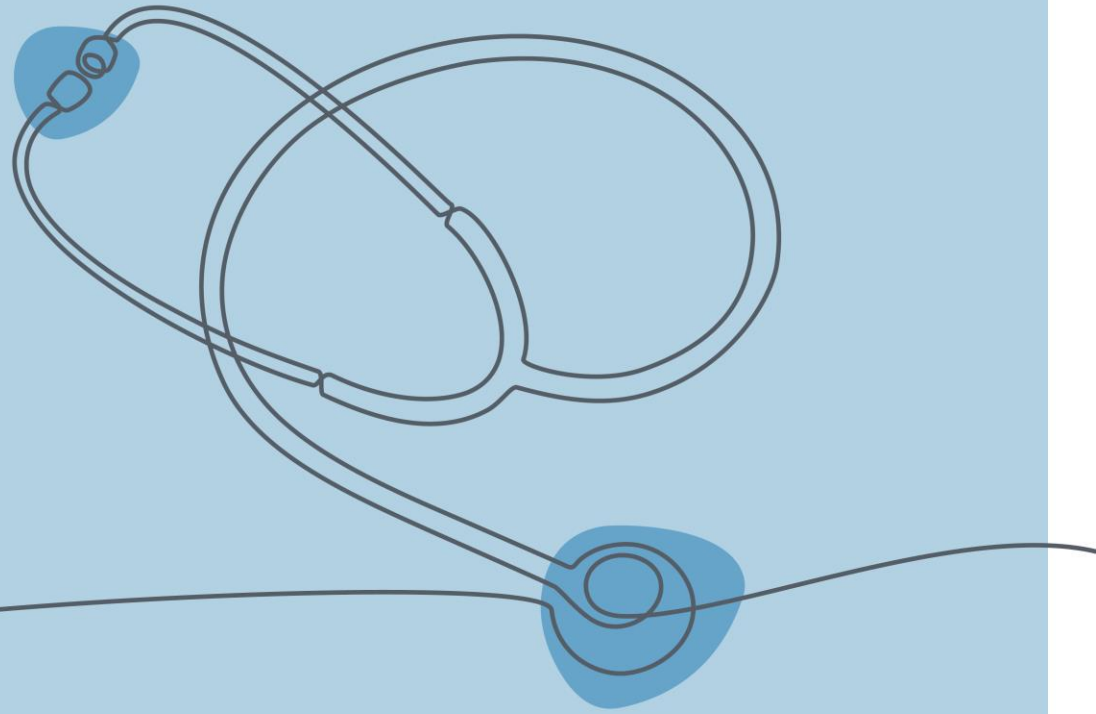
General Practice Liaison Officer Program presents

Championing Generalism Workshop

A collaborative, multi-disciplinary and multi-specialty learning opportunity for GPs covering conditions commonly managed in primary care



Case study: Trauma Service

Dr Frances Williamson | Staff Specialist, Emergency, RBWH
Michael Handy | Assistant Nursing Director, Trauma Service, RBWH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

MN GPLO CHAMPIONING GENERALISM

Trauma Service

RBWH

TRAUMA SERVICE

Trauma Service Dashboard

Report for Calendar Year 2024

Royal Brisbane Women's Hospital Trauma Service

Calendar Year 2024

*Note: The data for number of complications is based on the complication date. Data for #Deaths is based on discharge date.

#Admissions	%Admissions
1,618	62.3 %

#Presentations	#Complications*
2,597	99

#IHT	% IHT
124	4.8 %

#Deaths	#DSH
51	80

#MTP	#Red Blanket
20	12

**Note: Category None refers to cases where Trauma Page is not sent when it is expected. Category NA refers to cases where triage is not applicable e.g., self-present or direct IHT to Wards bypass triage system.

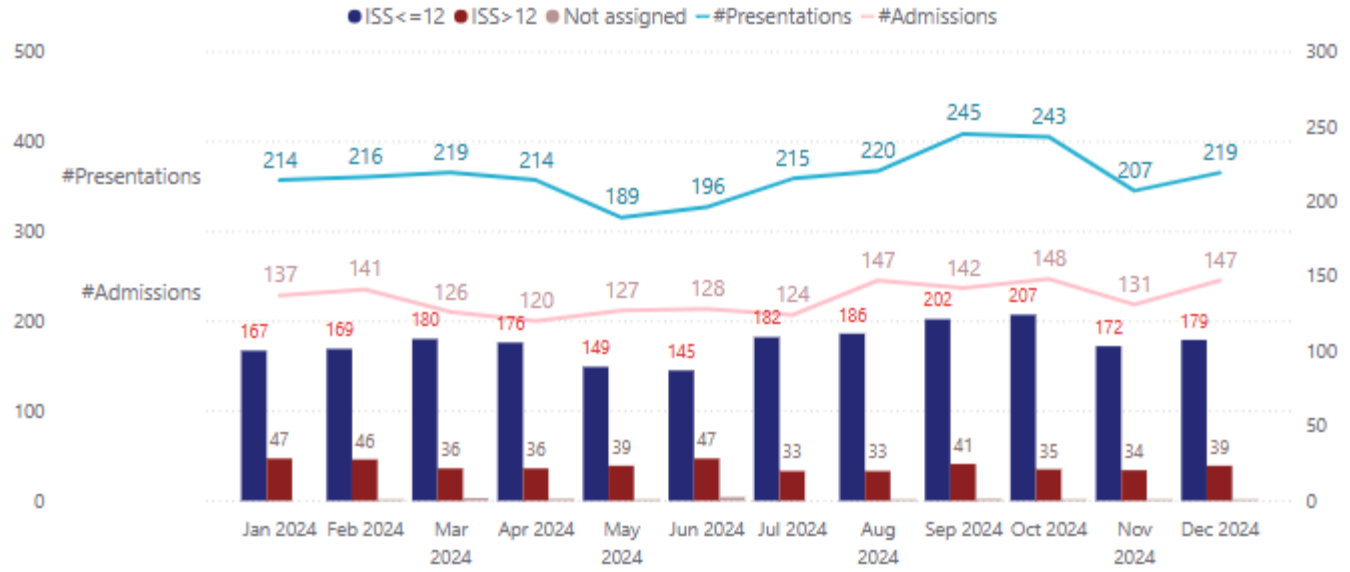
Event Type

Calendar Year 2024

Event Type	#Presentations	% of Total
MVC	818	31.50%
Fall	419	16.13%
MBC	397	15.29%
PBC	244	9.40%
Scooter E	228	8.78%
Pedestrian	124	4.77%
Stabbing	101	3.89%
Other	74	2.85%
Horse Related	60	2.31%
Assault	42	1.62%
Burn	28	1.08%
Scooter M	20	0.77%
Sporting	16	0.62%
Skateboard	15	0.58%
Gunshot	8	0.31%
Hanging	3	0.12%
Total	**2,597**	**100.00%**

Presentations and Admissions by ISS Groups

Calendar Year 2024



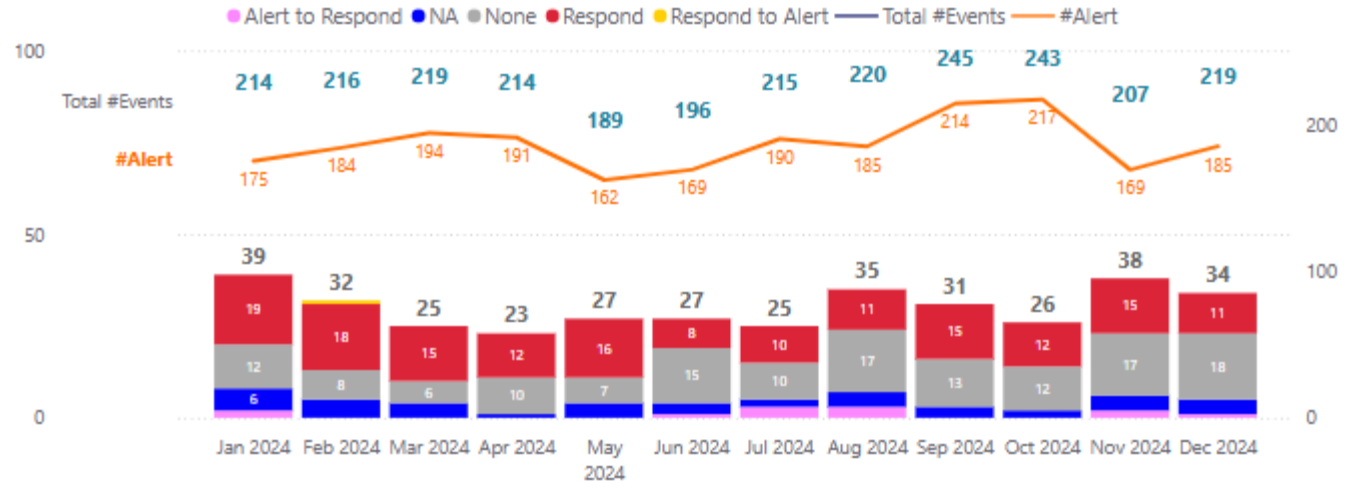
Trauma Page

Trauma Page**	#Presentations	% of Total
Alert	2,235	86.06%
Respond	162	6.24%
None	145	5.58%
NA	42	1.62%
Alert to Respond	12	0.46%
Respond to Alert	1	0.04%
Total	**2,597**	**100.00%**

ISS Group

ISS Group	#Pres	% of Total	% Hosp. Deaths
ISS<=12	2,131	82.06%	0.57 %
ISS>12	466	17.94%	8.67 %

Trauma Page



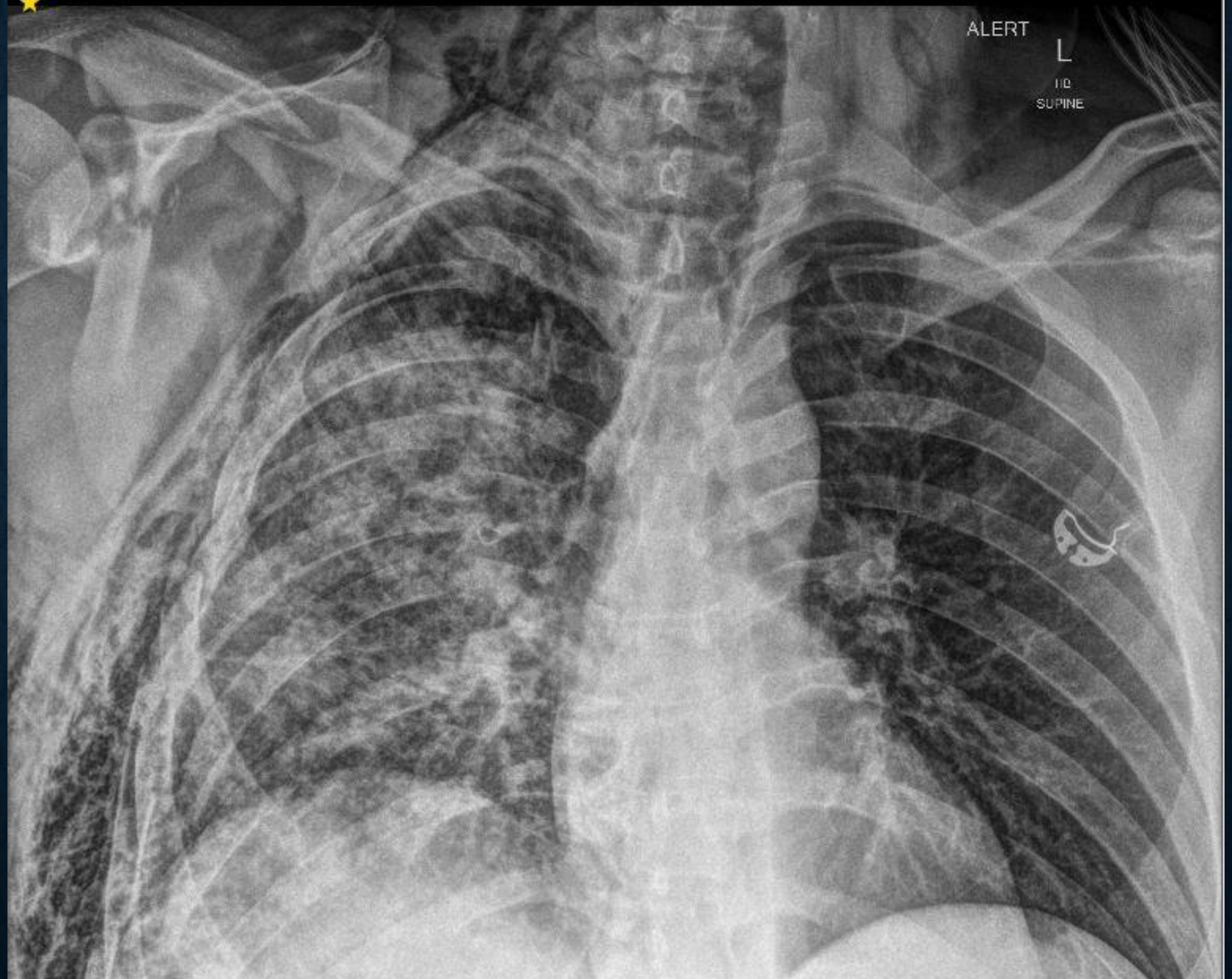
Last refresh: 27-May-2025 2:06 AM

Powered by DIGITAL METRO NORTH ANALYTICS

Queensland Government

PATIENT 1

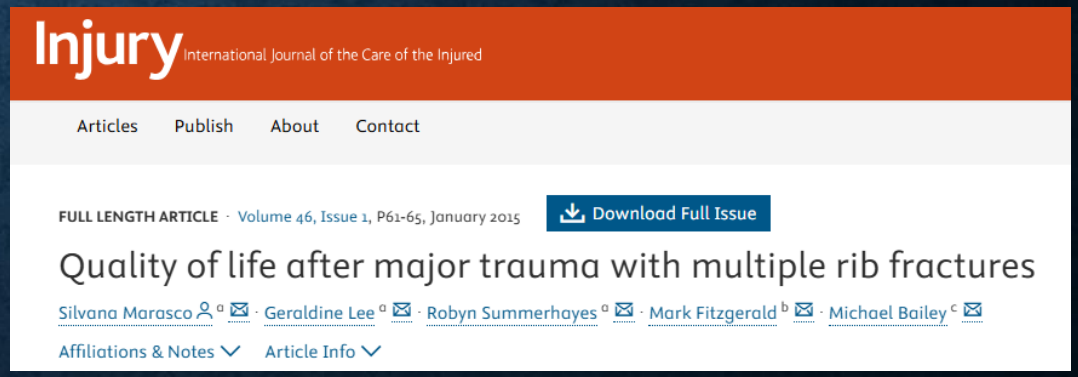
- 48-year-old male
- BIBA to ED post MBC
- Initially hypoxic, tachycardic and normotensive
- Undergoes initial assessment

