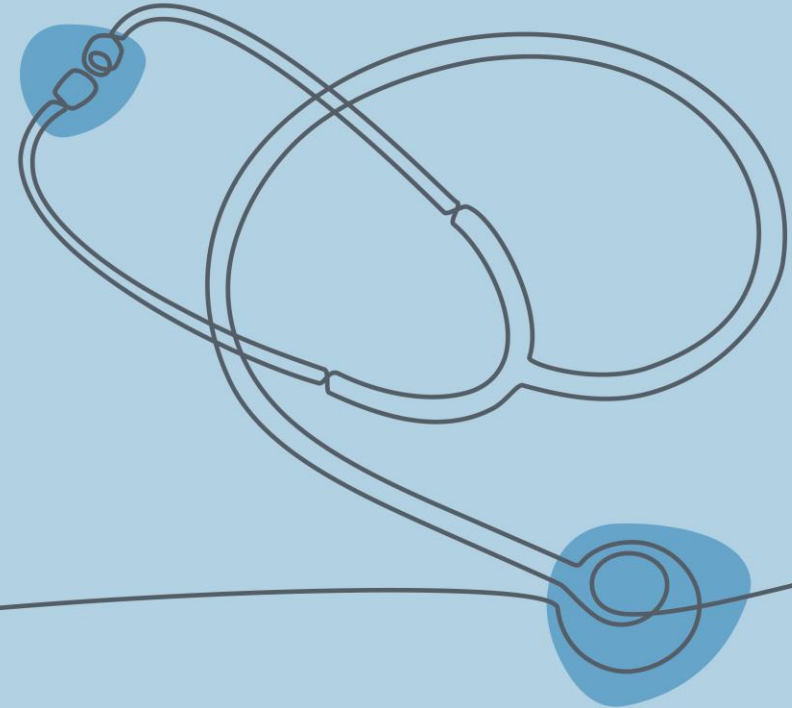


General Practice Liaison Officer Program presents

# Championing Generalism Workshop

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



**SATURDAY 21 MARCH 2026 | CSDS**

**phn**  
BRISBANE NORTH  
An Australian Government Initiative

 **Queensland Government**  
Metro North Health

# Acknowledgement

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*Metro North Hospital and Health Service and Brisbane North PHN respectfully acknowledge the Traditional Owners of the land on which our services and events are located. We pay our respects to all Elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the State.*

# ***Generalism***

**NOUN**

***a philosophy of care distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs.***

# The plan for today...

**A  
G  
E  
N  
D  
A**

8.00am

**Welcome address & getting to know you activity**

8.15am

**First session**

- The metabolic matrix: Rethinking obesity care
- Adolescent health: conversations & controversies
- Below the belt: Hernias, haemorrhoids & fissures

10.05am



**Morning tea**

10.35am

**Second session**

- Case studies
  - Dry eyes demystified: General practice insights for everyday practice
  - Virtual Ward
  - Asthma case study
- Oncology approaches: Hormonal therapy & immunotherapy

1.40 pm



**Lunch**

2.10pm

**Last session**

- Adult ADHD: diagnostic & management considerations
- Persistent pain
- What's the future for Medical AI?

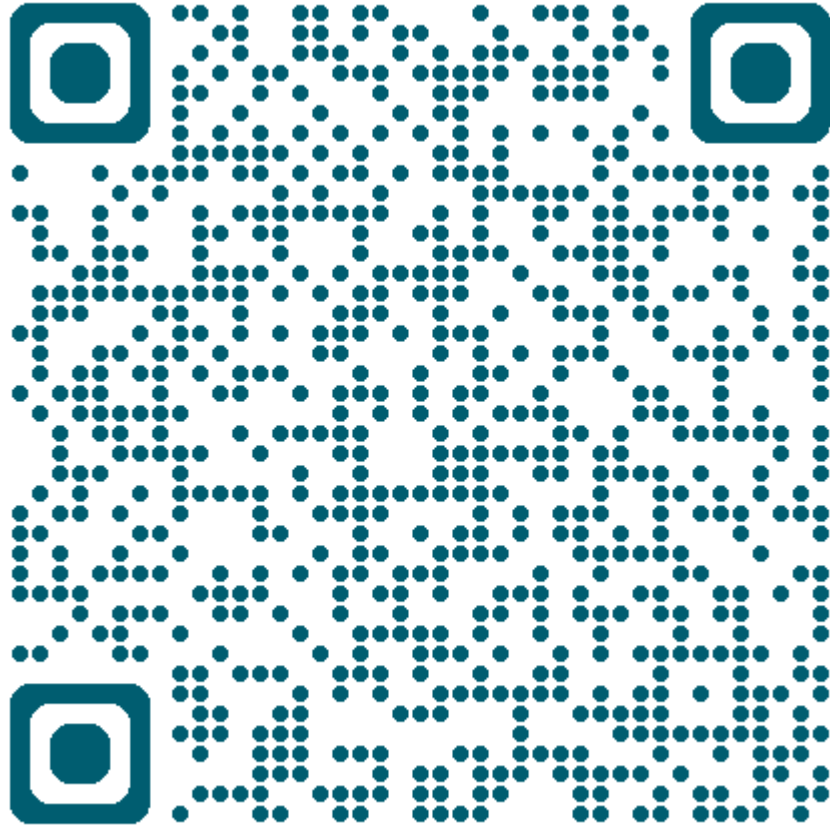
4.10pm

**Table Quiz**

4.25pm

**Closing address**

# Slides, resources and videos



## GP and primary care education

### Presentations and further resources from past education events

+ Caboolture Hospital education

+ Cardiology (updated 2025)

+ Championing Generalism Workshop (updated 2025)

+ Diabetes

+ Gastroenterology and Hepatology (updated 2025)

+ Gender Services

+ Genetics

+ Gynaecology (updated 2024)

+ Haematology and Oncology

+ Heart Failure

+ Immunology & ENT (updated 2024)

+ Kidney Health

+ Maternity (updated 2025)

+ Men's Health (updated 2024)

+ Mental Health (updated 2025)

+ Neurology

+ Oncology

+ Orthopaedics (updated 2024)

#### Contact

Email: [MNGPLO@health.qld.gov.au](mailto:MNGPLO@health.qld.gov.au)

#### Refer a patient

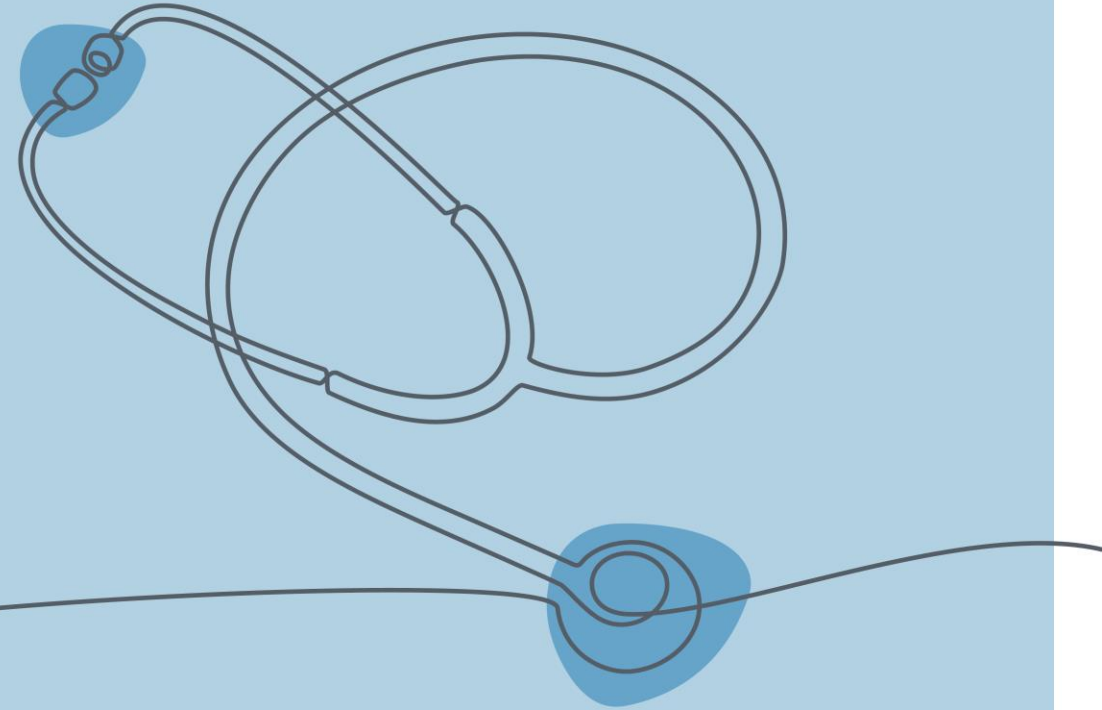
Access the [referral guidelines](#) to refer a patient.

Call the GP hotline for enquiries about referring on 1300 364 938

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



**The metabolic matrix: Rethinking obesity care**  
Dr Terri-Lynne South | Medical Director, Lifestyle Metabolic

**phn**  
BRISBANE NORTH  
An Australian Government Initiative

 **Queensland** Government  
Metro North Health



The metabolic matrix: rethinking obesity care

# Meet the speaker and disclosures



*Dr Terri-Lynne South*

Medical Director

BSc, MBBS (Hons), FRACGP, Grad Dip Nut & Diet

Terri-Lynne holds advanced degrees in both nutrition and medicine and brings over 25 years of experience as a medical practitioner to the table. Her passion lies in metabolic health, where she aims to provide a comprehensive health service grounded in both evidence and extensive experience.

has received Honoria for educational lectures and /or advisory roles and/ sponsorship to attend educational events and /or research

1. Novo Nordisk
2. Eli Lilly
3. iNOVA
4. Nestle
5. Boeringher

Has an advisory or leadership role in the following :

1. RACGP Specific Interest Group – Obesity Management
2. NACOS : National Association Clinical Obesity Services
3. TOC : The Obesity Collective
4. IO : Impact Obesity



# OUTLINE

---

- What are we *rethinking?*
  - Definitions
  - Risk factor Vs Chronic Condition
  - New therapeutic options
    - one drug : many systems
- What is “The Metabolic Matric ?”
- Past vs Present vs The Future : Obesity Diagnosis and Management
- Questions and Answers



**Setting the scene.....**

# Statistics on Obesity

**1 in 4** (25%) children and adolescents aged 2-17 and **2 in 3** (67%) adults were overweight or obese in 2017-18 >



**1 in 3** (31%) Australian adults were obese in 2017-18, an increase from **1 in 5** (19%) in 1995 >

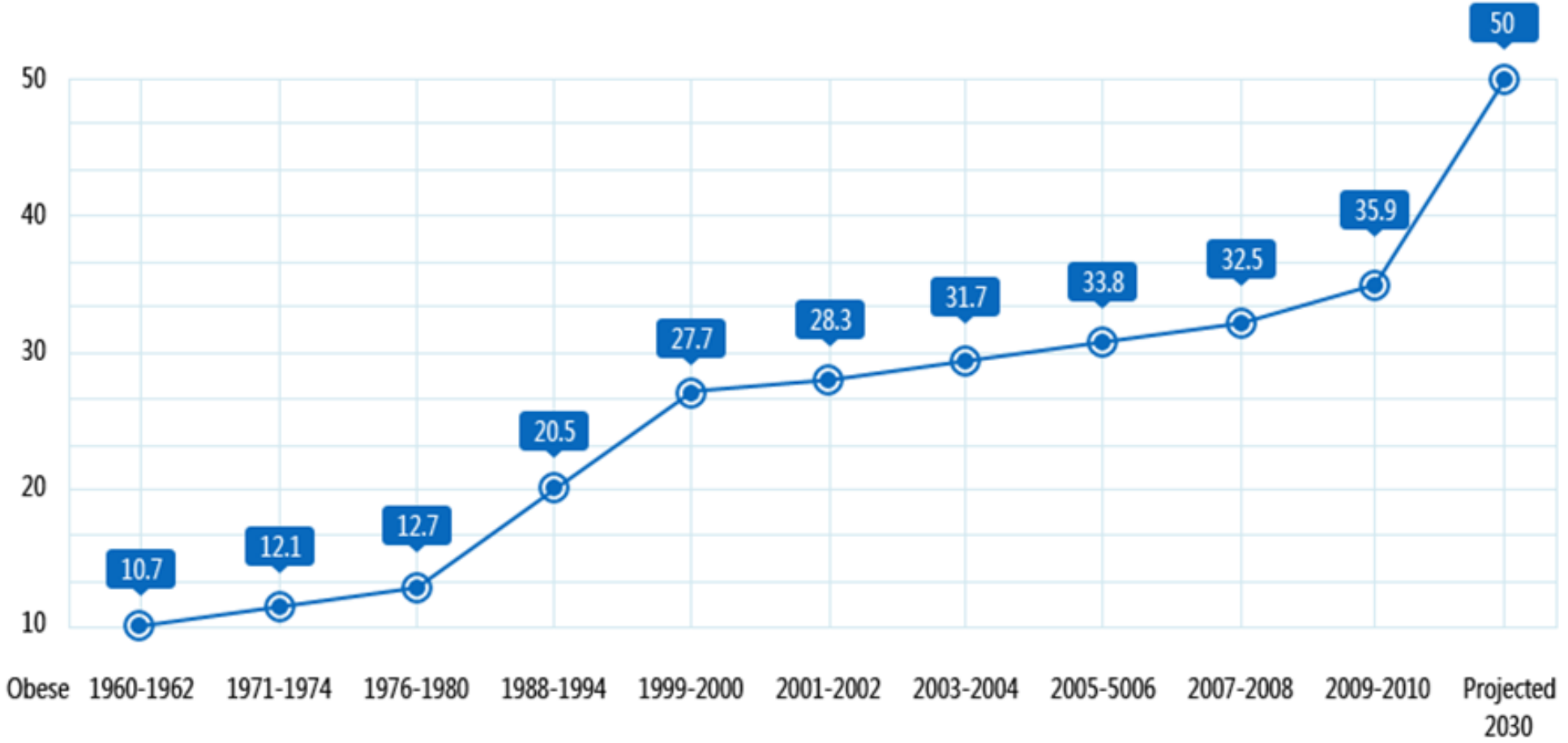


**8.4%** of the disease burden in 2018 was due to overweight (including obesity) >



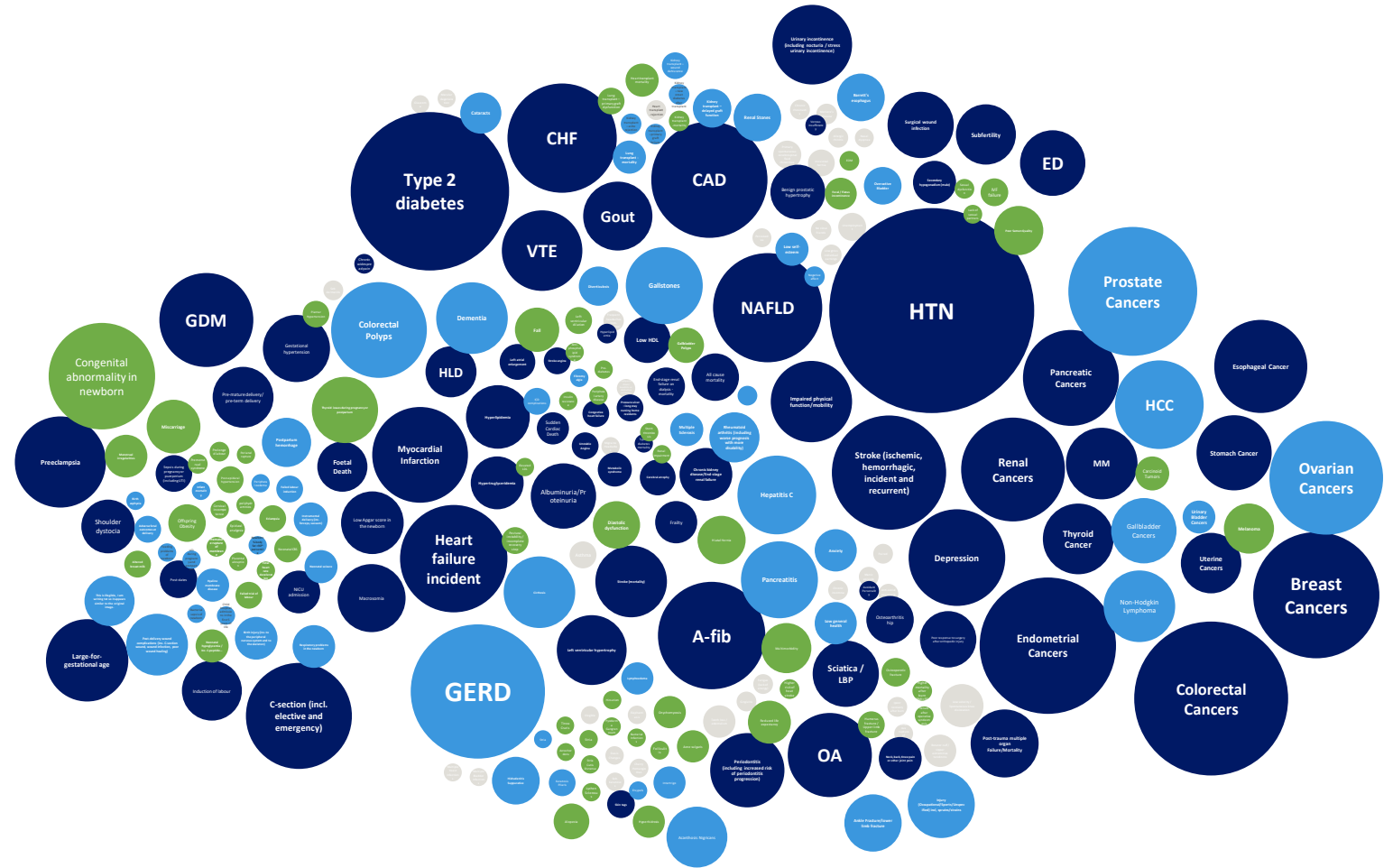
The prevalence of obesity among people born in 1973-1982 increased from **7%** at age 13-22 to **31%** at age 35-44 >

# Statistics on obesity



Derived from NHANES data

# Obesity is associated with multiple complications



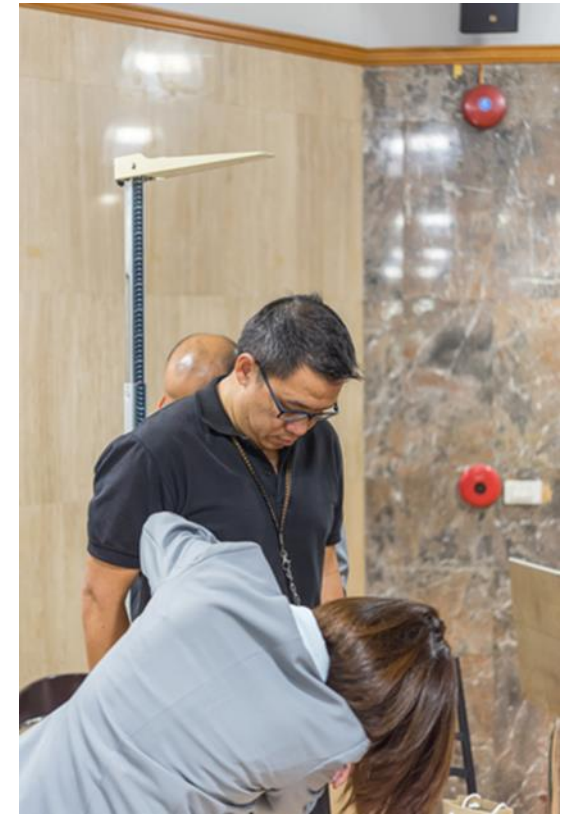
A-fib, atrial fibrillation; CAD, coronary artery disease; CHF, congestive heart failure; ED, erectile dysfunction; EOM, eosinophilic otitis media; GDM, gestational diabetes mellitus; GERD, gastroesophageal reflux disease; HCC, hepatocellular carcinoma; HTN, hypertension; HLD, hyperlipidemia; MM, multiple myeloma; NAFLD, non-alcoholic fatty liver disease; OA, osteoarthritis; VTE, venous thromboembolism.  
Horn et al. Postgrad Med 2022;134:359–75.

# Rethinking : Obesity Definition and Controversies

Past	Present	Future
Healthy Weight Range	BMI  Disease vs Risk factor  Edmonton Obesity Staging System  ?MHO (Metabolically Healthy Obese)  HAES (Health At Every Size)	ABCD <small>American College of Endocrinology</small>  Clinical Obesity <small>The Lancet Commission</small>  Obesity as part of a broader multisystem condition

# Barriers

- 22.2 % of patients have their BMI recorded
- 4.3 % have a waist circumference recorded
- < 1% of GP consultations center around obesity
- Average of 9 years delay



# Rethinking : Obesity Causation

Past

Present

Future

Individual:  
eat less and move more

Lifestyle failure

Complex interaction between individual genetics and the environment

Bio (40-70% genetics) – Psycho - Social (determinants of health)

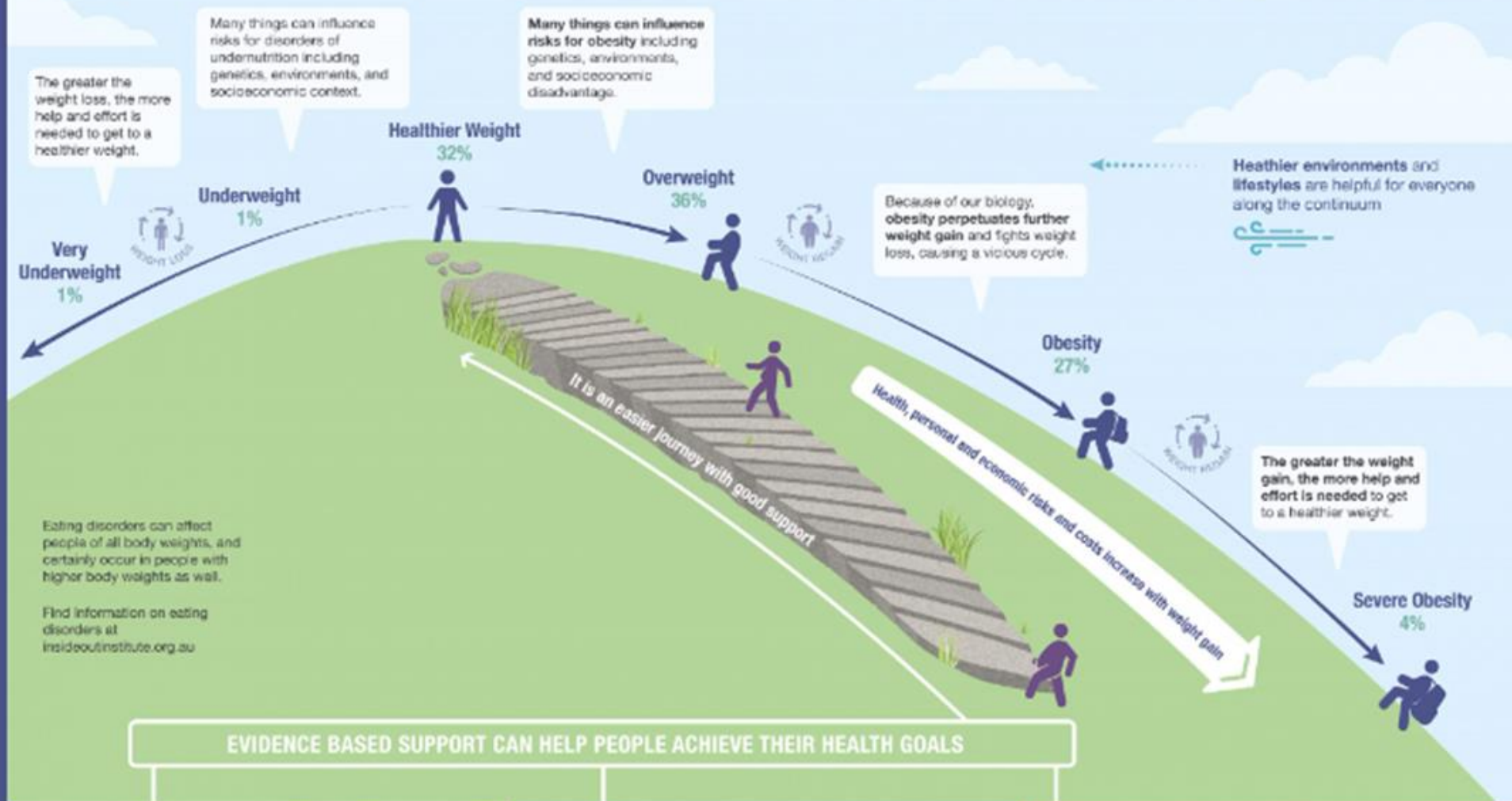
**Stigma\***

Gut health  
Epigenetics

# OBESITY IS DRIVEN BY POWERFUL BIOLOGICAL FORCES OPERATING IN AN OBESOGENIC ENVIRONMENT



The Obesity Collective  
Transform society with us



## PERSONAL LIFESTYLE CHANGES

Focus is on improving behaviours around healthy eating, physical activity, stress management and better sleep, by setting goals and self-monitoring



## WEIGHT LOSS PROGRAMS OR PRODUCTS

Programs that provide guidance, support or products (e.g. meals) to help with lifestyle and weight loss goals



## PROFESSIONAL SUPPORT

Additional support from health professionals which may include meal replacement options, medicines, surgery, a specialised obesity team, community and social support

# Rethinking : The Role of the GP

Past	Present	Future
???? Advise Referral	Primary Prevention  Secondary Prevention  Tertiary Prevention  ( 1 : 1 )	? Public Health ? Nodal Eg Heart Foundation Walking Group  Primary Prevention : Perinatal Health as an intervention ( 1 : many)

# The Role of The GP : Prevention and Management

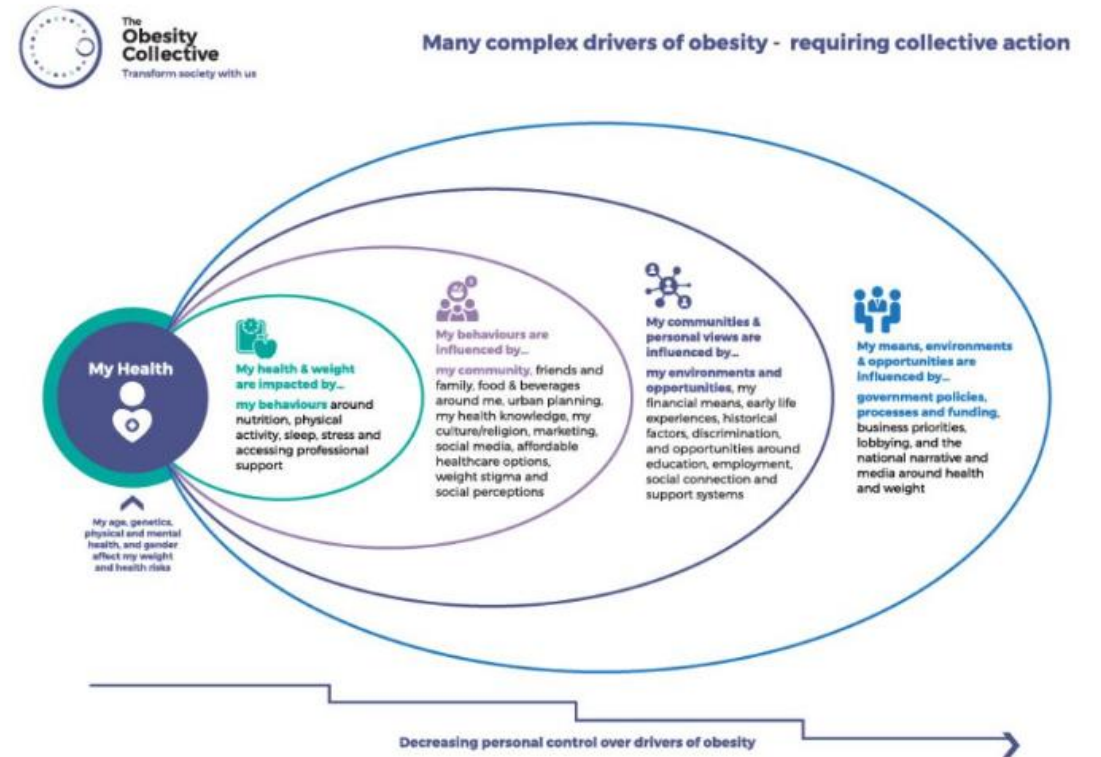
## Primary Prevention

- Opportunistic screening, case identification

## Secondary Prevention

- Whole-person, patient-focused assessment and advice
- Patient education and initiating management/referral

Tertiary prevention (of complications of obesity and/or its management)





## Obesity prevention and management

### Position statement

February 2019



#### Position

The Royal Australian College of General Practitioners (RACGP) recognises that obesity is one of the most important health issues facing Australia and affects the health, wellbeing and productivity of many Australians.<sup>1-3</sup> Obesity is linked directly and indirectly to many chronic conditions and also causes significant morbidity.

