allowing complete anaesthesia of the eye). People who opt for less anaesthetic in the form of eye drop anaesthesia or those wishing to have sedation can be accommodated as well. General anaesthetic is available but is rarely required.

Surgical techniques continue to be fine tuned. Most recently smaller incisions (less than 2.7mm and sutureless) allow for very rapid healing. The use of the Alcon Infiniti machine for the Ozil ultrasound technique allows very rapid and atraumatic break up of very dense cataracts.

The area of biggest change, however, has been the wide choice of intraocular lens implant options which can be customised to preference. A commonly used style of implant is a monofocal which allows excellent focus at the desired distance (for the majority, far distance vision). Medium range and near vision are sometimes chosen as focus options. Other monofocal lenses available include those that correct astigmatism (Toric lens implants). This is now in mainstream use and Bowen Hospital has recently acquired an excellent astigmatism marking tool, the Tomark Corneal Pendulum Marker. This has improved astigmatism "axis" marking and hence the accuracy of the astigmatism in implant surgery. Multifocal lens implants and Toric multifocal lens implants are now available. These allow a near and distance focus for people with and without astigmatism.

Another important aspect to Bowen Hospital cataract surgery care is the Day Stay and Theatre team staff. This team is very experienced, in particular the Eye Team Leader, Simon Auty, who is continually facilitating surgeons to trial new and improved tools for surgery.

For more information, please feel free to contact Dr Steve Mackey, phone (04) 499 4940.

Wellington Cardiac Services

We are pleased to confirm that patients in the greater Wellington region continue to have access to private cardiac services based at the Wakefield Heart Centre (WHC) now and in the future.

Cardiologists and Cardiothoracic Surgeons have recently agreed to a long-term arrangement with Wakefield Hospital to provide a full range of cardiac services from the current premises in Newtown, Wellington. As part of the arrangement, Wakefield Hospital will upgrade the WHC premises and facilities over the next few years to improve our services even further.

Our Cardiologists and Surgeons offer a full range of consultative, diagnostic and therapeutic services using leading edge technology and techniques in state of the art facilities. They provide seamless cardiac care from diagnosis through to treatment.

For all enquiries please phone **(04) 381 8115**, or fax (04) 381 8116. For after hours phone (04) 381 8100.

As we are affiliated providers with Southern Cross Insurance, members who have been previously assessed can be seen acutely by the Cardiologist on call, if referred by a General Practitioner.

WHC consultants would welcome the opportunity to meet with your practice group and update you on the latest developments in cardiology practice for your patients. If you would be interested in arranging a meeting, please call Jean O'Meara, Heart Centre Practice Manager, phone 04 381 8697 to arrange a suitable time.

WHC Cardiologists:

- Malcolm Abernethy
- Phil Matsis
- Stewart Mann
- Mark Simmonds
- Tim O'Meeghan
- Alexander Sasse

WHC Cardiothoracic Surgeons:

- John Riordan
- Barry Mahon
- James McGiven
- Glenn McKay

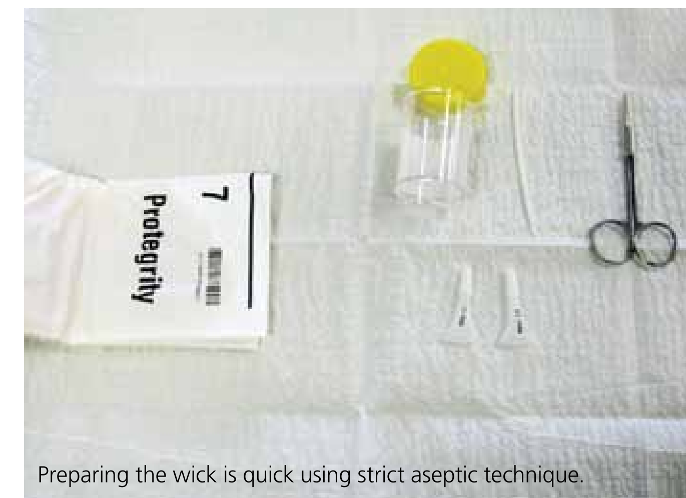
- Cardiac imaging and risk stratification
- Coronary angiography and intervention
- Cardiac surgery
- Cardiac pacemaker and loop recorder implantation
- Percutaneous treatment of valvular disease and closure of ASD/PFO
- Cardiac ICU
- Full time on call cardiologist