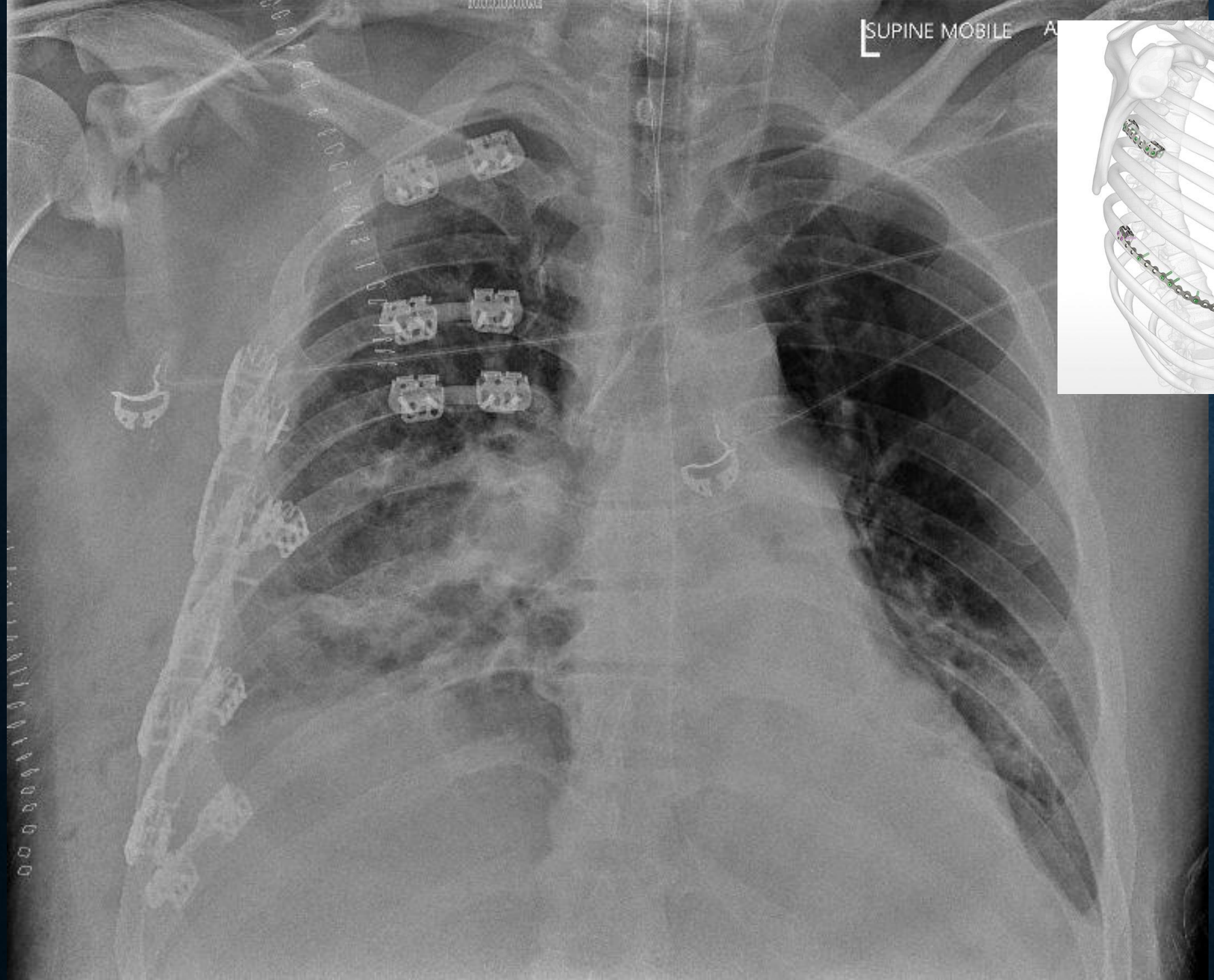

ALERT
L
SUPINE

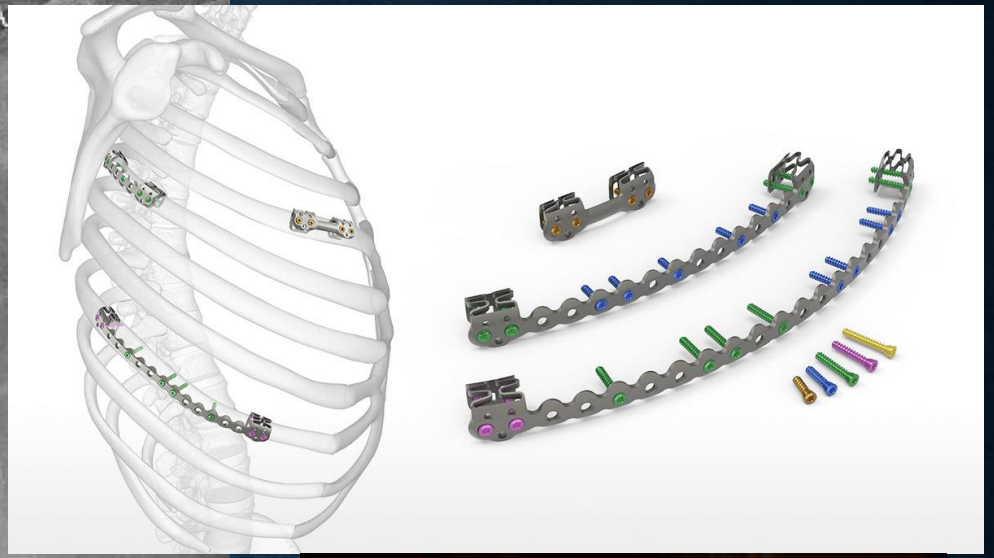
IN HOSPITAL CARE

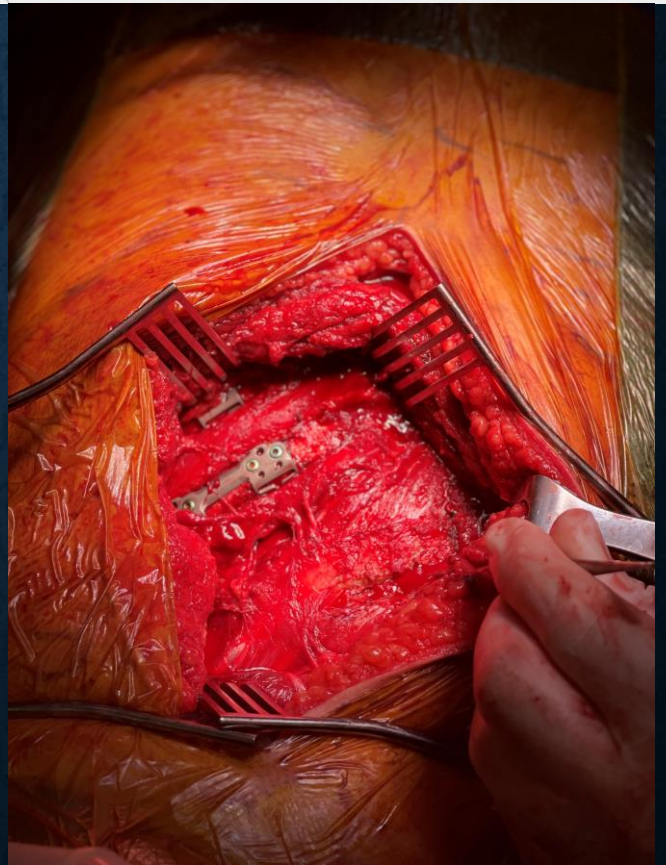
- Progressive ventilatory failure- HFNP
- Maximum pain management- PCA, ketamine infusion, regional block and oral analgesia
- Poor cough and IS
- → Progresses to SSRF

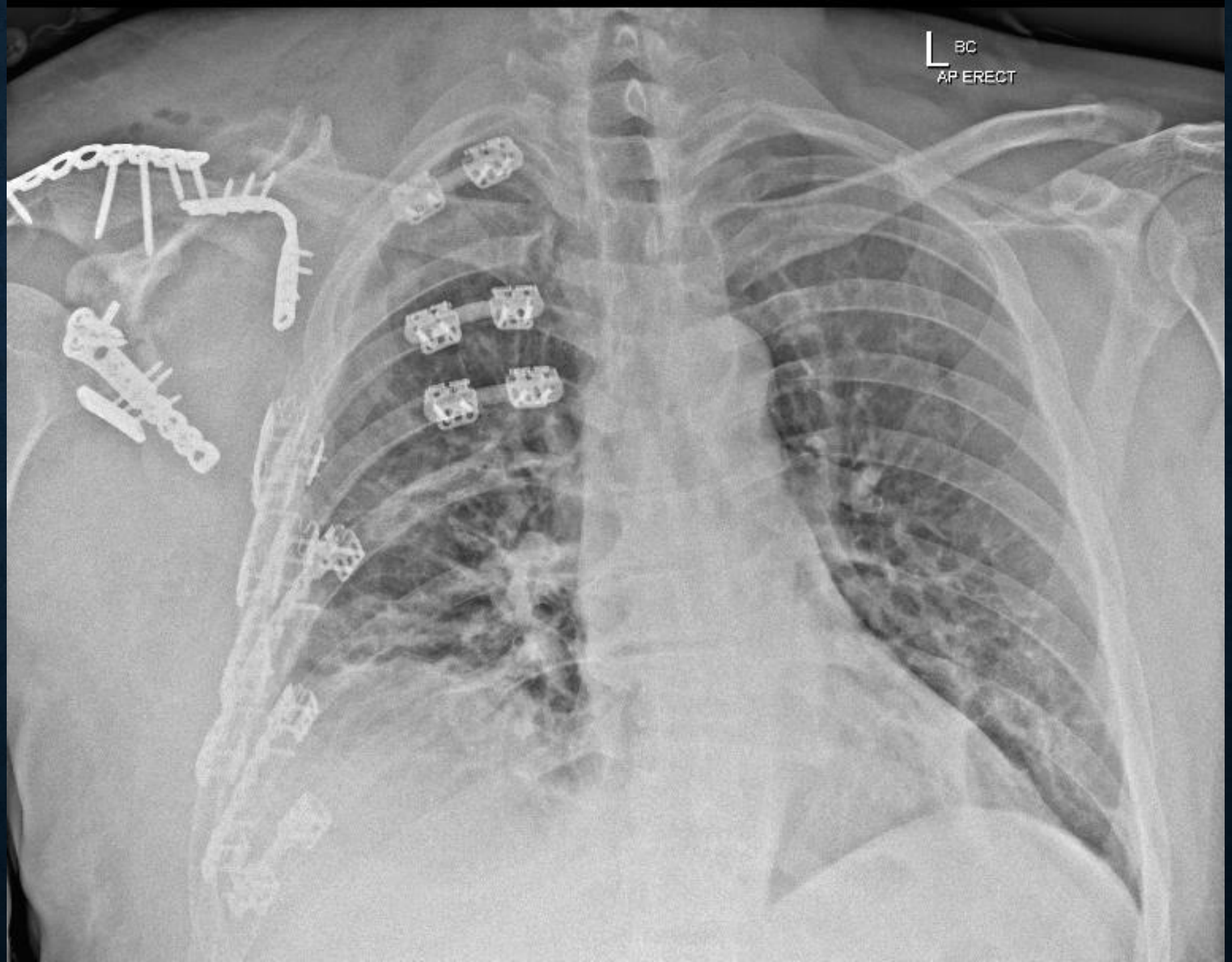
- Who gets SSRF?
- Flail, significant displacement, failure of non-op Mx




SUPINE MOBILE






L
BC
AP ERECT

RECOVERY

- Better outcomes- improved respiratory function, reduction in pain, earlier discharge

JTD JOURNAL OF THORACIC DISEASE
A PEER-REVIEWED, OPEN ACCESS JOURNAL FOR HIGH-QUALITY RESEARCH IN THORACIC DISEASES
2.1 Impact Factor | 4.6 CiteScore

Home | Journal Info | For Authors | For Reviewers | Ethics and Policies | Special Contents | Archives | Online First

Home / Vol 16, No 8 (August 31, 2024) / Treatment of traumatic rib fractures: an overview of current evidence and future perspectives

Review Article

Check for updates

Treatment of traumatic rib fractures: an overview of current evidence and future perspectives

Aimée J. P. M. Franssen[1#], Jean H. T. Daemen[1#], Julien A. Luyten[1], Berry Meesters[2], Annette M. Pijnenburg[2], Kostan W. Reisinger[2], Raoul van Vugt[2], Karel W. E. Hulsewé[1], Yvonne L. J. Vissers[1], Erik R. de Loos[1,2]

[1]Division of General Thoracic Surgery, Department of Surgery, Zuyderland Medical Centre, Heerlen, the Netherlands; [2]Division of Trauma Surgery, Department of Surgery, Zuyderland Medical Centre, Heerlen, the Netherlands

Cureus

Open Access Review Article

DOI: 10.7759/cureus.29664

Rib Plating as an Effective Approach to Managing Traumatic Rib Injuries: A Review of the Literature

Christopher Adereti [1], Jamesa Fabien [1], Jeanette Adereti [1], Muller Pierre-Louis [2], Daniel Chacon [2], Vincent Adereti [3]

1. Surgery, Ross University School of Medicine, Bridgetown, BRB 2. Medicine, Ross University, Bridgetown, BRB 3. Surgery, Texas Tech University, Lubbock, USA

Corresponding author: Christopher Adereti, cadereti@hotmail.com

This Issue | Views 4,473 | Citations 0 | Altmetric 10

Invited Commentary | Surgery

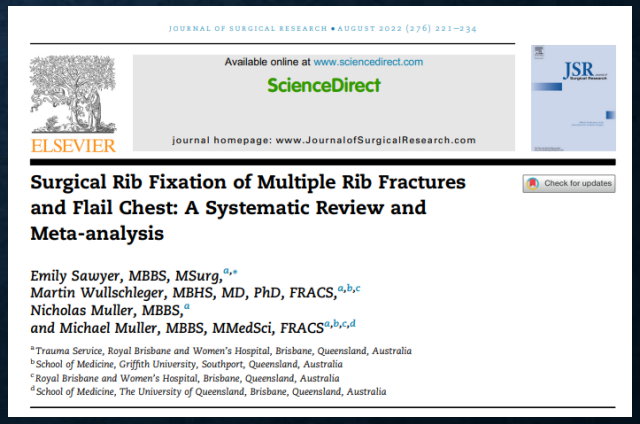
March 26, 2020

Rib Fractures, the Evidence Supporting Their Management, and Adherence to That Evidence Base

Garth H. Utter, MD, MSc[1,2]; Nikia R. McFadden, MD[3]

Author Affiliations | Article Information

JAMA Netw Open. 2020;3(3):e201591. doi:10.1001/jamanetworkopen.2020.1591



JOURNAL OF SURGICAL RESEARCH • AUGUST 2022 (276) 221–234

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Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.JournalofSurgicalResearch.com

JSR

Surgical Rib Fixation of Multiple Rib Fractures and Flail Chest: A Systematic Review and Meta-analysis

Check for updates

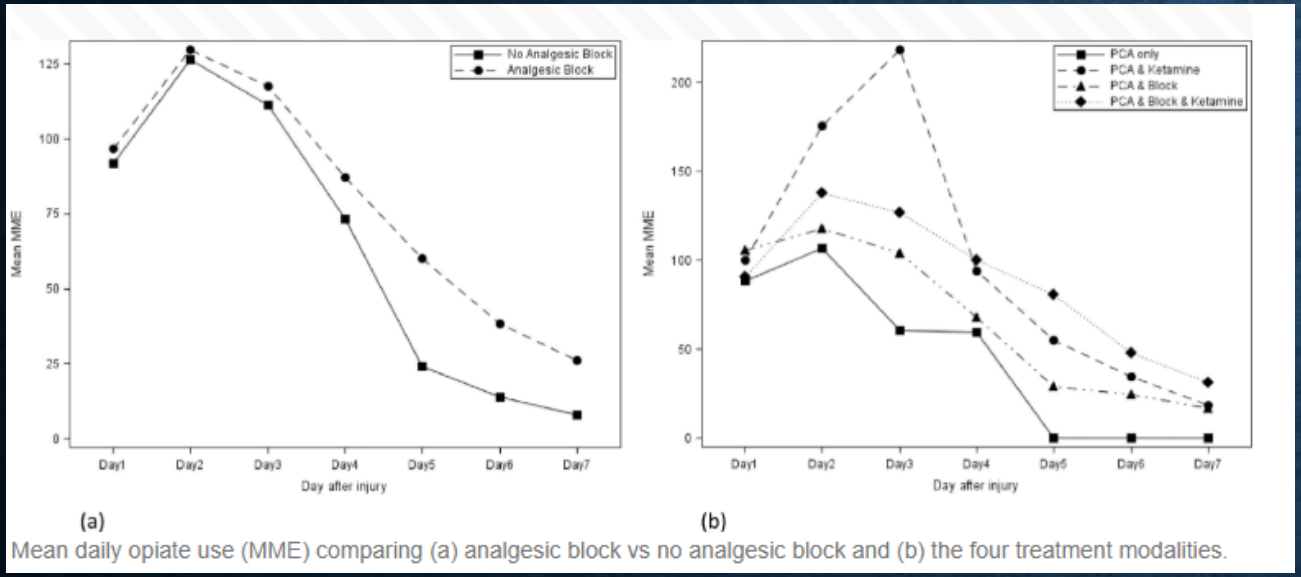
Emily Sawyer, MBBS, MSurg,[a,*]
Martin Wullschleger, MBHS, MD, PhD, FRACS,[a,b,c]
Nicholas Muller, MBBS,[a]
and Michael Muller, MBBS, MMedSci, FRACS[a,b,c,d]

[a]*Trauma Service, Royal Brisbane and Women's Hospital, Brisbane, Queensland, Australia*
[b]*School of Medicine, Griffith University, Southport, Queensland, Australia*
[c]*Royal Brisbane and Women's Hospital, Brisbane, Queensland, Australia*
[d]*School of Medicine, The University of Queensland, Brisbane, Queensland, Australia*

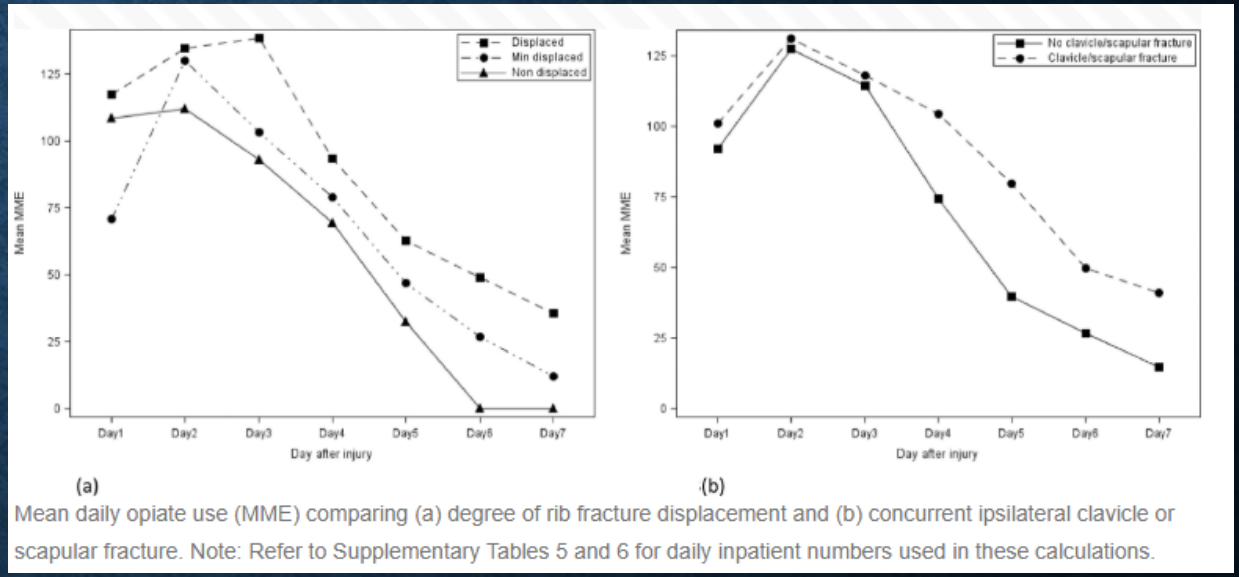
WHAT SHOULD I EXPECT POST D/C?

Pain management	Flying restrictions	Metalware failure
Lung function	Return to work/sport	Psychological

PAIN MX IN RIB FRACTURES



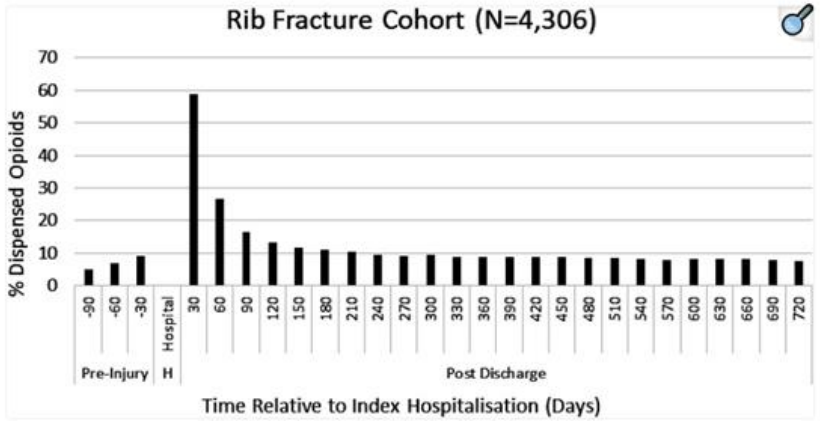
Mean daily opiate use (MME) comparing (a) analgesic block vs no analgesic block and (b) the four treatment modalities.



Mean daily opiate use (MME) comparing (a) degree of rib fracture displacement and (b) concurrent ipsilateral clavicle or scapular fracture. Note: Refer to Supplementary Tables 5 and 6 for daily inpatient numbers used in these calculations.

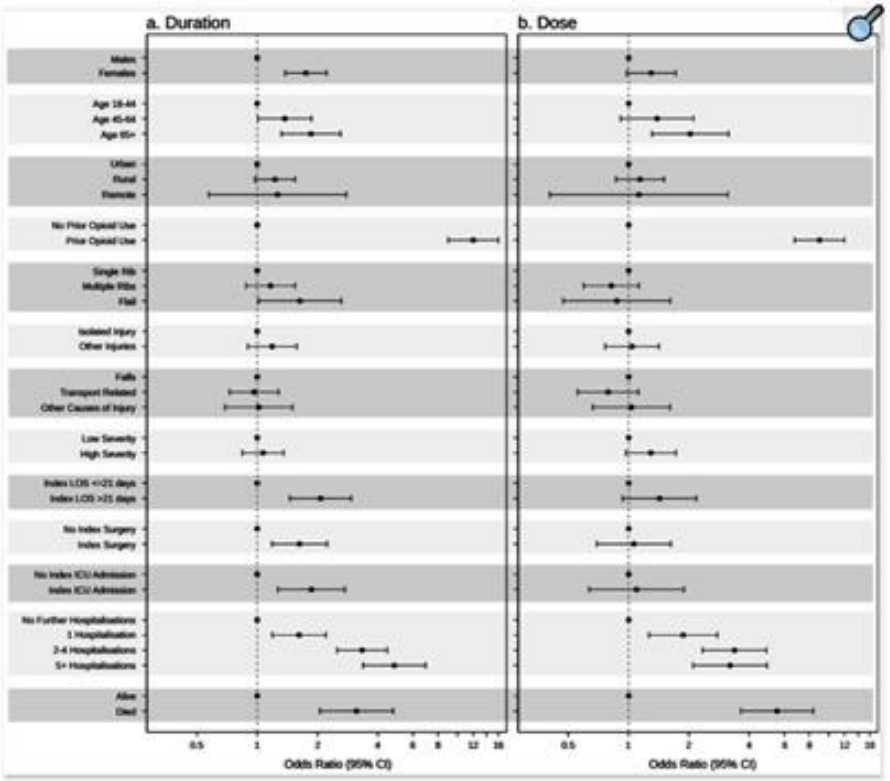
OPIOIDS IN RIB FRACTURE MX

Figure 2.