General practice has a central role to play in the prevention and management of obesity. This role needs to be supported through improved funding of effective and evidence-based services and therapies. Funding for research into obesity prevention and management is also much needed.



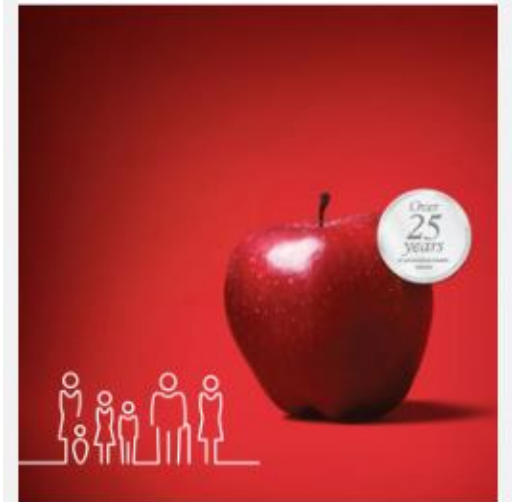
### Smoking, nutrition, alcohol, physical activity (SNAP)

A population health guide to behavioural risk factors in general practice  
2nd edition



### Guidelines for preventive activities in general practice

9th edition



racgp.org.au

Healthy Practitioner,  
Healthy Australia



Contents lists available at [ScienceDirect](#)

## Obesity Research & Clinical Practice

journal homepage: [www.elsevier.com/locate/orcp](http://www.elsevier.com/locate/orcp)



### The Australian Obesity Management Algorithm: A simple tool to guide the management of obesity in primary care<sup>☆</sup>

Tania P. Markovic<sup>a,b,\*</sup>, Joseph Proietto<sup>c</sup>, John B. Dixon<sup>d</sup>, Georgia Rigas<sup>e</sup>, Gary Deed<sup>f,g</sup>,  
Jeffrey M. Hamdorf<sup>h</sup>, Erica Bessell<sup>b</sup>, Nathalie Kizirian<sup>b</sup>, Sofianos Andrikopoulos<sup>i</sup>,  
Stephen Colagiuri<sup>b</sup>



# AOA

## • Australian Obesity Algorithm

Bio-psych-social Assessment

Treatment Layers (lifestyle → pharmacotherapy → surgery)

Multi-modal treatment

T.A. Matthews et al.

Obesity Research & Clinical Practice 16 (2022) 263–282

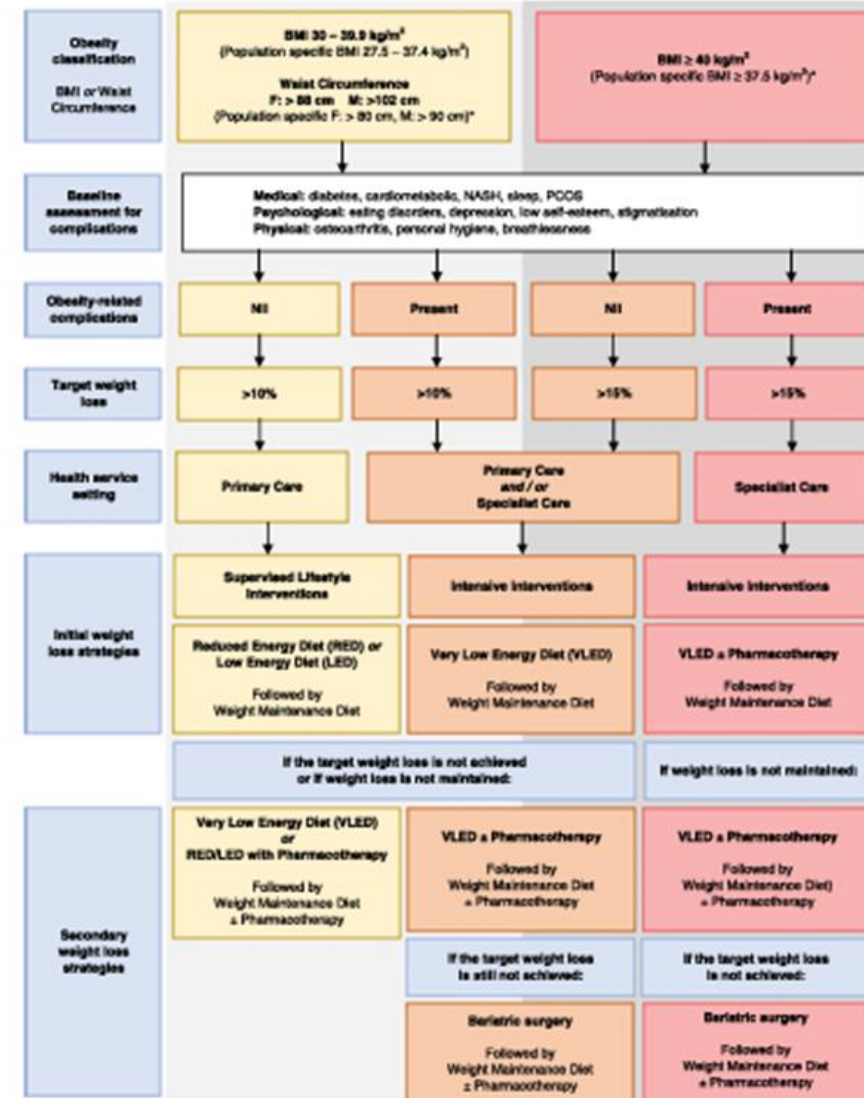
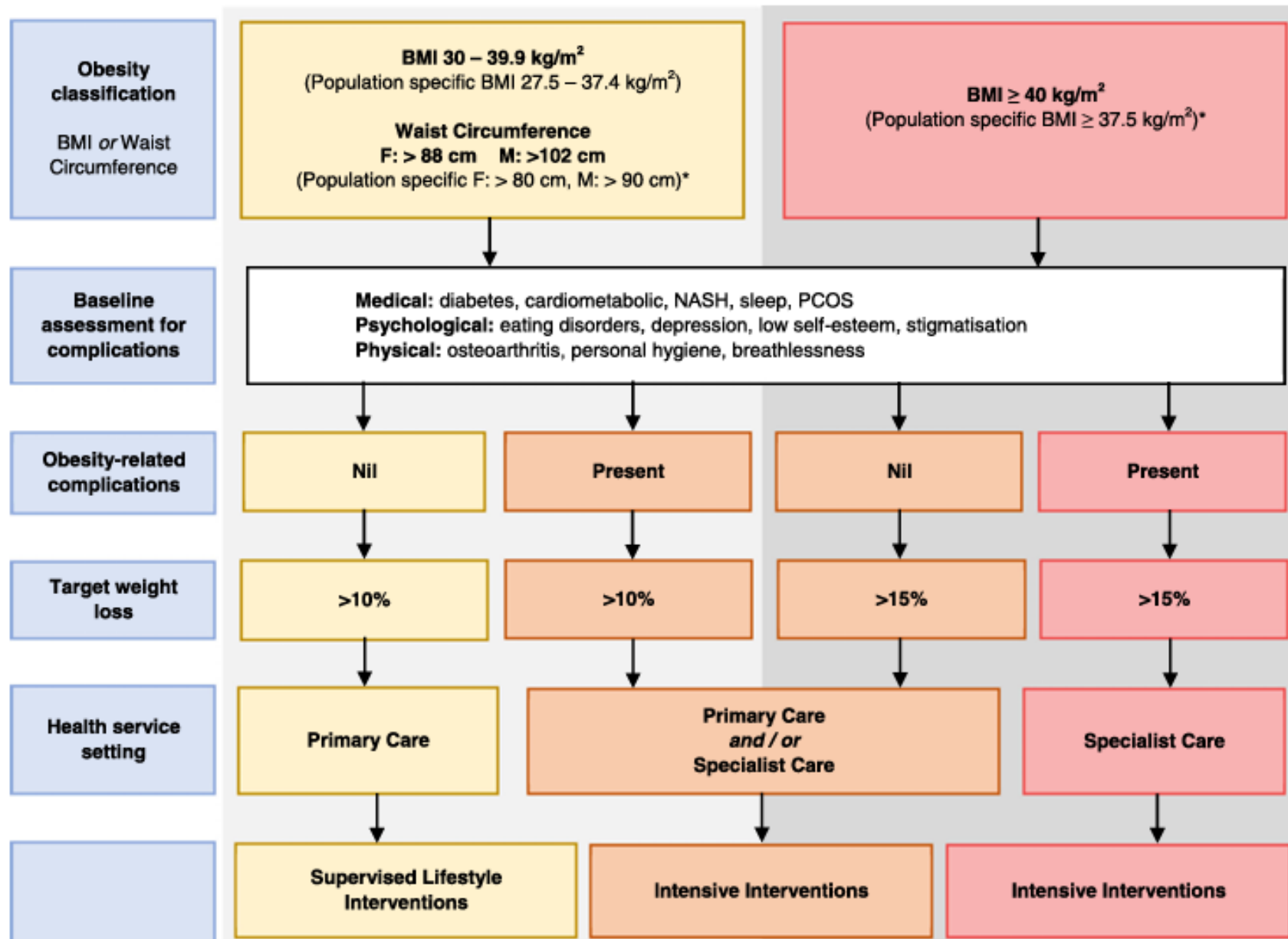


Fig. 1. Australian algorithm for the management of obesity. BMI, body mass index; LED, low energy diet; MASH, metabolic associated steatopathy; GERD, gastro-oesophageal reflux disease; OSA, obstructive sleep apnoea; PCOS, polycystic ovary syndrome; ED, erectile dysfunction; LUTS, lower urinary tract symptoms; RED, reduced energy diet; VLED, very low energy diet. \*Can only apply to Asian population and recommended for the Australian Indigenous population.



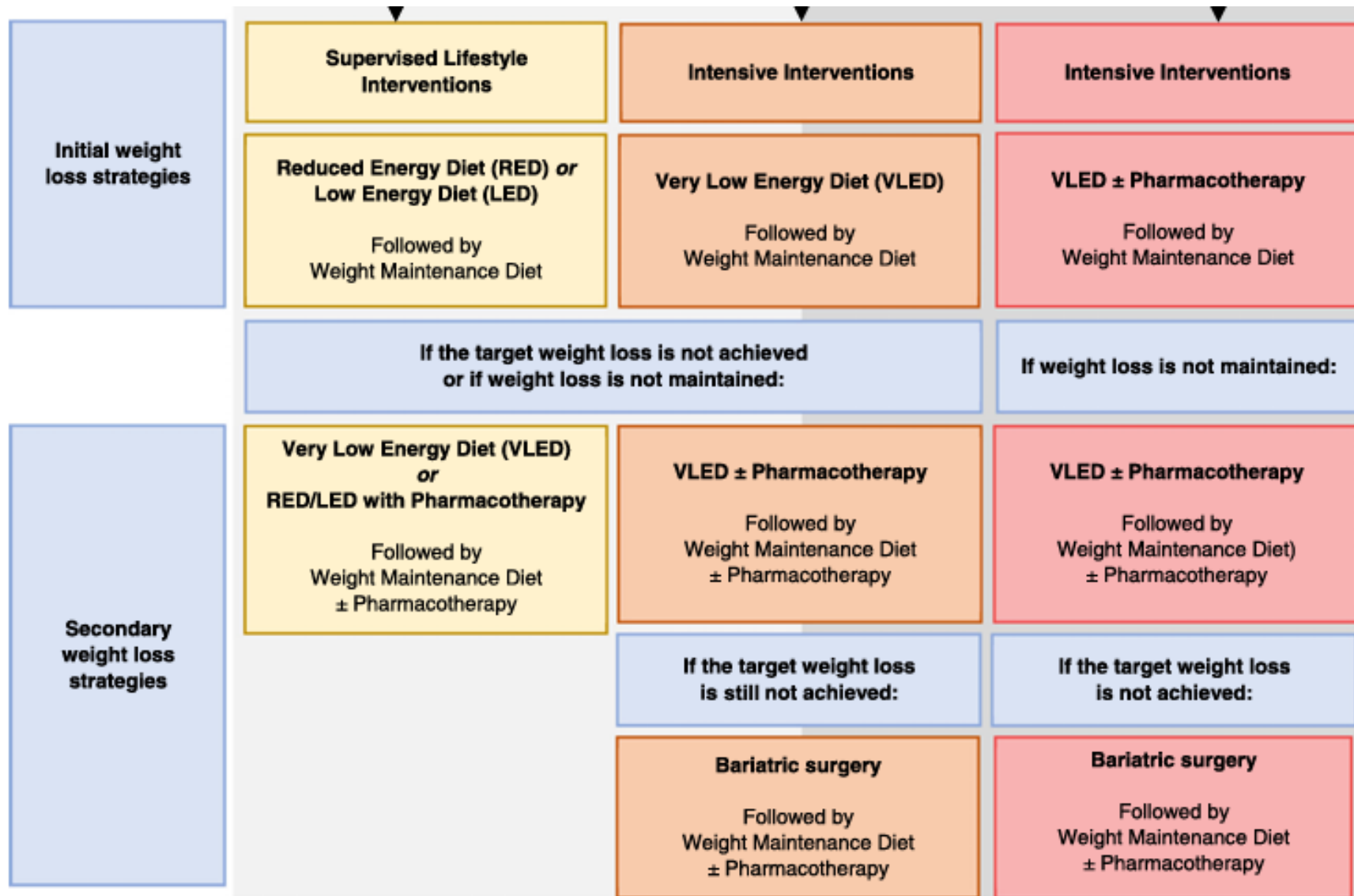
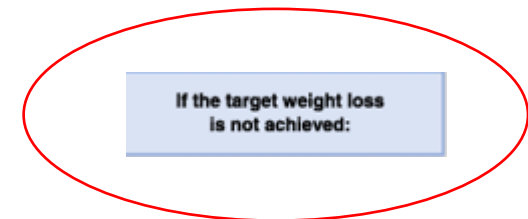
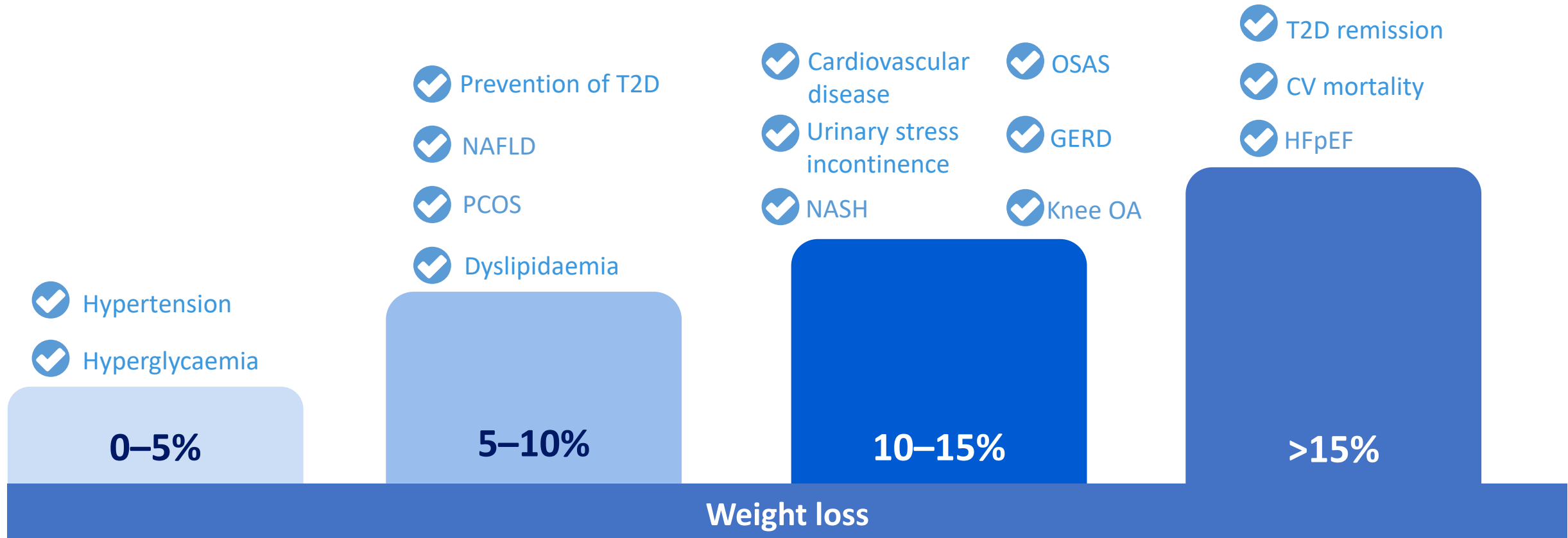


Fig. 1. Australian algorithm for the management of obesity. BMI, body mass index. LED, low energy diet. MASH, metabolic associated steatohepatitis. GORD, gastro-oesophageal reflux disease. OSA, obstructive sleep apnoea. PCOS, polycystic ovary syndrome. ED, erectile dysfunction. LUTS, lower urinary tract symptoms. RED, reduced energy diet. VLED, very low energy diet. \*Cut-offs apply to Asian population and recommended for Australian indigenous population.

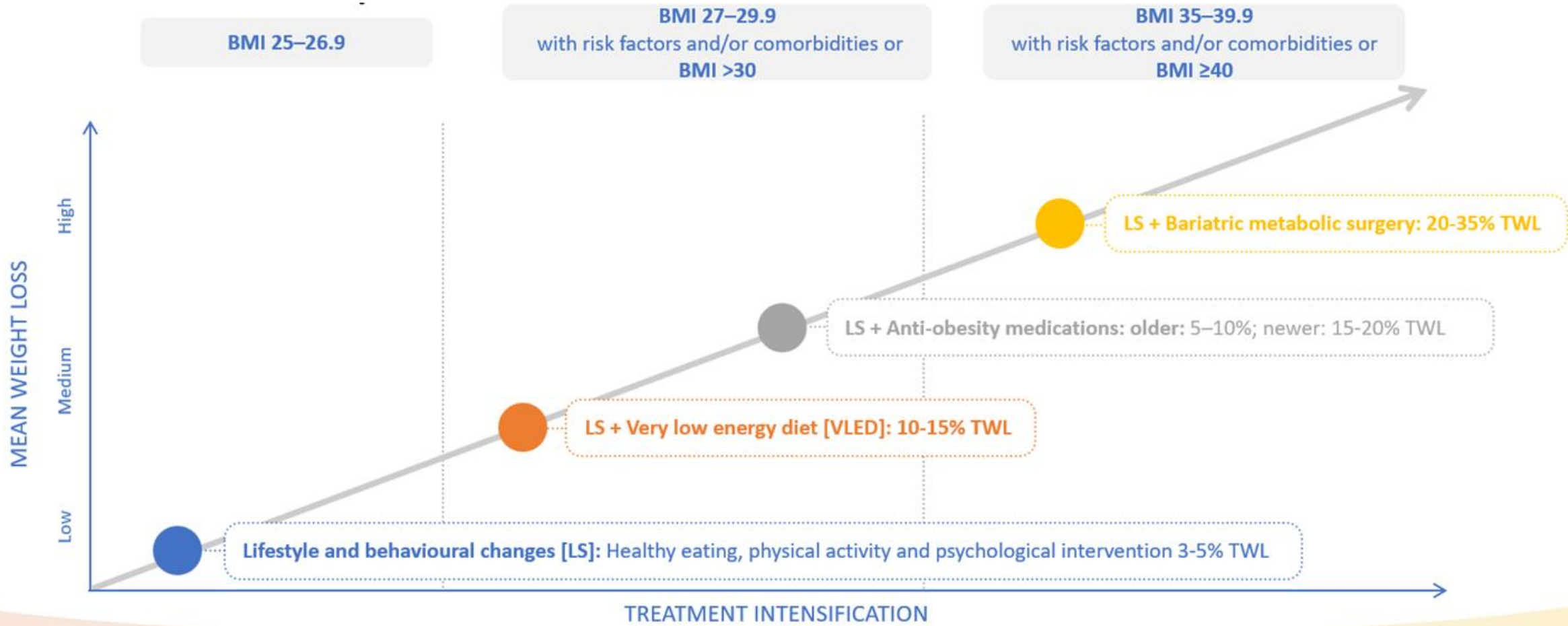


# The benefits of modest weight loss

Towards greater weight loss and overall health improvement



CV, cardiovascular; GERD, gastro-oesophageal reflux disease; HFpEF, heart failure with preserved ejection fraction; NAFLD, non-alcoholic fatty liver disease; NASH, non-alcoholic steatohepatitis; OA, osteoarthritis; OSAS, obstructive sleep apnoea syndrome; PCOS, polycystic ovary syndrome; TG, triglycerides.



Please note that some of these medications may not be available in all countries  
 BMI, body mass index  
 Adapted from Grima M, Dixon JB AFP 2013;42:532–41; National Health and Medical Research Council (2013) Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia. Melbourne: National Health and Medical Research Council

# Rethinking : Obesity Management

Past	Present	Future
<p>Eat less, move more</p> <p>Weight loss / specific number as a target / goal</p> <p>?Therapeutic Nihilism</p>	<p>Move away from a sole focus on weight loss and towards health gains</p> <p>If weight loss goal (% of TBWL)</p> <p>Greater understanding of chronicity and pathophysiology</p> <p>Weight stigma worsens outcomes</p> <p>More therapeutic options</p>	<p>Whole of systems change Public Health /Government (eg primary / secondary / tertiary prevention)</p> <p>Greater understanding of chronicity and pathophysiology</p> <p>Earlier intervention</p> <p>Personalised interventions</p> <p>Even more therapeutic options</p> <p>Blended therapeutic options (eg medications before/during/after surgery)</p>

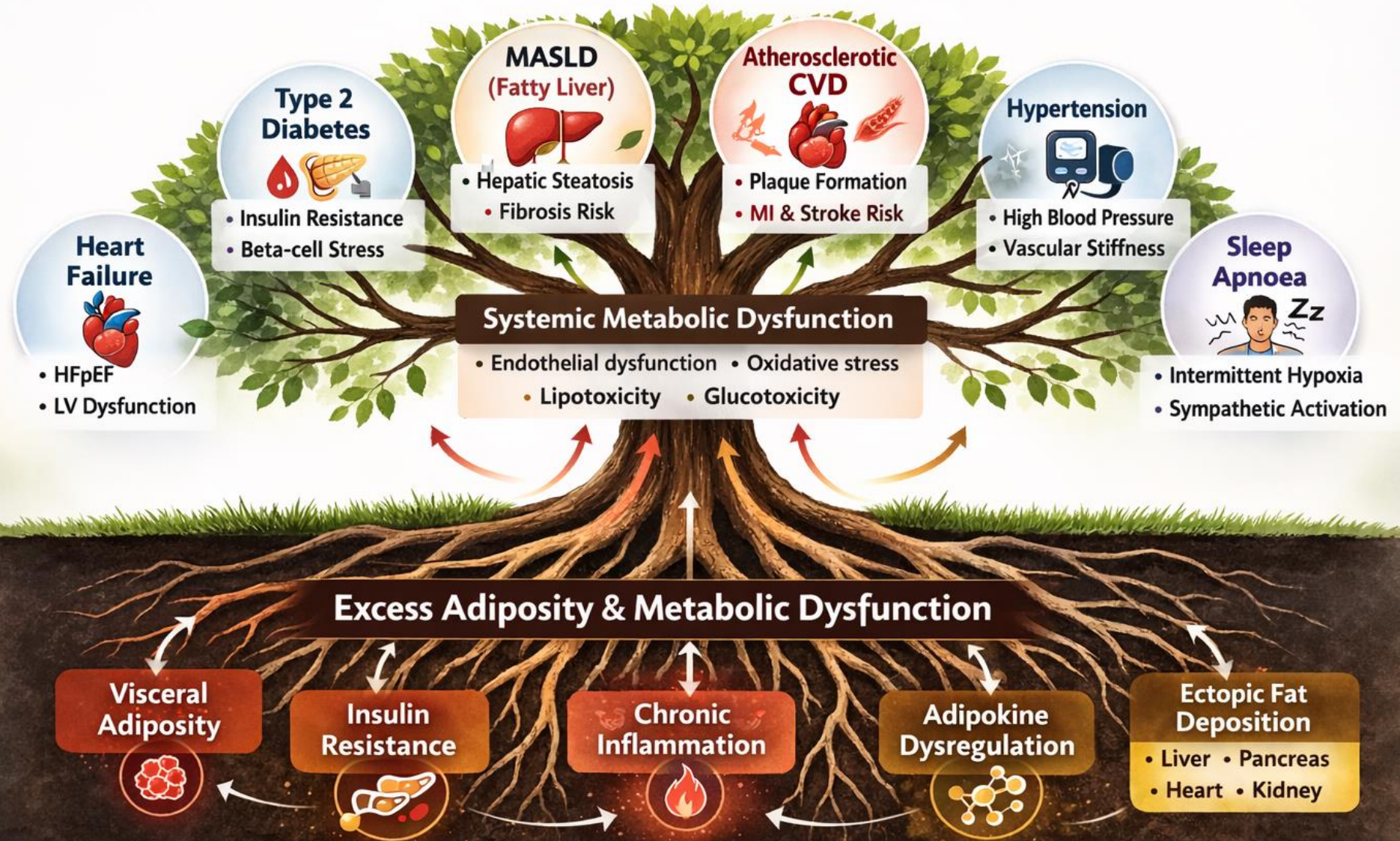
# Rethinking : Obesity as a singular /separate condition

Past	Present	Future
Obesity is a risk factor for other health conditions / diseases	Primary Prevention Secondary Prevention Tertiary Prevention ( 1 : 1 )	Obesity driver of other health conditions Other health conditions are the complications of obesity Obesity and other health conditions have a bidirectional relationship ( eg T2DM, Mental Health )

Obesity as a driver of other health conditions : “The Metabolic Matrix” and secondary and tertiary prevention focus

# Obesity: The Root System of Cardiometabolic Disease

*Chronic excess adiposity drives multisystem metabolic dysfunction*



*Obesity is a complex, chronic disease → Early intervention can reduce risk of downstream complications*

# CaReMeL Syndrome

Cardio – Renal – Metabolic – Liver – Lung

*The systems obesity drives – and GPs must integrate.*



**Disease in one system increases risk in the others.**

## The Generalist Role

Identify • Screen • Integrate • Modify trajectory

The singular common pathophysiology appears to be inflammation

# How do we see this “in real life” ....

Health conditions clustering together

A number of medications used to help a range of metabolic health conditions

Instead of disease specific drug silos....medications show cross-utility of treating “the metabolic matrix”.

