

Dear General Practitioners,

The SDHB becomes the Southern District Health Board on 1 May 2010. My email address will change but I have been assured mail to the old one will still get to me. See below for the one starting on May 1<sup>st</sup>. This will be the format if you want to email any member of staff of the Southern District Health Board : [firstname.surname@southerndhb.govt.nz](mailto:firstname.surname@southerndhb.govt.nz)

At the CME evening on Rheumatology the topic of **temporal arteritis (Giant Cell arteritis or GCA)** was raised and a protocol was requested. We have been looking at ways to ensure referrals to the hospital for temporal artery biopsy get handled with appropriate speed. Mostly this happens well but occasionally there are cases where the biopsy has taken longer than two weeks to be done. I recommend you fax your request to the Referral Centre 03 214 7276. Administrative staff will put the patient on the next minor surgical list.

**Patients who should be biopsied need**

- To be >50 years (more likely to be >60)
- An elevated acute phase response (usually an elevated CRP but ESR on very rare occasions)
- A symptom suggestive of temporal arteritis (temporal headache, abnormal temporal artery, jaw claudication, sudden visual loss, or diplopia)

Biopsy should be considered after consideration of alternative diagnoses (migraine, cerebral bleed etc) or when there is systemic inflammation (usually CRP+++ ESR+++ in the elderly without clear organ specific symptoms.

Someone under 50 with a strong clinical picture of Giant Cell Arteritis (GCA)

**Biopsy is not usually needed in**

Polymyalgia rheumatica (PMR) without symptoms of GCA (temporal headache, abnormal temporal artery, jaw claudication, sudden visual loss, diplopia) responding as one might expect (normalization of symptoms, within 1-2 days of prednisone 10-15mg along with near normalization of ESR CRP at 2/52)

**Refer then treat**

Start prednisone 40-60mg/day straight away.  
+/- aspirin 100mg, +/- bisphosphonates, vitamin D, calcium and a proton pump inhibitor.

**Driving capability in older or ill patients.** It is often very hard to tell a patient that their health is no longer good enough to drive safely. One option is to refer these people to the Assessment Treatment and Rehabilitation service at the hospital. If we all do this it may lengthen the waiting list for our patients with more pressing health needs. AT & R use tools to objectify their decision and are happy to share these with us. Like us, they test visual acuity and physical capabilities. They also use a one page test called a "Trail making test" in which a poor performance correlates strongly with poor driving performance. I have attached a copy to this newsletter and put it on the GPL page of the website. My understanding is that if it takes your patient more than three minutes to link the 1-A, 2-B, 3-C etc it is a fail. There are also driving instructors/testers who can do on road testing but they appreciate it if we can screen out those who definitely are medically unsafe to be driving.

**Department of Medicine update**

Dr Paddy O'Connor has left this month and it is with great sadness we say good-bye to her. Paddy is a respected physician who has shared her expertise in gastroenterology and general medicine generously. Respiratory medicine is well served at the moment with Anoop Nambiar back for May and June and Roland Meyer here for two weeks out of three. Jens Richter has been a registrar here on and off and now is back as a General Medicine physician. Alistair Scott is here again as a locum. Alasdair Millar, Anne Maloney and Massimo Giola are the other permanent physicians.

Recently I was shown the list of Pharmac seminars. They cover an interesting range of topics if anyone is interested in going to one: <http://seminarseries.pharmac.govt.nz/seminars.php>

Our local medical officer of Health, Dr Marion Poore, has written a great summary update of H1N1 which is available on the new website [www.southerndhb.govt.nz](http://www.southerndhb.govt.nz)

I hope this newsletter continues to be useful for at least some of you. I do appreciate feedback – good, bad or indifferent.