Proportion of persons in the rib fracture cohort having opioids dispensed for each 30-day interval, from 90 days prior to the index injury hospitalisation and from day of hospital discharge up to 720 days after.

Figure 3.



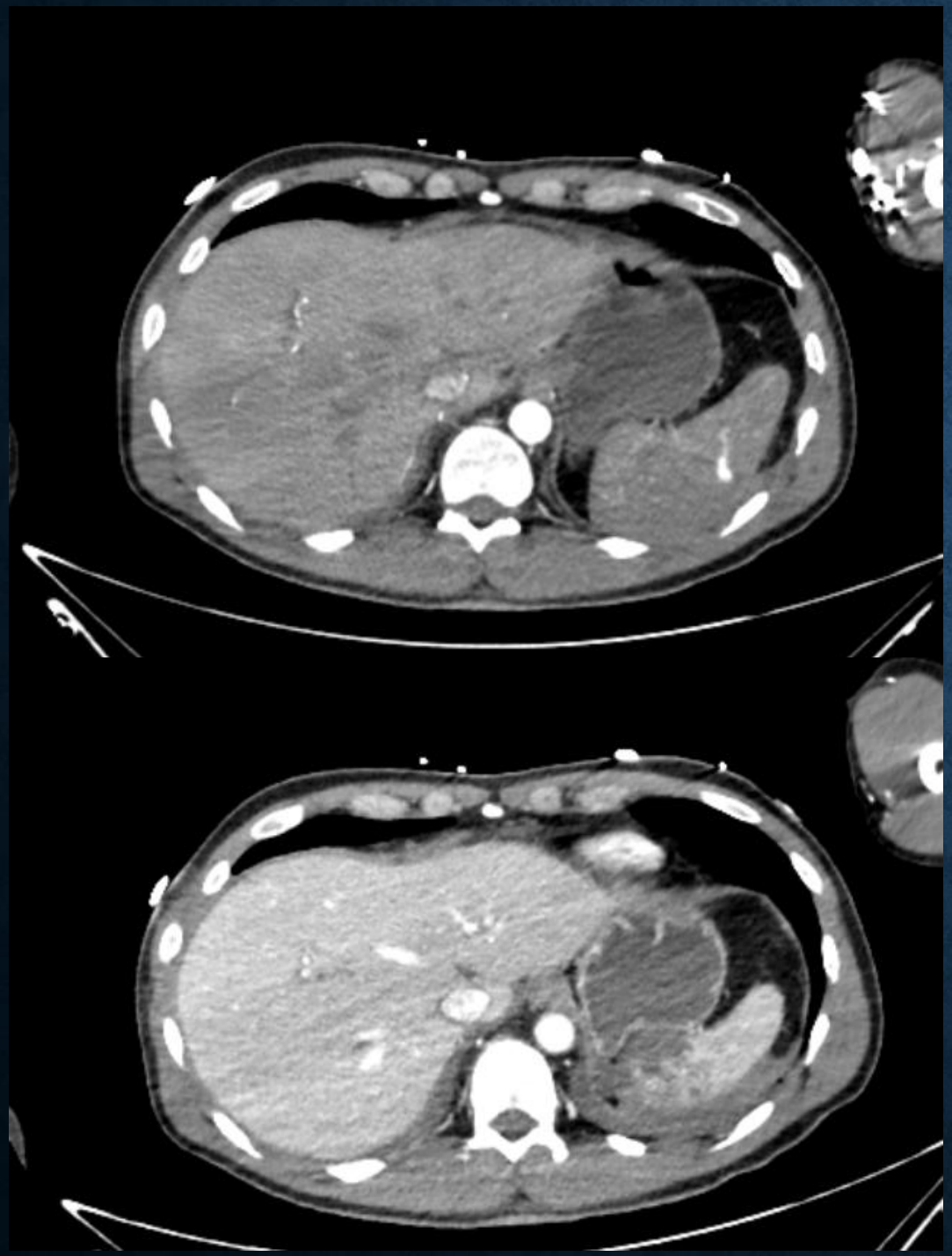
Factors associated with (a) long-duration opioid dispensing (>90 days cumulatively from the day of hospital discharge up to 720 days after), and (b) an increased OME end-dose, for the rib fracture cohort, using multivariable logistic regression showing Odds Ratios and 95% Confidence intervals.

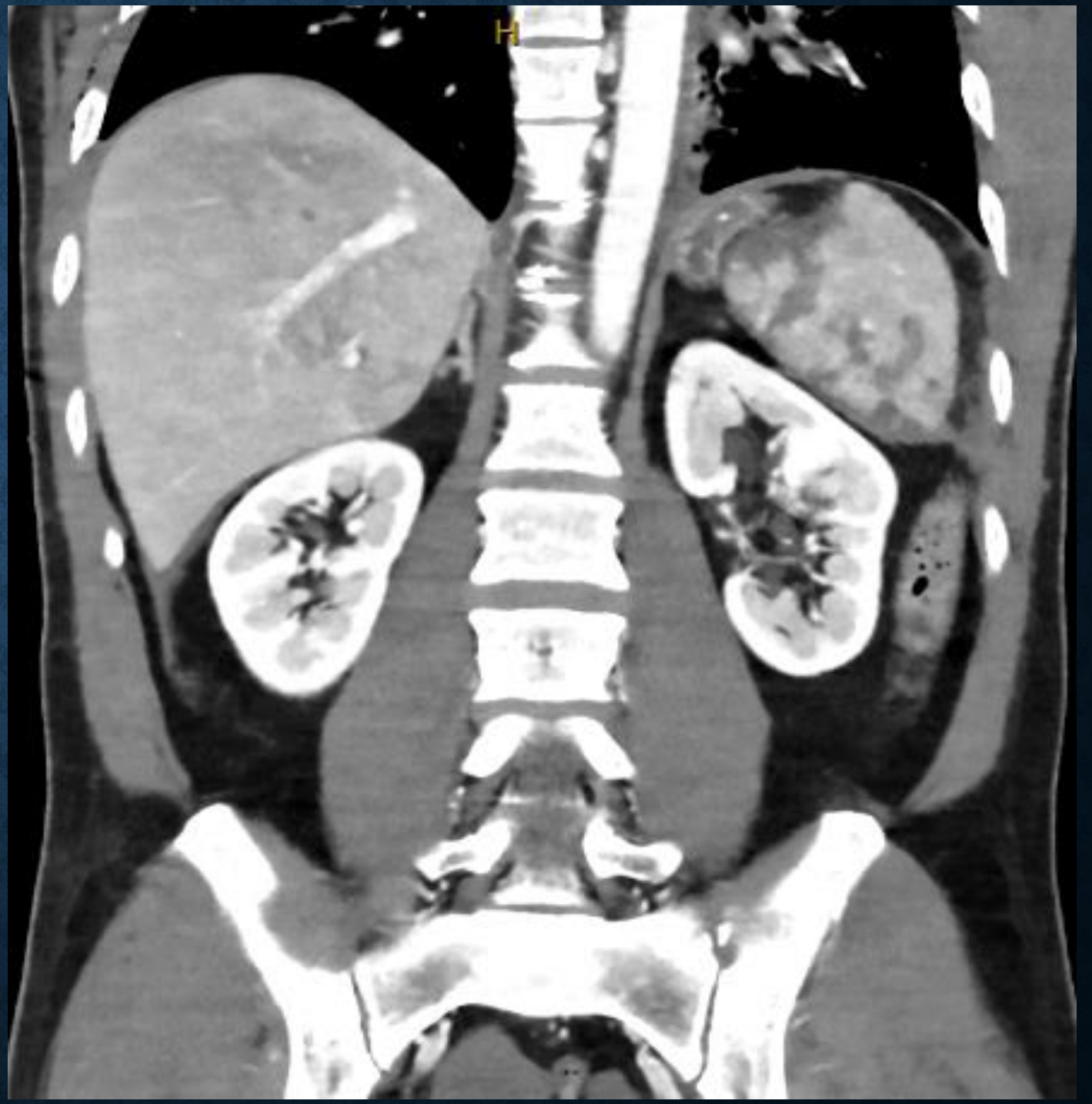
PATIENT 2

26-yr-old man

MBC into concrete barrier

Hemodynamically stable at scene

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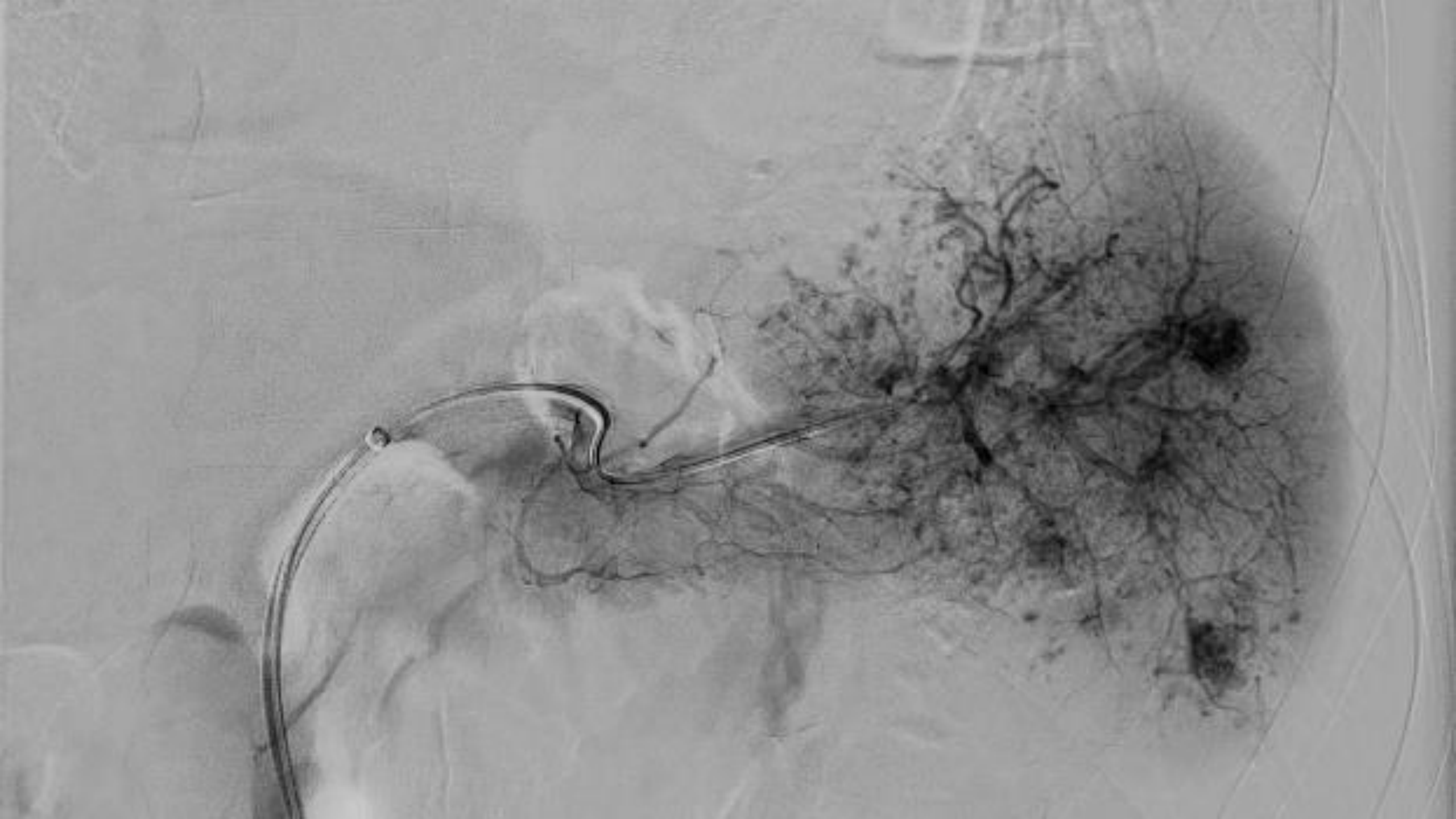


Spleen Australia ***a clinical service for people without a functioning spleen***

Recommendations for patients after ***SPLENIC ARTERY EMBOLISATION***

AlfredHealth

Website
Last updated
22/11/2023

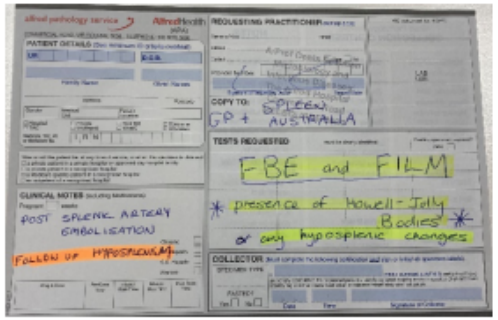
Disclaimer: These recommendations have been produced to guide clinical decision making. They have been derived from expert medical opinion and are not contained in the Australian Immunisation Handbook. They do not replace the judgement of a senior clinician.

Vaccinations can be given 2-5 days after procedure or just prior to discharge

Organism prevented	Vaccinations		Revaccinations
Pneumococcus	**Pneumococcal conjugate** (Prevenar 13)	≥2months → **Pneumococcal polysaccharide** (Pneumovax 23)	Nil
Meningococcus	**Conjugate ACWY** (Nimenrix) **0.5mL IM (only 1 dose required)**		Nil
Haemophilus influenzae type b	**Hib** (Act-HIB) **0.5 mL IM**		Nil
Influenza	**Influenza 0.5 mL IM or deep SC** *(If procedure is performed during winter season)*		Nil

It is safe to give pneumococcal meningococcal and Hib vaccines at the same time in separate injection sites (deltoid preferred site).

Additional information	
Vaccine administration	Splenic Artery Embolisation patients are eligible to receive FREE Government funded vaccines as per the National Immunisation Program
Pneumococcal vaccine	Pneumococcal conjugate (Prevenar 13) followed 2 months later by pneumococcal polysaccharide (Pneumovax 23) and no boosters
Antibiotics	Daily prophylaxis and emergency supply of antibiotics – **not required**
Follow up	Review by GP/specialist after FBE with film has been performed – to see if any hyposplenic changes + Howell-Jolly Bodies (HJBs) have been detected.
Blood tests	**TEST 1** to assess for hyposplenic changes including Howell-Jolly Bodies (HJB) **FBE with film** more than 4 weeks after SAE • If hyposplenic changes or HJB *are not detected* then patient is considered to have no evidence of hyposplenism • If hyposplenic changes or HJB *are detected* this indicates splenic dysfunction ->hyposplenism. • GP to **FAX results to 03 9076 7946 or call 03 9076 3828 for further assistance** **TEST 2** if further clarification of spleen function is still required then an **IgM memory B cell test** This blood test is performed at The Alfred hospital and at some other hospitals around Australia. Blood is collected in a **5ml EDTA tube** and is performed more than *6 months* after embolisation procedure.
Patient education	• Explain the reasons for vaccinations, the importance of testing for hyposplenism and follow up with GP/specialist • Education on recognising signs and symptoms a bacterial infection is important • Victorian patients who require infectious disease advice can be referred to Dr Denis Spelman on 03 9076 6081.
When to seek medical attention	Seek medical attention when symptoms of bacterial infection occur eg. fever, shivers, chills, and/or vomiting/diarrhoea.
Registration with Spleen Australia	Website: www.spleen.org.au Telephone: 03 9076 3828 Email: spleenaustralia@alfred.org.au



EXAMPLE OF PATH REQUEST SLIP

Please highlight request and hyposplenism
(these tests are not performed on automated pathology platforms that perform FBE)
Copy of results can come to Spleen Australia at Alfred Health for guidance

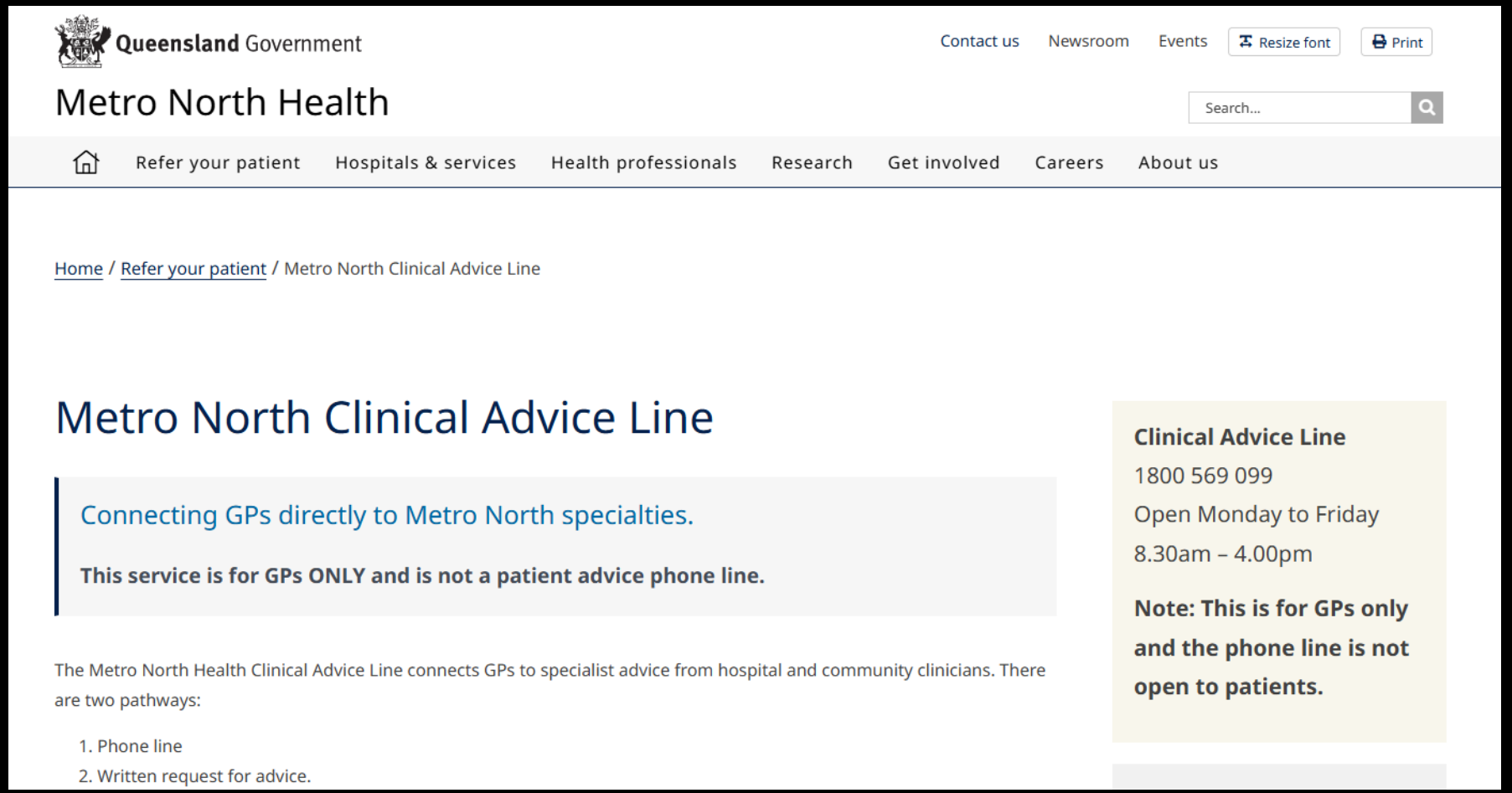
POST DC CARE

	Splenectomy	Splenic Embolization
Vaccinate	Yes	Only if hyposplenic (HJB test)
Register with Spleen Australia	Yes	Can do
Emergency supply of Abx	Yes	Only if hyposplenic
Return to activity/work	From 3 weeks	Low grade: graduated program form 2 weeks, full activity 6 weeks High grade: graduated program from 1-3 months
Contact sport	From 1 month	Avoid 3-6 months

SRAU- SURGICAL RAPID ACCESS

- **Non-Urgent OPD**-> *help guide referrals*
  - Gallbladder pathology
  - Skin lesions
  - Herniae
  - Incidental lesions
  - New bowel malignancy
- **Acute referrals**-> *avoid ED with direct admit pathways*
  - Diverticulitis
  - Abscesses
  - Appendicitis
  - Cholecystitis

HOW TO CONTACT TRAUMA/SRAU



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Metro North Clinical Advice Line

Connecting GPs directly to Metro North specialties.