SGLT2	GLP / GIP (incretin)
T2DM *	Obesity *
CKD *	+/- OSA *
CV risk reduction (in T2DM)*	+/- eCVD risk reduction *
HF *	
Modest weight effect	T2DM *
	CKD *
Possible MASLD benefit	MASLD
	Alcohol Use Disorder

# Rethinking : GLP-1 Medications - Indications

Past	Present	Future
Diabetes – type 2	Diabetes – type 2 Renal Disease – CKD Obesity Management Obesity and Secondary Cardiovascular Risk Reduction Obesity and Obstructive Sleep Apnoea	MASLD – (fatty liver) Heart Failure (HFPeF) Type 2 Diabetes prevention (prediabetes) Alcohol addiction Metabolic bariatric surgery Binge eating disorder Dementia Osteoarthritis of the knee PCOS Male hypogonadism Psoriasis Dyslipdeamia

# GLP-1RAs have multifactorial effects

## PHARMACOLOGICAL EFFECTS OF GLP-1RAs

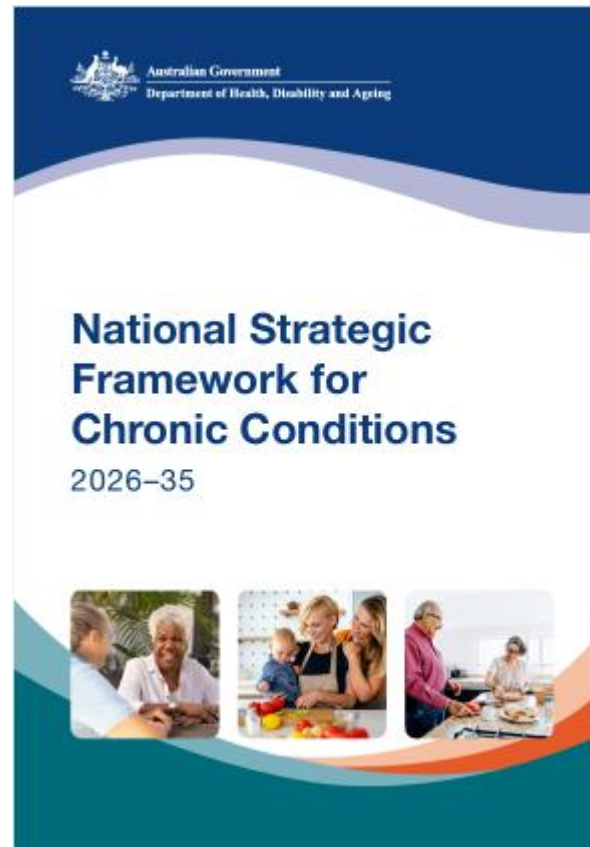


GI, gastrointestinal; GLP-1RA, glucagon-like peptide-1 receptor agonist; RAAS, renin-angiotensin-aldosterone system.

1. Campbell JE, DJ Drucker. *Cell Metab* 2013;17:819–37; 2. Armstrong MJ et al. *J Hepatol* 2016;64:399–408; 3. Armstrong MJ et al. *Lancet* 2016;387:679–90; 4. Tong J, D'Alessio D. *Diabetes* 2014;63:407–9; 5. Baggio LL, Drucker DJ. *J Clin Invest* 2014;124:4223–6; 6. Flint A et al. *J Clin Invest* 1998;101:515–20; 7. Blundell J et al. *Diabetes Obes Metab* 2017;19:1242–51; 8. Greco EV, et al. *Medicina (Kaunas)* 2019; 55:233; 9. DeFronzo RA. *Diabetes Obes Metab* 2017; 19:1353–1362; 10. MacDonald PE et al. *Diabetes* 2002;51(Suppl 3):S434–42.

# Rethinking : Obesity – a complex chronic health condition

- GP Management Plans



## What are chronic conditions?

Chronic conditions include a broad range of long-term health conditions. There are many different types of chronic conditions and people can experience more than one chronic condition at the same time, known as multimorbidity. Chronic conditions can occur at various stages in people's lives, although they become more common as we age. Chronic conditions have complex and multiple causes, both preventable and non-preventable.

### Types of chronic conditions include, but are not limited to:

- cancer
- heart, stroke and vascular disease
- chronic eye conditions
- diabetes
- **obesity**
- endometriosis
- chronic kidney disease
- musculoskeletal conditions (such as arthritis, back pain and osteoporosis)
- neurological conditions (such as dementia)
- mental health conditions
- rare diseases\*
- lung and respiratory conditions (such as asthma and chronic obstructive pulmonary disease)
- genetic conditions.

\* There are over 7,000 rare chronic conditions. Rare chronic conditions affect fewer than 5 in 10,000 people and 80% of rare chronic conditions have genetic causes.<sup>2</sup>

The above elements comprise a broad definition of chronic conditions for the purposes of the Framework. This broad definition is intended to ensure that the Framework applies across a broad range of conditions without focusing on condition-specific guidance.

# Obesity – a complex chronic health condition

- GP Management Plans



## Patient eligibility

Patients with a chronic or terminal medical condition and complex care needs requiring care or services from their usual GP and at least 2 other health or care providers are eligible for case conference services.

A **chronic medical condition** is one that has been, or is likely to be, present for at least 6 months. For example, asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke.

There's no list of eligible conditions. However, the Chronic Disease Management (CDM) items are designed for patients who require a structured approach and to enable GPs to plan and coordinate the care of patients with complex conditions requiring ongoing care from a multidisciplinary team.

Case conferences can be undertaken for patients in the community, for patients being discharged into the community from hospital and for people living in residential aged care facilities (RACF).



# The challenge for GPs now and in the future

- See the Obesity - Not just the downstream branch(s) and treat with evidence and individualised goals.
- “Treatment” – include prevention
- When our patient has one of the “**CaReMeL**” syndrome conditions – actively screen, risk assess and proactively treat for the others...
- Eg
  - Any T2D – think MASLD
  - Any MASLD – fib 4 +
  - Any MASLD – CVD risk ? CACS
  - Any BMI  $\geq 30$  – screen across CaReMeL

This is where general practice shines.

We are the only specialty that sees the whole matrix and whole person care

## The challenge for GPs now and in the future

System	What we see	What we should screen for
T2D	HbA1c	MASLD, CKD, ASCVD
MASLD	LFTs	FIB-4, CVD risk
HFpEF	LVEF%	SGLT2 eligibility
CKD	eGFR	GLP and SGLT2 eligibility
OSA	CPAP	Weight-targeted therapy
Hypertension	BP	Metabolic syndrome

**And treat  
any Obesity  
if present**

# A specific example

“If we treat diabetes without treating obesity, we are managing branches...not the root cause.

Semaglutide 1mg : diabetes

Vs

Semaglutide 2.4mg : obesity



# Rethinking : Practicalities

Use GP Management Plans Strategically

- **GP Chronic Condition Management Plan**
  - Obesity alone
- **GP Mental Health Plan**
  - Co-existing depression or anxiety
- **GP Eating Disorder Pan**
  - BED – Binge Eating Disorder
- **Case Conferencing**



# Rethinking : Practicalities

health **wellbeing** Queensland

ABOUT - OUR FOCUS AREAS - PROGRAMS & PROJECTS - HEALTH PROFESSIONALS - RESOURCES - MEDIA & NEWS - GET INVOLVED - Q

Clinicians Hub

About Model of Care Clinical Toolkit Referral Pathway Pod Squad Training and Research Join Us

CLINICIANS HUB

Helping clinicians prevent, identify and manage weight in Queenslanders.

Heart Foundation

Walk in a group Lead a walk Benefits of walking About us What's on Log In

Personal Walking Plans

Feel healthier and happier in six weeks with a free Personal Walking Plan.

LEARN MORE

myhealthforlife.com.au

My health for life

Queensland Government

THE PROGRAM DO A HEALTH CHECK LIVING WELL

HEALTHY FEELS good

START YOUR HEALTH CHECK

RACGP

Education Clinical resources Running a practice Advocacy News

Search LOGIN / JOIN

RACGP Healthy Habits

An evidence-based free digital tool to encourage patients to create and sustain positive lifestyle behaviours

VISIT THE HEALTHY HABITS WEBSITE

RACGP's **Healthy Habits** is an evidence-based digital health tool that enables GPs and their practice teams to encourage patients to achieve healthier lifestyles, through increased physical activity, improved nutrition and sleep health behaviours. Healthy Habits has been developed by the RACGP in partnership with the Commonwealth Department of Health and Aged Care.

Enjoy the benefits a healthier life offers

Whether it's eating well, maintaining a healthy weight, sleeping better or managing stress, our healthy lifestyle program will support you to achieve your goals.

**FREE, PRACTICAL PROGRAM**  
Funded by the Queensland Government. No co-payment or fees.

**FLEXIBLE OPTIONS**  
Choose from local group sessions, private phone coaching, in-language programs, or other delivery options.

**SUPPORT FROM A HEALTH COACH**  
Our coaches are experienced health professionals.

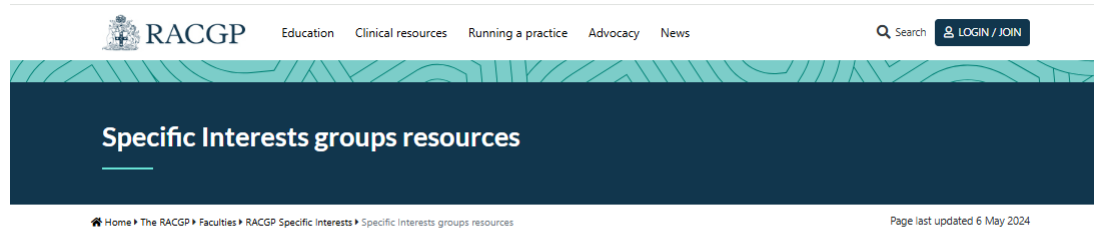
**USEFUL TIPS & TOOLS**  
As well as practical support we have great tips, facts and resources.

# Hope for the future : Obesity and Metabolic Health

## The Generalist Advantage

- We see multimorbidity first
- We see early disease
- We see risk clustering
- We coordinate care
- We prescribe across systems

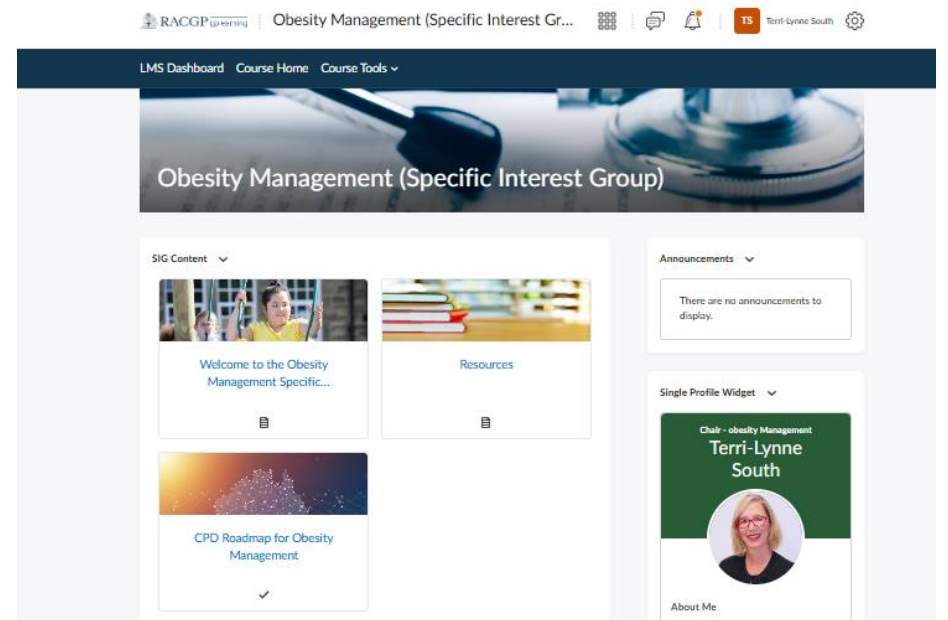
# More ?



The screenshot shows the RACGP website header with navigation links: Education, Clinical resources, Running a practice, Advocacy, News. A search bar and a LOGIN / JOIN button are also present. Below the header is a dark blue banner with the text "Specific Interests groups resources". At the bottom of the banner, there is a breadcrumb trail: Home > The RACGP > Faculties > RACGP Specific Interests > Specific Interests groups resources, and a note: Page last updated 6 May 2024.

## Information and webinars

Access information and webinars on issues related to Specific Interests groups.



The screenshot shows an LMS dashboard for the Obesity Management (Specific Interest Group). The header includes the RACGP logo, the course title "Obesity Management (Specific Interest Gr...", and user information "TS Terri-Lynne South". Below the header is a dark blue navigation bar with links: LMS Dashboard, Course Home, Course Tools. The main content area features a large banner image of a stethoscope and a gavel with the text "Obesity Management (Specific Interest Group)". Below the banner are three content cards under the heading "SIG Content": "Welcome to the Obesity Management Specific...", "Resources", and "CPD Roadmap for Obesity Management". To the right, there is an "Announcements" section with the message "There are no announcements to display." and a "Single Profile Widget" for "Chair - obesity Management Terri-Lynne South" with a profile picture and an "About Me" link.

QUESTION ??



**“Obesity is no longer optional knowledge for GPs. It is core business.”**

References can be arranged upon request.



Patient name: James METRONORTH DoB: 10 Dec 1939

**Request information**

Request date: 9 Mar 2026

\* Request type: **New referral** | Update | Continuation | Request for advice

\* Reason for referral:
 

- New condition requiring specialist consultation
- Deterioration in condition, recently discharged from outpatients < 12 months
- Other

\* Provider: **QHSR** | Private

**Consents**

\* Date patient consented to request: 09 Mar 2026

\* Patient is willing to have surgery if required? Yes | No | Not applicable

\* Condition and Specialty:  [HealthPathways ▶](#)

Suitable for Telehealth?

\* Are you the patient's usual GP?

**Request recipient**

\* Service/Location:
 

- General Medicine
- Endocrinology
- Endocrinology
- General Paediatric Medicine
- General Medicine
- Endocrinology
- General Medicine
- General Paediatric Medicine

Specialist name:

Organisation details:



Select the most appropriate condition template for your patient

- Condition specific clinical information +
- Investigations and imaging +
- Standard clinical information +
- Patient information +
- Insurance information +
- Referring GP's information +



Patient name: James METRONORTH DoB: 10 Dec 1939

Request information

Request date 9 Mar 2026

Request type **New referral** Update Continuation Request for advice

Reason for referral  New condition requiring specialist consultation  
 Deterioration in condition, recently discharged from outpatients < 12 months  
 Other

Provider **QHSR** Private

Consents

Date patient consented to request 09 Mar 2026

Patient is willing to have surgery if required? Yes No Not applicable

Condition and Specialty Endocrinology - Obesity (Diabetes and Endocrinology) (Adult) [HealthPathways](#)

Suitable for Telehealth? Yes No

Are you the patient's usual GP? Yes No

HealthPathways | Metro North  
[Adult Weight Management](#)  
[HealthPathways home page](#)

Links to appropriate HealthPathways for assessment & management support

Request recipient

Service/Location Please select

Specialist name Please select

Organisation details

Condition specific clinical information

Investigations and imaging

Standard clinical information

Patient information

Insurance information

Referring GP's information

- Home
- About HealthPathways
- Acute Services
- Allied Health
- Child and Youth Health
- End of Life
- Investigations
- Lifestyle and Preventive Care
- Motivational Interviewing
- Nutrition
- Adult Weight Management**
- Healthy Eating Services for Older Adults
- Nutrition Supplements for Adults
- Useful Nutrition Resources
- Physical Activity - Adults
- Physical Activity Support
- Self-management Support
- Screening
- Smoking and Vaping Cessation
- Travel Consultation
- Medical
- Mental Health
- Older Adults' Health
- Pharmacology
- Public Health
- Reproductive Health
- Specific Populations
- Surgical
- Women's Health
- Our Health System

## Adult Weight Management

See also:

- Older Adults' Weight and Nutrition
- Overweight and Obesity in Children and Adolescents

**Clinical editor's note**

Liraglutide (e.g., Saxenda) will be discontinued in December 2025.

### Background

About adult weight management

### Assessment

1. Ask the patient about their weight in a supportive, non-judgemental way:
  - Consider following the 5 As Model for brief interventions (Ask and Assess, Advise, Assist, Arrange) and setting SMART goals. See Motivational Interviewing.
  - Consider using a **health at every size (HAES)** approach. See also News GP – Understanding the 'Health at Every Size' Paradigm.
2. Take a diet history, including drinks, and consider asking the patient to keep a **food diary**.
3. Consider factors that affect weight management:
  - Underlying medical conditions:
    - Underweight e.g., hyperthyroidism, COPD, eating disorder, malignancy, impaired intake or absorption (nausea, vomiting, dysphagia, poor dentition, diarrhoea)
    - Overweight e.g., polycystic ovary syndrome (PCOS), hypothyroidism, binge eating disorder, sleep apnoea, Cushing's syndrome, osteoarthritis
  - Medications e.g., antidepressants, antipsychotics, antiepileptics, diabetes medications
  - Lifestyle factors e.g., dietary habits, exercise, smoking, alcohol intake
  - Psychosocial factors e.g., depression, anxiety, everyday functioning
  - Barriers to change e.g., time poor, financial limitations, social influences, shift work
4. Examine the patient:
  - Check vital signs.
  - Calculate **body mass index (BMI)** and measure **waist circumference**.
5. Arrange investigations on a case-by-case basis:
  - Arrange baseline E/LFT and lipids.
  - If a nutritional deficiency is suspected arrange, iron levels, vitamin B<sub>12</sub>, folate, trace elements, fat-soluble vitamins.
  - Consider additional investigations for co-morbidities or underlying cause e.g., thyroid or other endocrine disorders, obstructive sleep apnoea.

### Management

- BMI < 18.5 (patient underweight)
- BMI 18.5 to 25 (healthy weight range)
- BMI > 25 (patient overweight or obese)

- Home
- About HealthPathways
- Acute Services
- Allied Health
- Child and Youth Health
- Normal Paediatric Observations
- Abuse and Neglect
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- Behaviour and Development
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- Endocrinology - Child
- ENT Head and Neck Surgery - Child
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- Abnormal Bleeding and Bruising
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- Enuresis in Children
- Febrile Seizures in Children
- Headaches in Children
- Low Birth Weight Infants
- Measles
- Overweight and Obesity in Children and Adolescents**
- Pertussis (Whooping Cough)
- Plagiocephaly
- Poor Growth
- Short Stature in Children
- Unsettled Infant Behaviour
- UTI in Children and Youth
- Vitamin D Deficiency in Children
- Paediatric Medicine Requests
- Immunology - Child
- Infectious Diseases - Child
- Mental Health - Child
- Neurology - Child
- Neurosurgery - Child
- Oncology - Child
- Ophthalmology - Child

## Overweight and Obesity in Children and Adolescents

Red flags

- Short stature or dropping down height percentiles
- Significant weight-related co-morbidities
- Developmental delay or syndromic features

### Background

About overweight and obesity in children and adolescents

### Assessment

1. Discuss weight issues with the patient and family in an empathetic, non-judgemental, and supportive way.
2. Take a focused history:
  - Medical history and medications that may contribute to weight gain
  - Food and lifestyle – if the patient is in shared care, check routine at both households
  - Family history
  - Details of any previous weight management interventions, including outcomes
3. Perform a focused examination, aiming to confirm diagnosis and establish severity:
  - Assess height, weight and BMI and blood pressure (BP).
  - Determine if condition present is categorised as **overweight or obesity**.
  - Assess for possible underlying contributors.
  - Look for secondary complications.
4. Consider secondary causes of weight gain and weight-related co-morbidities.
5. Consider investigations:
  - Consider an on the spot BGL (glucometer) to assess for diabetes, especially in the presence of additional risk factors – see the Diagnosing Diabetes in Children and Youth pathway.
  - Consider other targeted investigations to check for co-morbidities.

### Management

Establishing rapport and engaging patient and family with treatment is the initial priority.

1. Discuss simple tips and provide further advice and education on behavioural change, emphasising the need for whole-family involvement:
  - Dietary advice
  - Physical activity advice
  - Sleep advice
2. Assist parents/carers to set weight management goals, and to review progress regularly (start fortnightly, then every 1 to 3 months).
3. Arrange further support – consider involving a team including practice nurse and allied health to assist with:
  - Lifestyle support programs
  - Allied health support

# Metro North Health

## Obesity

### Emergency department referrals

Phone on call Diabetic and Endocrinology Registrar via:

- Royal Brisbane & Women's Hospital switch - (07) 3646 8111
- The Prince Charles Hospital switch - (07) 3139 4000
- Redcliffe Hospital switch - (07) 3883 7777
- Caboolture Hospital switch - (07) 5433 8888

and send patient to the Department of Emergency Medicine (DEM) at their nearest hospital.

**If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.**

- Acute decompensation of cardiorespiratory/ renal function

### Does your patient wish to be referred?

### Minimum referral criteria

Does your patient meet the minimum referral criteria?

**Category 1**  
Appointment within 30 days is desirable

This is only applicable where a dedicated obesity service exists

- Patients with a serious obesity-related comorbidity<sup>a</sup> that is likely to deteriorate quickly, if urgent weight loss is not achieved
- Patients requiring urgent lifesaving operation/procedure that requires immediate weight loss for surgery/procedure to proceed (e.g. organ transplantation or assessment for organ transplantation, angiogram or cardiac surgery)
- <sup>a</sup>Serious obesity related comorbidities include (not an exhaustive list):
  - severe liver disease
  - severe pulmonary hypertension
  - recurrent venous thromboembolism
  - intracranial hypertension

**Category 2**  
Appointment within 90 days is desirable

- Patients with severe obesity-related comorbidities such as (not an exhaustive list):
  - nephrotic range proteinuria or rapidly progressing renal impairment
  - chronic respiratory failure or obesity hypoventilation syndrome
  - severe OSA
  - recurrent cellulitis or venous ulcerations
  - recurrent hospital admission for an obesity related condition
  - patients requiring weight loss for a semi-urgent or elective operation/procedure
  - poorly controlled diabetes with HbA1c > 9% and BMI >50
  - Patients with Prader Willi [Syndrome](#) (PWS) unless meet the criteria for Cat 1

**Category 3**

- BMI >55 kg/m2 younger age i.e. 18-65 without co-morbidities listed in Cat 1 or

Other Diabetes and Endocrinology conditions

**Send referral**

Hotline: 1300 364 938

**Electronic:**  
[GP Smart Referrals \(preferred\)](#)  
[eReferral system templates](#)  
 Medical Objects ID: MQ40290004P  
 HealthLink EDI: qldmnhhs

**Mail:**  
 Metro North Central Patient Intake  
 Aspley Community Centre  
 776 Zillmere Road  
 ASPLEY QLD 4034

**Health pathways**

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email: [healthpathways@brisbanenorthphn.org.au](mailto:healthpathways@brisbanenorthphn.org.au)

Login to Brisbane North Health Pathways: [brisbanenorth.healthpathwayscommunity.org](http://brisbanenorth.healthpathwayscommunity.org)

**Resources**

[General referral criteria](#)

**Category 3**

- BMI >55 kg/m2 younger age i.e. 18-65 without co-morbidities listed in Cat 1 or

Appointment within 365 days is desirable

**If your patient does not meet the minimum referral criteria**  
 Consider other treatment pathways or an alternative diagnosis.

If you still need to refer your patient:

- Please explain why (e.g. warning signs or symptoms, clinical modifiers, uncertain about diagnosis, etc.)
- Please note that your referral may not be accepted or may be redirected to another service

## Other important information for referring practitioners

Not an exhaustive list

- Refer to local [HealthPathways](#) or local guidelines
- Measure waist circumference in addition to calculating BMI if BMI <40
- Lifestyle modification (increased activity, dietary, weight, smoking, alcohol)
- Convey the message that even small amounts of weight loss may improve health and wellbeing
- Use multicomponent approaches — these work better than single interventions
- Refer appropriately to assist people to make lifestyle changes or for further intervention
- Support a self-management approach and provide ongoing monitoring
- Manage comorbidities when they are identified; do not wait until the person has lost weight
- Offer people who are not yet ready to change the chance to return for further consultations when they are ready to discuss their weight again and willing or able to make lifestyle changes
- Assess the person's readiness to adopt changes and person's confidence in making changes
- Alternative services
  - Primary healthcare services i.e. lifestyle groups
  - GPMP with a TCA and allied health referral
  - [SMoCC Service](#)
  - [Health + Wellbeing](#)
  - Health for life
  - Complex Obesity clinic does not offer Bariatric Surgery, please see [Metabolic Surgery Suitability CPC](#)

## Referral requirements

A referral may be rejected without the following information.

### Essential Referral Information

- Confirm patient's acknowledgement and readiness to undertake non-surgical weight loss measures
- Height, weight, BMI
- Details of any allied health support in place to assist with weight loss (any GPMP/TCA in place)
- Ensure all comorbidities clearly stated
- Current medications list
- Details of all treatments offered and efficacy
- Fasting lipids
- FBC, HbA1c, urinary albumin ratio
- TSH, ELFTs

### Additional Referral Information (useful for processing the referral)

- Advise any risk factors assessed using lipid profile (preferable fasting), BP and HbA1c measurement
- The person's lifestyle (diet and physical activity) and eating behaviour and/or any underlying causes for being overweight or obese



## HP can be used to create autofills:

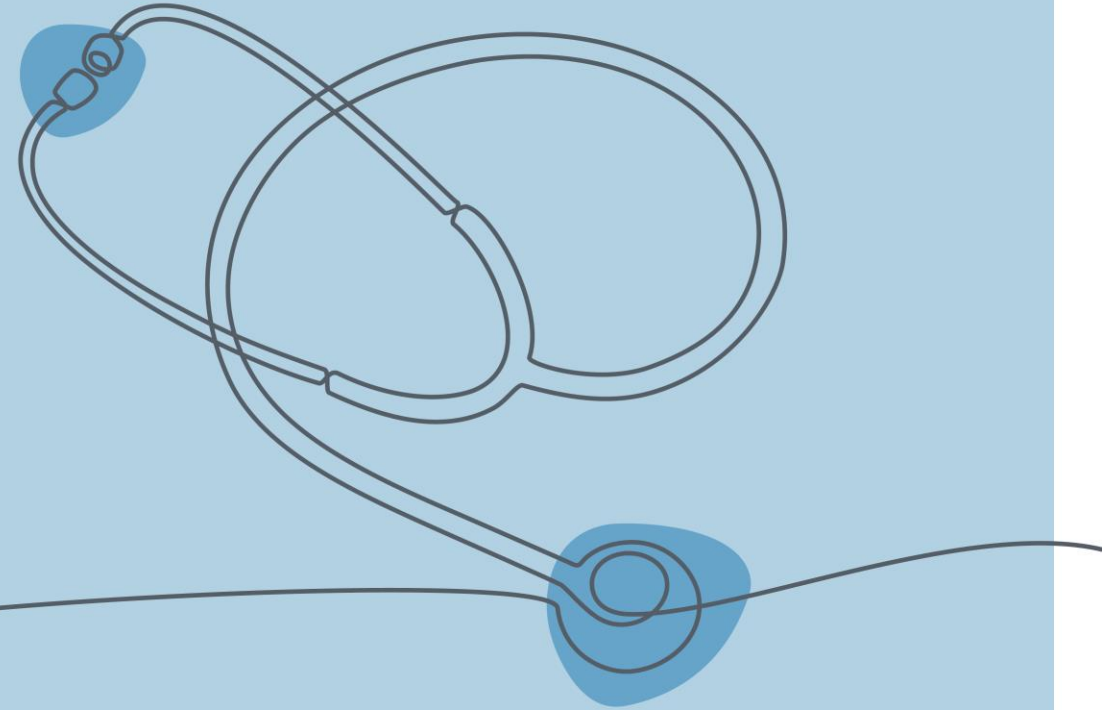
(eg from adult weight management pathway)

- started at 2.5 mg per week and increased every four weeks in 2.5 mg increments up to 15 mg per week if needed. Slow titration is indicated to reduce risk of side effects. Note that many patients achieve satisfactory weight loss outcomes on the 5 mg dose.
- Potential side-effects include (list not exhaustive):
  - nausea, upset stomach, stomach pain and/or vomiting.
  - diarrhoea.
  - constipation.
  - decreased appetite.
  - indigestion
  - headache, tiredness, dizziness.
  - changes in pancreatic enzyme (lipase) levels.
- Warnings and precautions:
  - history of, or risk factors for, pancreatitis or gall bladder disease.
  - severe gastrointestinal disease e.g., gastroparesis.
  - diabetic retinopathy – rapid improvement in glucose control may cause temporary worsening of diabetic retinopathy.
  - personal or family history of [multiple endocrine neoplasia type 2](#) [🔗](#).
  - potential risk for regurgitation and pulmonary aspiration during anaesthesia due to delayed gastric emptying. See Australian Diabetes Society – [Clinical Practice Recommendations: Periprocedural Use of GLP-1RAs and GLP-1/GIPRAs \(April 2025\)](#) [🔗](#) for details.
- Drug interactions:
  - Oral hormonal contraceptives – switching to non-oral contraception or additional barrier methods are recommended for 4 weeks after initiation, and for 4 weeks after each dose escalation.
  - Caution is required for oral modified release preparations, or oral medications with a narrow therapeutic index (e.g., warfarin, digoxin) due to delayed gastric emptying.
  - May cause increased risk of hypoglycaemia mainly when used with insulin or sulfonylureas.