Wick Used For Pre-Cataract Surgery Medication

this quality initiative recently received a "highly commended" award

Area: Ophthalmology
Article by Pam Kohnke, Theatre Manager, Bowen Hospital, and Simon Auty, Ophthalmic Theatre Team Leader, Bowen Hospital

Improving the patient experience and developing a more effective way of preparing patients for ophthalmology surgery was the subject of a quality initiative which received a "highly commended" award at the NZ Private Surgical Hospitals Association Quality Awards in September 2010.



Preparing the wick is quick using strict aseptic technique.

Since 2006 Bowen staff have been using an absorbent wick to deliver the Mydriatic and other pre-operative medications for selected lists. The eye wick dilates the pupil before cataract (and selected vitreo-retinal) surgery instead of the standard technique for dilation consisting of a pre-op dosing regime of four or five different minims administered as drops every 15 minutes.

Staff first became aware of the technique when the Bowen Theatre Manager attended a presentation of it at the ACORN Congress 2005 by Mackay Day Surgery in Queensland.

Further incentive to adopt this technique came when Bowen Hospital was awarded a District Health Board contract in 2010 to perform 200 cases (with lists of approximately 25 patients) in a little over a month.

The process has helped considerably to manage large lists in the day unit and has proven to be a cost effective way of preparing patients for surgery. Along with cost savings in materials and staff time, it has also resulted in a more comfortable experience for the patients.

Materials used

The minims used vary from surgeon to surgeon but a typical combination is Tropicamide 1%, Phenylephrine 2.5%, Diclofenac (Voltaren Ophtha) and Benoxinate. The wick is cut into 5-6mm lengths and placed into a sterile specimen pot. The minims (except the Benoxinate) are then dispensed into the pot soaking the wicks in the resulting solution.

Results

Good dilation of pupils is achieved even after only 15 minutes of application. Patients are more comfortable, with the majority in the initial trial reporting a preference for the new technique (wick) compared with the previous drop regime.

No instances of corneal abrasion on post operative examination have been experienced and no instances of infection reported.

Significant time savings for staff have resulted, with a reduction in Nurse/Patient contacts for preparation administration down from four to five contacts to two.

This has allowed more quality time for the important things – patient care.

The technique was presented at the RANZCO Conference in 2007 and has spread to many facilities throughout New Zealand.

The process

1 Step 1: Two drops of Benoxinate (Oxybuprocaine) are instilled to operative eye

2 Step 2: The wick is inserted in lower fornix using sterile disposable forceps

3 Step 3: The eye is taped shut with small tegaderm

4 Step 4: The wick is removed after 45-50 minutes by day unit or theatre staff

References

Dubois, V et al. Randomised controlled single-blind study of conventional versus depot mydriatic drug delivery prior to cataract surgery, *"BMC Ophthalmology"* 2006, 6-36

Kirby, H. Report on use of eye wicks with ophthalmic medication for dilation of pupils before cataract surgery at Mackay Day Surgery, *"Day Surgery Australia"* Jul 2004, 4, 2, 6-7

Ong-Tone, L. Use of a wick to deliver preoperative mydriatics for cataract surgery, *"Journal for Cataract and Refractive Surgery"* Nov 2003, 29, 2060-2062

Seeing More, Doing More

Dr Ian Wilson

Area: Gastroenterology
Specialist: Dr Ian Wilson, phone (04) 381 8110

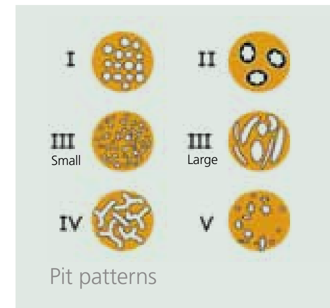
For more than 40 years, Gastroenterologists and Surgeons who perform endoscopy have been mining the long dark tunnels of the gastrointestinal tract to uncover various diseases and damage and to target therapy where possible. More than ever, we are now able to see more and do more.