This service is for GPs ONLY and is not a patient advice phone line.

The Metro North Health Clinical Advice Line connects GPs to specialist advice from hospital and community clinicians. There are two pathways:

1. Phone line
2. Written request for advice.

Clinical Advice Line
1800 569 099
Open Monday to Friday
8.30am – 4.00pm

Note: This is for GPs only and the phone line is not open to patients.

THANK YOU

General Practice Liaison Officer Program presents

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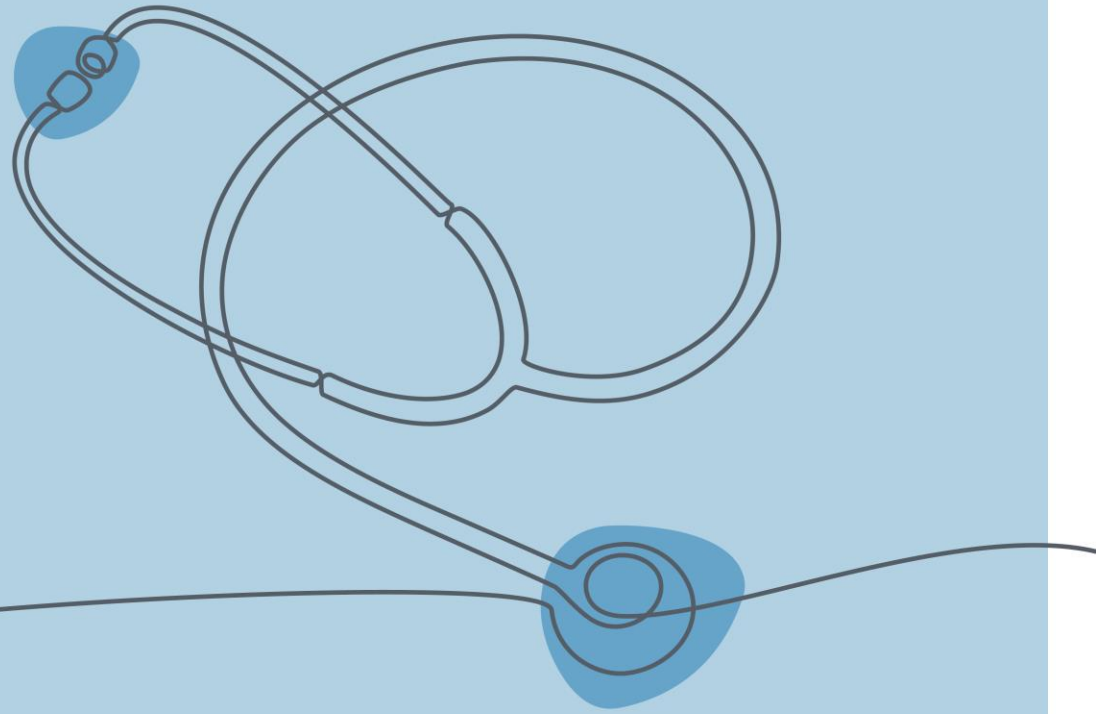
A collaborative, multi-disciplinary and multi-specialty learning opportunity for GPs covering conditions commonly managed in primary care



Case study: General Paediatrics

Dr Priyam Jha | General Paediatrician, TPCH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Championing Generalism Workshop

DR. PRIYAM JHA – GENERAL PAEDIATRICIAN

WITH THANKS TO DR. ARCHANA CHACKO - PAEDIATRIC RESPIRATORY & SLEEP PHYSICIAN

MAY 31ST 2025

Case 1

- 3yo boy
- Referred with speech delay and behavioural difficulties

- Mostly single words, few two word phrases
- Emotional dysregulation
- “Meltdowns”
- Unremarkable Birth Hx/PMHx., no significant Fam Hx.
- Single parent, some support from own parents.
- Mum is EXHAUSTED

Sleep History

- Bedtime routine - what activities? How long? Screens?
- Where are they sleeping?
- What is being used to get to sleep?
- How long to fall asleep?
- Night wakings?
- How do they resettle? How long?
- Wake up time?
- Naps? What time? Where? How? How long?
- Daytime activity?
- Snoring? Waking up snoring?

Sleep

- Bedtime routine: Dinner, bath, book then bed. No screens after dinner.
- Put down in his own bed about 7pm
- Waking ~11pm, screaming, inconsolable. Lasting up to an hour sometimes
- Moves into Mum's bed, then wakes 3-4 more times, up for the day at 5-6am
- Very active sleeper
- Snores
- Has a bottle of cow's milk to resettle each wake up and for the day nap

Diet

- BF: Oats, fruit
- MT: Fruit
- Lunch: Daycare, eats everything offered
- Dinner: Eats the family meal, not picky

- Think about allergic rhinitis
  - Atopy?
  - Constant clear rhinorrhea?

Examination

- Height and weight 50th centile
- Sat close to Mum throughout, very distressed on examination
- Heard a few poorly pronounced single words directed at Mum
- HS 1 + 2 + 0
- Chest clear
- Abdo soft no masses
- Grade 3 tonsils
- Ears NAD

- Think about:
  - Craniofacial abnormalities (micrognathia? High arched palate?))
  - Dysmorphic features?
  - Poor growth? Obesity?
  - Allergic shiners?

Investigations

- Bloods: FBC, Fe studies, B12/folate, Vit D
- Audiology

Issues

- ?Iron deficiency
- Obstructive Sleep Apnea
- Night terrors
- Sleep Association
- Speech delay and behavioural difficulty
  - Parental concern – could this be ASD?

Management

- Referrals
  - Consider respiratory (sleep study) vs. ENT
  - Speech Path
- Think about allergy
  - Do we need a trial of Mometasone nasal?
  - Montelukast?
  - Immunologist?

Outcome

- Mildly iron deficient, managed with supplements and reduction of cow's milk
- Referred to ENT, Ts&As – HUGE difference
- Audiology NAD
- Sleeping through – night terrors stopped
- Speech caught up
- No further behavioural difficulties (outside normal toddler behaviours)

Points to note

- Iron deficiency
  - Specifically asking about cow's milk intake
  - Maintain ferritin above 50
- OSA
  - Symptoms can look different in toddler age group
  - Adenoids/tonsils most common cause
  - Think about allergy
- Night terrors
- Insomnia
  - Sleep association - it's only a problem if it's a problem
  - Vs. limit setting

Behavioural Interventions

- Work with the family's values
- Sleep Schedule
  - Sleep routine/hygiene
- Intervention
  - Unmodified Extinction
  - Modified Extinction
  - Bedtime Fading
  - Possums approach
- Trouble shooting including positive reinforcement

Sleep Schedule

Queensland Children's Lung and Sleep Specialists
www.qclass.com.au

Dr. Archana Chacko

- Same bedtime each night
- If child naps, should end
  - 6-9mo: ≥2 hours before bedtime
  - ≥ 9mo: ≥3 hours before bedtime

Sleep Schedule - Bedtime routine

Queensland Children's Lung and Sleep Specialists
www.qclass.com.au
Dr. Archana Chacko

- Stand alone intervention
- 3-6 activities (no screens)
- 1st & last activity preferred
- Feeding early or removed
- Last step in child's sleeping area
- If reluctant to start, start bedtime routine with game
- Troubleshooting:
  - Visual schedule
  - Praise/Rewards
  - Rearrange steps
  - Start earlier

Mindell JA et al. Sleep 2009; 32: 599-606

- Clinical Practice Guidelines : Micronutrient deficiency
- Kids Health Info : Night terrors (night-time wakings)
- Kids Health Info : Obstructive sleep apnoea (OSA)
- https://possumssleepprogram.com/
- https://www.childrens.health.qld.gov.au/resources/our-work/ellen-barron-family-centre/an-introduction-to-the-ellen-barron-family-centre
- https://www.northwestprivatehospital.com.au/Early-Parenting-Centre/About-Us

Case 2

- 13yo M
- Referred for chronic abdominal pain

- 1 year history of pain

Central abdominal aching pain

Mostly in the mornings, usually settles with heat packs and sometimes simple analgesia

Normal bowel habits, no nausea/vomiting, no weight loss

Missing school

Sleep

- Goes to bed 10pm, Takes about 2 hours to get to sleep, sleeps through the night, wakes with alarm at 7am
- On weekends might stay up till 2-3am and sleep till midday
- Bedtime routine
  - Dinner, then shower
  - Usually watches youtube on his phone in bed
  - Parents remind him to turn phone off about 30mins before sleep, stays charging in room
- Caffeine:
  - Has a cup of tea with breakfast most mornings
  - Occasionally has a coke or Monster energy drink after school when he has money (admits to a couple of times a week)
- Physical activity
  - Walks 10mins to school
  - After school does homework, then screen time/social media

HEADSS

- Home
  - Lives at home with Mum, Dad and 16yo sister
- Education
  - In Year 7
  - High achiever, A grades
- Eating and exercise
  - Might have breakfast
  - Doesn't eat at school (it's not cool!)
  - Snacks after school, chips, sandwiches etc
  - Eats a rounded dinner
- Drugs and Alcohol: Denies
- Sexuality/gender: Reports no partner, not sexually active
- Suicide/depression/self harm/sleep
  - Admits to ruminating while lying in bed, thinking about assessments, co-curriculars

Investigations

- None

Issues

- Poor sleep hygiene
- Anxiety
  - Pervasive – likely contributing to the chronic abdominal pain
  - Lots of rumination at bedtime

- Sleep hygiene
  - Stop the caffeine
    - Consider a swap – e.g. if coke, swap to caffeine free. Decaf tea/coffee.
  - Screens to stop 60mins before bedtime
  - Screentime not in bedroom, phone kept outside of room
    - Side note: Safety aspect
  - Add regular physical activity to the day
    - Walking to or from school?
    - Walk the dog?
    - Focus on something small and enjoyable that gets body moving and some fresh air
- Kids Health Info : Sleep problems - children and teens

- Anxiety
  - MHCP for a psychologist
  - BRAVE program
  - Triple P fearless kids
  - Headspace
  - Smiling Minds App – sleep specific meditations

SMILING MIND

- Kids Health Info : Sleep problems - children and teens
- Login | BRAVE Self-Help Program
- Fear-Less Triple P Online | Triple P

A brief note on medications

- Melatonin
  - For sleep initiation
  - AE
    - Well tolerated
    - Long term uncertain
  - Formulations:
    - Liquid (compounded, $40/month)
    - Tablet – CR
    - Slenyto
      - Prolonged release
      - Expensive - $200/month
      - On PBS for Smith-Magenis
      - Good evidence in ASD
    - OTC formulations (iherb)
      - Cheap
      - Uncertainty as to actual melatonin content
  - Will not work if sleep hygiene remains poor

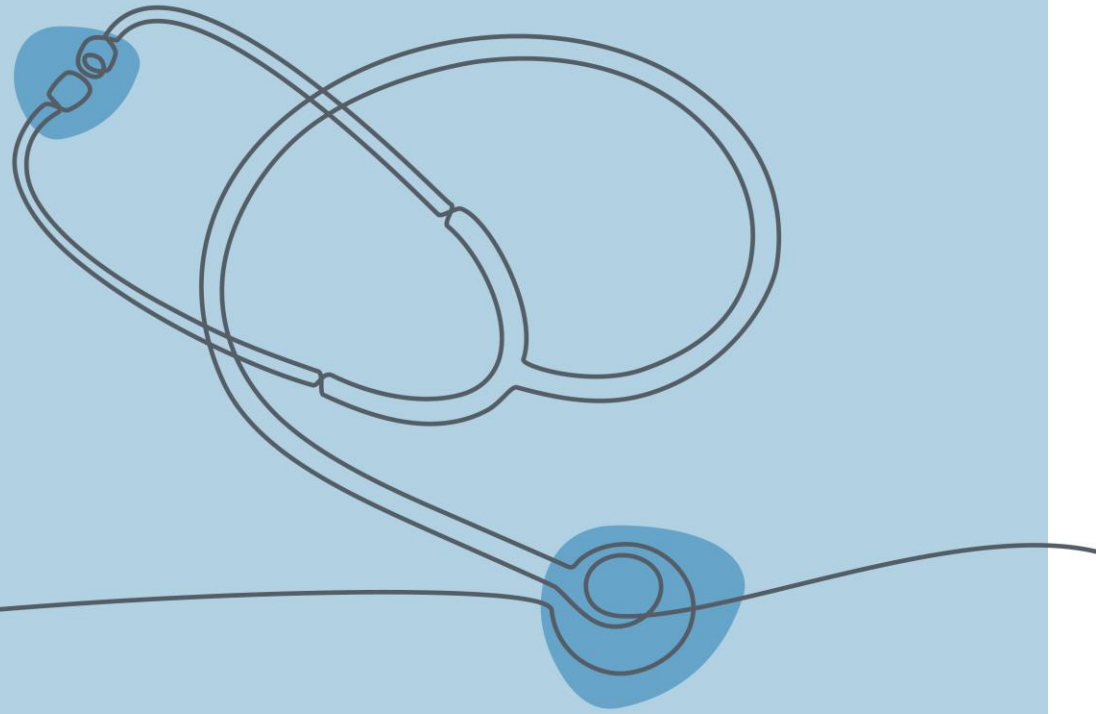
- Clonidine

  - For sleep maintenance
  - Crushable tablet
  - Long acting (guanfacine) on PBS for ADHD (not crushable)
  - AE
    - Hypotension
    - Excessive daytime drowsiness
    - Rebound hypertension – needs to be weaned slowly
- Further escalation under guidance of respiratory/sleep physician
  - E.g. antihistamines, benzodiazepines, antipsychotics

General Practice Liaison Officer Program presents

Championing Generalism Workshop

A collaborative, multi-disciplinary and multi-specialty learning opportunity for GPs covering conditions commonly managed in primary care

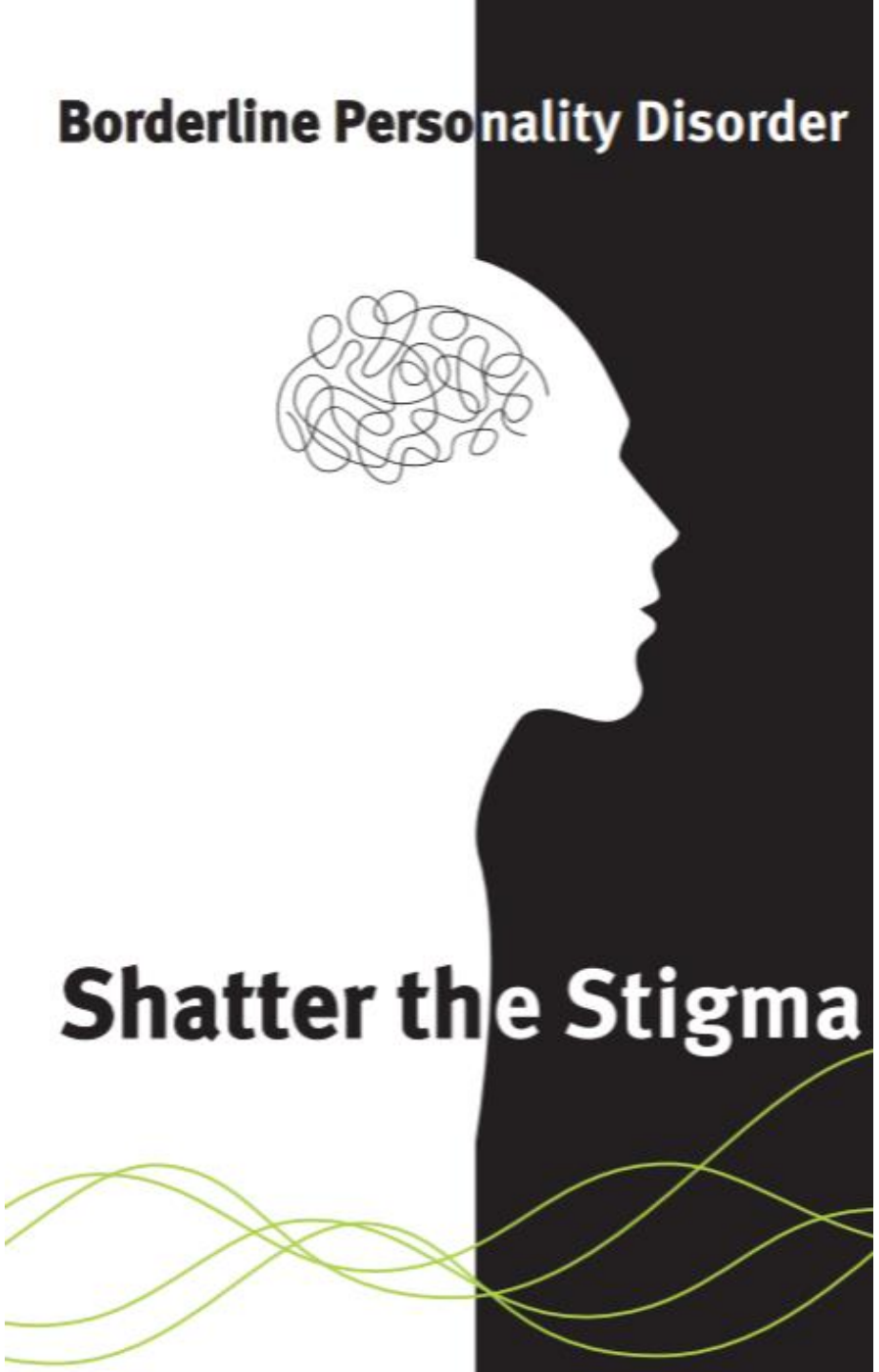


Case study: Managing Acute Distress in primary care: Practical Strategies for GPs

Samantha Duff | Metro North Mental Health Personality Disorder Project Lead & Psychologist

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health



Metro North Mental Health

Managing Acute Distress for General Practitioners

A Case Study of JS

Written and presented by: Samantha Duff
MNMH Personality Disorder Project Lead/Psychologist

Metro North Health | Queensland Government

Recognition of Lived Experience

Metro North Mental Health recognises the lived and living experience of people living with mental illness, problematic alcohol, and other drug use, as well as those impacted by suicide and trauma, their families, carers, and support people. We respect and value their opinions and their input into service delivery and change.