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



## Adolescent health: conversations & controversies

Professor Simon Denny | Director, Mater Young Adult Health Centre, Mater Hospital Brisbane

**phn**  
BRISBANE NORTH  
An Australian Government Initiative

 **Queensland Government**  
**Metro North Health**

# **Controversies in Adolescent & Young Adult Medicine**

**Professor Simon Denny**

**Adolescent Physician and**

**General Paediatrician**

**Director of Mater Young Adult Health Centre**

**Mater Hospital Brisbane**

The are approximately 4.2 million young people aged 13 - 25 in Australia representing 16% of the total population

# Controversies in AYA medicine

- Developmental age
- Communication
- Hidden Illnesses e.g. POTS/ hEDS
- Increasing incidence of ASD, ADHD
- Gender Health

# Principles of Quality AYA Care

## Strengths-based



Believe, validate and encourage patients and their personal development

## Holistic & Contextual



Understand and work with young person in the context of their whole life

## Participation

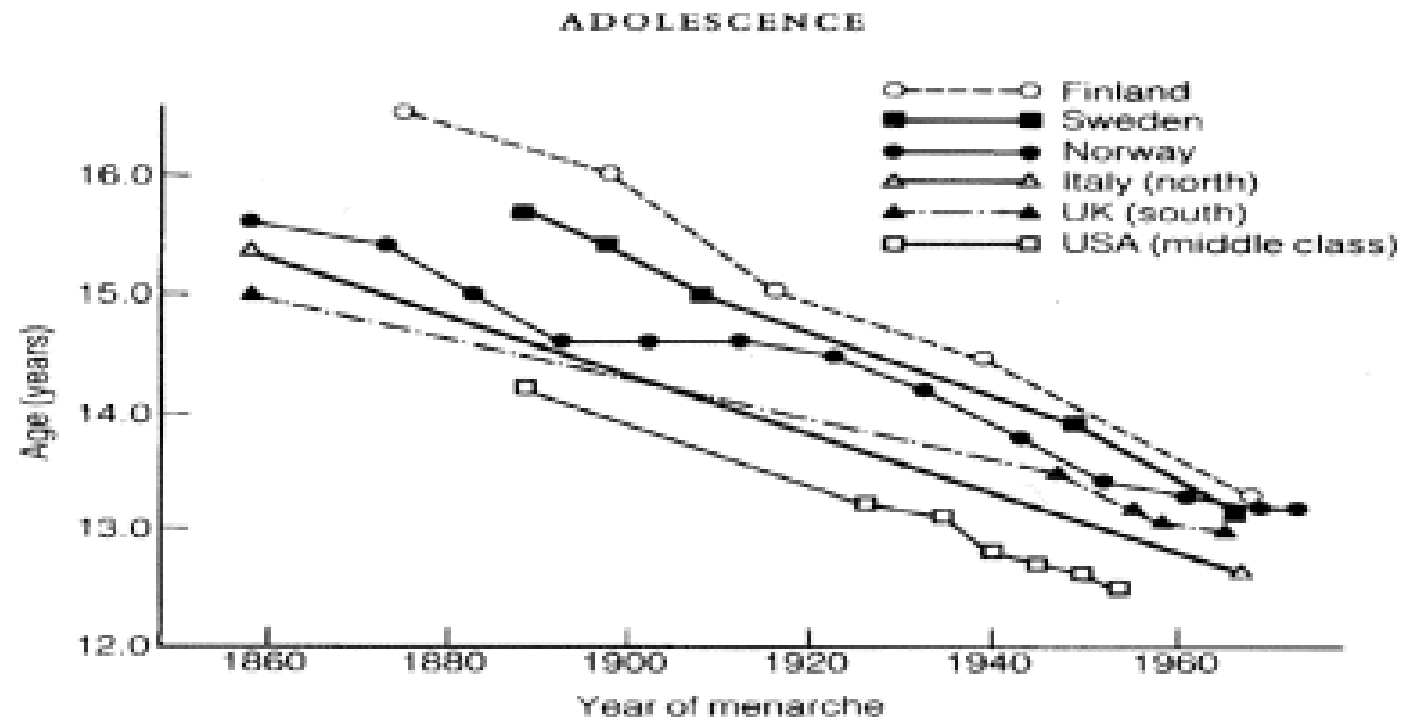


Foster and promote skill & development through capability adapted opportunities

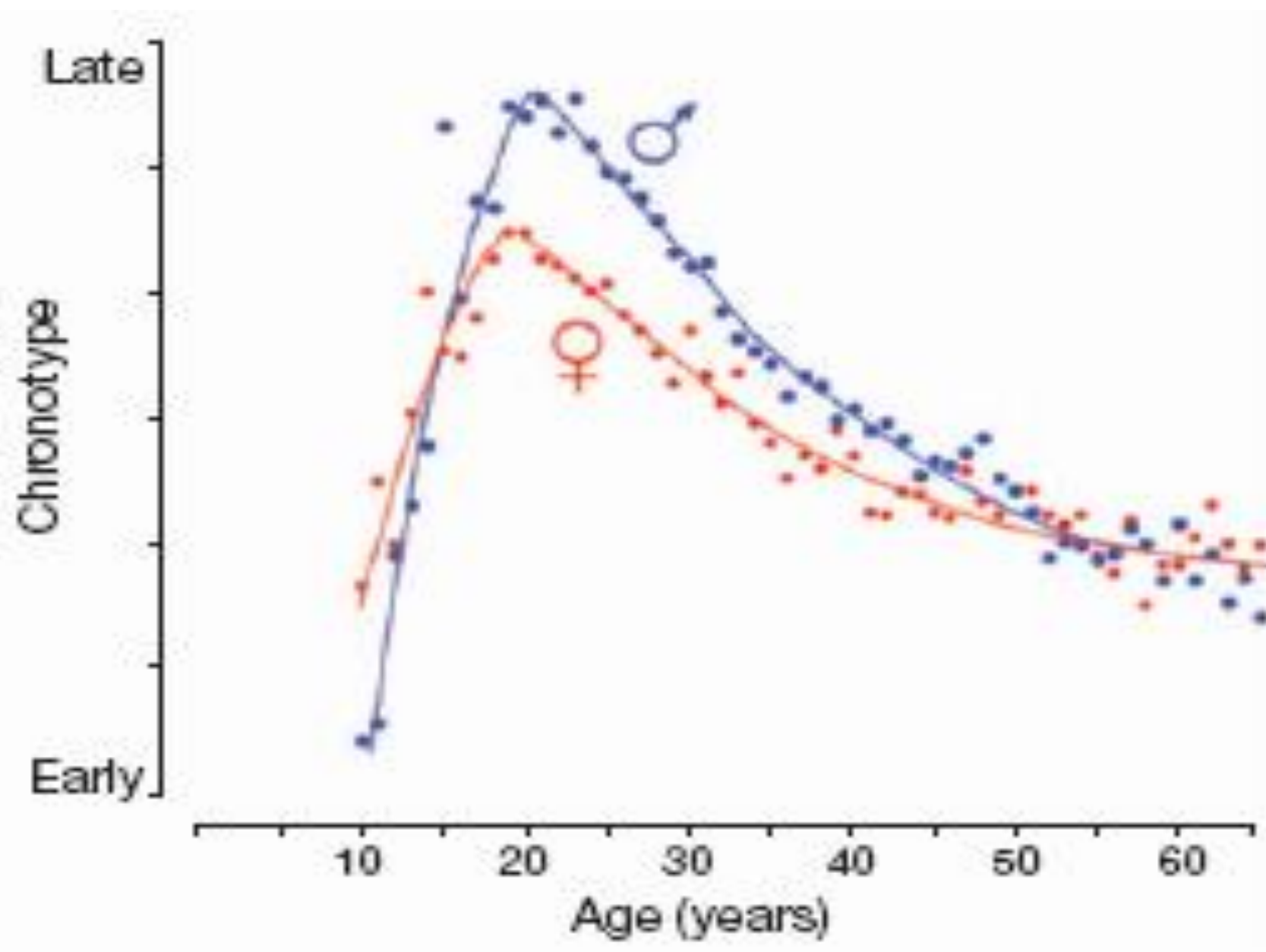
## Relational

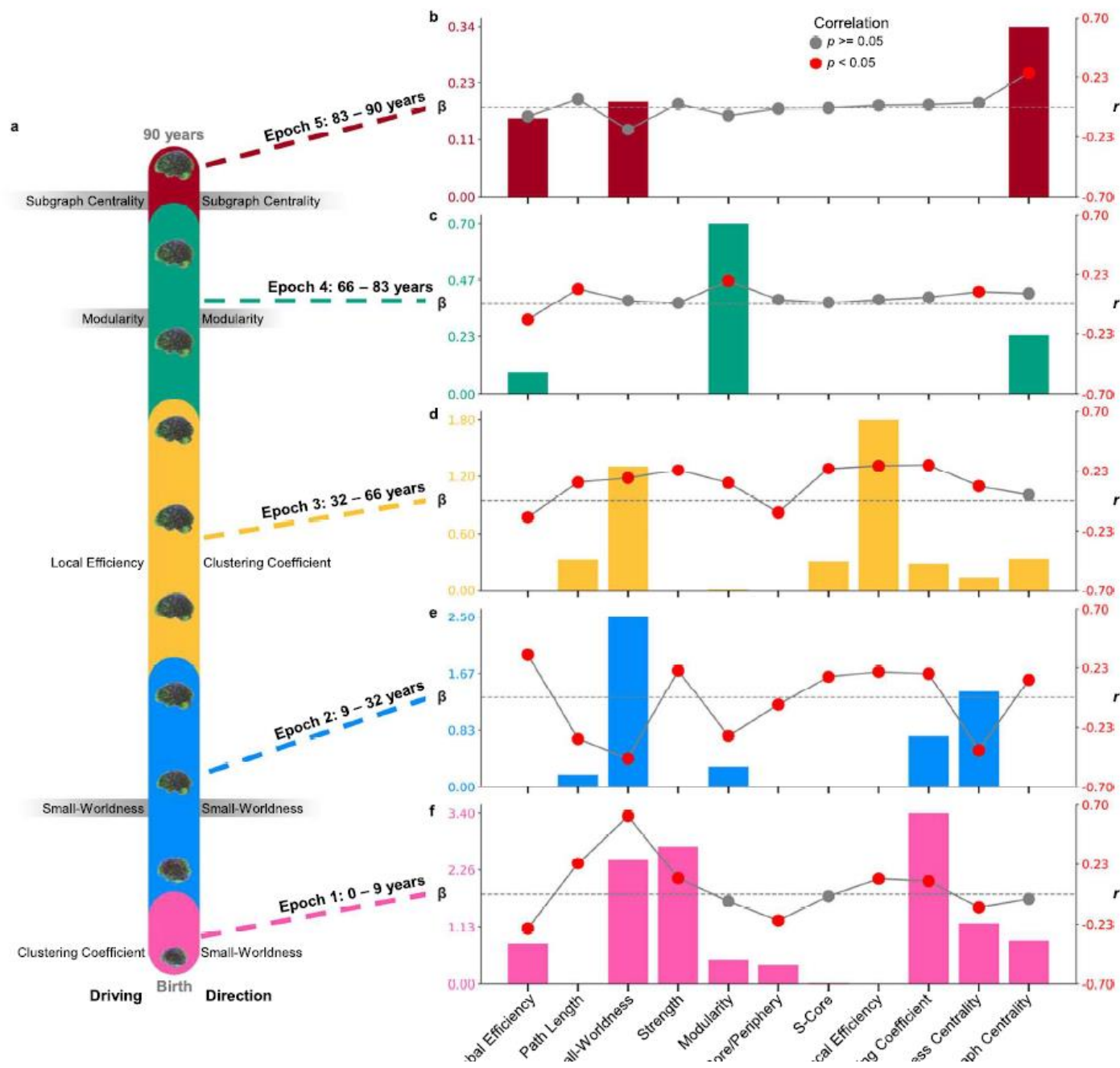


Partnership, patient and family centred



**FIGURE 2.** Age at menarche, 1860-1970. (Data from Tanner.<sup>9</sup>)



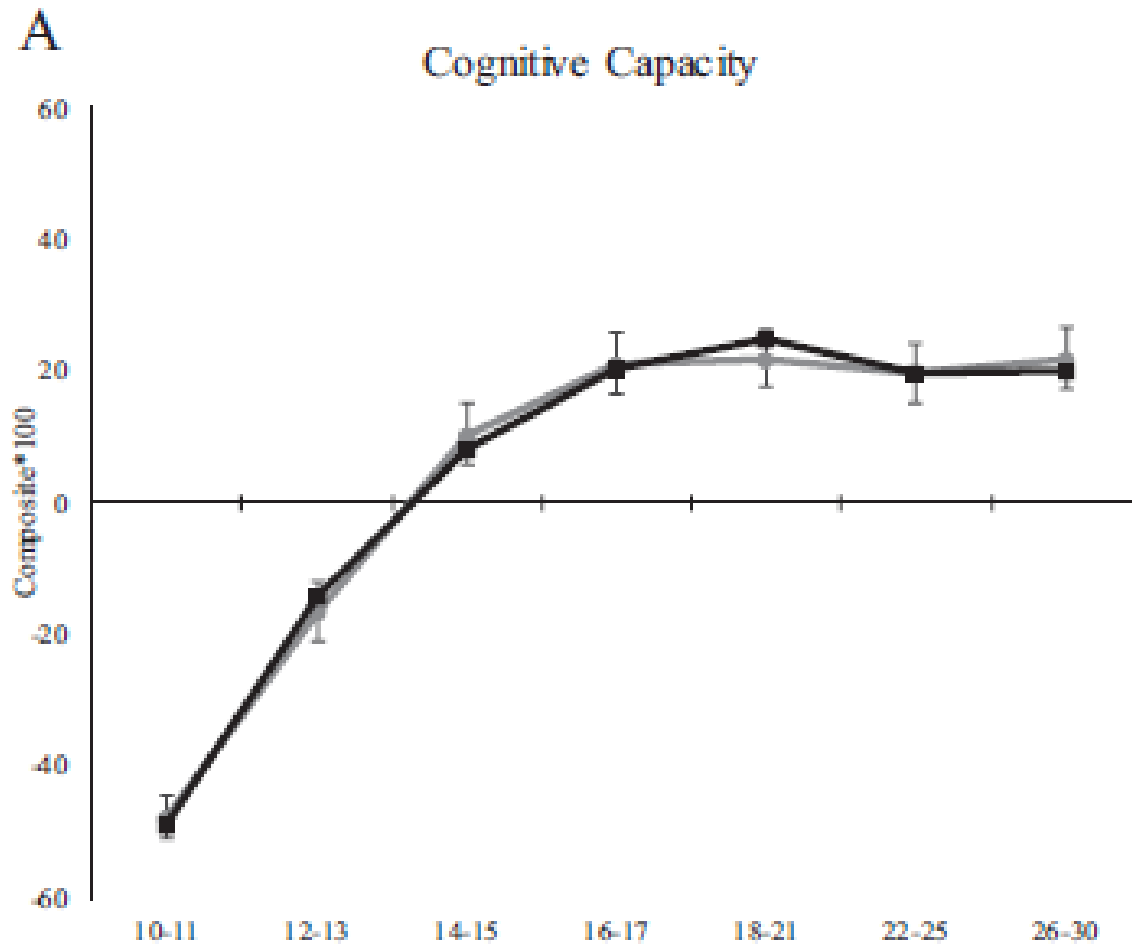


Mousley, A., Bethlehem, R.A., Yeh, F.C. and Astle, D.E., 2025. Topological turning points across the human lifespan. *Nature communications*, 16(1), p.10055.

*"They now love luxury; they have bad manners, contempt for authority; they show disrespect for elders and love chatter in place of exercise. They are now tyrants, not the servants of their households. They no longer rise when elders enter the room. They contradict their parents, chatter before company, gobble up dainties at the table, cross their legs, and tyrannize their teachers."*

# Controversies in AYA medicine

- Developmental age
- **Communication**
- Hidden Illnesses e.g. POTS/ hEDS
- Increasing incidence of ASD, ADHD
- Gender Health



Icenogle, G., Steinberg, L., Duell, N., Chein, J., Chang, L., Chaudhary, N., Di Giunta, L., Dodge, K.A., Fanti, K.A., Lansford, J.E. and Oburu, P., 2019. Adolescents' cognitive capacity reaches adult levels prior to their psychosocial maturity: Evidence for a "maturity gap" in a multinational, cross-sectional sample. *Law and human behavior*, 43(1), p.69.

<p><b>H</b> Home</p>	<p>Who lives with you, and where do you live? What are relationships like at home What does your room like: Do you share a room or have your own space?</p>
<p><b>E</b> Education Employment</p>	<p>Are you enrolled in a school or are you working? Where? How often do you go? What are your favourite subjects/favourite parts of work? Do you feel connected to your school/workplace?</p>
<p><b>E</b> Eating &amp; Exercise</p>	<p>What are your favourite foods? Where do you prefer eating? Eating out or at home? Do you exercise or like any sports?</p>
<p><b>A</b> Activities</p>	<p>What do you like to do in your spare time? What do you like to do for fun? How do you spend time with friends?</p>
<p><b>D</b> Drugs</p>	<p>Do you or any of your friends or family use tobacco/vapes? Alcohol? Other drugs? Have you ever used tobacco/vapes, alcohol or other drugs in the past? How confident are you to ask for help or advice with alcohol or drugs?</p>
<p><b>S</b> Sexuality</p>	<p>Are you sexually active? Have you ever been in a romantic relationship Tell me about the people you have dated. Have your relationships been enjoyable? How confident are you to seek support and advice around sex and sexual health?</p>
<p><b>S</b> Suicide</p>	<p>Have you felt sad or stressed recently? Is this more than usual? Are you having any troubles getting to sleep? Have you had any thoughts about hurting yourself?</p>
<p><b>S</b> Safety</p>	<p>Do you feel unsafe in any way? Or have you felt unsafe in the past? Have you ever been seriously injured? Have you experienced violence at home or school/work?</p>

# Communication Tips

- Explaining confidentiality and seeing a person by themselves is the best communication tool you have
- Explain confidentiality with parents in the room
- Do this routinely for all adolescents age 14 and over
- If you get resistance from parents – roll with it

# Controversies in AYA medicine

- Developmental age
- Communication
- **Hidden Illnesses e.g. POTS/ hEDS**
- Increasing incidence of ASD, ADHD
- Gender Health

# The Hidden Illnesses

- POTS
- Hypermobility
- DGBI
- MECFS
- Widespread pain
- Headaches
- Mast Cell Activation Disorder
  
- And are invariably associated with ASD/ Trauma




# POTS - tips

- Cause is not known but is associated with a range of conditions
- Use the NASA lean test or standing test/ don't need tilt table testing
- Rule out dehydration/ lack of intake/ other causes e.g. prolonged bed rest
- Simple measures are important: fluids and salt (I use salt tablets)
- Medications are often needed to help with exercise
- Exercise for long term improvement

# Hypermobility




- Ask about and assess
- Associated with pain and range of conditions
- hEDS is probably no different from hypermobility spectrum disorders

## **Bridging the Diagnostic Gap for Hypermobile Ehlers-Danlos Syndrome and Hypermobility Spectrum Disorders: Evidence of a Common Extracellular Matrix Fragmentation Pattern in Patient Plasma as a Potential Biomarker**

Marco Ritelli<sup>1</sup>  | Nicola Chiarelli<sup>1</sup> | Valeria Cinquina<sup>1</sup>  | Valeria Bertini<sup>1</sup> | Silvia Piantoni<sup>2</sup> | Alessia Caproli<sup>2</sup> | Silvia Ebe Lucia Della Pina<sup>2</sup> | Franco Franceschini<sup>2</sup> | Guido Zarattini<sup>3,4</sup> | Woodrow Gandy<sup>5</sup> | Marina Venturini<sup>6</sup> | Nicoletta Zoppi<sup>1</sup> | Marina Colombi<sup>7</sup> 

ORIGINAL ARTICLE 

# **Bridging the Diagnostic Gap for Hypermobile Ehlers-Danlos Syndrome and Hypermobility Spectrum Disorders: Evidence of a Common Extracellular Matrix Fragmentation Pattern in Patient Plasma as a Potential Biomarker**

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“Notably, hEDS/HSD displayed a shared FN and COL1I fragment signature, supporting their classification as a single disorder and prompting reconsideration of the hEDS criteria.”

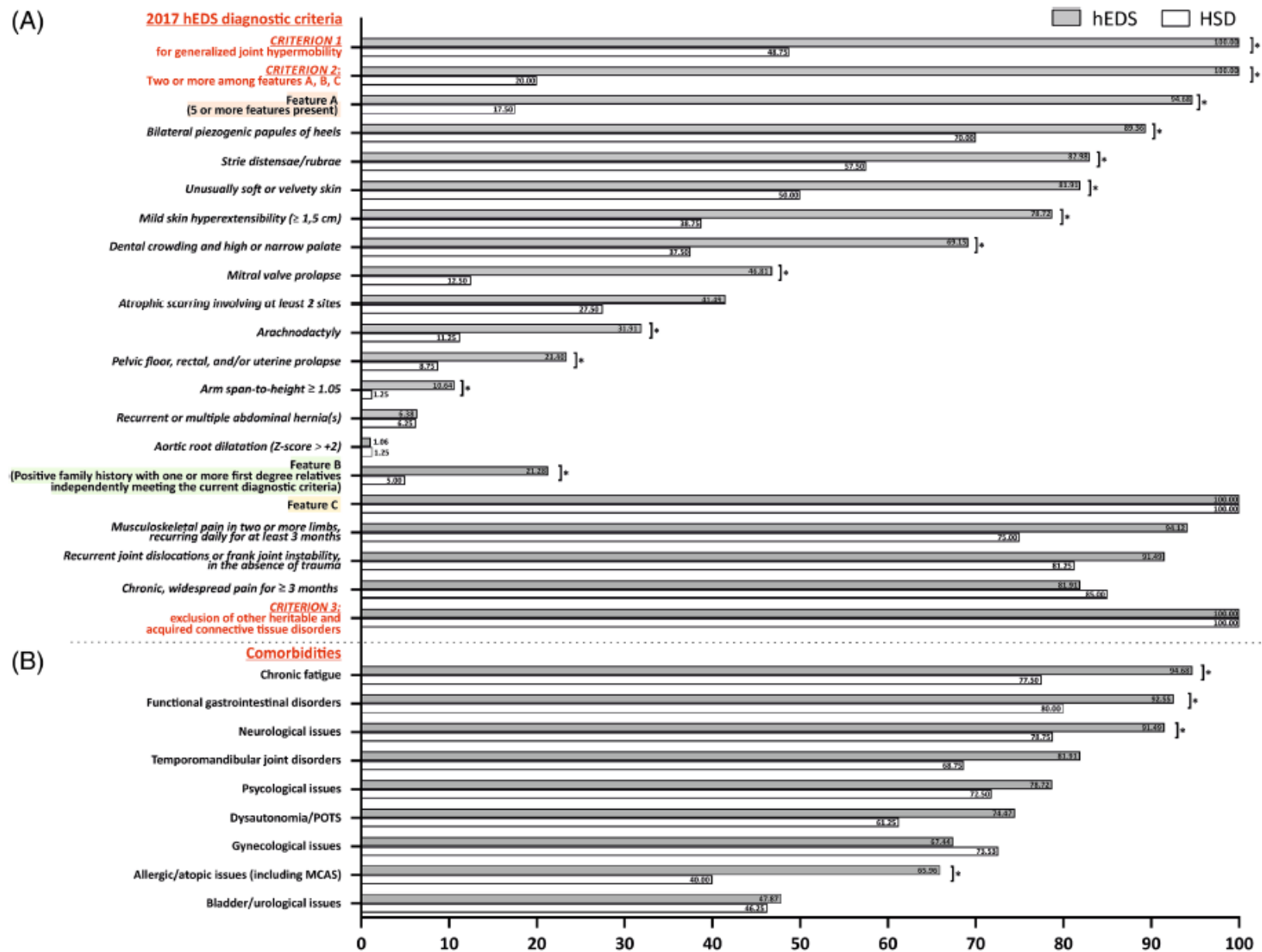
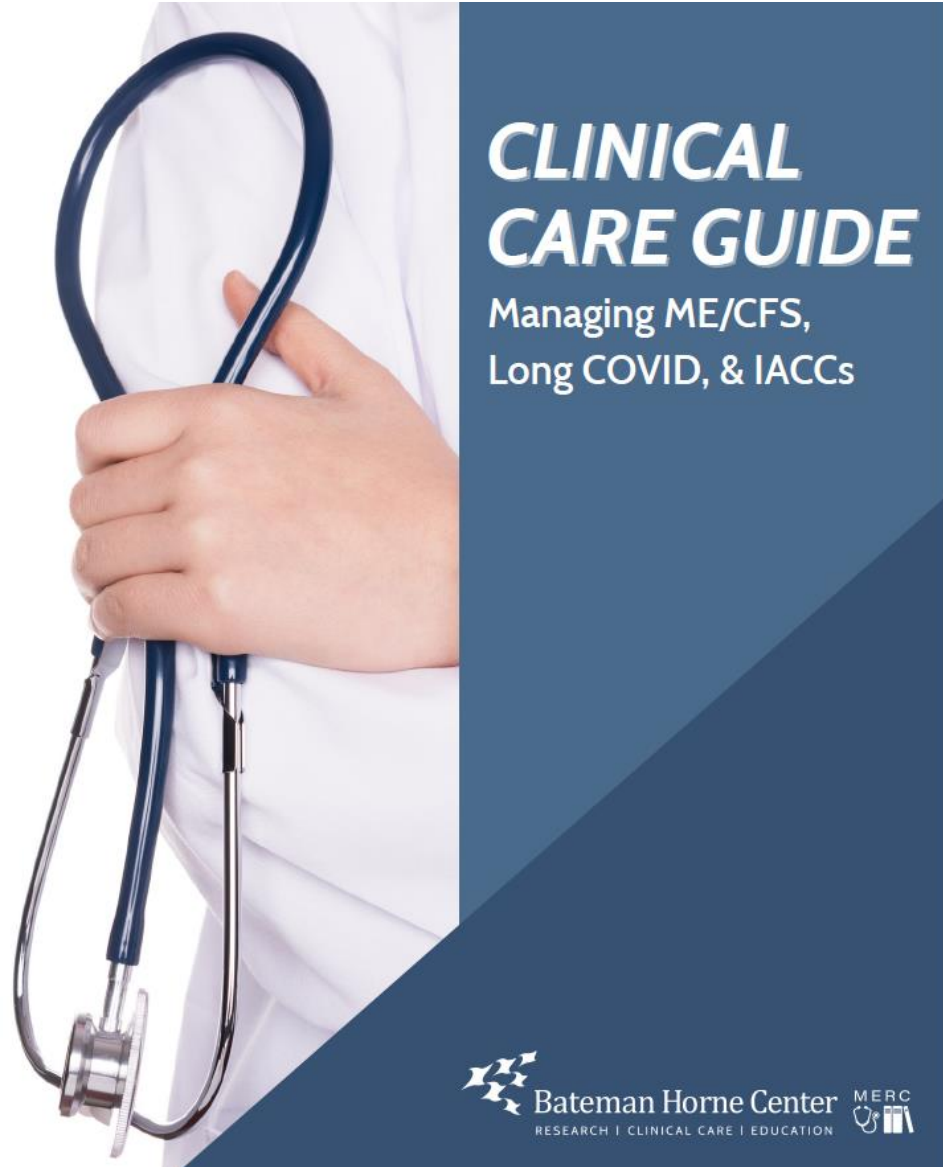


FIGURE 1 | (A) Prevalence of three mandatory diagnostic criteria for an hEDS diagnosis according to the 2017 EDS classification in the entire cohort of 174 patients, including 94 hEDS and 80 HSD individuals. Chronic pain was considered mutually exclusive with recurrent musculoskeletal pain. (B) Frequencies of comorbidities in the 2 different cohorts. \*Presence of statistically significant differences between hEDS and HSD (for frequencies and  $p$ -values see [Additional Results](#)).