**Estimated Waiting times for a First Specialist Assessment – April 2010**

Speciality	Priority	Estimated Wait
Audiology	All referrals	2-6 months
Cardiology	Urgent	6-8 weeks
	Semi-urgent	8-12 weeks
	Routine	5-6 months
Dental	Adult routine	6 months
	Child Routine	2-3 months
Dermatology	Urgent	4-8 weeks
	S-urgent	3-4 months
	Routine	6-8 months
Diabetes	Urgent	1 month
	Routine	9 month
Endocrinology	Routine	6 months
	S-urgent	1-2 months
ENT	Urgent	2-4 weeks
	S-urgent	4 months
Gastroenterology Medical OP	Urgent	3-4 weeks
	Semi urgent	5-6 months
	Routine	6 months
Gastroscopy	A	3-4 weeks
	A/B	6-8 weeks
	B and C	6 and 9 months
Colonoscopy	A	3-4 weeks
	A/B	4-6 weeks
	B	3-4 months
	C	6 months
General Medicine		3-4 months
Gynaecology	urgent	6-8 weeks
	S-urgent	4-5 months
	Routine	6 months
Neurology	Urgent	1-2 weeks
	S-urgent	2-6 weeks
	Routine	4-6 months

Speciality	Priority	Estimated Wait
Maxillofacial surgery	All referrals	No waiting list
Neurosurgery	Urgent	Within 1 month
	S-urgent	Within 1 month
	Routine	6 months
Ophthalmology	Urgent	1-2 weeks
	Semi-urgent	2-6 months
	S-urgent cataract	1-3 months
	Routine cataract	3-4 months
Orthopaedics	Urgent	4 months
	S-urgent	6 months
Renal Medicine	Urgent	2-4 weeks
	S-urgent	2-3 months
	Routine	4-6 months
Paediatric surgery	Routine	4 months
Paediatrics Medical	Routine In'gill	5 months
	Gore	5 months
	Queenstown	5 months
Respiratory	Urgent	< 2 weeks
	Semi-urgent	2-8 weeks
	Routine	4-6 months
Rheumatology	Urgent	1-2 months
	Semi urgent	3-4 months
	Routine	4-6 months
Surgical Services	Urgent	Within 1 month
	S-urgent	1-2 months
	Routine	2-3 months
Urology	Urgent	1-3 weeks
	S-urgent	6-8 weeks
	Routine	3 months
Minor surgery	Urgent	4 weeks
	S-urgent	4-6 weeks
	Routine	4-6 months
AT and R	Urgent	< 4 weeks
	S-urgent	2-3 months
	Routine	< 6 months

Mental Health	
SMHET Invercargill Community Mental Health Team (ICMHT)	Triaged same day Within 2 weeks
Rhanna	Contact made same day
CAFS	Urgent < 24 hours Routine 1 month

Oncology		
Haematology	Urgent Semi-urgent	5 days 16 days
Oncology	Urgent Semi-urgent	3 days 18 days
Radiotherapy	Urgent Semi-urgent	1 days 16 days

Medical Imaging Waiting Times		
MRI	Urgent	Same day
	Semi-urgent	2 weeks
	ACC	10 days
	Private	10 days
	Routine	4 weeks
CT	Semi-urgent	1 -2 weeks
	ACC	Within 10 days
	Private patients	Within 10 days
	Routine OP	6-7 weeks
Ultrasound		30 weeks
Mammography	Recall patients	<1 weeks
	Urgent	1 week
Nuclear Medicine	Urgent	2-4 weeks
	Semi-urgent	6 weeks
	ACC	10 days
	Private	2 weeks
	Routine	4 weeks
	Cardiac scans	6.5 months
X-ray appointments	X-ray	3.5 months (2 for CXR or AXR)
	Urgent	please phone MRTs ext 8459
IVU		3 months
Ba. F Thru / Ba Enemas		3 months

Diagnostic testing		
ECGs, spirometry, arterial brachial indices, Ambulatory BPs	urgent	1 week
	semi urgent	2 weeks
	routine	4 weeks
Holters	urgent,	2-3 weeks
	semi-urgent	3-6 weeks
	routine	6-8 weeks
Echocardiograms		6-8 weeks
Sleep studies:		3 months (ref via Respiratory)
Nerve conduction studies	Refer to Peter Taylor at Windsor Specialist Centre and clearly mark whether private, public or ACC	