Trigger Warning

- Today's presentation includes discussion of suicide and domestic violence

Case Study

- JS is a 19-year-old male
- Books appt requesting help with his mental health and substance use
- Becomes angry with reception staff in the waiting room due to long wait to see a GP.
  - The clinic admin attempt to manage this by explaining there was an urgent appointment for someone who had a broken arm that needed to be prioritised
- Comes into the appointment annoyed and combative
- When you attempt to explain the delay JS becomes visibly distressed crying
- Making comments about wanting to end his life "I just can’t do it anymore", "I don’t want to be here", "I just need it to all stop", "Nobody cares about me", "nobody is helping me"
- You observe fresh wounds on his arms consistent with NSSI/DSH (cutting), superficial in nature and healing

Case Study Continued

- When you ask what has been going on you elicit the following:
  - Traumatic background with a domestically violent father who was physically abusive in the home and a Mo who was emotionally unavailable due to the abuse she was suffering
  - Recent relationship breakdown with girlfriend
  - Using Cannabis and drinking
  - Unstable accommodation
  - Unemployed
  - A Hx of psychiatric admissions
  - On antidepressants
  - Notes from previous hospital admissions indicate Borderline Personality Disorder

Can you identify the red flags or risks in this scenario?

What would you do?

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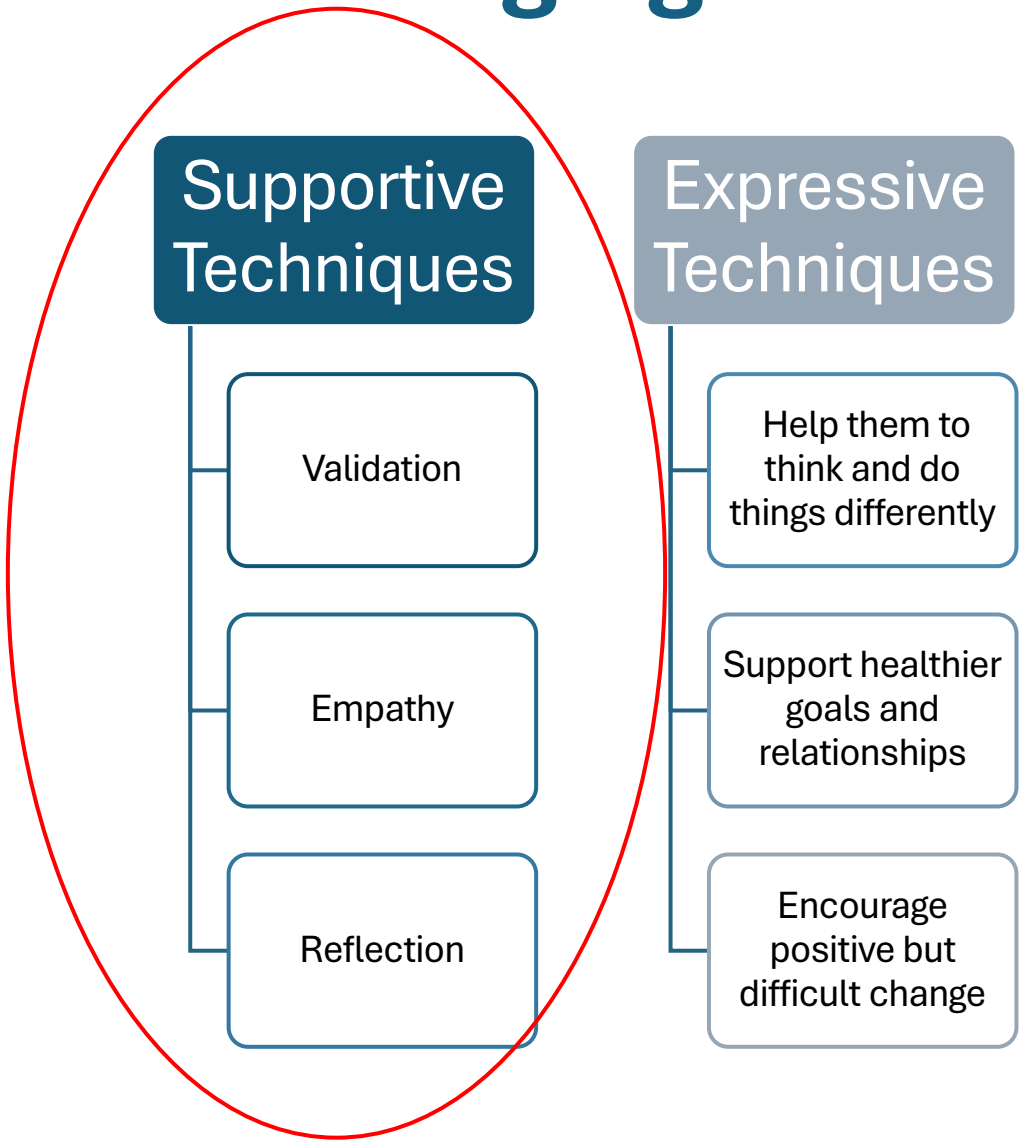
Micro Skills of Managing Distressed People

- Active Listening (your body needs to be communicating I am listening)
  - Eye contact
  - Leaning in
  - Sit back from your computer, turn and face the person
  - Relaxed
  - Gentle nodding/minimal encouragers
  - Avoid overdoing it
- Reflection/Paraphrase
  - Repeating back a summary of what your heard in your own words "So when your girlfriend rejected you it felt like you had nothing left, Am I getting that right?"
  - Use sparingly
  - Seek clarification
  - Avoid labelling peoples emotions or telling them how they feel.
- There is no right thing or magic statement you can say to someone who is really distressed; mostly it is about reflecting what you see and hear and being empathic
  - "I can see how hard this is for you to talk about"
  - "Thank you for sharing with me"
  - "I am sorry that happened to you"
- Be curious
- The person is the expert on their own life and their own experiences

Micro Skills of Managing Distressed People

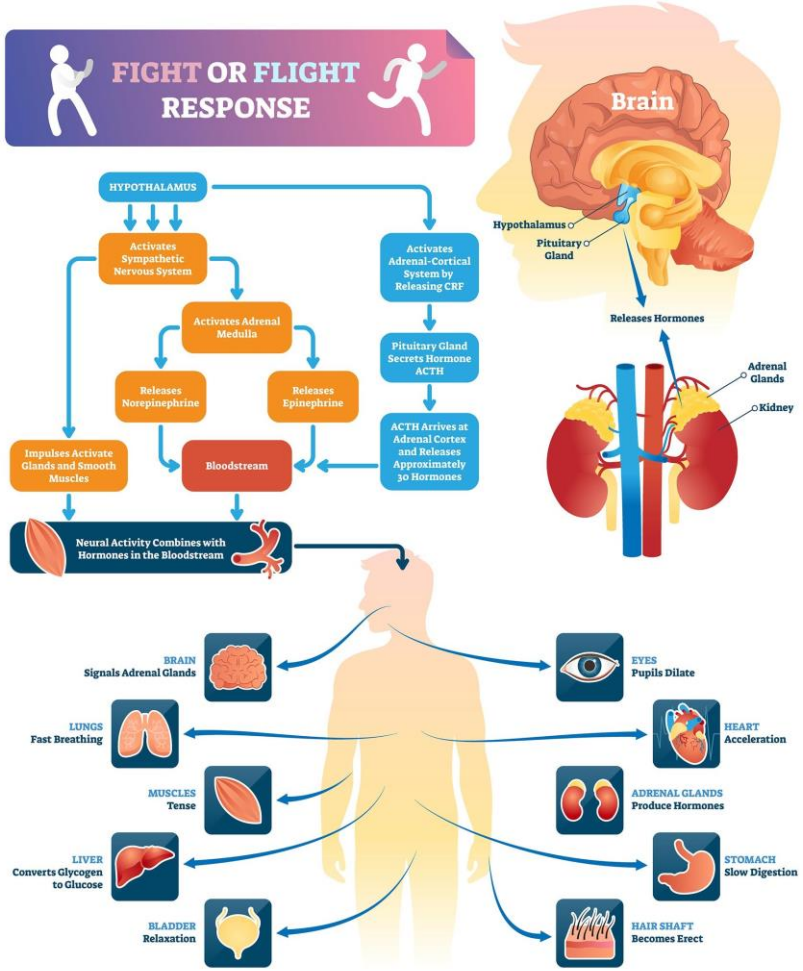


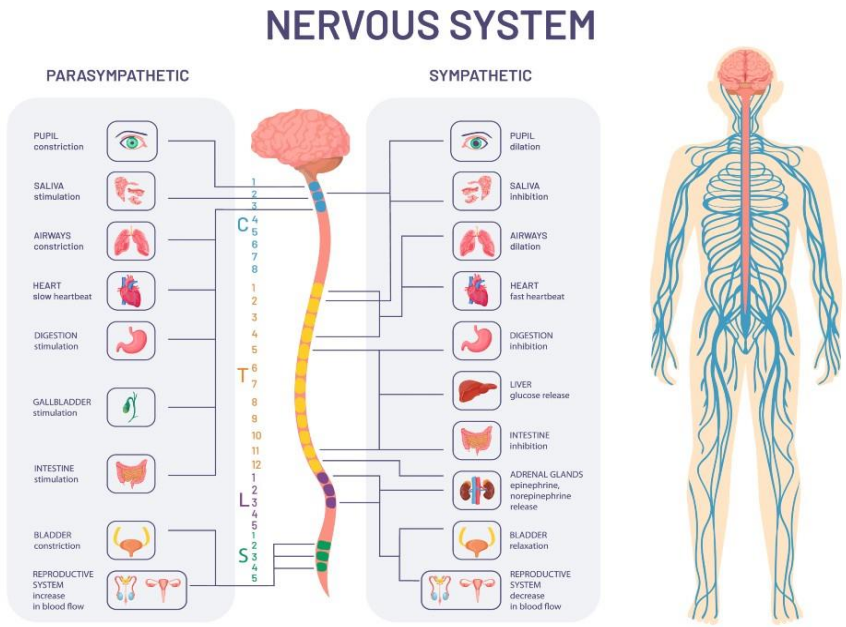
Validation and Empathy – Get out of problem-solving mode and into feeling

- Brené Brown on Empathy
- Inside Out Sadness comforts Bing Bong

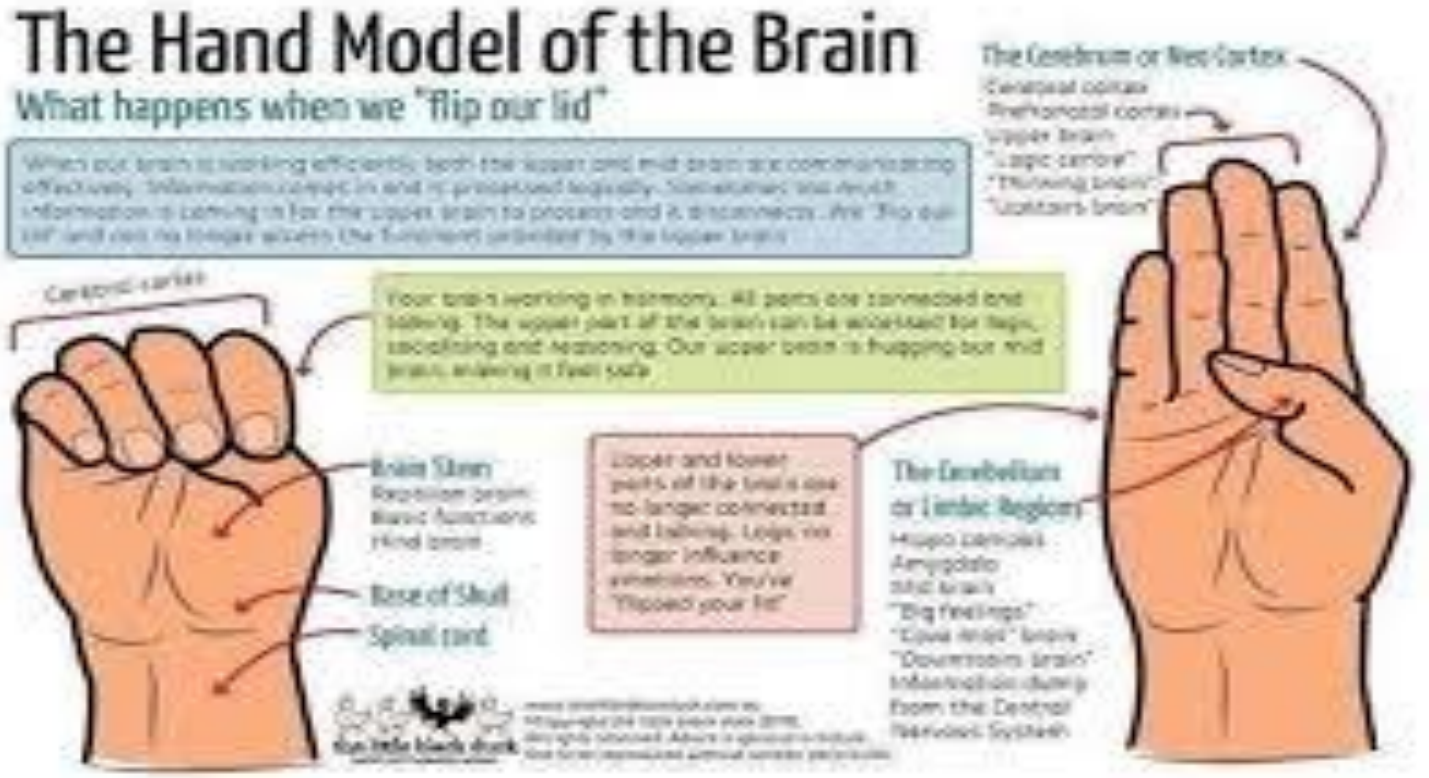
- Empathy– Holding time and space to sit in someone's pain with them and be able to tolerate that.
- Validation - Seeing and recognising someone's pain and meaning that deeply.
- People typically know the solutions to their own problems and just need to be seen and heard before being gently guided to solutions.

The (very basic) Neuroscience of Distress





The (very basic) Neuroscience of Distress



When people are distressed (their sympathetic nervous system is activated) they are operating in the primitive emotion/amygdala/survival driven part of the brain. There is no capacity for problem solving or rational thinking here.

They need to calm their body to get their pre-frontal cortex back online to make clear, calm rational decisions and problem solve

So when someone is distressed we work in the body first always. Less talking less thinking. Calm the body.

Quick skills to calm the body

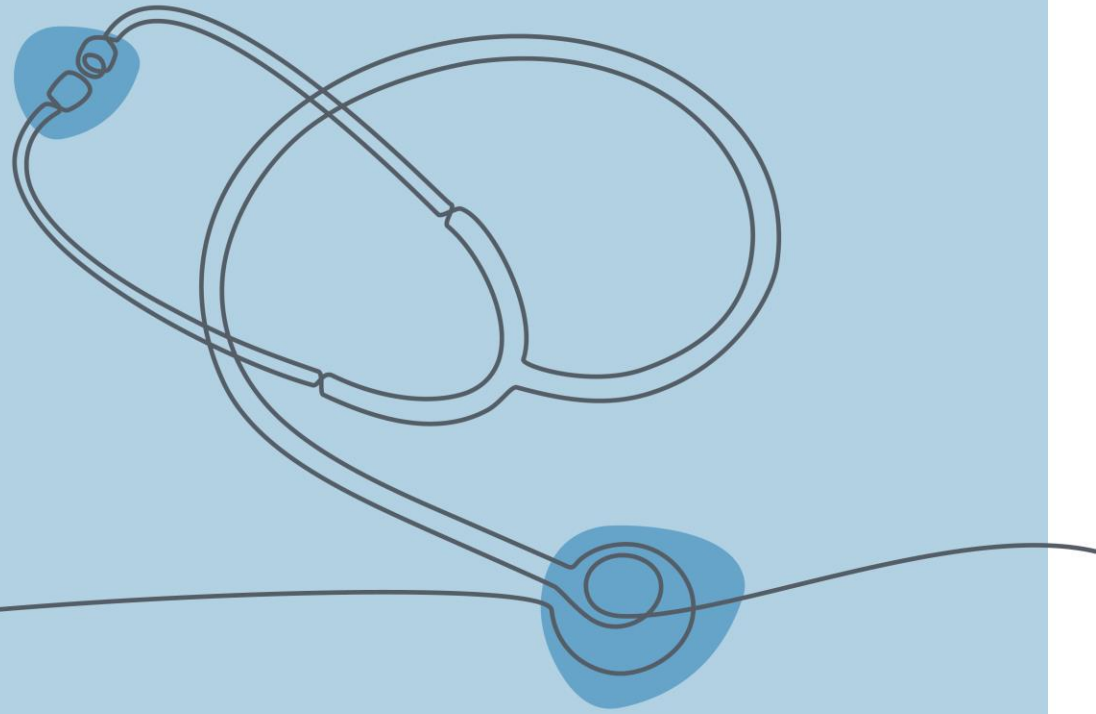
- Abdominal Breathing/Box Breathing
  - Only ever done with the psychoeducation about the nervous system
    - Imagine being told to "just breath" when you are having the worst day of your life with no context
  - Breath comes from down in the belly
  - Outbreath always longer than the in breath
  - Box Breathing Practice
  - take a deep breath
- Dive Reflex
  - Place face in a bowl of ice cold water/ice packs and stick your head between your knees
  - Mammalian Dive Reflex Demonstration
- Grounding
  - 54321 - The 5-4-3-2-1 Method: A Grounding Exercise to Manage Anxiety
  - Dropping Anchor - Dropping the Anchor
- Mindfulness
  - Body Scan - The Body Scanner! Mindfulness for Children

Tips for working in your 15mins....