# DGBI Tips

- Increasingly common
- Overlap with eating disorder behaviours and ?cannabis hyperemesis
- DGBI often leads to ARFID with a poorer prognosis
- Simple gut health measures – treat constipation, variety of foods etc, exercise
- Try neuromodulators
- Treat associated conditions e.g. POTS
- Domperidone quite helpful and sometimes Na Cromoglycate if Mast Cell Disorder



## **ME/CFS**

Link: [Clinical Care Guide First Edition 2025 V7](#)

# ME/CFS – from Bateman Horne Center

- Patients experience long wait times, limited treatment options, and medical skepticism/gaslighting. Many arrive at appointments exhausted, cognitively impaired, and wary of being dismissed.
- Clinicians must contend with evolving recommendations, limited patient visit times, the absence of definitive biomarkers, and the frustration of seeing patients who do not improve despite best efforts. Traditional diagnostic models often fail when dealing with multisystem dysfunction and fluctuating symptoms
- Recognize the patient's lived experience. Many patients have spent significant time tracking symptoms, researching treatments, and testing their own limits. Clinicians should validate and leverage this knowledge while providing a framework for safe, structured treatment trials.
- Trial-and-pivot over trial-and-error. Without clear guidelines, treatment often relies on carefully monitored interventions rather than definitive cures. Adjusting strategies based on patient response is not failure—it is informed decision-making.

# ME?CFS

- COVID – 4x times the risk
- Significant disability – worse than most other severe diseases
- Significantly undiagnosed/ misdiagnosed – 90%
- Areas of controversy: revised 2021 NICE guidelines, role of GET and CBT and lack of MDT teams

Advertising

[AJGP](#) > [March](#) > [Is the RACGP HANDI recommendation of incremental physical activity for chronic fatigue syndrome](#)

[Viewpoint](#)

Volume 55, Issue 3, March 2026

# Is the RACGP HANDI recommendation of incremental physical activity for chronic fatigue syndrome/myalgic encephalomyelitis harming patients?

[Jacqueline Stallard](#) [Stephan Praet](#) [Sandeep Gupta](#) [Angela Smith](#)

# The Hidden Illnesses

- POTS
- Hypermobility
- DGBI
- Chronic Fatigue
- **Mast Cell Activation Disorder**

and are invariably associated with ASD/ Trauma/ ADHD

# Mast Cell Activation Disorder

- Mast Cell Activation Syndrome (MCAS) is a condition where dysfunctional mast cells release excessive mediators into the bloodstream (Theoharides, 2015).
- 3 criteria for diagnosis
  - Multisystem symptoms include flushing, urticaria, angioedema, abdominal cramping, diarrhoea, nausea, palpitations, presyncope, headache, and brain fog.
  - Evidence of raised mediators in plasma or urine
  - Response to mast cell directed therapy (antihistamines)
- Still controversial – with two competing schools of thought

Participant	MCAS Score	Plasma PGD2 (pg/mL) [35–115]	Urine NMH (mcg/g Cr) [30–200]	Urine 2,3-dinor-11 $\beta$ -PGF2 $\alpha$ (pg/mg Cr) [<1802]	Plasma Histamine (ng/mL) [<1.0]	Tryptase Baseline (ng/mL)	Tryptase Flare (ng/mL)	Response to MC Therapy
MCAS01	23	3038.3*	9732*	10926*	0.137	5.2	N/A	No
MCAS02	30	671.2*	8567*	5936*	0.116	6	7	Yes
MCAS03	30	222.5*	7394*	735	0.142	4	3.8	Yes
MCAS04	24	1255.9*	9182*	4054*	0.089	5.4	4.1	Yes
MCAS05	27	1351.0*	19095*	7521*	0.101	4.7	N/A	No
MCAS06	23	1074.9*	11731*	9303*	0.079	4.4	N/A	Yes
MCAS07	23	543.7*	14626*	0	0.078	4.1	3.5	Yes
MCAS08	31	582.7*	16530*	3790*	0.08	9.1	N/A	Yes
MCAS09	29	9704.3*	7467*	50999*	0.083	11.5	12.4	Yes
MCAS10	28	2831.0*	14850*	10510*	0.095	4.3	N/A	N/R
MCAS11	35	1233.9*	10824*	3435*	0.094	3	N/A	Yes
MCAS12	31	1101.6*	13202*	4777*	0.079	5.1	5.3	Yes
MCAS13	22	3183.9*	14454*	0	0.085	3.5	N/A	No
MCAS14	33	2057.6*	5915*	4613*	0.076	3.8	N/A	Yes
MCAS16	28	879.1*	8465*	6924*	0.094	4	N/A	Yes

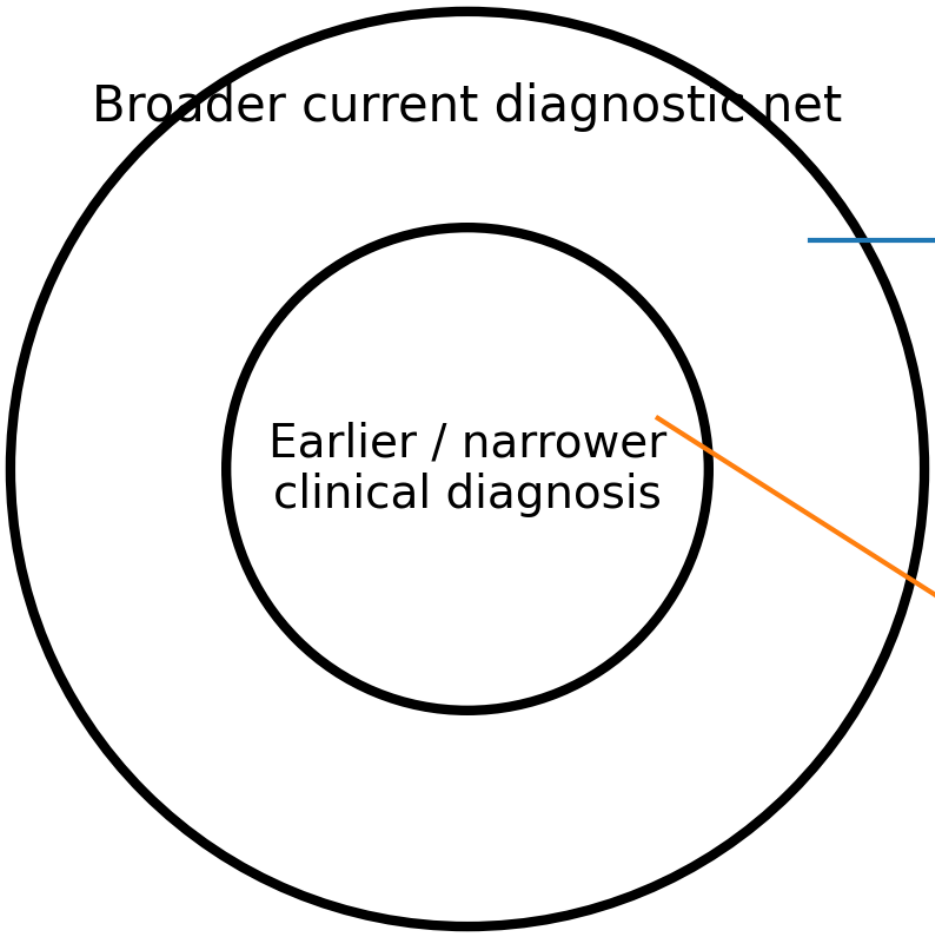
# Medications

- H1 Antihistamines
  - First try cetirizine 10mg twice a day for two weeks
  - Then try fexofenadine 120mg twice a day (or 180mg) for two weeks
  - Then try loratadine 10mg twice a day
- H2 Antihistamines: famotidine 20mg BD
- Various next approaches: ketotifen, Na Cromoglycate, low dose lorazepam, GLP1, Omalizumab
- Supplements inc Vit C, Vit D, quercetin

# Controversies in AYA medicine

- Developmental age
- Communication
- Hidden Illnesses e.g. POTS/ hEDS
- **Increasing incidence of ASD, ADHD**
- Gender Health

# How measured incidence can rise without a simple 'true epidemic'



- Includes people now more likely to be identified due to:
- broader criteria
  - more awareness
  - better screening
  - recognition of girls, adults, subtler presentations
  - service / school / funding pathways

The increase in diagnosed cases may reflect a wider circle of who counts as a case, not only a rise in underlying disorder.

So the question becomes does the wider diagnosis help the young person?

# Controversies in AYA medicine

- Developmental age
- Communication
- Hidden Illnesses e.g. POTS/ hEDS
- Increasing incidence of ASD, ADHD
- **Gender Health**

# Gender Health

- A lot of polarised views which has been detrimental to the care of some of our most vulnerable patients
- Transgender and gender fluidity is not new and has been recognised for millennia
- The current debate around the use of puberty blockers and hormones focuses on whether these interventions are evidence based – there have been no rcts
- But it is the wrong question – there is no doubt gender hormones work – the question is for whom?
- But current debates around the evidence using outcomes like mental health. Gender affirming hormones can help mental health but they are only part of a wider context of care

# Summary

- Ongoing controversies seem to all reflect an underlying mistrust of patient experience
- I do worry about the role of labels on the developing identity of the adolescent
- But I also wonder if invalidation lead to more illness, either through causing a disconnect with mind/ body or needed to prove ‘the doctors wrong’
- No matter what the controversy – the patients that seem do the best take agency and control over their own health care



## What is Safe Space?

A Safe Space is an inclusive, welcoming and supportive environment for people experiencing emotional distress.

**Strathpine Safe Space**   
 Unit 6 327 Gympie Road,  
 Strathpine  
 ☎ 07 3493 6710  
 ✉ safespace@neaminational.org.au  
 Open: Mon - Fri, 5.00 pm - 9.00 pm  
 Sat & Sun, 3.00 pm - 7.00 pm

**Caboolture Safe Space**   
 24 George Street, Caboolture  
 ☎ 07 5232 1590  
 ✉ SafeSpace.Caboolture@stride.com.au  
 Open: Mon - Fri, 5.00 pm - 9.00 pm  
 Sat & Sun, 10.00 am - 2.00 pm

**Bardon Safe Space**   
 180 jubilee Terrace, Bardon  
 ☎ 07 3004 0101  
 ✉ SafeSpace@communify.org.au  
 Open: Mon - Fri, 5.00 pm - 9.00 pm  
 Sat & Sun, 9.00 am - 1.00 pm

**Redcliffe Safe Space**   
 440 Oxley Avenue, Redcliffe  
 (on the corner, next to the Skate Park)  
 ☎ 0435 827 817  
 ✉ SafeSpace@redcliffeyouthspace.org  
 Open: Mon - Fri, 5.00 pm - 9.00 pm  
 Sat & Sun, 3.00 pm - 7.00 pm

Each Safe Space is part of a broader Safe Spaces Network coordinated by Wesley Mission Qld. For further information email: SafeSpaceNetwork@wmq.org.au 



## Welcome to Safe Space



Feeling distressed?

Need a safe space to go to?

Looking for an alternative to the emergency department?



- All ages welcome
- After hours support
- Peer-led
- Crisis support
- ED alternative



## Committed to providing exceptional healthcare to young people

The Mater Young Adult Health Centre Brisbane is a speciality providing adolescents and young adults with high quality, uniquely tailored programs that address their emotional, social and developmental needs.

The centre delivers support across a wide range of specialities to respond to the complex healthcare needs of young people.

## Mater Young Adult Health Centre Services

- [Clarence Street](#) →
- [Emotional Health Unit](#) →
- [Young adult inpatient services](#) →
- [Young Adult Support Unit \(YASU\)](#) →

## Young adult programs

- [Youth disaster recovery](#) ↓
- [Transition support services](#) ↓
- [Thrive day program](#) ↓
- [Art therapy](#) ↓
- [Health advocacy legal clinic](#) ↓

## Mater youth consultancy - the voice of young people

Established in October 2014 during the centre's planning phase, the Mater Youth Consultancy ensures young people have the opportunity to provide feedback, share their ideas and participate in key decisions about the delivery of new or existing services.

[Find out how you can participate](#)

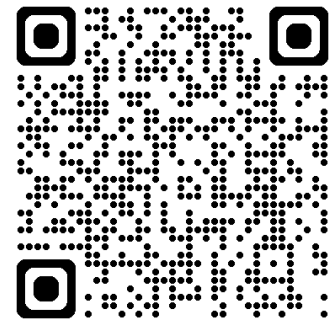
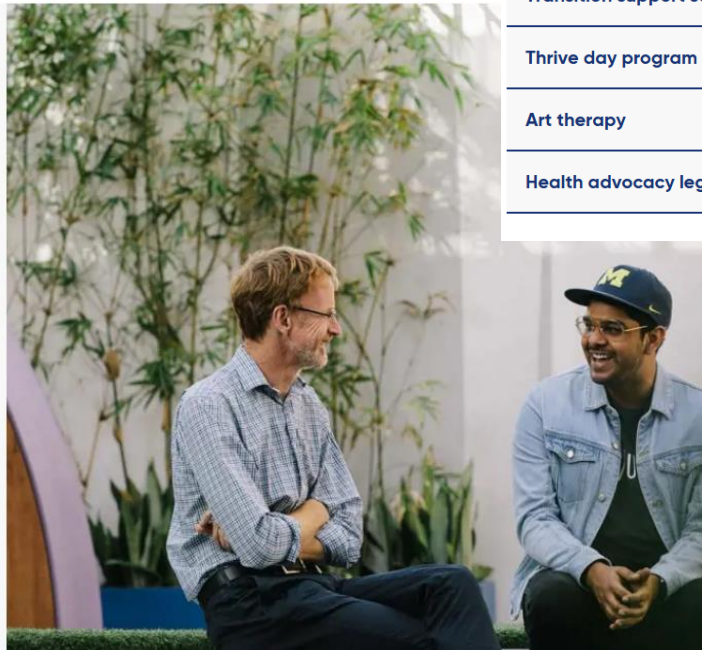
## What we do

The Mater Young Adult Health Care Centre Brisbane provides services and support for young people in hospital, access to specialist health clinics, professional emotional health support, as well as free, confidential services for young people who experience issues with substance use.

Depending on the service/s you require access to, you may need a referral from your GP or medical professional to the Mater Young Adult Health Centre Brisbane.

We recognise that it is important for young adults to be cared for with people their own age so they can share their experiences with a peer, and that being able to interact with someone else their age normalises their experience and helps them process what they're going through.

[View our specialists](#)



## Emotional Health Unit



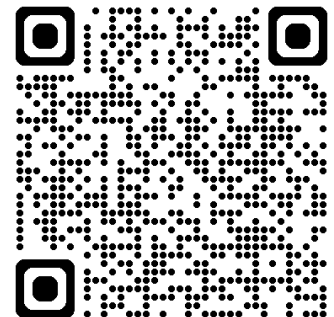
### Dedicated to young adults aged 16-25

Some of the more common mental health challenges that may be faced by young adults include depression, anxiety and eating disorders. But there are many more concerns that could be added to this list. Along with these come other problems and behaviours that can impact on everyday functioning, making the most basic of tasks overwhelming.

The Emotional Health Unit here at MYAHC delivers specialist mental health care to young adults which is evidence based and consumer driven. The care that is provided by our experienced mental health team is based on the individual strengths of our patients and is focused on their recovery.

Thanks to the generosity of Mr Peter Flynn of the [Amanda Flynn Foundation](#), Mater will deliver specialist inpatient care to young adults who are experiencing anxiety, depression and other mental health conditions at the Amanda Flynn Clinic. In Partnership with [ClearThinking](#) Queensland, appropriate models of care for young adults have been created for the Recovery College.

[Contact the Emotional Health Unit team](#)



# Postural Orthostatic Tachycardia Syndrome (POTS)

## Background

[About postural orthostatic tachycardia syndrome \(POTS\) ▼](#)

## Assessment

1. Take a history. Ask about:

- common presenting symptoms:
  - Orthostatic ▼
  - Gastrointestinal ▼
  - Thermoregulatory/secretory ▼
  - Urinary ▼
  - Neurological ▼
  - Vasomotor ▼
- symptoms suggesting an alternative cardiac cause e.g., chest pain
- impact on daily tasks (including home, school/work, lifestyle)
- possible triggering event ▼
- duration and pattern of symptoms ▼
- associated conditions ▼
- family history of POTS, or family members with POTS-like symptoms or [associated conditions](#) ▼.

2. Ask the patient to complete the [Malmo POTS Survey \(MAPS\)](#) [☑](#) (a score of  $\geq 42$  is suggestive of POTS).

## Management

1. Provide education:

- Explain that there is no cure for POTS but there are treatments that can relieve the symptoms.
- First-line treatment is lifestyle modifications.
- Give [written information](#) [☑](#).

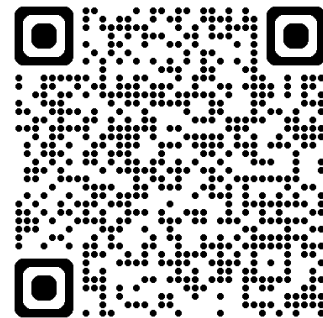
2. Recommend lifestyle modification:

- [Salt and fluid modification](#) ▼
- [Compression garments](#) ▼
- [Dietary adjustments](#) ▼
- [Managing triggers](#) ▼
- [Exercise](#) ▼

3. Reduce or stop medications that cause hypotension, diuresis, or tachycardia if possible.

4. Consider requesting multidisciplinary care for all patients. If possible, refer to practitioners with experience managing POTS.

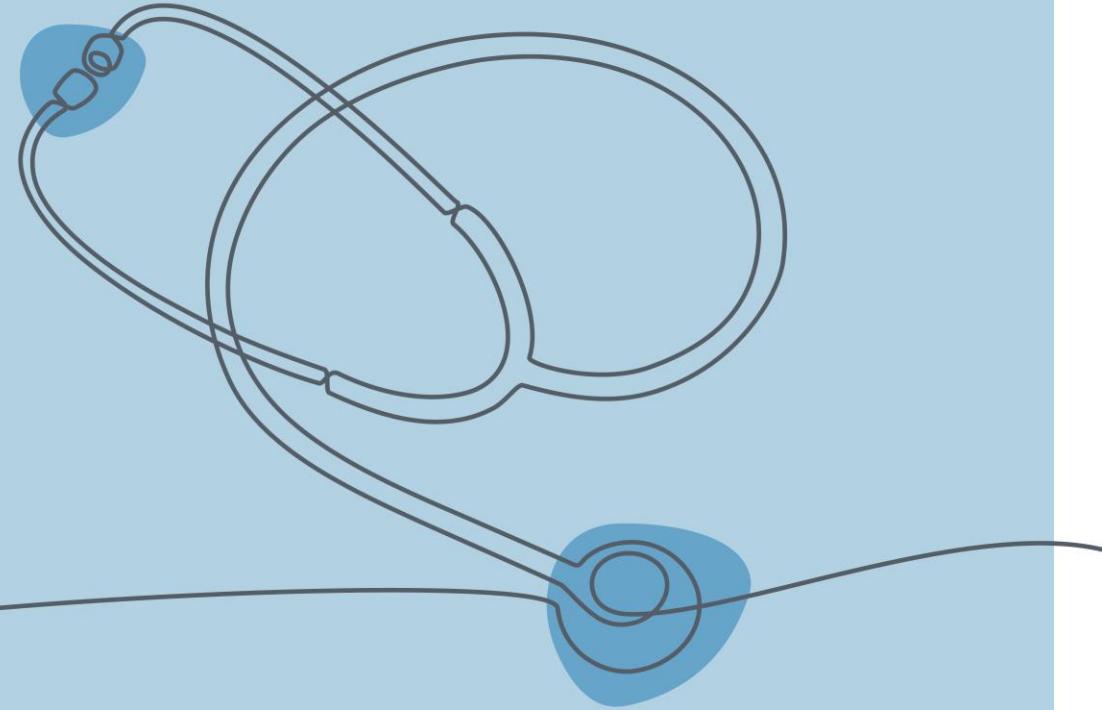
- See Australian POTS Foundation – [Clinician Directory](#) [☑](#).



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



## Below the belt: Hernias, haemorrhoids & fissures

Dr Andrew Hughes | Senior Staff Surgeon, TPCB

**phn**  
BRISBANE NORTH  
An Australian Government Initiative

 **Queensland** Government  
Metro North Health



# BELOW THE BELT: HERNIAS, HAEMORRHOIDS & FISSURES

DR ANDREW S. HUGHES

MBBS FRACS

VMO SAWMH, NWPH, SVPHN

SENIOR STAFF SURGEON TPCH

FEX EXAMINER RACS 2025-

DISCLOSURES: WORKSHOPS/MEETINGS/SUPERVISION HONORARIA - DEVICE TECH, MEDTRONIC,  
ETHICON 08-25

SPONSORSHIP TO INTERSTATE EDUCATIONAL EVENTS MEDTRONIC, GSA, GORE 2016-2024

NO INTEREST IN HAVING ALL YOUR HAEMORRHOID AND FISSURE PATIENTS

# THESE THREE BENIGN DIAGNOSES TEST SURGICAL JUDGEMENT, MANAGEMENT

- LET ME EXPLAIN
- TAKE HAEMORRHOIDAL BLEEDING
- "I HAD BANDING 2 YEARS AGO; IT WORKED FOR 3 MONTHS; CAN I HAVE IT AGAIN?"
- "WHAT DID YOUR GP/SURGEON TELL YOU ABOUT IT?"

Permanent	Temporary excess soft tissue
No change to lifestyle needed	Most improve with simple diet
No education on bowel habit	Must be gentle with the outlet

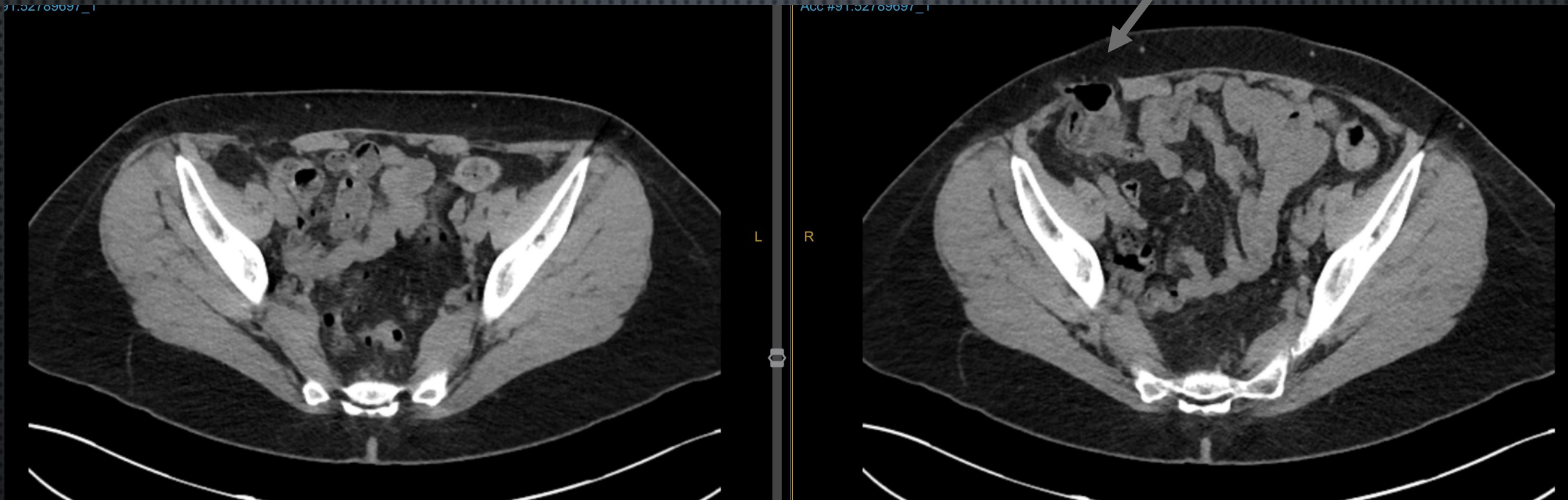


# HERNIA BELOW THE BELT

- GROIN HERNIAE
- SPIGELIAN HERNIAE
- INCISIONAL HERNIAE EG PFANNENSTIEL
- ULTRASOUND
- RECURRENCE
- RECTUS DIVARICATION / VENTRAL / UMBILICAL – VERY HIGH BELT

# SPIGELIAN ON SEMILUNAR LINE

Small bowel in  
interparietal sac



# MODES OF HERNIA PRESENTATION

- PAIN WITHOUT LUMP
  - NON-HERNIA VS SMALL EXPANDING / 'SHARP' NECK
- LUMP WITHOUT PAIN
  - COUGH IMPULSE – REFER
  - NO COUGH IMPULSE – USS
- LUMP WITH PAIN +/- OBSTRUCTIVE SYMPTOMS – URGENT REFERRAL

# STYLE OF SURGICAL PRACTICE

- USS UBIQUITOUS; OFTEN PATIENT PRIMED FOR OPERATION ON BASIS OF RESULT
- SOME COLLEAGUES USE JUST 'GO WITH IT' FOR EXPEDIENCY
- HERE'S WHAT WE KNOW ABOUT OPERATION FOR PAIN:
  - UP TO 3X RISK OF POST-OP CHRONIC PAIN
  - REST CAN ALLEVIATE PAIN FROM OTHER CAUSES FOR FALSE REASSURANCE
  - GPs OFTEN LEFT WITH PATIENT NO BETTER OFF, WITH THE CONUNDRUM OF DIAGNOSIS INCLUDING NERVE INJURY FROM OPERATION, RECURRENCE EVEN EARLY

# THE THOROUGH SURGEON

- EXAMINES PT LYING AND STANDING
- ASKING PT TO PINPOINT SYMPTOM WITH ONE FINGER
- NOT INVAGINATING THE EXTERNAL RING
- EXAMINE THE BONY PELVIS AND HIP
- IF NO COUGH IMPULSE, CONSIDER IMAGING DEPENDING ON SYMPTOMS
- AT LEAST REST FROM REPETITIVE EXERCISE, SIMPLE MULTIMODAL ANALGESIA , OFFER REVIEW