We Are Seeing More

Just like the improvements in the images seen on your flatscreen TV or computer, there have been major advances in the resolution of the images obtained at endoscopy. High resolution video endoscopes and LCD screens have significantly increased the quality of the endoscopy image. Zoom endoscopy and digital zoom (magnification) have increased the image obtained up to 105 times. Atlas demonstrating pit patterns of mucosa and polyps distinguish between benign and malignant tissue before histology is obtained.

Chromoendoscopy, or chromoscopy, refers to the topical application of stains or dyes at the time of endoscopy in an effort to enhance tissue characterisation. Narrow Band Imaging (NBI) is an optical filter technology (digital chromoendoscopy) that improves the visibility of capillaries, veins and other subtle tissue structures.

Endoscopic confocal microscopy (which remains mostly an experimental tool) produces images at the cellular level and the ability to detect dysplasia or cancer cells at endoscopy before histology is obtained.



Pit patterns

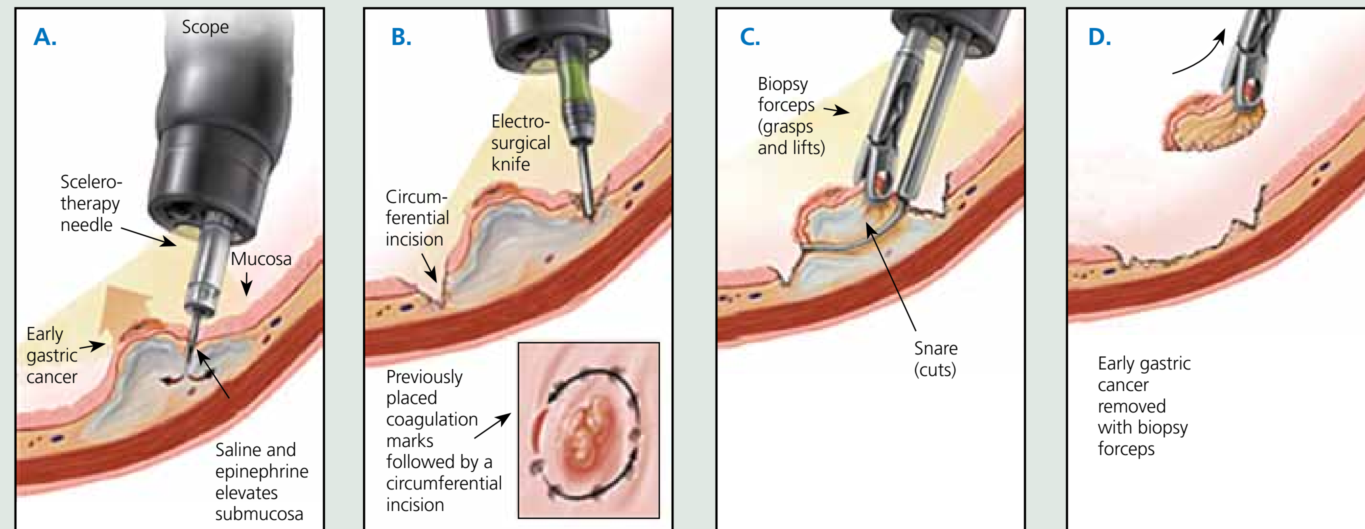
Increasingly available and coming soon to Wellington, endoscopic ultrasound outlines the intestine beyond the mucous layer and can identify and allow access to abnormalities outside the gut.