- Setting warm but firm boundaries:
  - Sign post for people that the appt is only 15mins but how can we use this time effectively
  - Giving choice (where possible)
  - Involve others (where possible) - do you have a practice nurse who could assist?
  - "Wow it seems like there is a lot going on for you right now, I can hear how difficult this all is for you. I am mindful that we only have 15minutes together today, what would be most helpful for you today?"
- Make a plan:
  - Make a follow-up and suggest a longer appt if necessary
  - "I really want to help you with this and understand better what is going on, could we make another appointment later in the week, perhaps a longer one so we have time to really talk about this".
- Escalate where you need to (e.g. crisis support lines or ED)
- You would be surprised what a small amount of containment can do for people

General Practice Liaison Officer Program presents

Championing Generalism Workshop



A collaborative, multi-disciplinary and multi-specialty learning opportunity for GPs covering conditions commonly managed in primary care

Case study: Weight Management - A team effort for better health

Andrea Cawte | Diabetes Educator & Dietician, RBWH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Weight Management

Obesity isn't rocket science…….it's more complicated than that

Andrea Cawte: Senior Dietitian & Credentialled Diabetes Educator
William Beningfield: Physiotherapist

Queensland Government

Learning Objectives

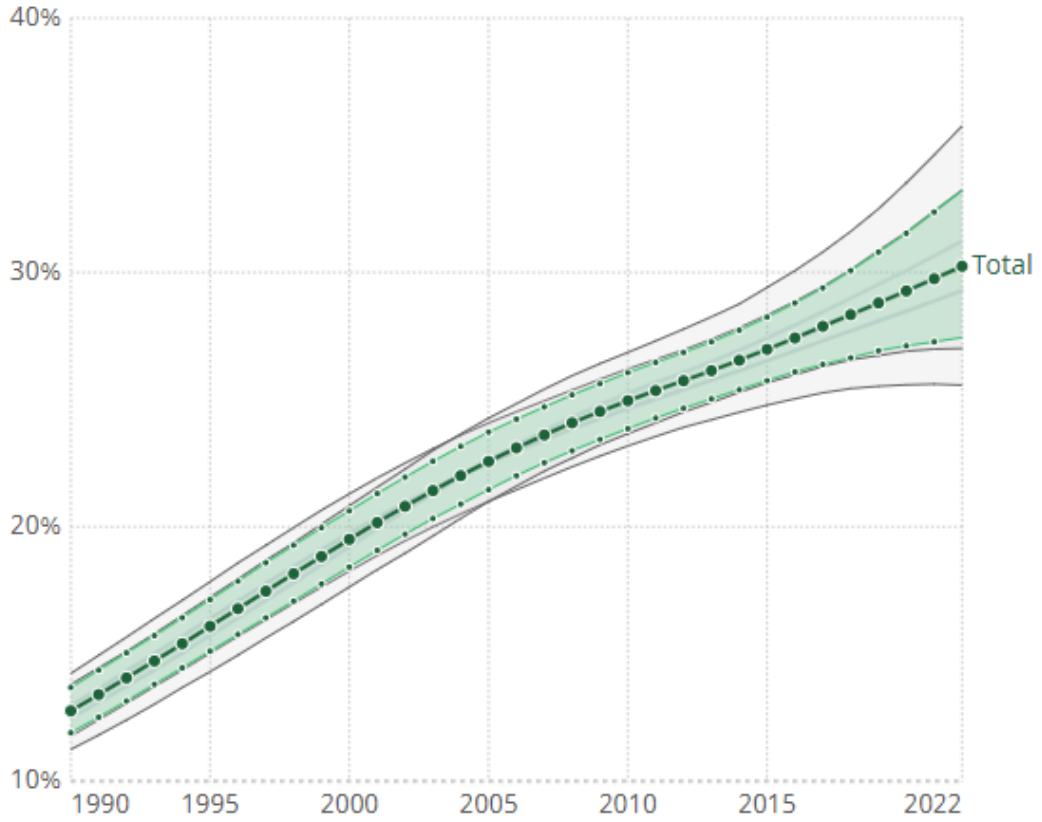
- Understand overweight & obesity
- Understand the importance of an MDT approach to weight loss
- Understand the treatment options
  - Diet and Exercise
  - Psychology
  - VLED
- Understand why positive change is challenging and how you can help
- Weight stigma & bias
- Progression of a health journey
- Sustaining long term-weight loss

Overview of Obesity in Healthcare

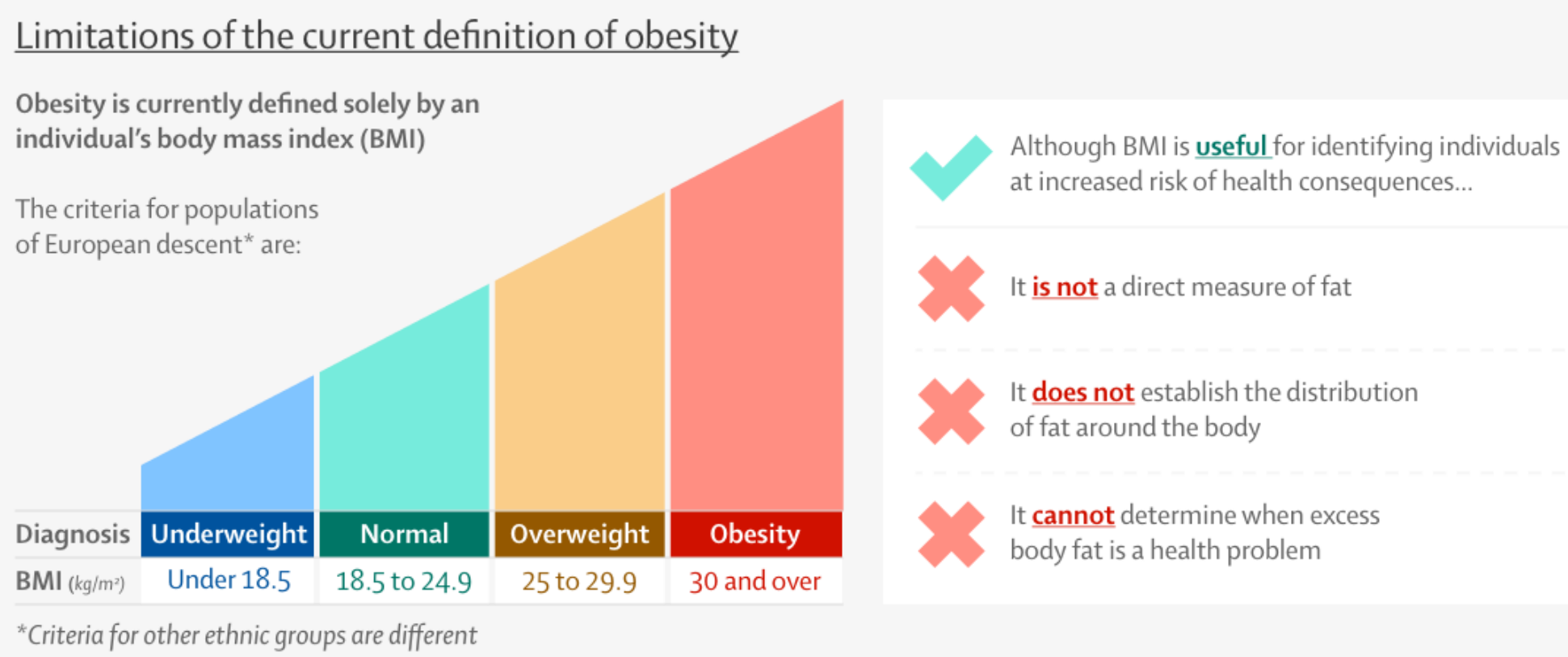
- **"Obesity is a chronic complex disease defined by excessive fat deposits that can impair health"**
  World Health Organization 2022
- **New definition by the Lancet January 2025**
- **890 million people living with obesity worldwide – 16% of total population**
- **In Australia almost a third of adults (32%) meet the criteria for obesity, with similar trends in the US and Europe (AIHW, 2022)**
- **The healthcare burden of obesity is significant, contributing to 44% of diabetes cases, 23% of ischemic heart disease, and between 7-41% of certain cancers.**

Australia, Total
1990 – 2022

Age-standardised prevalence of obesity among adults (18+ adults)



Overview of Obesity in Healthcare

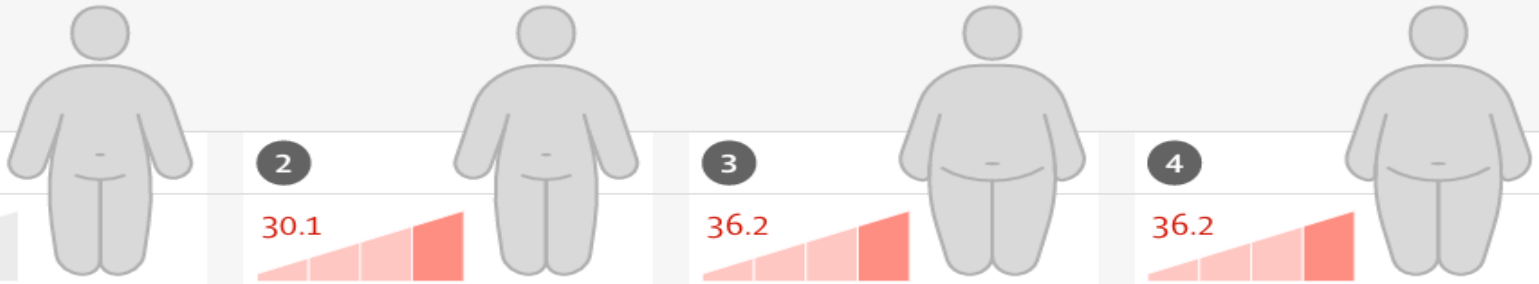


Lancet infographic - Clinical Obesity

Overview of Obesity in Healthcare

Lancet infographic - Clinical Obesity

Relying on BMI alone to establish if someone has obesity is problematic as this can inaccurately classify a person as having or not having excess body fat, and also lead to under-diagnosis of many whose health is impaired and over-diagnosis of many who are healthy.



#	1	2	3	4
BMI (kg/m²)	28.2	30.1	36.2	36.2
Diagnosis	Overweight	Obesity	Obesity	Obesity
Excess body fat?	✔ Yes	✖ No	✔ Yes	✔ Yes
Signs and symptoms?†	✖ No	✖ No	✖ No	✔ Yes
Notes	Under-diagnosis of obesity	Over-diagnosis of obesity	Obesity with preserved health	Obesity with ongoing illness

Limitations of BMI-based diagnosis

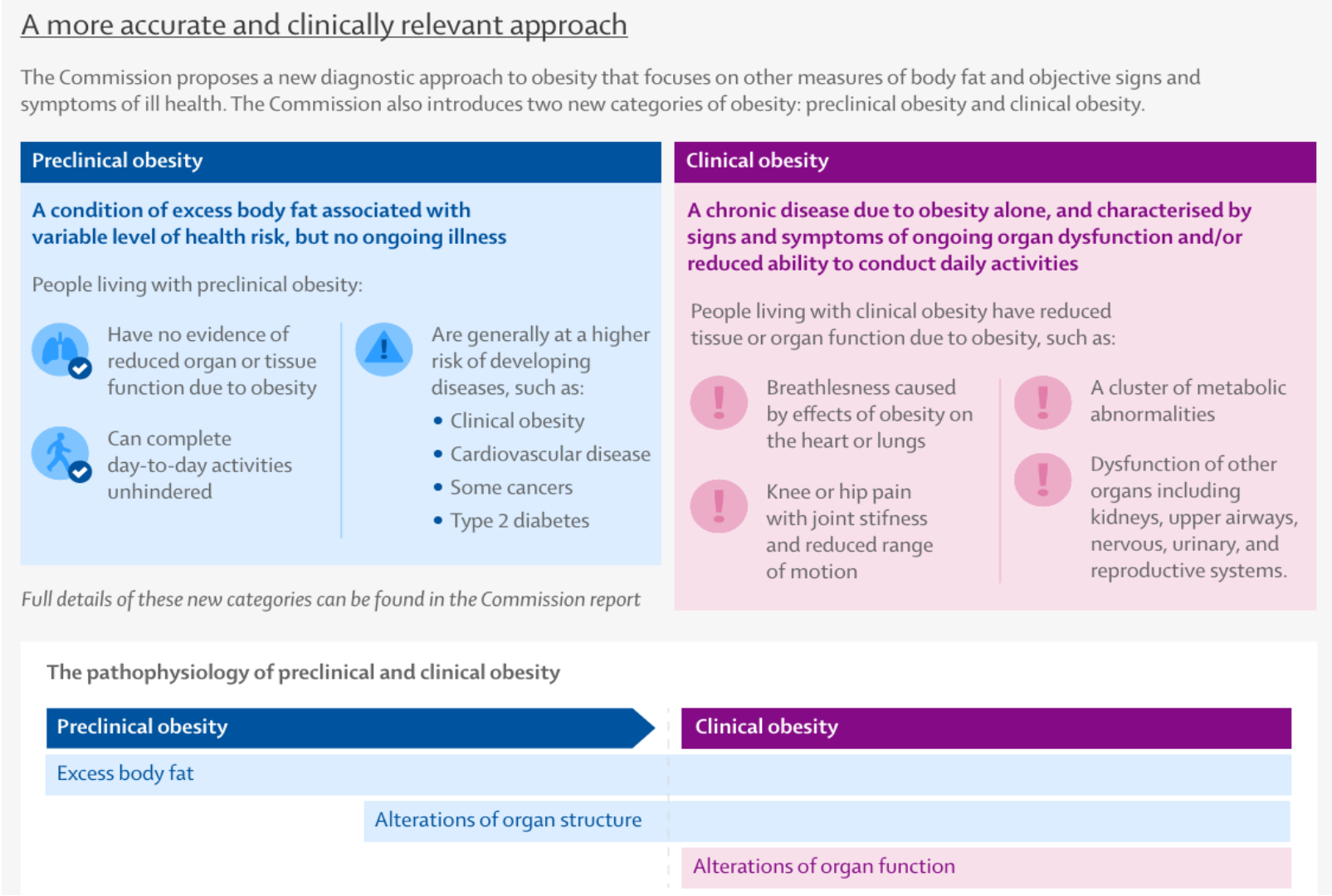
!	People with excess body fat do not always have a BMI above 30, meaning that their health risk can go unnoticed.	Individuals with high muscle mass (eg, athletes) tend to have high BMIs despite normal fat mass. Diagnosing such people as having obesity or a disease is inappropriate.	Some people with excess body fat (and high BMI) can nevertheless maintain normal organ function and an unhindered ability to conduct daily activities (hence, they have no illness); others instead manifest objective evidence of ongoing illness. Current definition and measures of obesity do not reflect health/illness at individual level and are therefore inadequate for disease diagnosis.

Overview of Obesity in Healthcare

Useful links to the new definition of obesity:

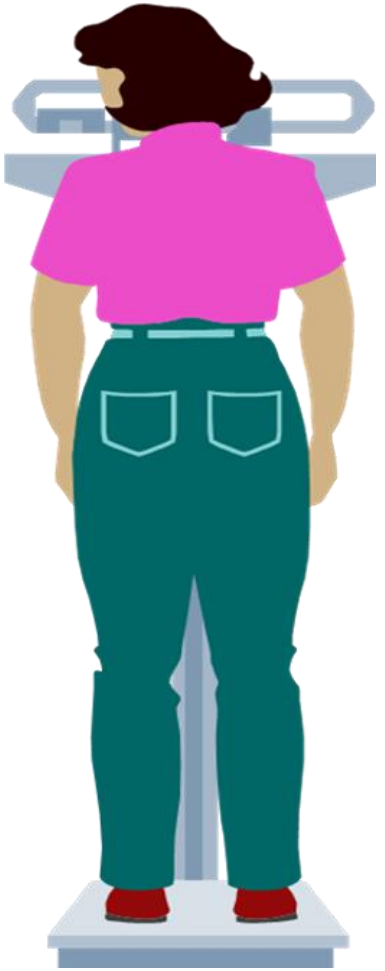
[Lancet infographic - Clinical Obesity]

[Definition and diagnostic criteria of clinical obesity]



Case Study - Debbie

- Debbie – 47yrs, works part time in call centre, reasonably healthy, 3 children
- Initial GP visit for lower back pain
- Obs
  - Stage 2 HTN 144/82
  - HR 87 bpm
  - Wt 93kg – gradually increasing since kids
  - Ht 1.79m
  - BMI 29kg/m2



Gold Standard Approaches To Weight Loss

Debbie needs an MDT approach for success

Healthy lifestyle education / support

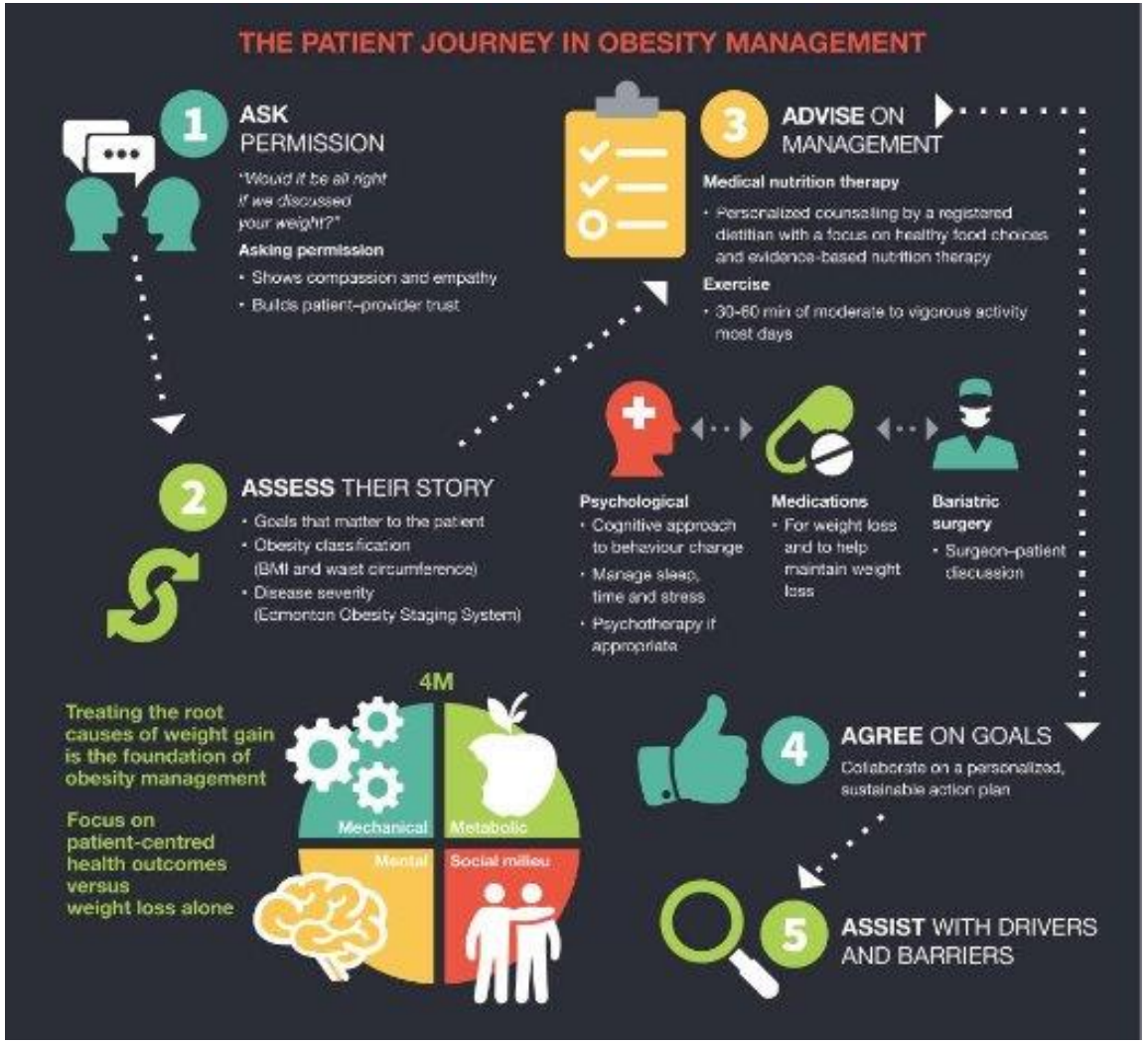
Ultra processed, high energy, nutritionally poor diet + sedentary lifestyle