# PROS / CONS USS

- 13 FOLD INCREASE IN GROIN USS 2000 TO 2018; \$40 MILLION IN REBATES; 6500 PER WEEK\*
- OFTEN HELPFUL FOR WHAT IT RULES OUT
  - FLUID FILLED MASS CYSTIC NODE, SEROMA, SAPHENA VARIX
  - SOLID MASS EG NODE, SARCOMA
- MOVEMENT WITH STRAIN OR COUGH REPORTED AS HERNIA
- 5-10 MM IF REAL WILL NOT PRODUCE BOWEL COMPLICATION
- IN SYMPTOMATIC PATIENTS WITH LARGER DEFECTS, MAY CHANGE MANAGEMENT IF SIGNS ABSENT

\*Rod Jacobs 18/2/26 newsGP

# DYNAMIC MRI VS STRAIN CT

- CAN DEMONSTRATE TO PATIENT PRE-OP WHAT NEEDS REPAIR
- WORKCOVER FOR OBJECTIVE EVIDENCE IF REFERRED WITH UNILATERAL, BILATERAL SIGNS
- SPIGELIAN HERNIAE
- PAIN WITHOUT SIGNS WHERE DIAGNOSIS DESIRED – MRI \$

# STRAIN CT

hours ago  
2026 04:04 PM

37900\_1

M, 71 Y  
DOB: Jun 18, 1954  
PID: 92.161961

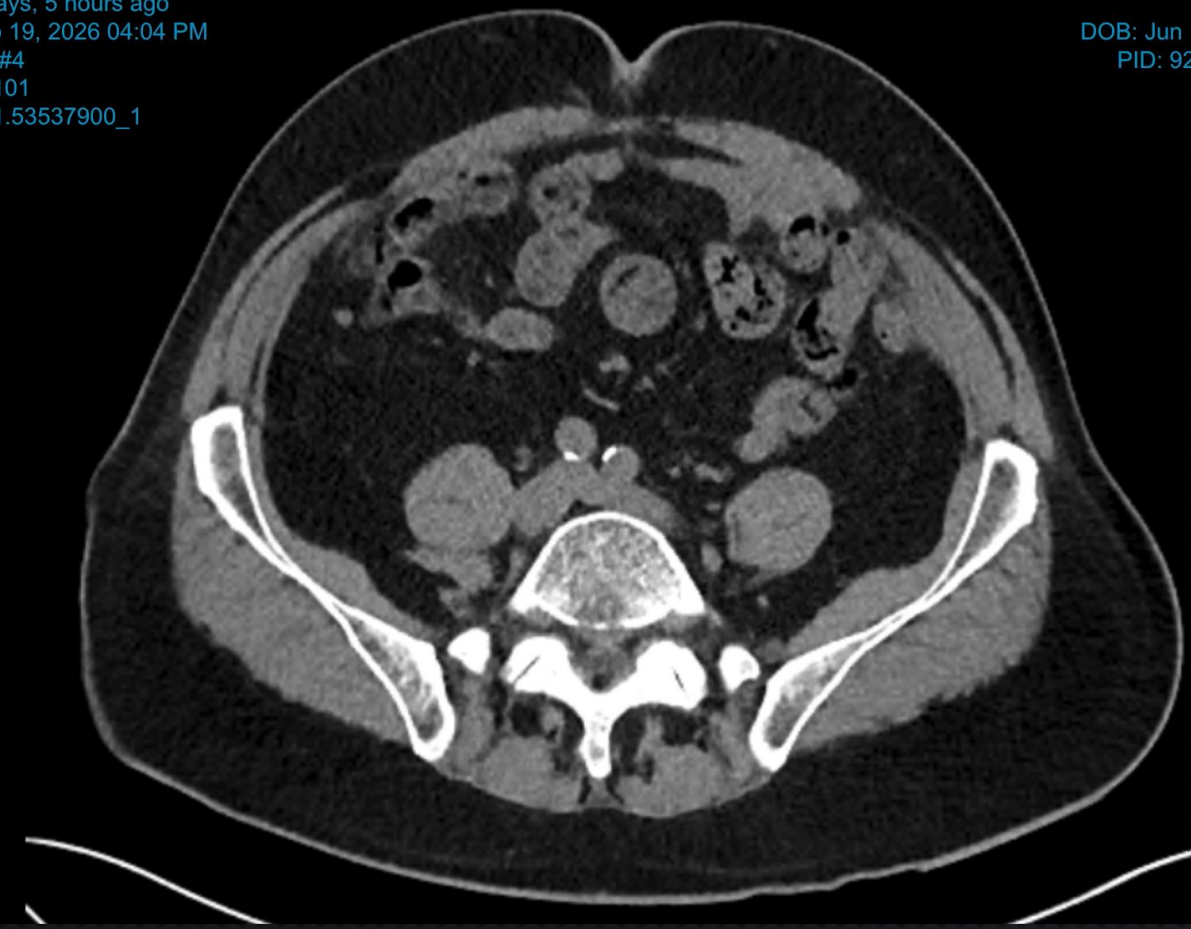
★ 24 days, 5 hours ago  
Se: Feb 19, 2026 04:04 PM  
Se: CT #4  
Im: 14/101  
Acc #91.53537900\_1

DOB: Jun  
PID: 92



L

R



# DYNAMIC MRI – STILL OR CINE

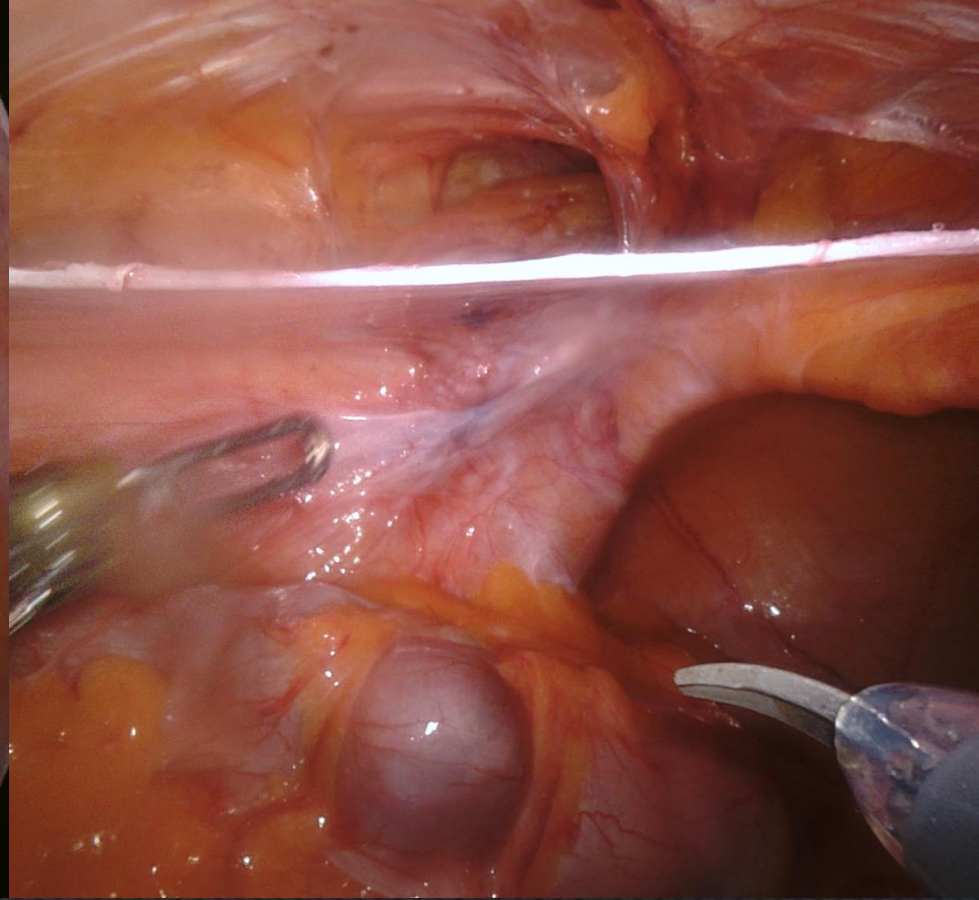
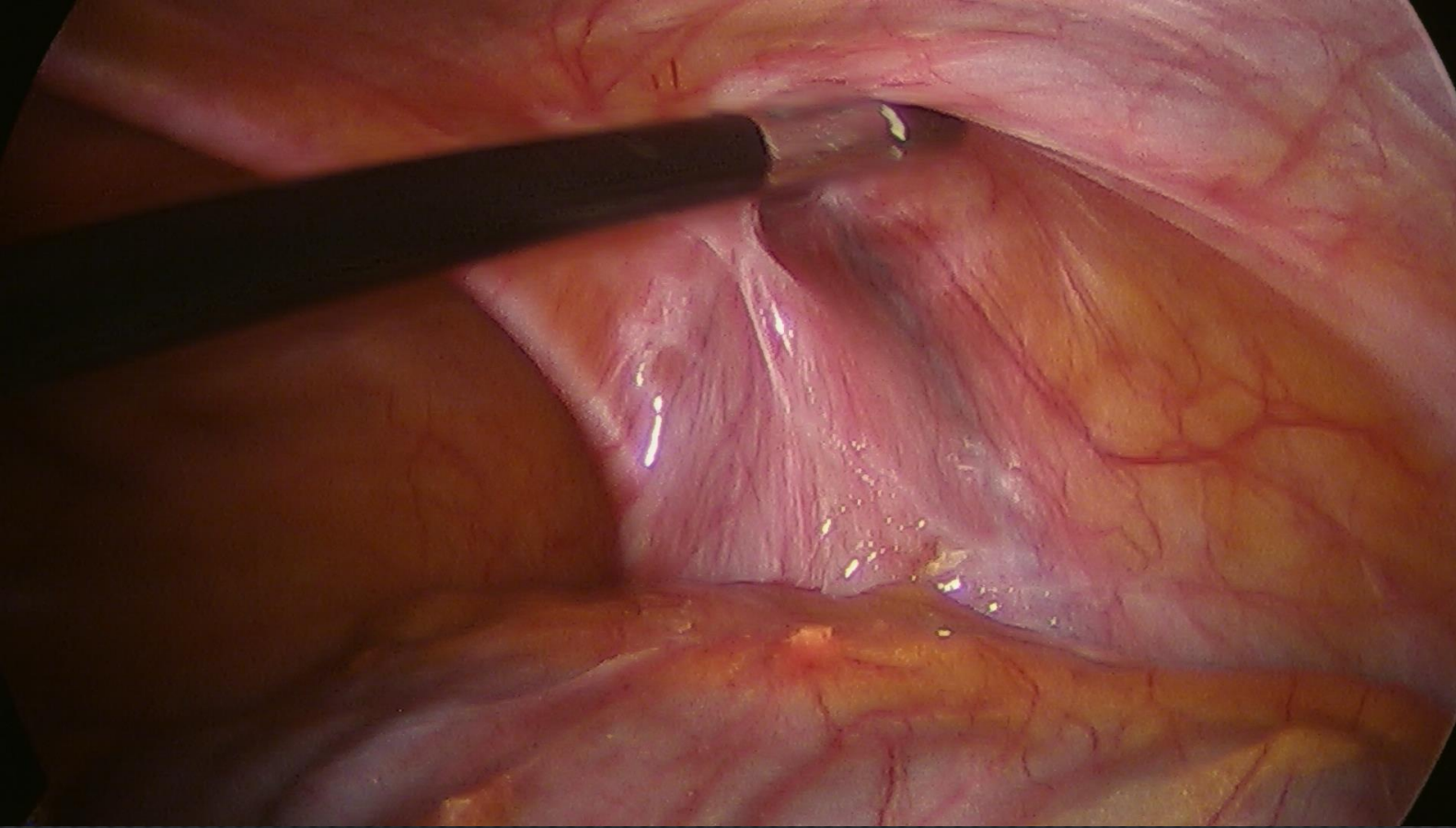


# 'WATCHFUL WAITING'

- IS VALID FOR SMALL CLINICAL HERNIAE
- IS VITAL FOR PAINFUL GROIN WHILST REST/PHYSIO/SIMPLE ANALGESIA
- ACUTE PRESENTATION WARNINGS
- RISK/BENEFIT EG HEART TRANSPLANT 30 YRS, 8 YRS OBSERVATION
- OFTEN LESS SYMPTOMATIC AS DEFECT ENLARGES

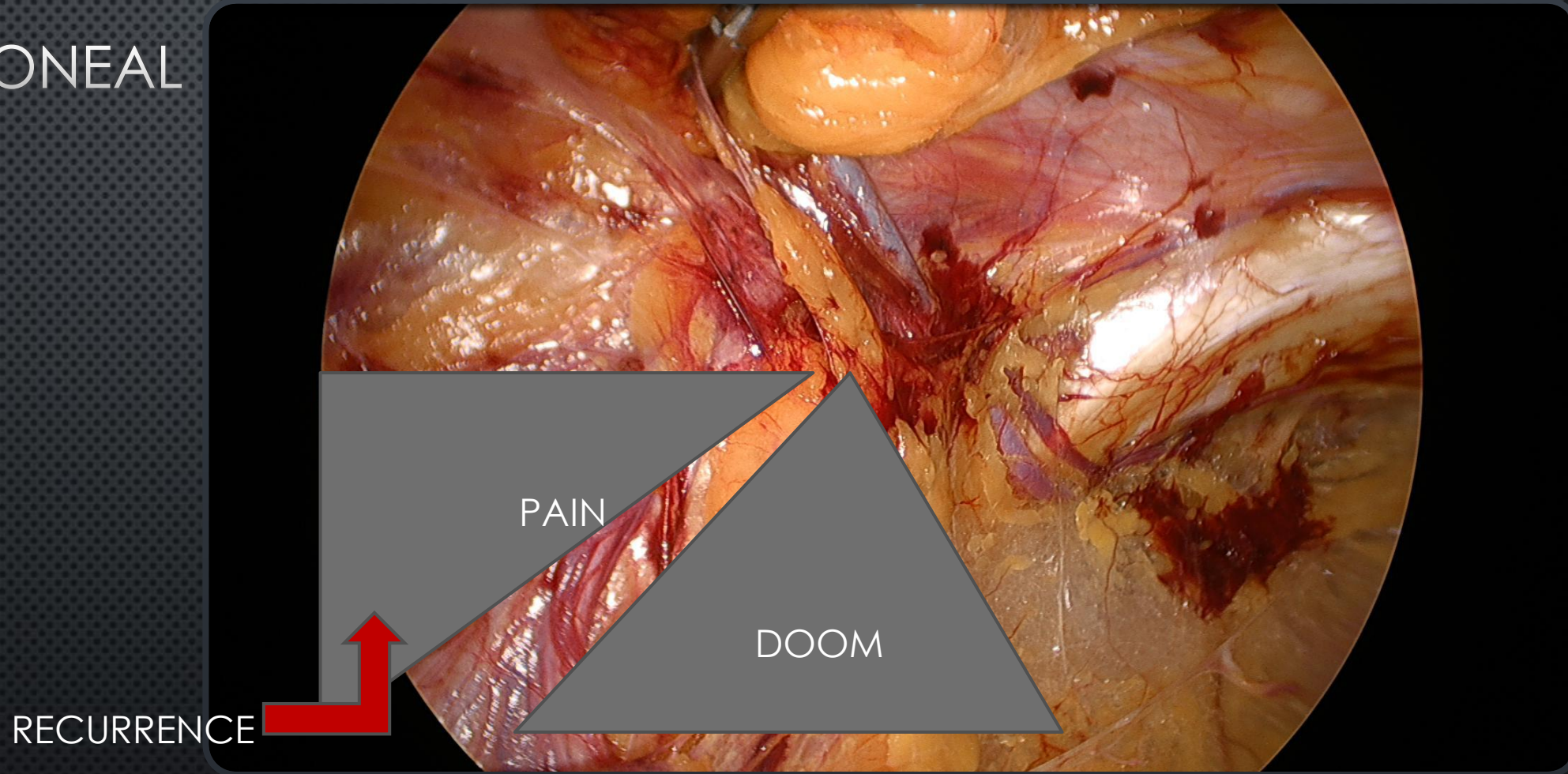
# DOES USS MATTER

- WORKCOVER NEEDS SECOND OPINION
- PT NEEDS SECOND OPINION
- HISTORY AND EXAMINATION MISMATCH
- CT AS BACKUP ESPECIALLY WITH RECURRENT HERNIA/VENTRAL RECONSTRUCTION PLANNING
- NOT NECESSARY FOR PRIMARY UMBILICAL / INGUINAL HERNIAE
  - DIRECT/INDIRECT/FEMORAL/OBTURATOR/PRE-FEMORAL DON'T MATTER



INTRAPERITONEAL VIEW

EXTRAPERITONEAL  
VIEW



# THE BOTTOM LINE



International Journal of Surgery

Volume 11, Issue 5, June 2013, Pages 374-377



Review

## Recurrence after groin hernia repair-revisited

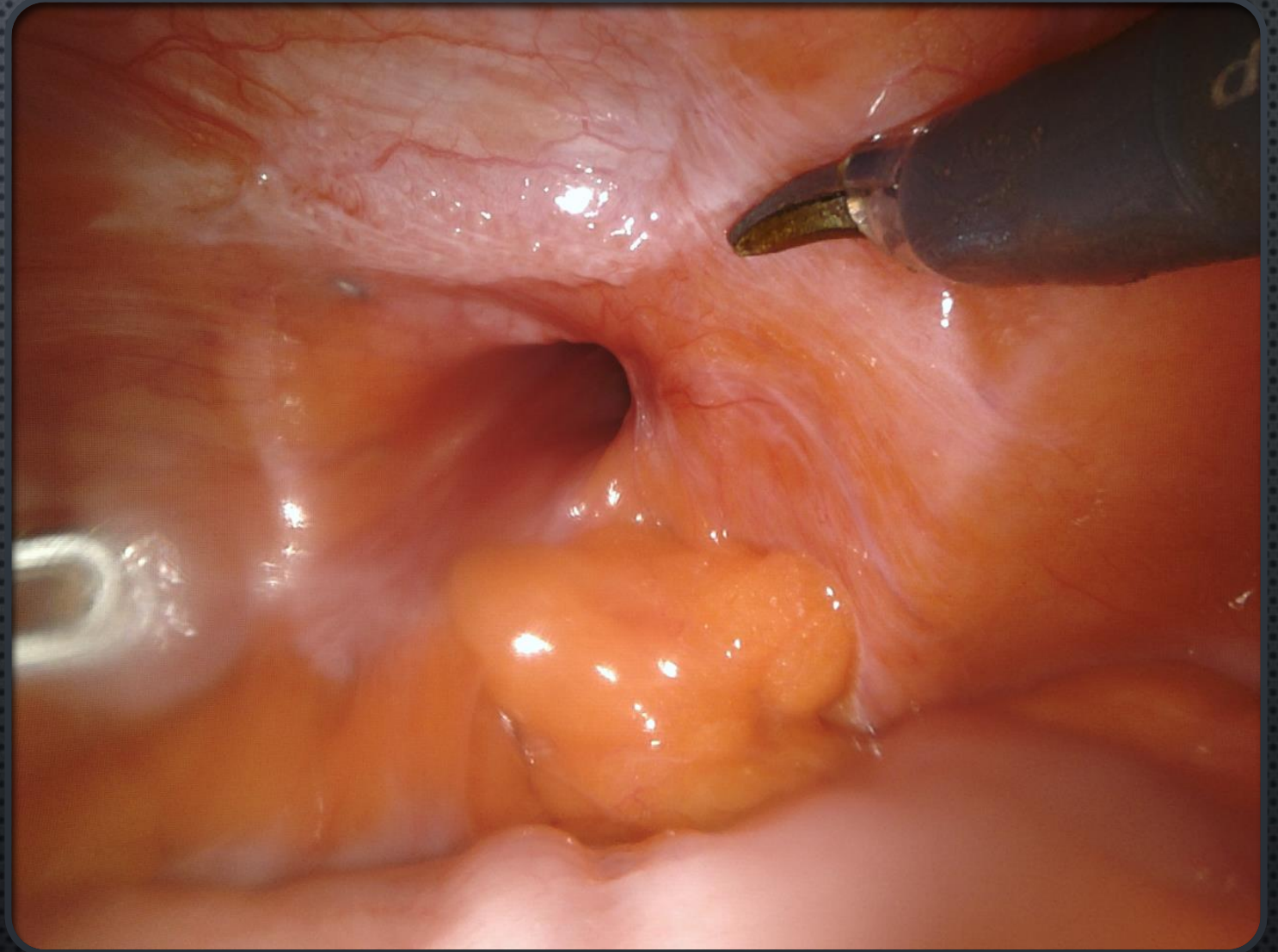
Sri Vengadesh Gopal <sup>a</sup>  , Achuthan Warriar <sup>b</sup>

# QUALITY OF SERVICE

- LONG LEARNING CURVE FOR 'SIMPLE' HERNIA – SHORTCUTS, LITTLE CARE, LITTLE MESH
- RECURRENCE DUE TO .... "INCOMPLETE DISSECTION. COMPLETE LAPAROSCOPIC PREPERITONEAL DISSECTION IS TEDIOUS, BUT INADEQUATE DISSECTION RESULTS IN POOR OVERALL ASSESSMENT OF THE GROIN FLOOR, MISSED HERNIAS, AND INSUFFICIENT DELINEATION OF FASCIAL STRUCTURES.
- INCOMPLETE DISSECTION LEADS TO A NUMBER OF SECONDARY MECHANISMS OF RECURRENCE, INCLUDING INSUFFICIENT PROSTHETIC SIZE AND OVERLAP, INCOMPLETE FIXATION, AND LIPOMATOUS HERNIA RECURRENCE."
- COFFS HARBOUR PAPER

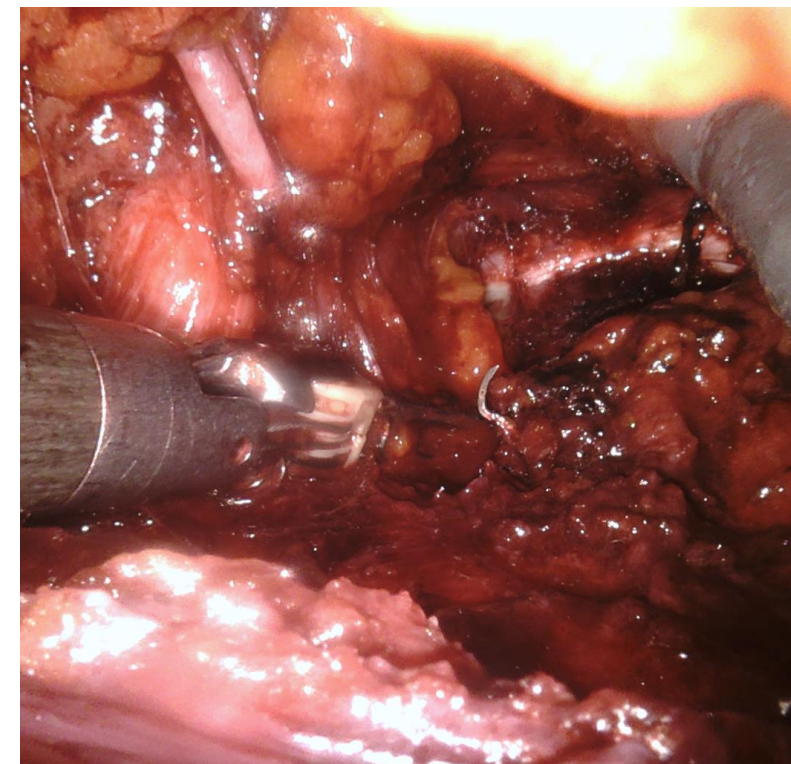
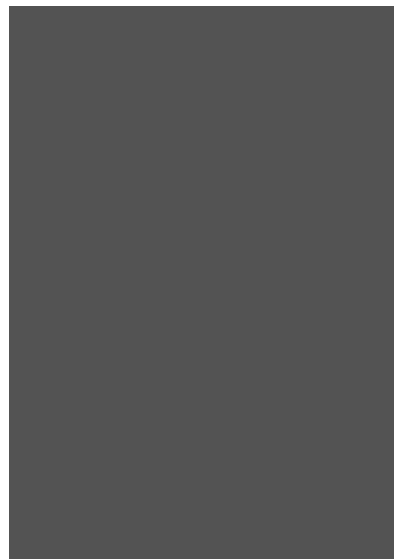
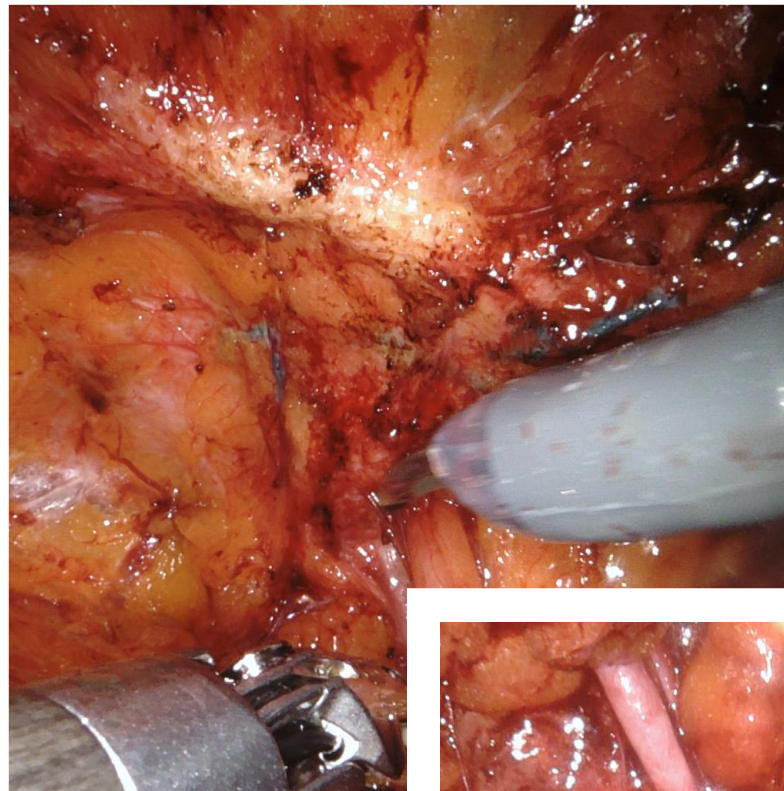
## LONG TERM RECURRENCES