We Are Doing More

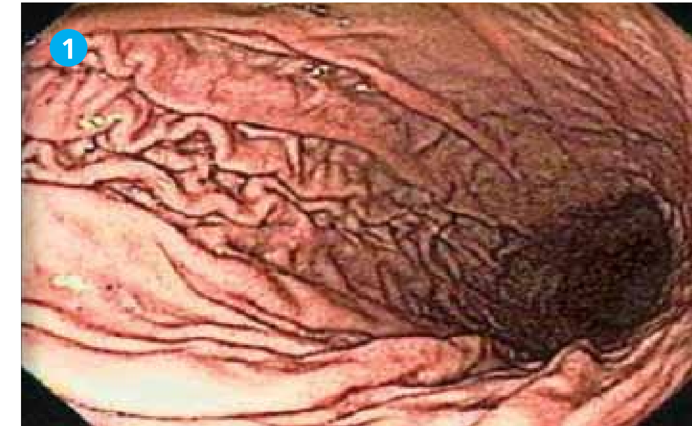
All this increased visual information has been accompanied by a significant increase in endoscopic interventions. In particular, endoscopic mucosal resection (EMR) of large polyps or dysplastic mucosa has become common place. Techniques to lift the mucosa away from the submucosa have enabled much safer removal of large segments of intestine without risk of bleeding or perforation.

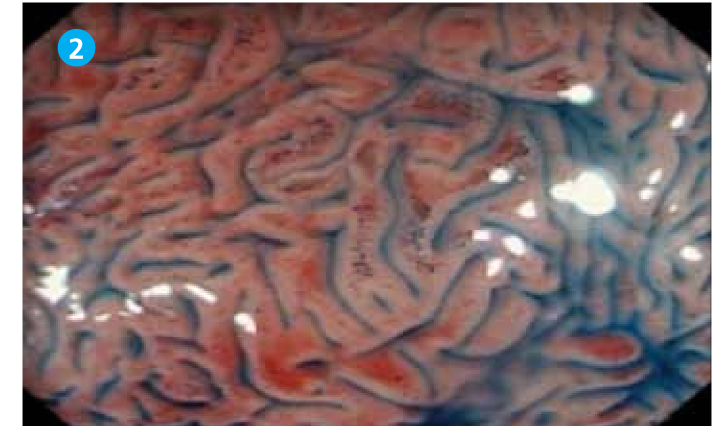
In the oesophagus, high grade dysplasia or even superficial adenocarcinoma can be removed by endoscopic techniques using bands, polypectomy and in some units endoscopic submucosal dissection (ESD). Large, lateral spreading polyps in the colon can now be removed safely where previously those patients would have required a surgical excision.

Endoscopic Mucosal Resection. Cross section of stomach wall.



Reference: www.hopkins-gi.org





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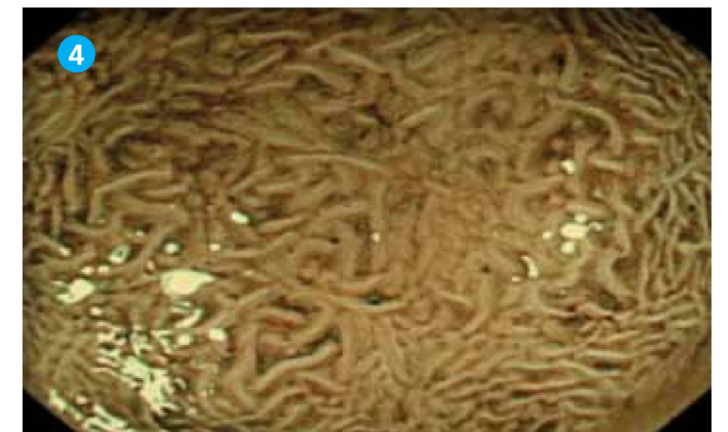
http://home.hiroshima-u.ac.jp/hirolive/