Diet & exercise

GP

Dietitian

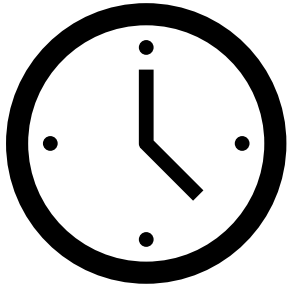
Exercise physiologist



Canadian Medical Assoc Journal CMAJ 2020 Aug 4; 192(3): E875-E891 Obesity in Adults: a clinical practice guideline

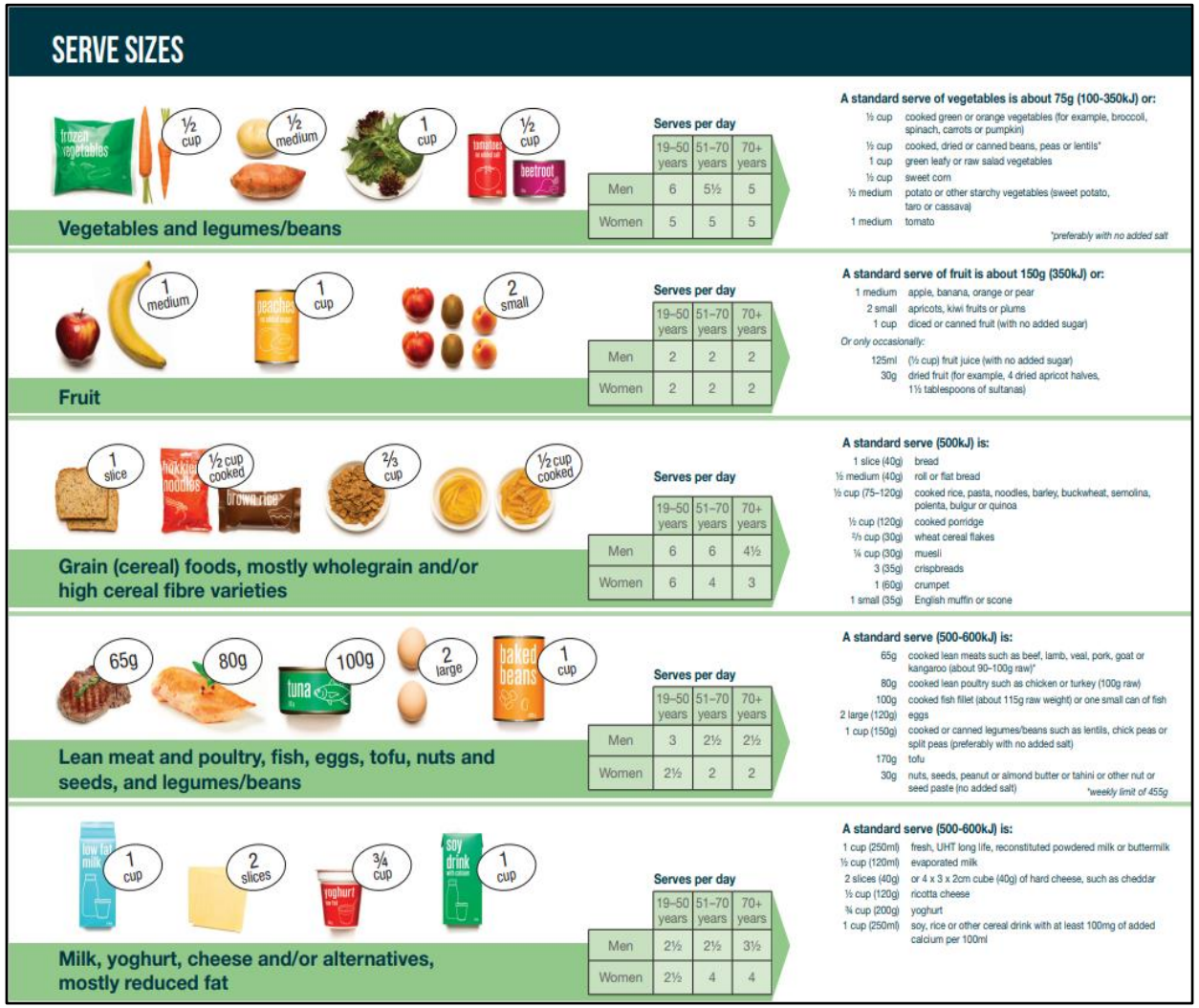
Dietitian Assessment

- **Reason for referral**
- **Patients goal**
  - ascertain weight loss required to impact health
- **Anthro:**
  - Weight, waist circumference, BMI
- **Biochem:**
  - relevant pathology relating to health conditions
- **Clinical:**
  - previous medical history
  - presenting medical condition
  - nutrition impact symptoms
  - readiness to change
- **Diet:**
  - allergies/intolerances
  - diet history/eating patterns/food choices
  - dietary assessment and diagnosis



- **Plan:**
  - discuss with patient their goal time frames
  - discuss with patient their preferred approach to care – eg one on one, group, phone clinic, which disciplines they would like to engage with
  - offer up some solutions with the above in mind eg COACH, HELP, surgery, individual appointments
  - Ensure the solution fits the patient AND the level of weight loss anticipated will impact the disease management
- **Follow up:**
  - in a timely manner
  - in a meaningful way – discuss whether the path chosen is effective/working/too challenging
  - discuss alternatives if appropriate OR when the patient would like to check in again if now is not the right time

Treatment Options – Dietary Improvments

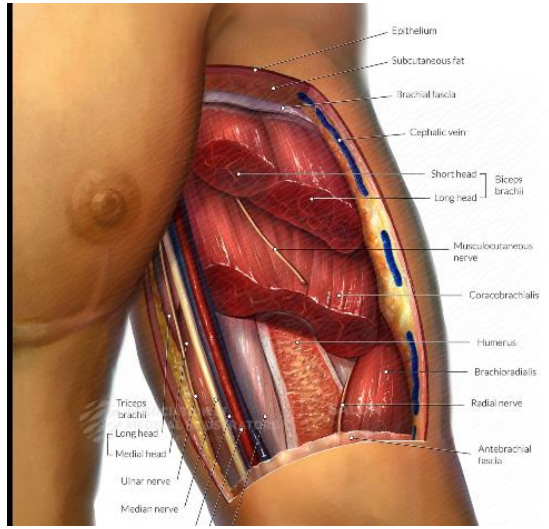


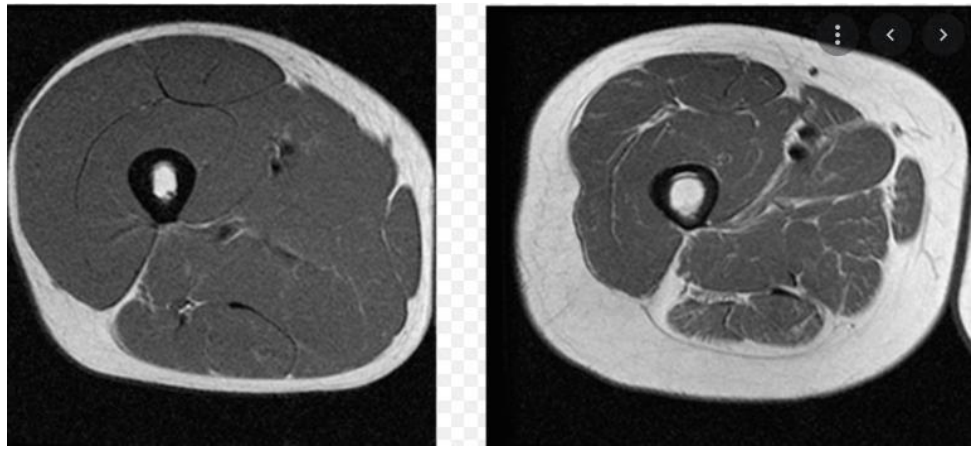
Debbie – dietitian referral

- **Patients goal**
  - 5-10kg
- **Clinical:**
  - previous medical history
  - presenting medical condition
  - nutrition impact symptoms
  - readiness to change
- **Diet:**
  - Lots of convenience food due to time constraints having family
  - Lack of cooking skills and confidence around trying new foods/meals
  - Finance – both parents working and money is tight
- **Plan:**
  - Motivated and ready to change
  - Would like regular check-ins to keep her accountable and for support
  - Decided on dietitian monthly and practice nurse monthly for weigh-in, so contact every fortnight
  - Dietary changes as discussed with dietitian for easy to prepare, healthy food on a budget
- **Follow up:**
  - Monthly (fortnightly including weigh-ins)
  - To ensure plan is working and tweak if not

Treatment Options – Exercise Guidelines

Energy balance – muscles are your engine, fat is the fuel





ACTIVITY	TIME/WK
	150 mins per week
	2 sessions per week

Benefits of Exercise

- Reduced risk of mortality and premature death
- Reduced risk of cardiovascular disease and reverses disease process
- Reduces blood pressure and risk of stroke
- Reduced risk of developing type 2 diabetes in addition to management and preventing further progression
- Reduced risk of colon and breast cancer
- Reduced risk of developing osteoporosis and low bone mineral density
- Improved joint pain (particularly back and knee pain)
- Improved mental health, depression, anxiety
- Improved quality of life
- Helps maintain weight loss

Exercise & Weight Loss

NO

- No changes in body weight
- No weight gain compared to control groups
- Significant health benefits, particularly cardiovascular and metabolic
- Some weight loss with daily vigorous exercise for 12-16 weeks

(Fonseca-Junior, SA, Rodrigues, Oliveira, & Fernandes-Filho,

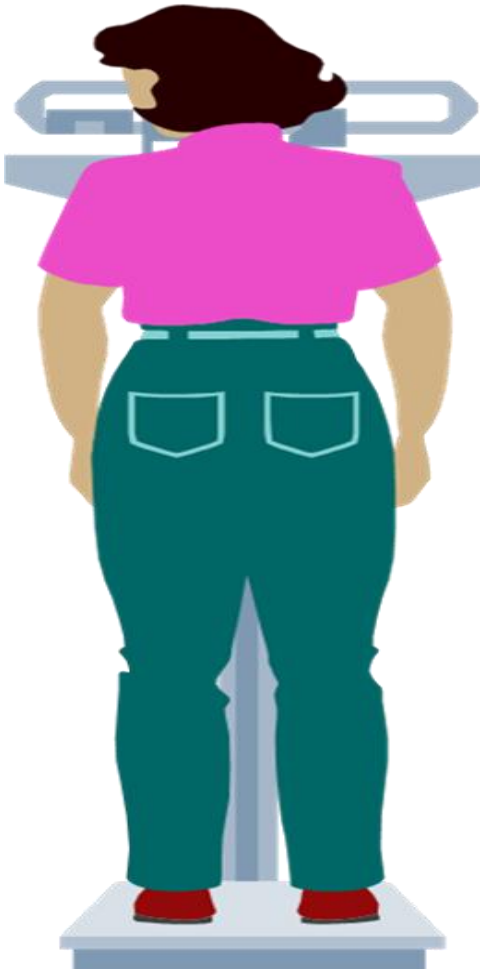
Debbie – exercise physiology referral

- **Reason for referral**
  Weight loss and reduced back pain
- **Patients goal**
  To reduce back pain
  Lose weight
  Increase activity and become more involved in family life
- **Clinical**
  Past medical History
  Presenting condition
  Current heart and lung function
  Exercise history and tolerance
- **Exercise**
  Currently no formal exercise routine
  Will try to walk a few days a week
  Household work and occasional gardening
- **Plan**
  Set up exercise calendar and planner
  Begin upper limb and lower limb strengthening 2-3 times per week
  Cardio 2-3 times per week (30 mins moderate level walk)
- **Follow up**
  Weekly sessions to begin with for 1 x personal training session

Debbie – success and relapse

- Debbie is engaged, loses 4kg over 4 months and is happy
- Her back pain is resolved

- Then Debbie goes full time at work and is time poor
- Disengages from health coaches
- Represents 18/12 to GP with increased back pain and knee pain after fall at work
- GP reassesses
  - BP 182/91
  - HR 88 bpm
  - Wt 108kg – increase of 15kg, due to time poor and comfort eating
  - Ht 1.79m
  - BMI 34kg/m2
- Debbie confides she feels ashamed of her past ‘failure’ and her increasing body size

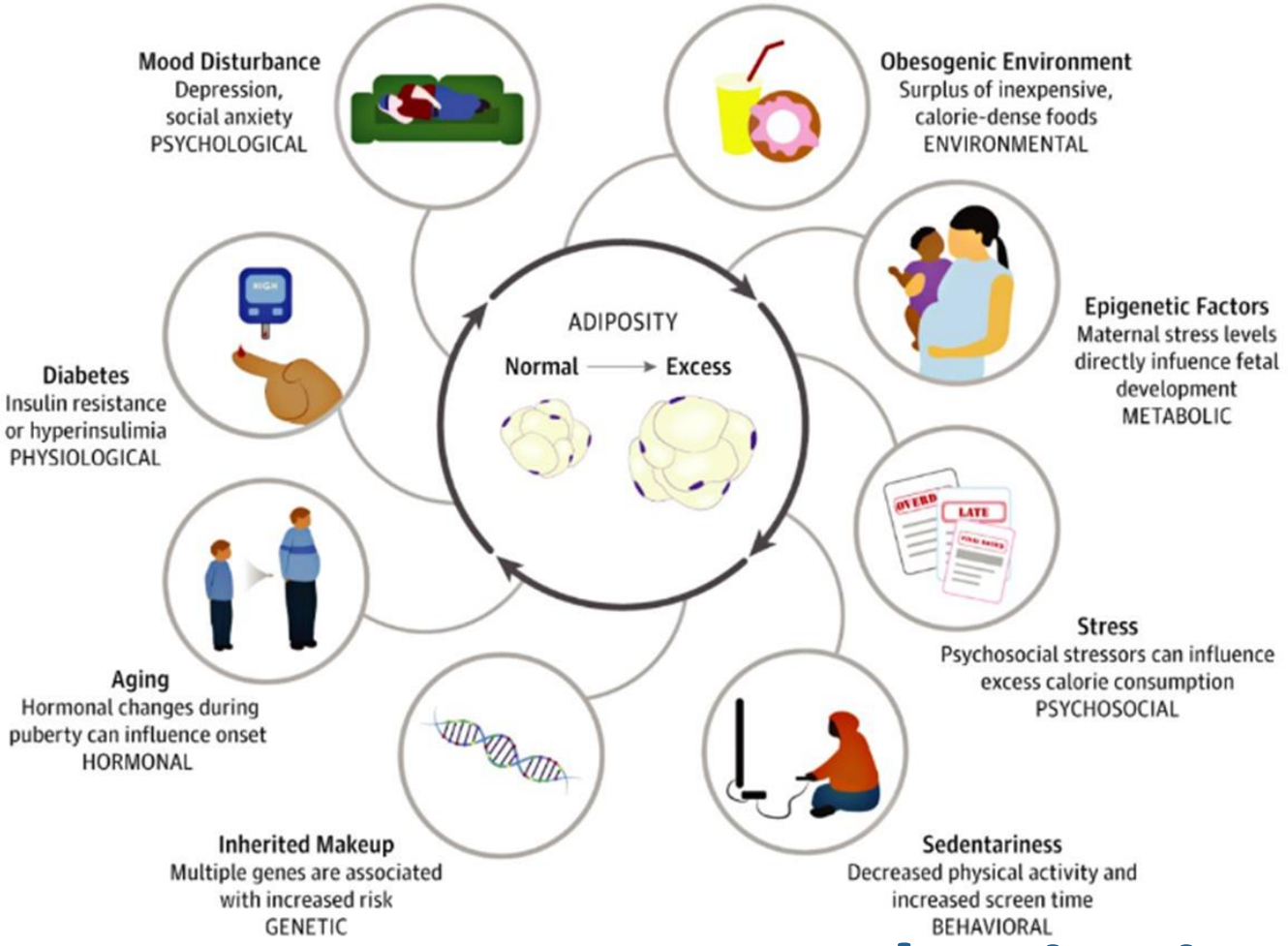


Why is relapse so easy?

Hedonic System

Appetite Regulation Hormones

Underlying Health Issues



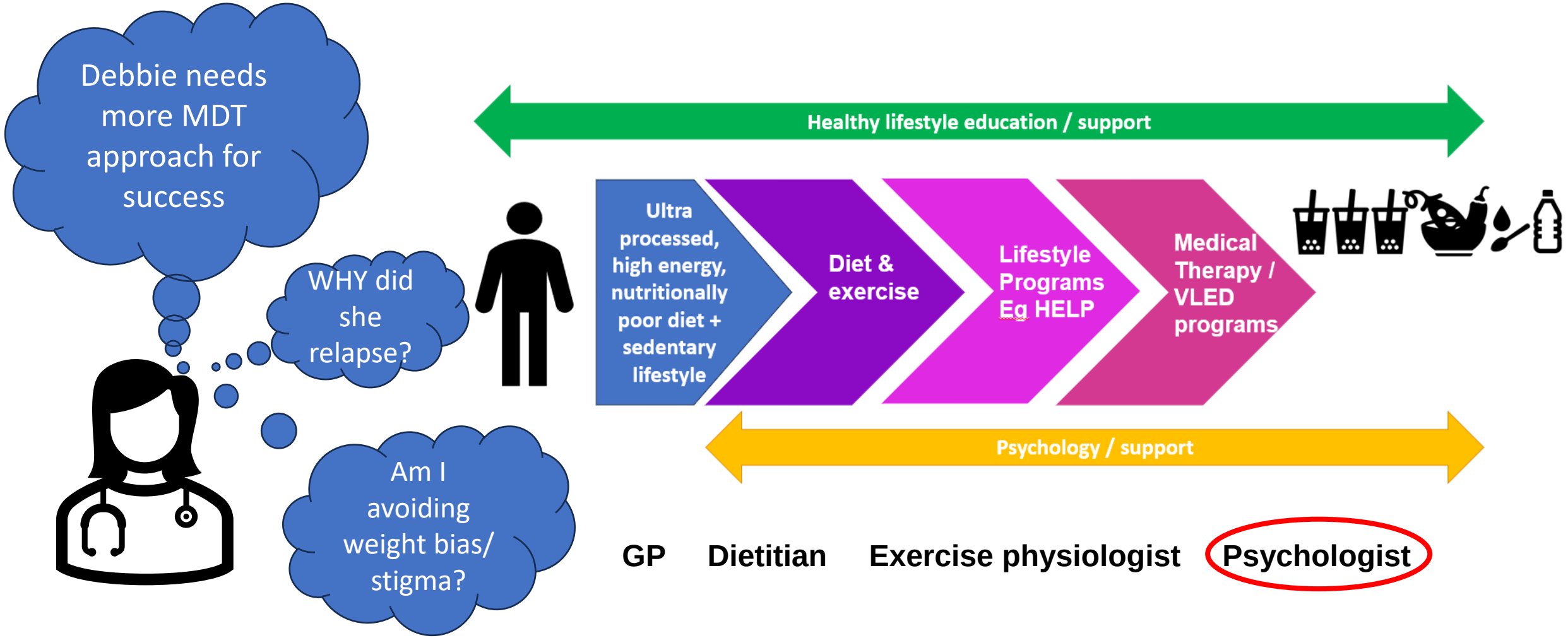
Worsening diet quality

Weight stigma & bias

Set-point theory

Obesity is Multifactorial

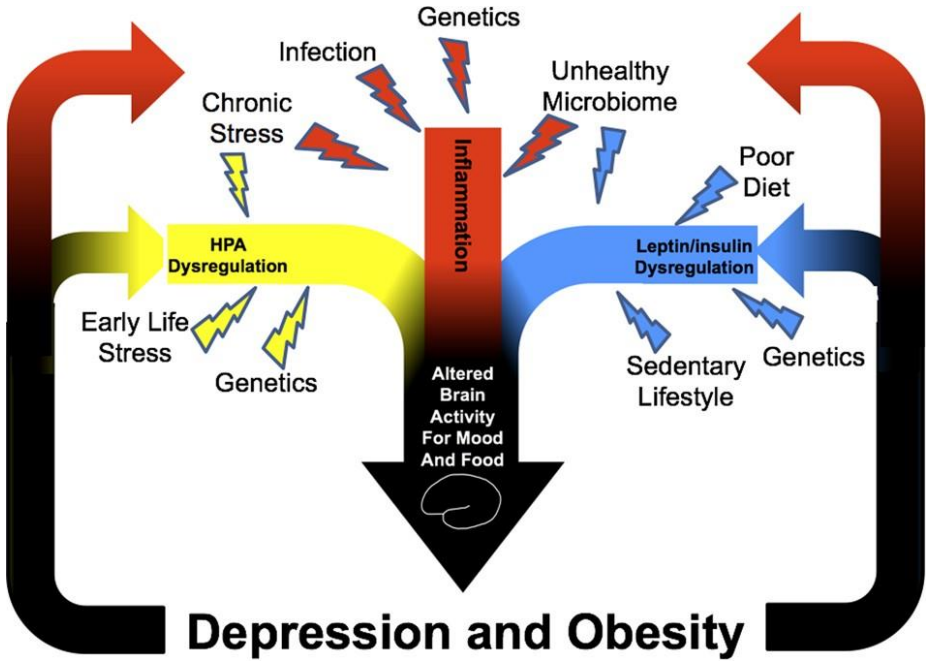
Gold Standard Approaches To Weight Loss



Weight Stigma

- A combination of implicit and explicit prejudice and discrimination based on body weight