- GENERALLY INDIRECT
- DISPLACED, SHRIVELED OR  
INADEQUATE DISSECTION/MESH

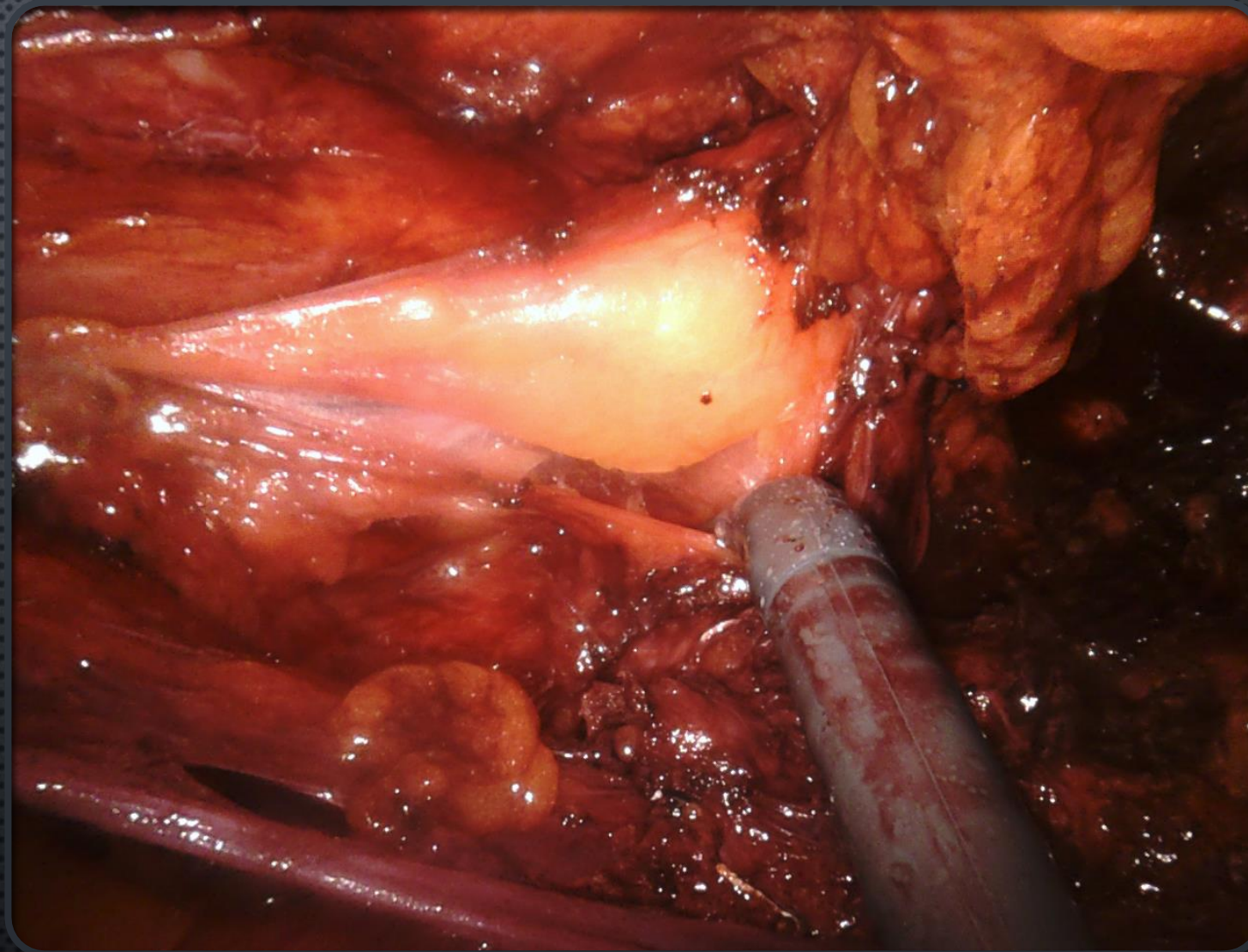


# TOUGH DISSECTION

- BETWEEN FLAP AND MESH, OR
- BETWEEN MESH / PERITONEAL FLAP AND ABDOMINAL WALL/VESSELS

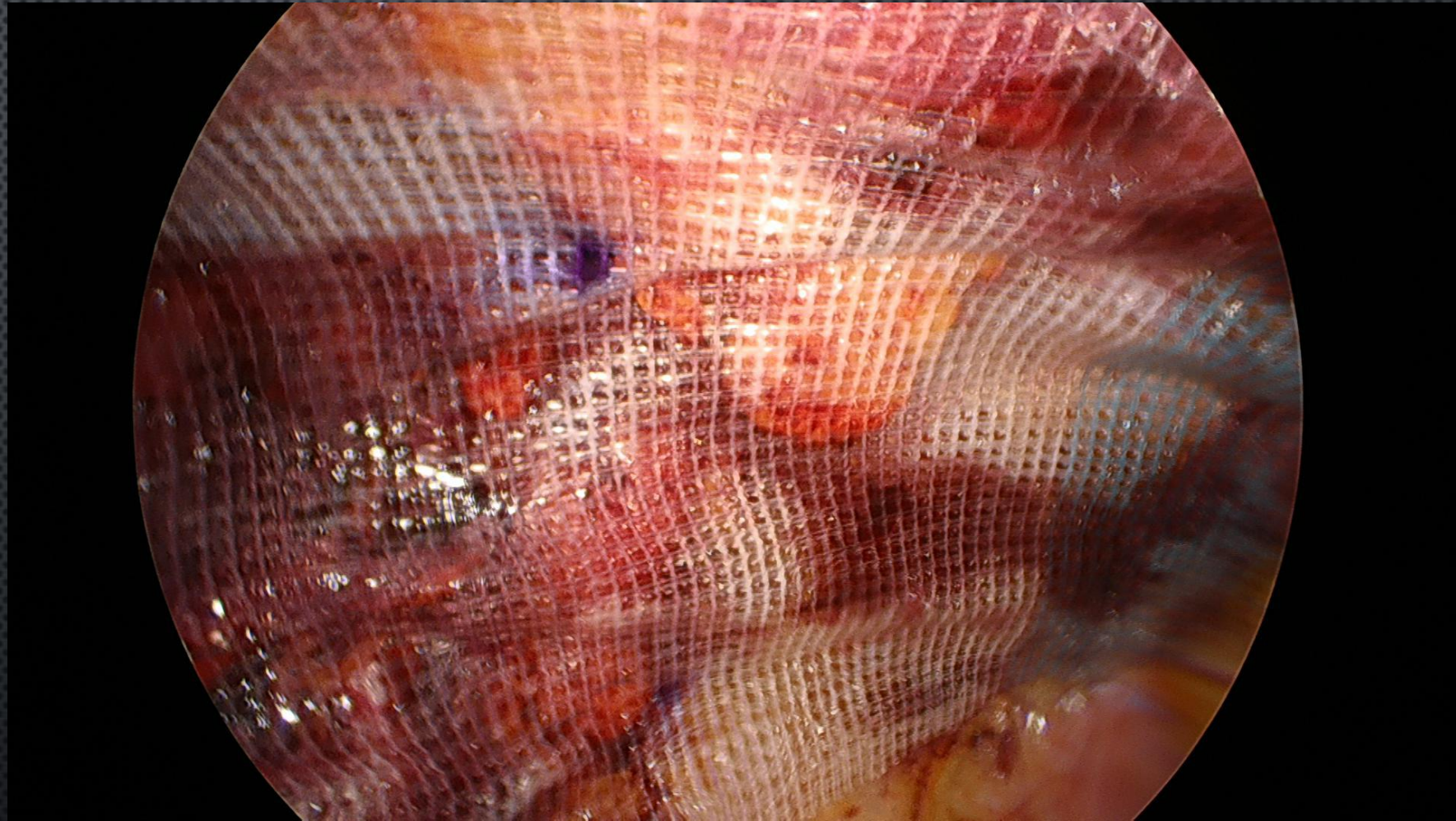


LIPOMA  
COMPONENT

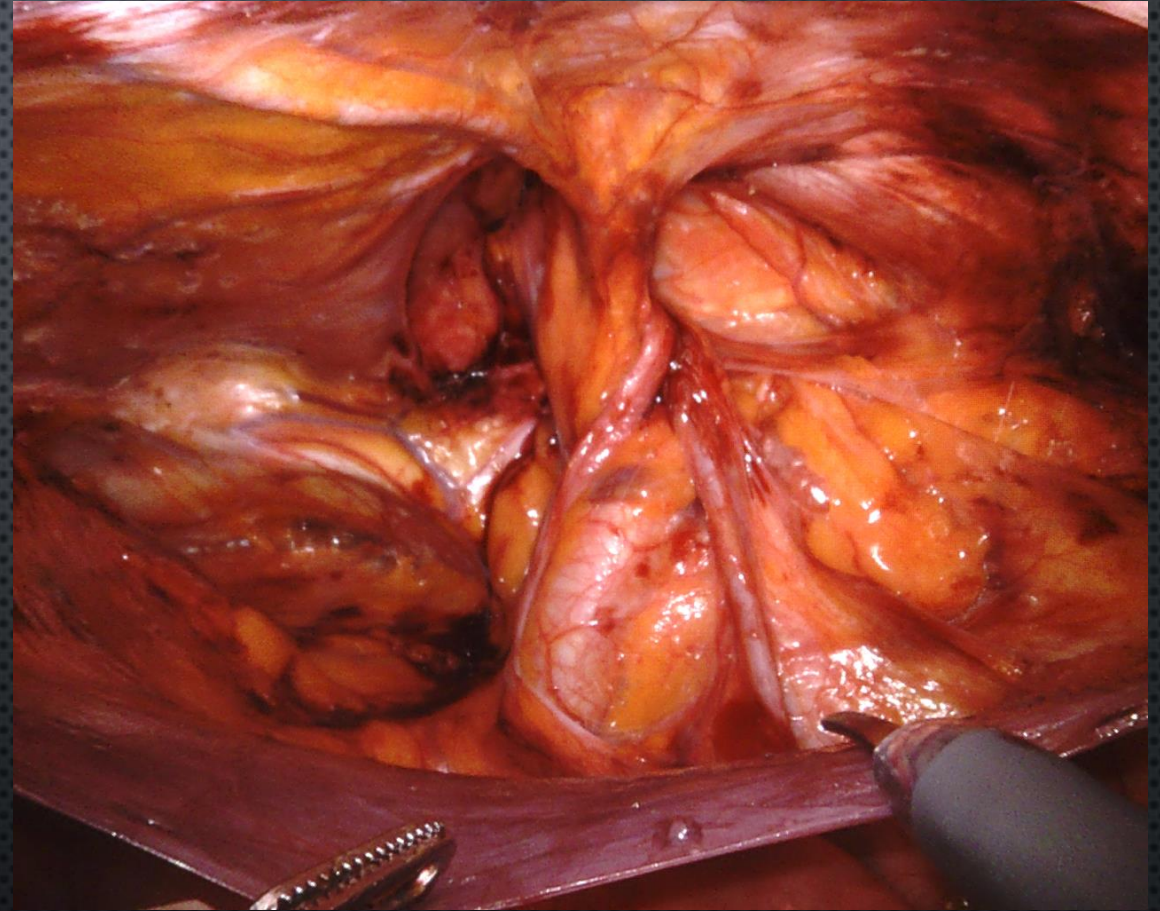
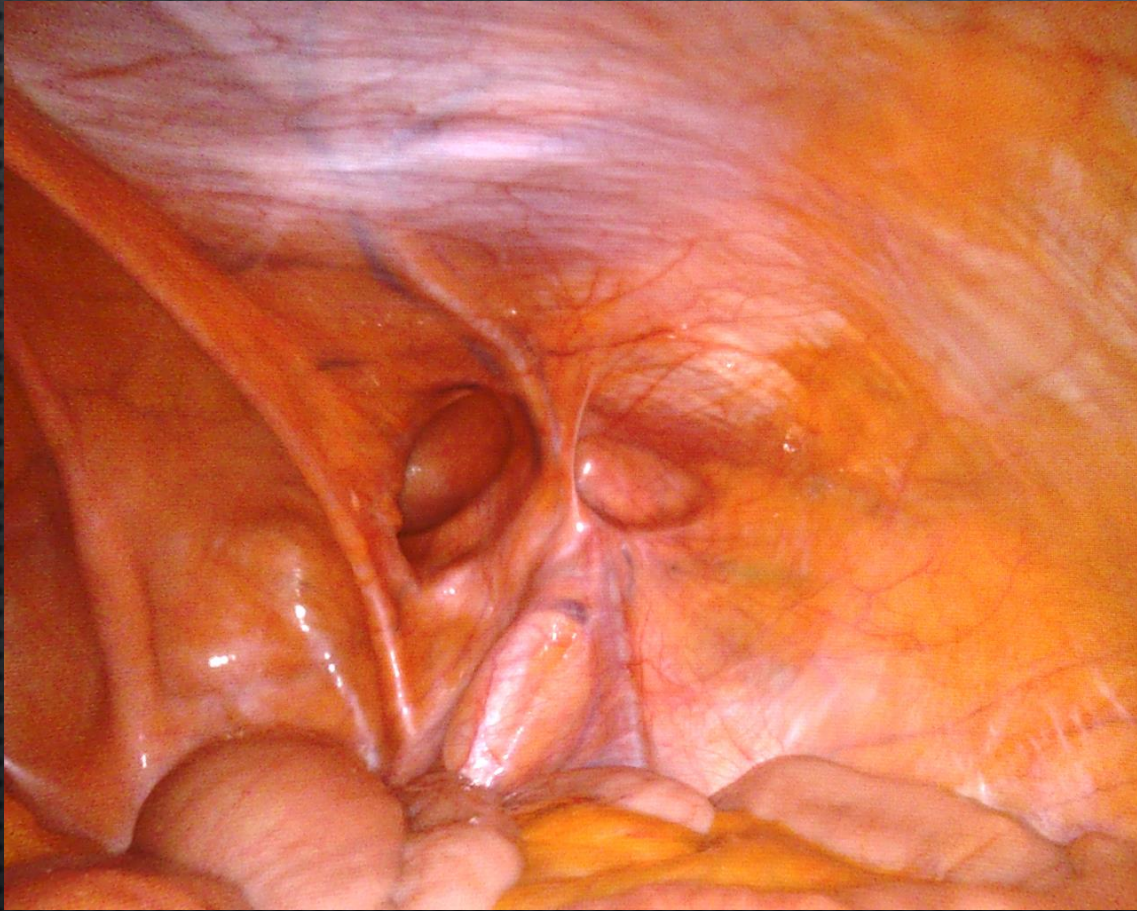


## MESH WITH WIDE EXPOSURE

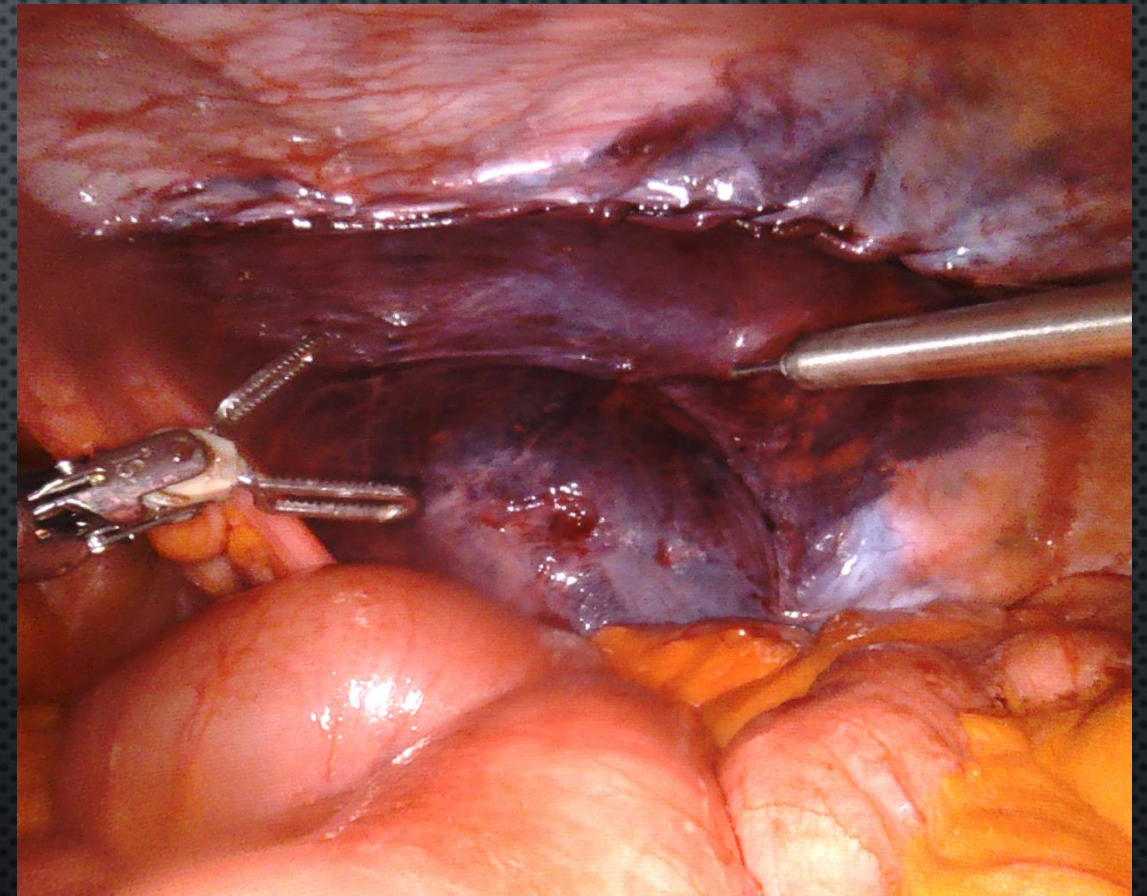
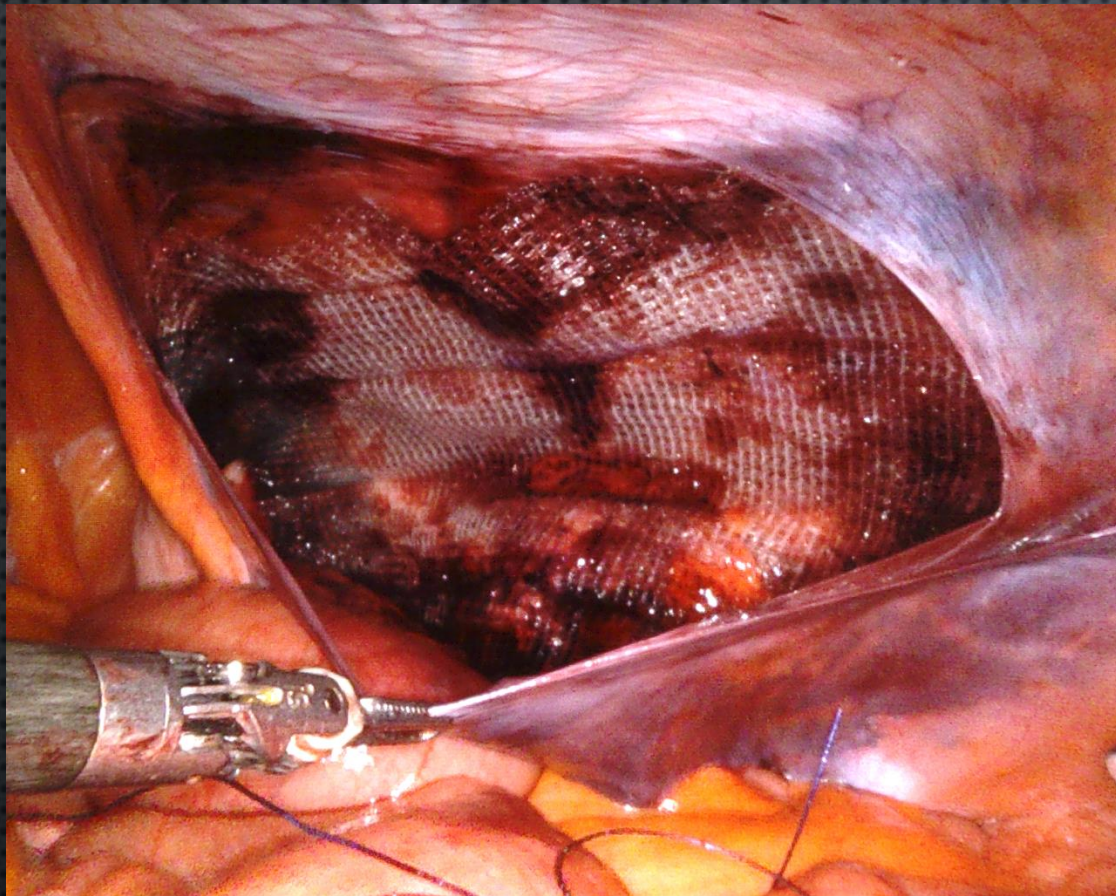
Self-gripping  
Non-penetrating fixation  
No movement  
Equal fixation including  
Triangles doom and pain



# AN APOLOGETIC FOR ROBOT FOR HERNIA



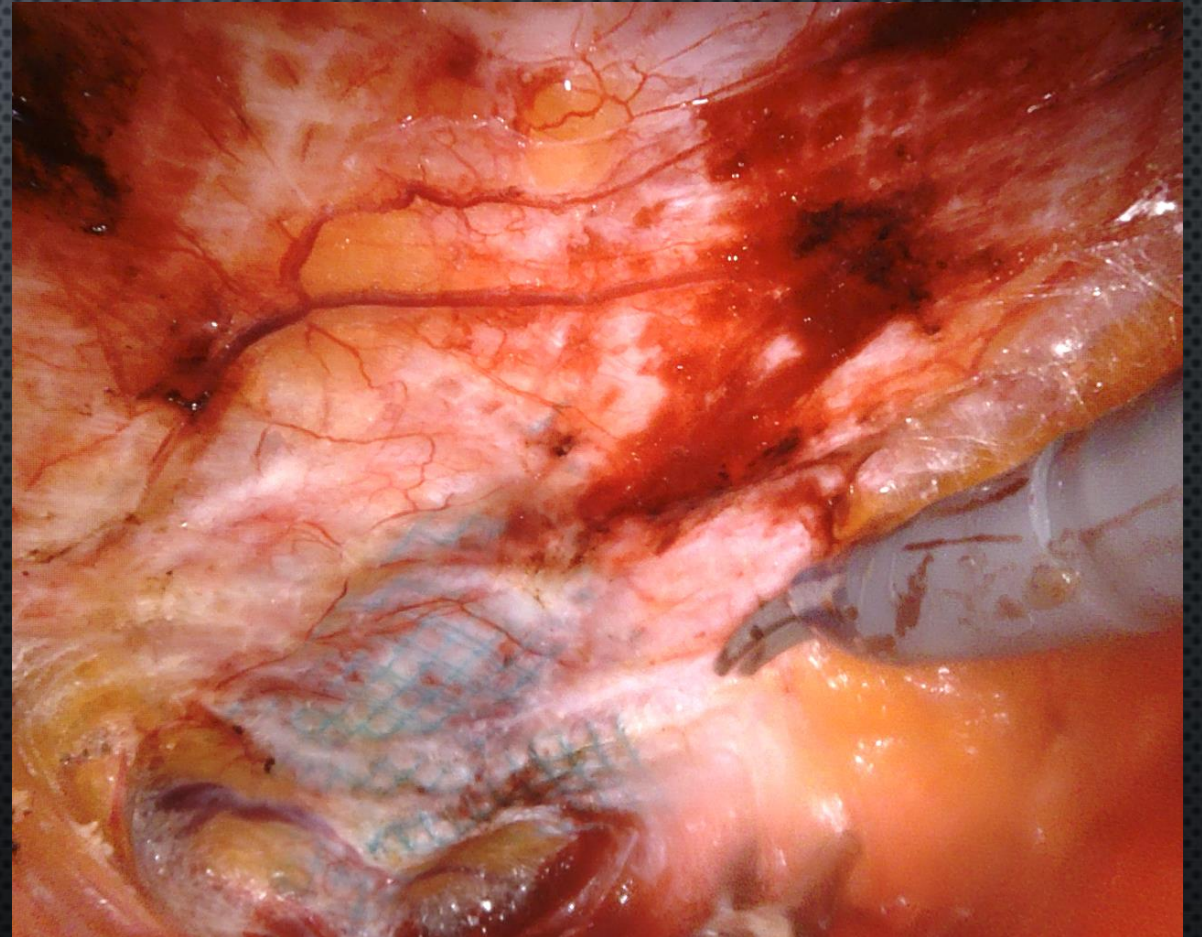
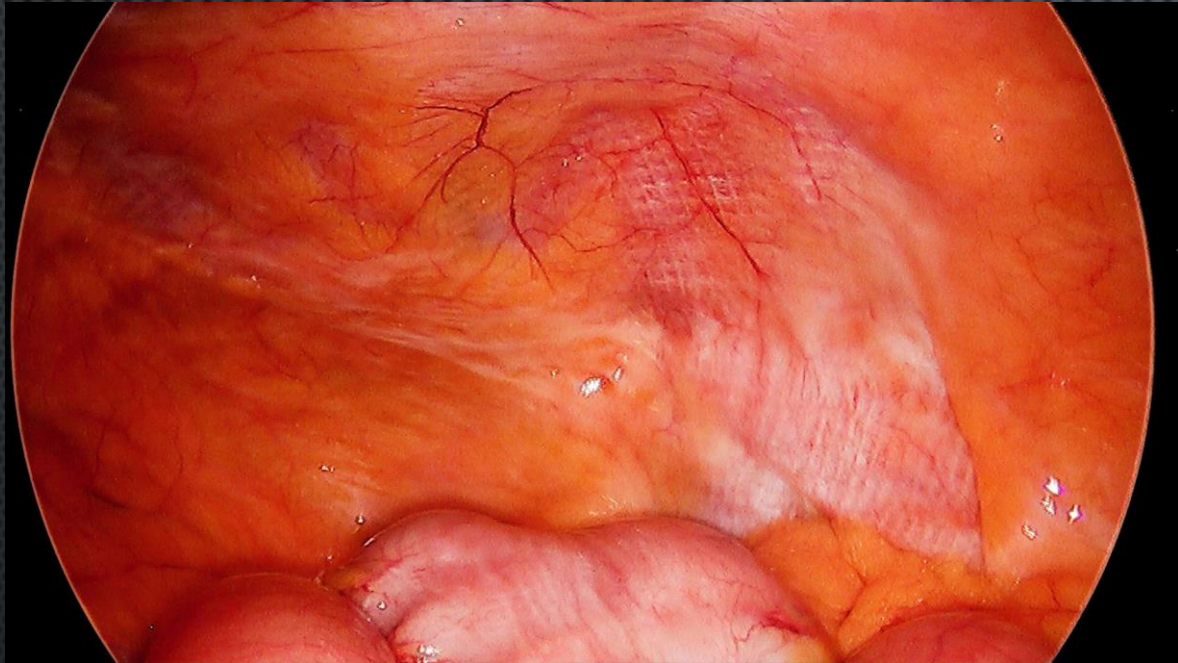
# MESH PLACEMENT AND PERITONEAL FLAP CLOSURE



# MESH – WHAT ABOUT ABC, BBC, NBC?

- CLEAN PROCEDURE
- INERT MATERIAL
- INCORPORATED
- EXPLANT EXTREMELY RARE
- ALL REPAIRS ASSOCIATED WITH A RISK OF CHRONIC PAIN – CONSENT
- I REFER ON THOSE WHO INSIST ON NO MESH AND SEE FOR THEIR RECURRENCE

# HOW DOES IT WORK LONG-TERM?

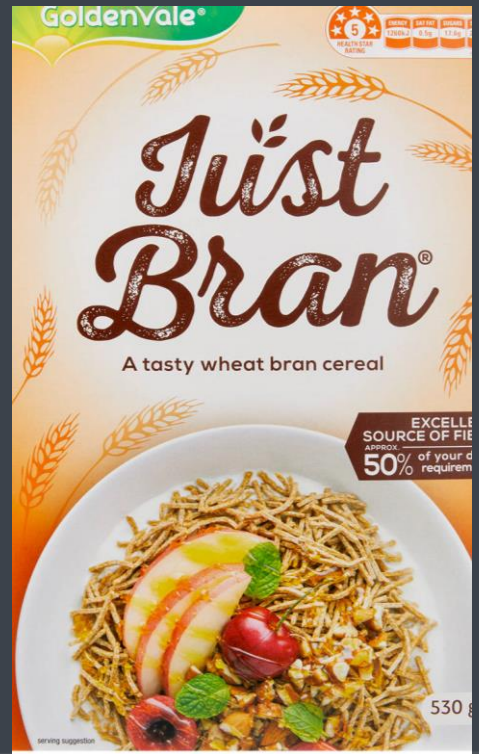


# HAEMORRHOIDS

- ANY PR BLEEDING REFER FOR COLONOSCOPY, LIKE A MACROSCOPIC FIT/FOBT +
- DEFINITIVE MANAGEMENT REQUIRES COLONOSCOPY ANYWAY, AS MALIGNANT CELLS CAN IMPLANT ON THE DENTATE LINE
- INTERNAL CAN'T BE FELT
- SEEN ON PROCTOSCOPY – UNRELIABLE
- DEFINITELY ON RETROFLEXION OF SCOPE IN THE RECTUM
- EXTERNAL HAEMORRHOIDS / PERIANAL HAEMATOMA RED GRAPE RESOLVES TO SKIN TAGS, NO ROLE FOR INCISION OR EXCISION