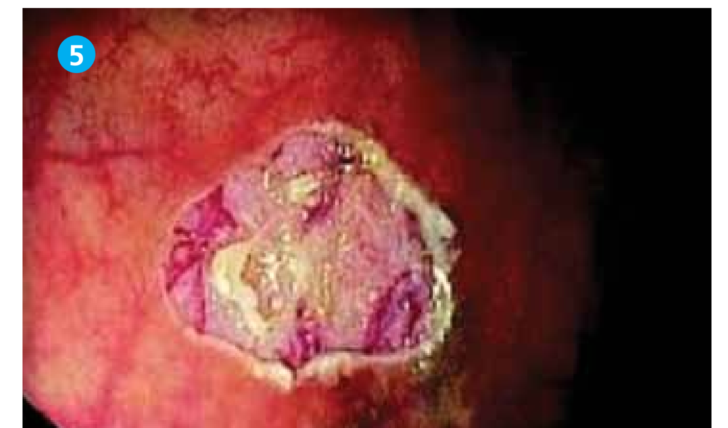
Endoscopic submucosal dissection, a specialised technique more commonly practised in Asia, can remove long segments of oesophagus containing Barrett's change or superficial adenocarcinoma in the stomach.

Natural Orifice Transluminal Endoscopic Surgery (NOTES) has enabled surgeons to pass endoscopic tools through the stomach wall into the peritoneum and perform typical abdominal operations such as cholecystectomy and appendicectomy, closing the stomach defect after the operation and bringing the organs removed out through the mouth. Sounds good but remains an experimental tool and is a long way from prime time.

In Summary

Endoscopy images are improving with increased optical technology. We are seeing more and we are able to do more. Endoscopic resection techniques have been developed that now allow the safe removal of mucosal pathology that would previously have required a surgical intervention.

For any further information or questions about the items raised in this article, please contact Dr Ian Wilson, Gastroenterologist at the Wakefield Gastroenterology Centre, askme@gastro.co.nz



1. The long and winding road
2. Chromoendoscopy image of pits
3. Adenoma polyp under NBI (Narrow Band Imaging)
4. Pit pattern under NBI
5. Endoscopic mucosal resection of colonic polyp

Breast Cancer Treatment

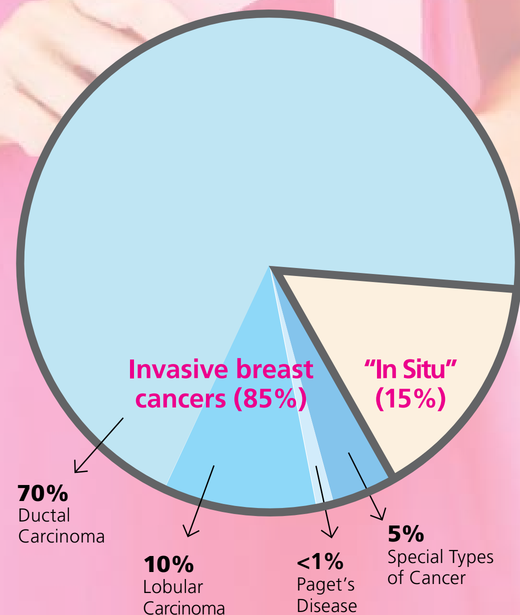
Mr Grant Broadhurst

Area: Breast Surgery
Contributor: Mr Grant Broadhurst, Royston General Surgeon, phone (06) 873 8007.

Breast Cancer Usual Sequence of Management by Breast Specialists

- Lump discovered or screen detected abnormality.
- Triple assessment of the lump at a breast clinic. This includes a clinical assessment, mammogram and ultrasound followed by a core biopsy or fine needle aspiration (FNA).
- Results are communicated to both the patient and GP.
- Breast Cancer Information Packs are given to patient at time of diagnosis.
- Consultation to discuss treatment options.
- Surgery as indicated.
- Cases are discussed at multi disciplinary meetings involving surgeons, oncologists, radiation oncologists, pathologists and radiologists. When indicated referrals are made to radiation and medical oncology clinics after discussion with patient.
- Once treatment complete, a two to five year follow up plan is arranged along with annual mammography for ten years.

Classification of Cancer Type



"In Situ" (15%)

Often described as precancerous.