- Erroneous belief that obesity is caused by lifestyle choices alone. Although there is strong evidence that obesity is predominantly genetic and epigenetic in nature



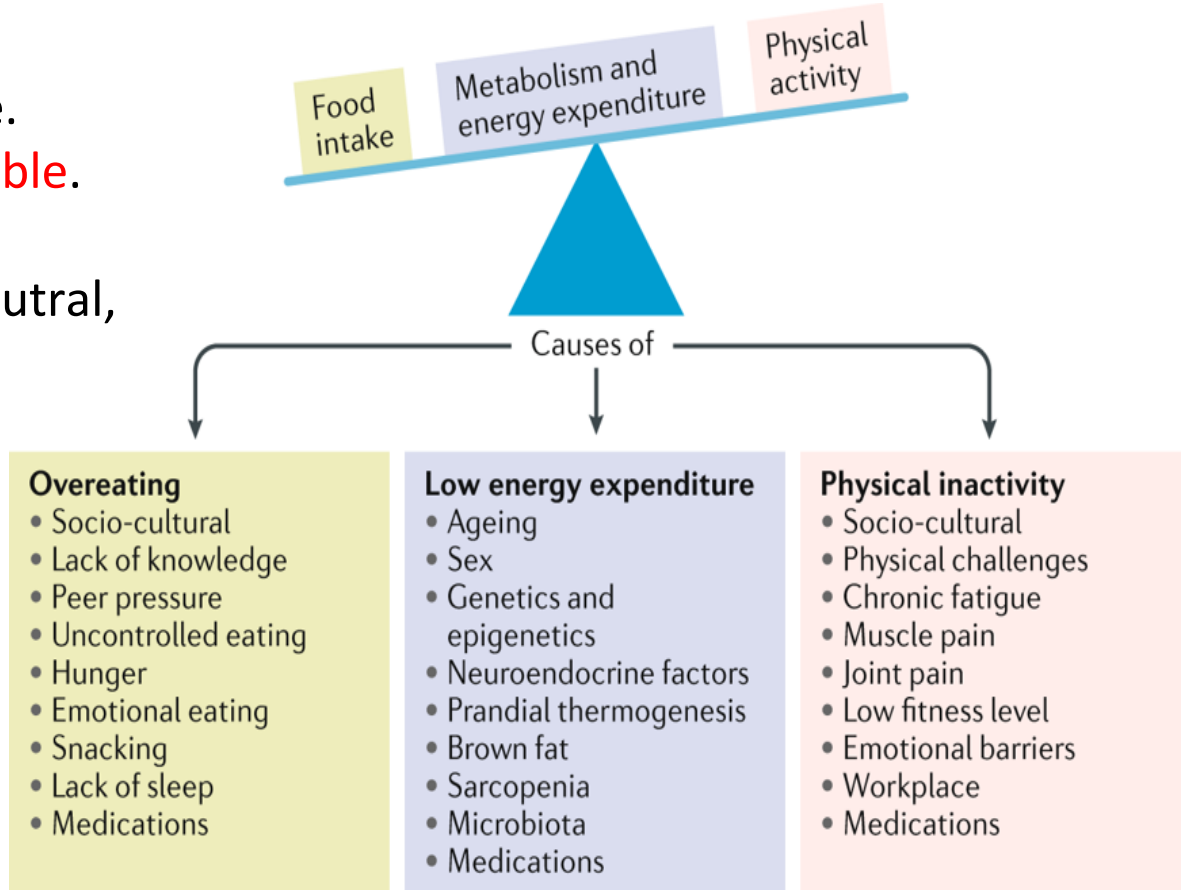
Impact of weight stigma:

- The emphasis on thinness perpetuates the internalization of the thin ideal, contributing to poor self-esteem and negative body image.
- Weight stigma is pervasive in healthcare settings, often resulting in delayed care or avoidance of care altogether by patients (Puhl & Heuer, 2010).
- Repeated weight loss efforts, especially when unsuccessful, lead to lower self-esteem, increased stress, and depressive symptoms and risk for eating disorders (Stice et al., 2013).

Strategies to Reduce Weight Stigma

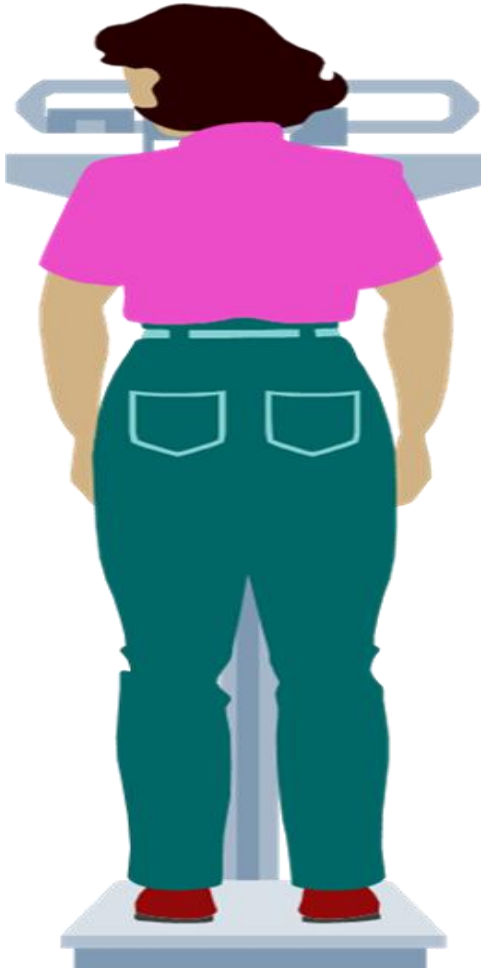
- Educating healthcare providers about weight bias and its effects on care.
- Focusing on health behaviours rather than weight alone.
- Avoid discussing body weight as if it were easily modifiable.

- Using language and imagery related to weight that is neutral, respectful and person-first:
- E.g. People with higher body weight, People with obesity, Larger-bodied people (NEDC 2022).
- Reframe discussions around weight to the complex determinants of health and our collective response to the obesogenic environment, rather than individual blame and responsibility. (Cancer Council 2022).



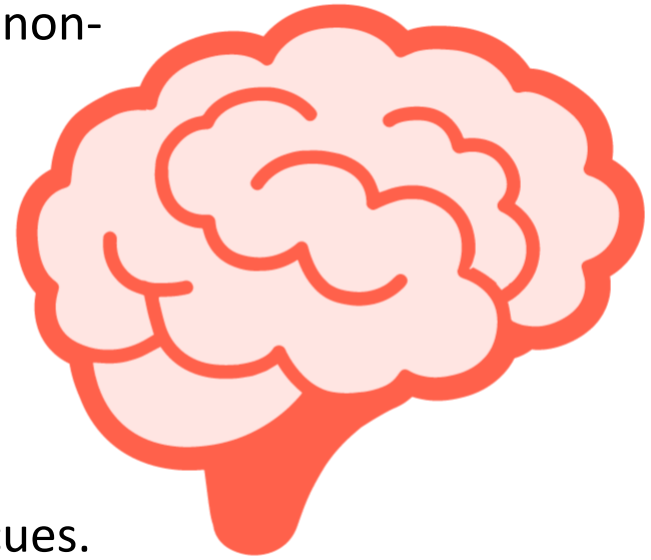
Debbie – re-engagement

- Debbie is keen to re-engage with the dietitian and exercise physiologist as these worked for her before
- She feels ashamed about her body shape now, and confides she wants to lose weight as quickly as possible to regain some self-esteem
- Debbie is happy to accept a referral to a psychologist for help with low self esteem about her body shape, and help with comfort eating



Psychological Approaches To Weight Loss

- Cognitive-behavioural therapy (CBT; e.g. Dalle Grave et al. 2020) addressing non-homeostatic eating and unhealthy patterns that contribute to weight gain



- Self-monitoring (tracking food intake and physical activity)
- Goal-setting
- Problem-solving strategies to overcome barriers.
- Environmental modifications to support healthy eating and exercise.

- Mindfulness-based approaches promote awareness of hunger and fullness cues.
- Acceptance-based therapies (e.g., ACT) focus on flexibility and embracing discomfort with less use of behaviours like non-homeostatic eating.

- Not always simple to access hospital psychology services for weight management

Treatment Options - VLED

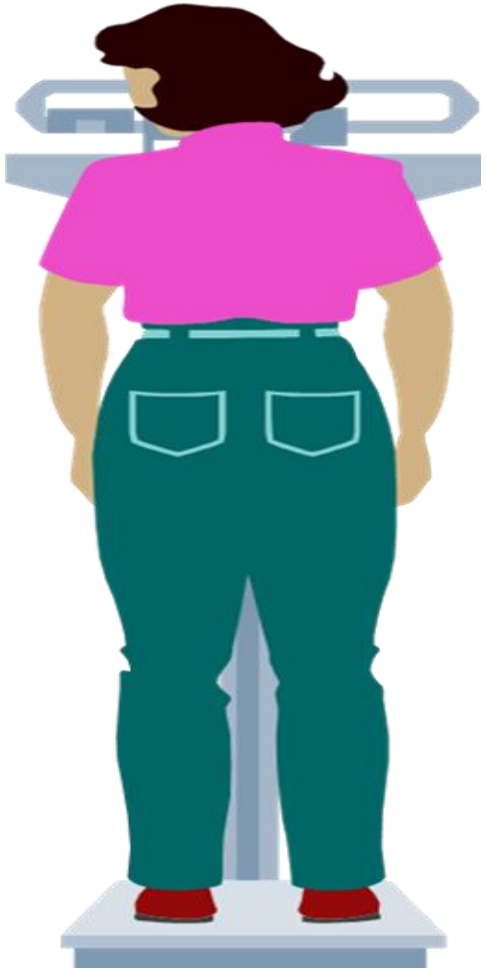
What is a VLED?

A very low energy diet (VLED) replaces three meals with a nutritionally complete product plus two cups of non-starchy vegetables, one teaspoon of oil and at least two litres of fluid daily – approx. 3200kJ/day, to facilitate rapid weight loss.

Generally, works best as part of a multidisciplinary approach which includes exercise.

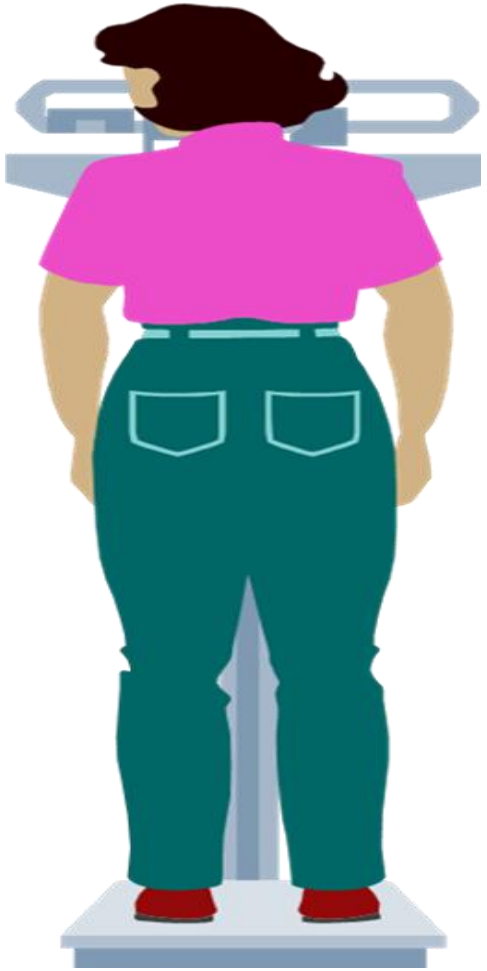
Debbie – re-engagement

- Decides to undertake a VLED with supervision by the GP, and support from the dietitian to kick start her weight loss journey
- Restarts her regular exercise routine including both cardio and weight bearing exercises
- Starts seeing a psychologist for help with comfort eating and support for her weight loss journey

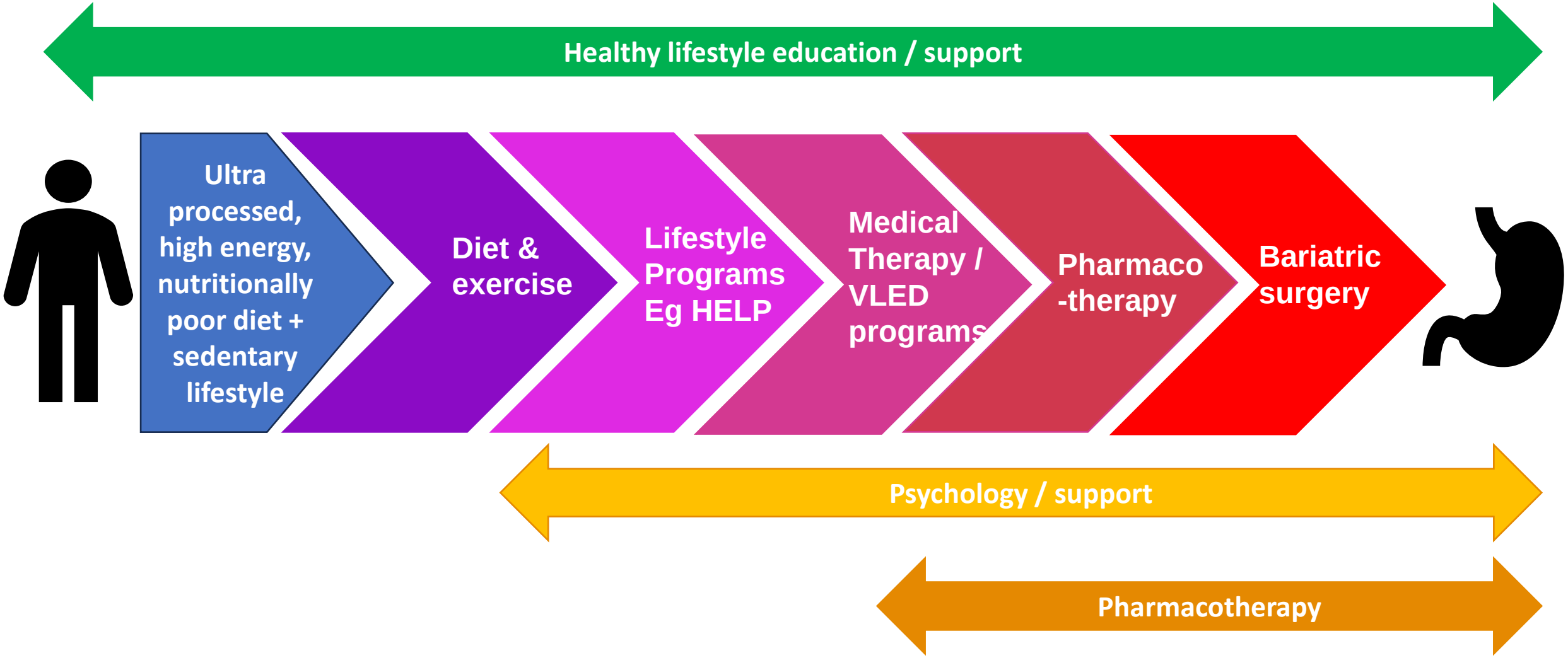


Debbie – success

- After 3 months of VLED, regular exercise and psychological support, Debbie has lost 17kg and is well on her way to better health
- She has dropped 4 dress sizes, and although she is not much lighter than her initial visit to the GP, her body shape has changed significantly
- Debbie is transitioned from the VLED back to healthy eating by the dietitian over the next 2 months – including healthy food choices and portion control
- Debbie now knows that health is a life-long journey, but feels more empowered to control this using the knowledge and support gained from her MDT



Progression of Health Journey



Risks of Dieting and Eating Disorders

- Dieting frequently leads to greater body dissatisfaction over time, as weight loss goals are often unattainable or unsustainable.

- Restrictive dieting is one of the strongest predictors of both disordered eating and eating disorders. About 35% of “normal dieters” progress to pathological dieting, and up to 25% of those develop eating disorders

- The treatment of obesity in people with comorbid conditions like binge eating disorder requires careful management. After achieving stable eating patterns and improved psychological well-being, sustainable weight loss may be introduced.

Managing these risks:

- A balanced focus on weight loss, health behaviors, and functional goals rather than strict caloric restriction.
- Screen for eating disorders before initiating weight loss programs.

Sustaining Long-Term Weight Loss

- Refer to the multidisciplinary team from the start for advice, education and support
- It is paramount that the intervention is selected by the patient as many diets are unsustainable and fail to address the underlying habits and psychosocial factors that lead to weight gain
- Individuals who maintain weight loss report regular exercise and self-weighing.
- Long-term weight loss maintenance requires ongoing behavioural changes, regular physical activity, self-monitoring, and ongoing support.
- Successful weight loss interventions are those that prioritize **patient-centred care, address underlying psychological and behavioural factors, and incorporate multidisciplinary support**. Long-term success hinges on the ability to maintain lifestyle changes over time

Any Questions?