D.C.I.S. (Ductal Carcinoma In Situ) Not invasive. The cancer cells are confined within the milk ducts. DCIS accounts for 25% of breast tumours detected by Breast Screening Programmes. Does not have the ability to spread to lymph nodes or elsewhere in the body.

L.C.I.S. (Lobular Carcinoma In Situ) Not invasive. The cancer cells stay inside the milk making lobules. Risk of future development of DCIS or invasive breast cancer in either breast.

Invasive breast cancers (85%)

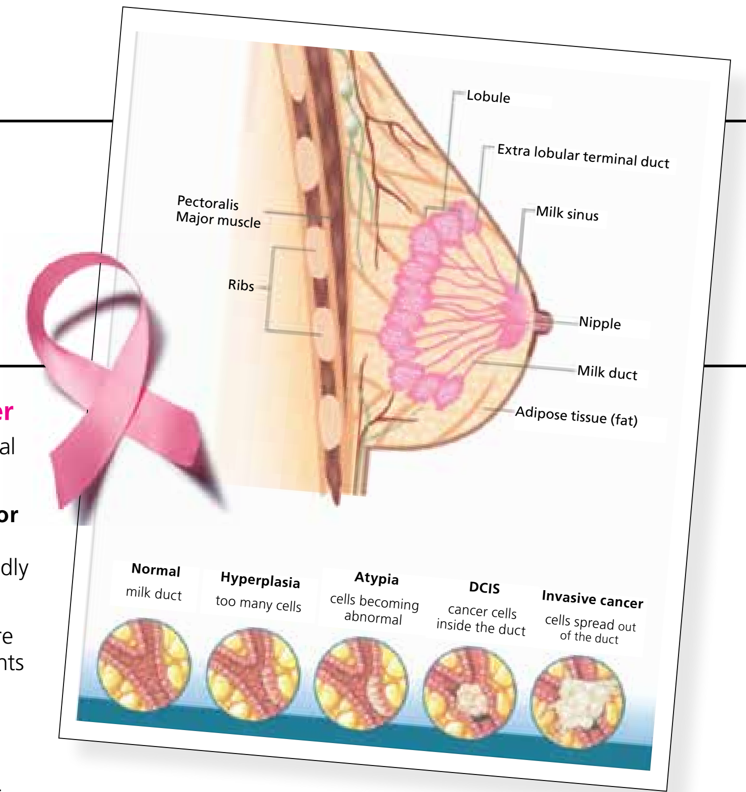
Have the ability to invade locally into the surrounding tissues and spread elsewhere in the body (lymph nodes and other organs). There are many different types.

Ductal Carcinoma (70%)
Is invasive and the cancer cells are growing into the surrounding breast tissue, outside the milk duct. This is the most common type of breast cancer.

Lobular Carcinoma (10%)
Is invasive and cancer cells are now growing outside the lobules. More difficult to identify on mammograms and more likely for there to be more than one tumour.

Paget's Disease (<1%)
Neoplastic condition of the nipple which may indicate a tumour elsewhere in the breast.

Special Types of Cancer (5%)
- Medullary
- Mucinous (Colloid)
- Tubular
- Adenoid cystic
- Papillary
- Secretory
- Inflammatory



Surgery

Breast conserving treatment: Lumpectomy (or wide excision) of the cancer followed by up to six weeks of radiotherapy. Suitable for small tumours.

Mastectomy: Removal of the breast. Used for larger more extensive tumours. Some women may request it.

Reconstruction: There are various types of reconstruction, which may be offered to women at the time of surgery or at a later date.

Sentinel Node Biopsy: This relatively new technique has proven to have fewer side effects than more traditional techniques for excision of lymph nodes.

The "sentinel node" (or nodes) from the axilla is sent to the pathologist to ascertain spread of disease. Identifying the node may be undertaken in one of two ways. However, both techniques are increasingly used simultaneously:

1) **A radioactive tracer** is injected into the tissue around the tumour or beneath the nipple. The tracer mixes with lymphatic fluid and travels to lymph nodes.
2) **Blue dye / Patent "Bleu V"** injection around the nipple at the time of surgery travels immediately in the lymph system and readily identifies the sentinel node when axillary incision is made.

Success rate for location of sentinel node with dye alone is greater than 90% and combined technique 98%.

Axillary Clearance: Complete removal of all lymph nodes from the lower levels of the axilla. This used to be the standard treatment for all invasive breast cancers. Increasingly only used for those women with advanced breast cancer and/or when the breast cancer has spread to the lymph nodes.

Grading of Breast Cancer

High Grade 3 – Very abnormal cells with rapid growth.

Intermediate Grade 2 and/or Low Grade 1 – Cells appear abnormal and grow more rapidly than normal cells.

The higher the grade, the more likely it is that systemic treatments will be recommended.

Pathology

Pathology report will include:
- Size and location of tumour
- Lymph node status
- Surgical margins
- Grade of tumour
- Receptor status – oestrogen, progesterone and c-erb B-2 (HER2) which predicts response to herceptin.

Hormone Therapies

These will be considered where oestrogen or progesterone receptors are identified on the cancer cells and may include:
- Anti-oestrogens, eg. tamoxifen
- Ovarian treatments include:
  - Radiotherapy to ovaries
  - Oophorectomy
  - Luteinizing hormone-releasing hormone (LHRH) Antagonist (eg. Zoladex) is considered for pre-menopausal women
- Post Menopausal
  - Aromatase inhibitors – stop/inhibit oestrogen production, include Anastrozole, Letrozole and Exemestane.

Chemotherapy

The decision to have chemotherapy depends on:
- A higher risk of spreading cancer, bigger tumour, positive lymph nodes, high grade tumour, vascular invasion
- More likely to have chemotherapy recommended if there are **not** hormone receptors
- General health
- Personal preference
- Age – younger.

For the larger or more advanced breast cancers, systemic treatment with chemotherapy may be used to shrink the tumours prior to surgery.

Herceptin

Available in New Zealand as an additional therapy for patients whose tumour contains c-erb B-2 (HER2) receptors and are already receiving chemotherapy.

Radiotherapy

Radiotherapy is required for all patients receiving breast conservation surgery excepting a small number with very small areas of low grade DCIS, who have a very low risk of recurrence.

For those patients undergoing mastectomy, only those who are at particular risk of a local recurrence will require radiotherapy. The majority will not.

Radiotherapy is normally given over the course of five or six weeks; on a daily basis (five days a week). Ideally this commences six weeks from the time of surgery or following chemotherapy. Occasionally, patients may be offered shorter, accelerated (more intensive) courses.

Post Surgery Considerations

- Pain
- Wound infection
- Bruising – haematoma formation
- 'Cording' (a palpable tight and painful band of tissue running down the arm towards the hand)
- Seroma
- Changes in sensation
- Lymphoedema
- Reduced shoulder / arm movement.

Discharge

Discharge considerations include:
- District Nurse referral if patient discharged with drain in situ
- Usual consideration of home help and personal cares
- 'Softie' prosthesis where there has been a mastectomy
- Axillary cushion for comfort on those women who have had axillary node dissection.

For further information, please contact Mr Grant Broadhurst, General Surgeon, phone (06) 873 8007.

References

- *"Breast Cancer – Te Matepukupuku o ngā Ū – A guide for women with breast cancer"*, published by NZ Cancer Society
- *"EBC – Guide for women with early breast cancer"*, published by Australian Cancer Society
- *"Nursing 2009"* magazine.

Recommended Reading

- Cancer Society Breast Information Packs are a valuable source of information for patients, family and nurses
- *"Dr Susan Love's Breast Book"* published by Da Capo Press is highly recommended reading for nurses and women with breast cancer.

Acknowledgement:
Wakefield Health Ltd would like to acknowledge the contribution made by Jude McGhie, Senior Registered Nurse, Royston Hospital.

Bowen Centre Opening

Phase One of the Bowen Hospital redevelopment, the Bowen Centre, was officially opened by the Minister of Health, the Hon. Tony Ryall in March 2011.

This 3,300m² state of the art facility comprising five levels has been constructed to provide specialist consulting rooms for surgeons and physicians including a new Endoscopy Suite for Bowen Hospital and covered car parks for the convenience of patients, visitors, staff and doctors. It also provides accommodation for Pacific Radiology who provide radiology and imaging services on site.

With the completion of the Bowen Centre and the relocation of Radiology, Endoscopy and consulting services from the original Bowen Hospital building, work on Phase Two of the redevelopment is now underway. This will involve the construction of five new operating theatres to replace the three original theatres that have served the community so well over so many years.

After the new theatre block is completed around December this year, the existing theatre suite will be redeveloped to provide for an improved Day Surgery service.

This redevelopment is expensive. Phase One of the Bowen Centre cost Wakefield Health Ltd around $16.5m. Phase Two is expected to cost a similar amount. This is a major investment but it is one that Wakefield Health has been prepared to make because of our confidence in the future demand for elective surgery, and the increasing role that we believe private hospital providers will have in the delivery of healthcare to New Zealanders.

Top: Dorothy Shaw (Bowen Hospital Manager), Don Moodie (Architect/Project Manager), Andrew Blair (Chief Executive, Wakefield Health Ltd), Katrina Shanks (MP), Angela Lindsay-Hawkins (Endoscopy Suite Nurse Manager), Hon. Tony Ryall (Minister of Health) and Alan Isaac (Chairman, Wakefield Health Ltd). **Lower left:** Hon. Tony Ryall with Dorothy Shaw.

Phase One:
- consulting rooms
- endoscopy suite
- radiology services
- car parking
- services block

Patient Referrals To Our Hospitals

Wakefield Health Limited owns and operates three surgical hospitals – Wakefield and Bowen Hospitals in Wellington and Royston Hospital in Hawke's Bay – independent of any particular health insurer. That means we can treat patients who have health insurance regardless of who the insurer is, as well as patients who choose to self fund, or are entitled to care funded by ACC or DHBs.

Despite our independence, we often find that there is confusion amongst those people who have Southern Cross insurance who believe that they can only be treated at Southern Cross hospitals. That is not the case. In fact a majority of patients treated in our hospitals have Southern Cross insurance.

In a recent initiative aimed to benefit Southern Cross insurance policy holders, Wakefield Health Ltd entered into an expanded Affiliated Provider Agreement with Southern Cross Medical Care Society for the provision of endoscopy procedures at Wakefield, Bowen and Royston Hospitals, and for cataract and other eye procedures at Bowen and Royston Hospitals. The major benefits of this agreement are price certainty for your patients and a streamlined prior approval and claim process.

In considering referrals for specialist consultations and treatments we encourage you to offer your patients access to our hospitals and to the consultants associated with them regardless of whether your patients have Southern Cross insurance or not. Details of the consultants available at our hospitals can be found on our websites and in the Specialist Directory enclosed. Further information on the Affiliated Provider Scheme is available on the Southern Cross Medical Care Society website.

For further information please contact:

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Education And Conference Centre

Wakefield Hospital has recently opened a new Education Centre on campus.

This facility is a purpose built, state of the art venue comprising five seminar rooms of varying sizes featuring audio visual equipment, DVD player, wireless connection, multi-speaker sound system, whiteboards, air conditioning, full kitchen and rest-room facilities.

In March Wakefield hosted a successful GP CME meeting in the Education Centre which was attended by approximately 50 GPs. The meeting was presented by Wakefield Cardiologists who also provided some practical demonstrations of coronary angioplasty and stents in the catheter laboratory and stress echo in cardiac physiology.

Its prime location, within the hospital, makes it an ideal venue for conferences, training, cocktail parties and evening events. We are very happy to offer room hire at the Education Centre to all General Practitioners, **free of charge.**

We are able to assist you with full set up options to accommodate your specific needs. Catering and equipment hire can also be provided at minimal cost.

To view the Education Centre, or to make a booking, please contact Debbie Lee, Personal Assistant to the Hospital Manager, on (04) 381 8100 extension 5337.

Contact Us

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