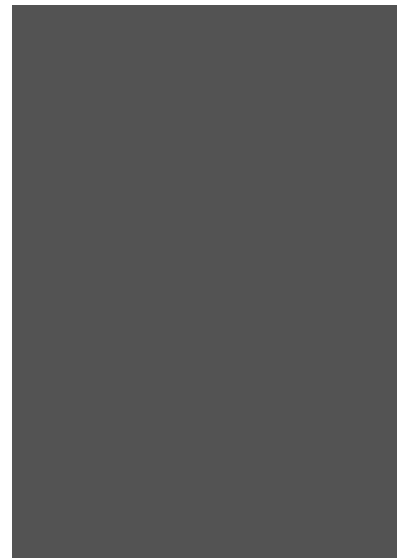
# SO WE DON'T SWEAT IT

- PAINFUL BRPRB – FISSURE UNTIL PROVEN OTHERWISE
- PAINLESS BRPRB – INTERNAL HAEMORRHOIDS LIKELY
  
- AUGMENTED FIBRE AND FLUID INVALUABLE FOR MOST PATIENTS
- AIM 2-2.5 LITRES WATER PER DAY, SMART DEVICE REMINDERS
- BRAN STICK CEREAL BETTER VALUE THAN SUPPLEMENTS, NOT THAT BAD TASTING, MAKES EVERYTHING BETTER



# HAEMORRHOID TREATMENT

- REASSURE WITH COLONOSCOPY
- BANDING ONLY FOR THOSE COMPLIANT WITH FIBRE/FLUID, ONLY FOR GRADE I
- GRADE II MADE WORSE BY BANDING
- GRADE III / IV NEED EXCISION
- LIGASURE 'COLD BIPOLAR' HAS MADE LONGO STAPLED HAEMORRHOIDECTOMY LESS COMMON UNLESS CIRCUMFERENTIAL GRADE IV
- HAL RAR ALSO NOT UNIVERSAL ANSWER TO THE PAIN / URGENCY PROBLEM



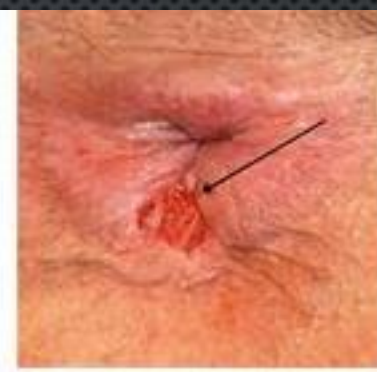
# OPEN HAEMORRHOIDECTOMY

- PROPERLY CONSENTED OFTEN DISSUADES PTS
- INDICATED FOR ANAEMIC PTS ONCE OTHER CAUSES RULED OUT
- DOAC SECONDARY HAEMORRHAGE COINCIDES WITH RECOMMENCEMENT
- SKIN BRIDGES AND SUBMUCOSA PRESERVED
- NO CLOSURE, PUDENDAL BLOCKS, SALT WATER BATHS, ICE GLOVE FINGERS, 6 WEEKS, FISSURE TREATMENT IF PERSISTENT WOUND

# ANAL FISSURE



Chronic  
anal fissure



Acute  
anal fissure

- PINPOINT TENDERNESS POSTERIORLY, THICK PAPER CUT LIKE APPEARANCE +/- SENTINEL TAG
- WON'T TOLERATE A PR EXAM, CLASSICALLY POSTERIOR
- FIND THE TENDER SPOT WITH GLOVED FINGER AND EMPHASISE TOPICAL THERAPY FOCALLY
- RECTOGESIC QID 6 WEEKS; BARRIER, VASOACTIVE, HEADACHE
- OFTEN REPEAT COURSE NECESSARY
- GENTLE HYGIENE
- SPHINCTEROTOMY 2X/YR, SHORT, CONSERVATIVE
- BOTOX \$1000 +, IRONICALLY WORSE BUT TEMPORARY INCONTINENCE

# SUMMARY

- CLINICAL EXAMINATION OVER IMAGING FOR MOST HERNIAE
- CT PRE-OP ASSESSMENT FOR COMPLEX HERNIAE
- MESH INERT AND NOT OPTIONAL
- GOOD QUALITY SURGERY
  
- OUTLET BLEEDING LARGELY NON-OPERATIVE

THANK YOU



Patient name: James METRONORTH DoB: 10 Dec 1939

Request information

Request date 9 Mar 2026

Request type: New referral (selected), Update, Continuation, Request for advice

Reason for referral: New condition requiring specialist consultation (selected), Deterioration in condition, recently discharged from outpatients < 12 months, Other

Provider: QHSR (selected), Private

Consents

Date patient consented to request: 09 Mar 2026

Patient is willing to have surgery if required? Yes, No, Not applicable

Condition and Specialty: general surger (input), HealthPathways (link)

- Suitable for Telehealth? General Surgery, Endocrine surgery (General Surgery) (Adult)
- Are you the patient's usual GP? General Surgery, Hepatobiliary/pancreatic surgery (General Surgery)...
- General Surgery, Upper gastrointestinal surgery (General Surgery) (...)
- General Surgery, Breast - benign and malignant (General Surgery) (A...
- General Surgery, Colorectal bowel disease (General Surgery) (Adult)
- General Surgery, Hernia repair (General Surgery) (Adult)
- General Surgery, Perineal disease and faecal incontinence (General S...
- General Surgery, Skin and soft tissue pathology - benign and malignan...
- Plastic and Reconstructive Surgery, General plastic surgery (Plastic and Reconstructive ...)
- Paediatric Surgery, Lymphadenitis (Paediatric Surgery)
- General Surgery
- Paediatric Surgery
- General Medicine, Pre-operative medical assessment (General Medicin...
- General Medicine

Select the most appropriate condition template for your patient

Patient information

Insurance information

Referring GP's information



Patient name: James METRONORTH DoB: 10 Dec 1939

**Request information**

Request date: 9 Mar 2026

Request type: **New referral** | Update | Continuation | Request for advice

Reason for referral:
 

- New condition requiring specialist consultation
- Deterioration in condition, recently discharged from outpatients < 12 months
- Other

Provider: **QHSR** | Private

**Consents**

Date patient consented to request: 09 Mar 2026

Patient is willing to have surgery if required? Yes | No | Not applicable

Condition and Specialty: General Surgery - Hernia repair (General Surgery) (Adult) [HealthPathways](#)

Suitable for Telehealth? Yes | No

Are you the patient's usual GP? **Yes** | No

**Request recipient**

Service/Location: Please select

Specialist name: |

Organisation details:

General Surgery	REDCLIFFE HOSPITAL	11.7 km	
General Surgery	THE PRINCE CHARLES HOSPITAL	16.7 km	+
General Surgery	CABOOLTURE HOSPITAL	18.7 km	+
General Surgery	ROYAL BRISBANE & WOMEN'S HOSPITAL	22.5 km	+
General Surgery	MATER HOSPITAL	27.0 km	Out of catchment +

Condition specific clinical information

Investigations and imaging

Standard clinical information

Patient information

Insurance information

Referring GP's information

See the services closest to home for your patient (distance as the crow flies)

## General surgery

### Conditions

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the CPC out of scope section.

- [Breast – benign and malignant](#)
- [Colorectal bowel disease](#)
- [Endocrine surgery](#)
- [Hepatobiliary/Pancreatic Surgery](#)
- [Hernia repair](#)
- [Perineal disease and faecal incontinence](#)
- [Skin and soft tissue pathology – benign and malignant](#)
- [Upper gastrointestinal surgery](#)

### Paediatric services

Referrals for children and young people should follow the [Children's Health Queensland referral guidelines](#).

### Emergency department referrals

All urgent cases must be discussed with the on call Surgical Registrar to obtain appropriate prioritisation and treatment. Contact through:

- Royal Brisbane and Women's Hospital (07) 3646 8111
- The Prince Charles Hospital (07) 3139 4000
- Redcliffe Hospital (07) 3883 7777
- Caboolture Hospital (07) 5433 8888

Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

If any of the following are present or suspected, phone 000 to arrange immediate transfer to the emergency department or seek emergent medical advice if in a remote region.

- Suspected strangulation/incarceration or obstruction of any hernia
- Acute, severe abdominal pain with or without associated sepsis
- New onset of obstructive jaundice
- Acute painful perianal conditions
- Acute cholecystitis
- Gallstones with symptoms of cholangitis
- Acute pancreatitis
- Bowel obstruction

### Send referral

Hotline: 1300 364 938

#### Electronic:

[GP Smart Referrals \(preferred\)](#)

[eReferral system templates](#)

Medical Objects ID: MQ40290004P

HealthLink EDI: qldmnhhs

#### Mail:

Metro North Central Patient Intake  
Aspley Community Centre  
776 Zillmere Road  
ASPLEY QLD 4034

### Health pathways ?

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email:

[healthpathways@brisbanenorthphn.org.au](mailto:healthpathways@brisbanenorthphn.org.au)

Login to Brisbane North Health

Pathways:

[brisbanenorth.healthpathwayscommunity.org](http://brisbanenorth.healthpathwayscommunity.org)



## Hernia repair

### Emergency department referrals

All urgent cases must be discussed with the on call Surgical Registrar to obtain appropriate prioritisation and treatment. Contact through:

- Royal Brisbane and Women's Hospital (07) 3646 8111
- The Prince Charles Hospital (07) 3139 4000
- Redcliffe Hospital (07) 3883 7777
- Caboolture Hospital (07) 5433 8888

Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

### Does your patient wish to be referred? ?

### Minimum referral criteria

Does your patient meet the minimum referral criteria?

#### Category 1

Appointment within 30 days is desirable

- Irreducible and partially reducible hernia, of any kind that is suggestive of high risk of strangulation
- Symptomatic femoral hernia
- Episode of irreducibility
- Suspected intermittent bowel obstruction of incarcerated hernia

#### Category 2

Appointment within 90 days is desirable

- Symptomatic hernia of any kind with significant impact on activities of daily living
- Clinical uncertainty
- Incisional hernia
- Asymptomatic femoral hernia

#### Category 3

Appointment within 365 days is desirable

- Reducible asymptomatic hernia

### If your patient does not meet the minimum referral criteria

Consider other treatment pathways or an alternative diagnosis.

If you still need to refer your patient:

Other General surgery conditions

### Send referral

Hotline: 1300 364 938

#### Electronic:

[GP Smart Referrals \(preferred\)](#)

[eReferral system templates](#)

Medical Objects ID: MQ40290004P

HealthLink EDI: qldmnhhs

#### Mail:

Metro North Central Patient Intake  
Aspley Community Centre  
776 Zillmere Road  
ASPLEY QLD 4034

### Health pathways ?

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email:

[healthpathways@brisbanenorthphn.org.au](mailto:healthpathways@brisbanenorthphn.org.au)

Login to Brisbane North Health

Pathways:

[brisbanenorth.healthpathwayscommunity.org](http://brisbanenorth.healthpathwayscommunity.org)

### Locations

[Caboolture Hospital](#)

[Redcliffe Hospital](#)

[Royal Brisbane and Women's Hospital](#)

[The Prince Charles Hospital](#)

### Resources



# Hernia in Adults

## Background

About hernia in adults

## Assessment

- Take a history and check:
  - features of the lump or swelling (if present).
  - associated signs or symptoms, including features suggesting complications.
  - impact on activities of daily living (ADL).
  - co-morbidities which may increase perioperative risk e.g., cardiovascular disease, frailty, COPD/asthma, anaemia, chronic kidney disease (CKD).
- Consider risk factors for abdominal hernias (new or recurrent).
- Examine the patient:
  - Check height and weight and calculate BMI.
  - Examine the abdominal wall with the patient both lying and standing.
  - Note reducibility (avoid describing the hernia as incarcerated as this is an ambiguous term which may imply simple irreducibility or strangulation):
    - Reducible
    - Irreducible without strangulation
    - Strangulated
- Consider type of hernia:
  - Inguinal
  - Ventral
  - Incisional
  - Femoral
- Consider imaging (abdominal ultrasound or CT) in patients with suggestive symptoms without a palpable hernia or in patients with difficult physical examination e.g., obese.

## Management

- Request acute general surgery assessment if signs of strangulation or obstruction.
- Consider requesting non-acute general surgery assessment for all other hernias, particularly if hernia is:
  - irreducible or difficult to reduce.
  - symptomatic.
  - femoral (regardless of symptoms – higher risk of strangulation).
- In all patients, optimise management of any co-morbidities e.g., hypertension, diabetes, COPD/asthma, frailty.
- Address relevant lifestyle factors.
- Consider requesting allied health support or lifestyle modification programs to support patients in making lifestyle changes, using Chronic Condition Management items if eligible.
- If patient very frail or with very high perioperative risk of complications (e.g., complex or multiple co-morbidities):
  - consider conservative management if minimally symptomatic.
  - seek general surgery advice if femoral hernia due to higher risk of strangulation.

# Haemorrhoids

See also Colorectal Symptoms.

## Background

About haemorrhoids

## Assessment

- Consider haemorrhoids in patients presenting with:
  - rectal bleeding. If isolated rectal bleeding, follow the Colorectal Symptoms pathway.
  - perianal discomfort, anal pruritus, mucous discharge, or soiling.
  - intermittent or persistent palpable lump after defecation.
  - pain is uncommon but may be present if strangulated internal haemorrhoid, acute perianal haematoma, or fissures.
- Consider risk factors for haemorrhoids.
- Check for other symptoms suggestive of serious pathology (e.g., inflammatory bowel disease (IBD), colorectal cancer (CRC)) and risk factors for CRC.
- Examine the patient – follow recommended protocol and consider a chaperone.
  - Look for signs of anaemia (e.g., pallor, tachycardia, heart murmur).
  - Palpate abdomen for focal tenderness, masses, or organomegaly.
  - Palpate for regional adenopathy.
  - Inspect the perianal area.
  - Perform a rectal examination.
  - Record any lesions relative to the patient's position (e.g., anterior, posterior, left or right).
  - Record the grade if internal haemorrhoids.
- Consider differential diagnosis. See also the Colorectal Symptoms pathway.
- Consider additional investigations, particularly if 40 years or older, haemorrhoids not confirmed on examination, other symptoms suggestive of serious pathology or with risk factors for CRC.
  - Baseline FBC, E/LFTs and iron studies.
  - Immunochemical faecal occult blood test (iFOBT) in patients with symptoms other than overt bleeding (particularly if of screening age for CRC), or if considering referral for colonoscopy as this will assist with triage category.
  - ESR/CRP and faecal calprotectin if IBD possible.

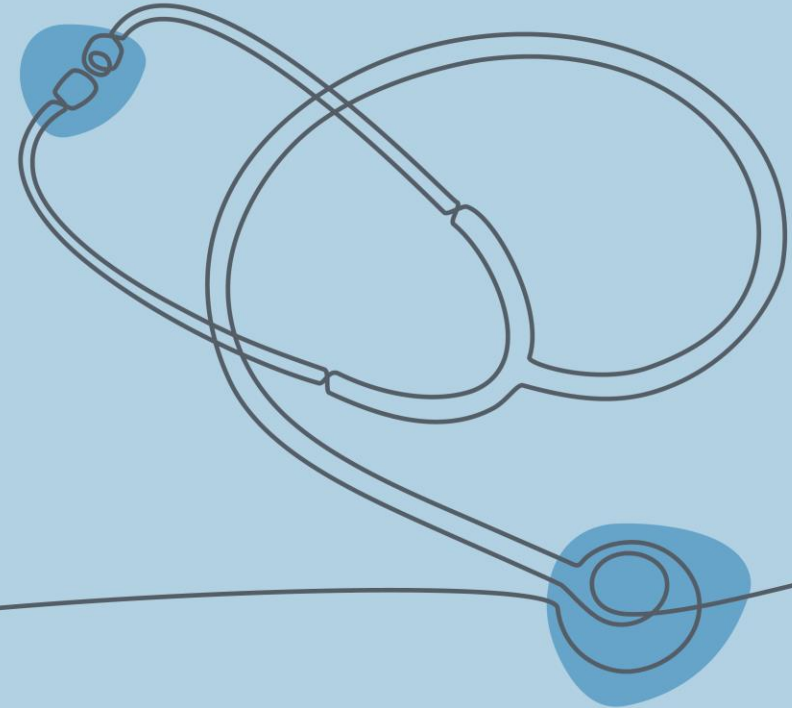
## Management

- Manage perianal haematomas.
  - If acute or significantly symptomatic, consider aspiration with large bore needle (if within 24 hours of onset), or incision and drainage (under local anaesthetic).
  - If subacute (> 5 days), resolving, or mildly symptomatic, manage conservatively.
- Manage haemorrhoids.
  - Recommend general measures to help relieve symptoms and prevent recurrence.
  - Treat discomfort with topical preparations:
    - Soothing haemorrhoidal preparations
    - Compound haemorrhoidal preparations
  - If constipated, consider stool softeners or bulk-forming laxatives. See also Constipation in Adults.
  - Consider requesting non-acute general surgery assessment for procedural or surgical management if:
    - persistent symptoms that have not responded to conservative management

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



## Oncology approaches: Hormonal therapy & immunotherapy

Dr Darshit Thaker | Senior Staff Specialist, Cancer Care, RBWH & Caboolture



Metro North Health

# Oncology approaches: Hormonal therapy and Immunotherapy

Dr. Darshit A Thaker

Senior Staff Specialist, Medical Oncology

RBWH, CBH, MNHHS

CABOOLTURE PRIVATE HOSPITAL

Senior Lecturer, UQ Medical School

# Case JB

- 86 yr old Male
- Metastatic Prostate Cancer with PSMA PET avid retroperitoneal lymphadenopathy
- Presented with back pain and mild LUTS
- Other medical conditions: diabetes mellitus type 2, heart failure, dyslipidaemia, polymyalgia rheumatica, pacemaker in place, atrial fibrillation non-valvular, GORD, Depression.
- Medications: Venlafaxine, Paracetamol 665mg, Oxycodone/Naloxone 10/5mg/BD, Rivaroxaban, Sacubitril/Valsartan, Gliclazide, Bisoprolol, Rosuvastatin, Linagliptin, Furosemide, Metformin, Dapagliflozin and Glargine insulin.

- Lives with wife
- Walks with 4WW
- G8 8/17
- CGA showed Rockwood FI 0.6 s/o moderate Frailty
- ECOG 2

# Treatment options

- Androgen Deprivation Therapy (ADT)
- Chemotherapy
- Androgen Receptor Pathway Inhibitors (ARPI)
  
- HOW SHOULD WE TREAT THIS PATIENT?

# ANDROGEN DEPRIVATION THERAPY (ADT)

- Indications:
  - Low volume disease or PSA only progression
  - With adjuvant or neoadjuvant chemotherapy and/or ARPI
  - Not fit for more aggressive therapy
- Different types:
  - medications (tablets or injections) that reduce the production of testosterone.
  - Surgical removal of the testes (orchidectomy) to stop the production of androgens.
- Injections include (GnRh agonist and antagonist):
  - Goserelin
  - Leuporelin
  - Triptorelin
  - Degarelix
- Tablets include (anti-androgens):
  - Bicalutamide
  - Cyproterone acetate

- Patient was started on Bicalutamide, Goserelin was commenced after few weeks
- WHAT SHOULD WE CAREFUL ABOUT?
- Flare reaction
- Side effects

- Osteoporosis
- Changes in body appearance, physical strength, mood and cognition
- Increased risk of heart and endocrinologic disease
- Sexual dysfunction: reduction or loss of libido, impotence, infertility
- Hot Flashes and Fatigue

# Osteoporosis and Bone Fractures

- ADT increases bone turnover, decreases bone mineral density, and increases the risk of bone fractures
- Loss of bone mineral density usually after six to nine months of ADT, and longer therapy confers a higher risk.
- Osteoporotic skeletal fractures occur in up to 20 percent of males within five years of starting ADT.
- Other contributing factors: reduced intake of calcium, low vitamin D levels, alcohol abuse, smoking, and chronic use of corticosteroids.
- BMD scan once every two years
- Calcium/Vit D supplements, Bisphosphonates

# EMOTIONAL AND COGNITIVE CHANGES

- Increased incidence of depression, anxiety and mood fragility
- Some evidence of ADT accelerating development of dementia
- A meta-analysis of 14 studies of males with prostate cancer who did or did not receive ADT. The risk of new-onset dementia or Alzheimer disease modestly but significantly higher in males receiving ADT compared with those who did not (HR 1.21, 95% CI 1.11-1.33, and HR 1.16, 95% CI 1.09-1.24).
- Longer exposure (>12 months) increase the risk further

# BODY COMPOSITION AND METABOLISM

- Gynaecomastia and thinning of body hair (increased ratio of estrogen to androgen activity)
  - Loss of lean body mass (Sarcopenia)
  - Increased body fat in subcutaneous adipose tissues
  - Decreased muscle strength
  - Decreased insulin sensitivity leading to Hyperglycemia and increased risk of developing diabetes
  - Increase in serum LDL-cholesterol and triglycerides

# Cardiovascular Risk

- Meta-analysis on observational data from eight large studies (n=415,000) patients managed with any form of ADT (GnRH agonist, orchiectomy, oral antiandrogens), the relative risk for any type of CVD was 1.38 (95% CI 1.29-1.48).
- Increased risk in patients with pre-existing CVD and other contributing factors
- **STAMP screening question:** Stroke; Transient ischemic attack; Abdominal aortic aneurysm or other aortic disease; Myocardial infarction or angina; Peripheral vascular disease
- Careful decision making, Geriatrician consultation and Close monitoring
- HERO study: Less cardiac risk with Degarelix (GnRh anta-gonist) compared to other ADTs

# Thromboembolic events

- Increased risk of deep venous thrombosis, pulmonary embolus, arterial embolism.
- SEER database study of 155,000 men, significantly increased risk of thromboembolic events in Men on ADT compared with those not on ADT(15 versus 7 percent, HR 1.56)
- Watchful monitoring and proactive investigation is paramount
- Patients on Anti-coagulants should continue

# Sexual Dysfunction

- Loss of Libido and erectile dysfunction occur within few months of starting ADT
- Reduction in size of penis and testicles follow
- Recovery of sexual function usually happen after discontinuation of ADT
- Couple counseling and well informed decision making is necessary

# Other side effects

- Hot flashes
- Insomnia
- Nausea
- Excessive sweating
- Fatigue
- Anemia, usually mild to moderate, normochromic, and normocytic

# Hormonal therapy for Breast cancer

- Tamoxifen: Pre-menopausal patients. Main side effects: DVT/PE, Hot flashes, mood swings, arthralgia, thinning of hair, weight gain, small risk of uterine cancer
- Aromatase inhibitors: Post-menopausal patients. Main side effects: Arthralgia, mood swings, Osteoporosis, hot flashes, weight gain, thinning of hair

# Risk Reduction Strategies

- High risk patients starting on hormonal therapy, should be followed and managed by a multidisciplinary team and treated according to best practices including:
  - If lipids are abnormal, use statin therapy to lower low-density lipoprotein cholesterol.
  - If blood pressure exceeds goal based on cardiovascular risk, add anti hypertensive therapy
  - If fasting glucose is elevated and hemoglobin A1c is abnormal, approaches to lowering glucose are appropriate.
  - For mood and cognition, needs formal assessment and appropriate medications
  - For Hot flashes, venlafaxine, desvenlafaxine, clonidine, Vioza etc
  - Patients with known CVD should take aspirin (generally 81 mg/day) unless contraindicated.
  - Patients who continue to smoke should be referred to smoking cessation programs.
  - Structured exercise program: Moderate exercise, to include three or more hours of aerobic activity weekly, plus resistance training and weight-bearing exercises

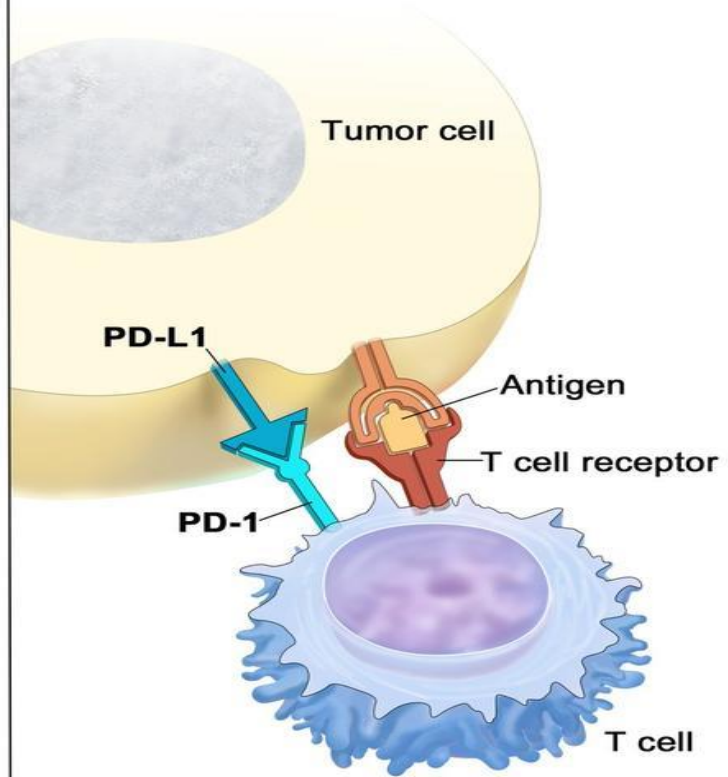
# Case GW

- 82 yr old Male,
- Presented to GP with couple of episodes of hemoptysis and progressive fatigue, ECOG 2 with few comorbidities
- Imaging study showed 6cm mass in left lung with multiple nodules in right lung and mediastinal LN
- Bronchoscopy and Biopsy confirmed Metastatic lung adenocarcinoma.
- EGFR/MET/RET/ROS1/ALK/NTRK mutations negative
- PDL-1 receptor expression on tumour cells >90%
- Patient not keen for chemotherapy but open for other options including Immunotherapy (recently found out on News!)

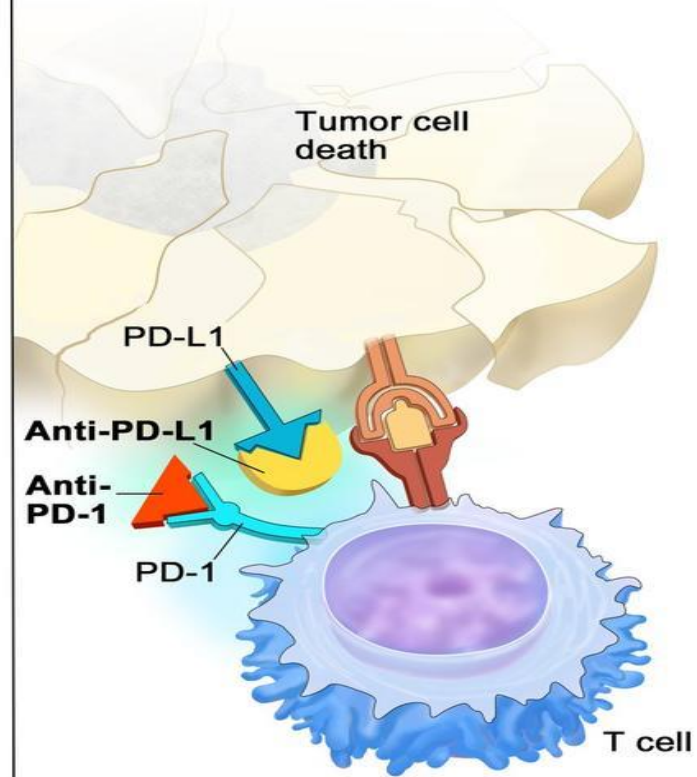
# Immunotherapy

- Immune-checkpoint inhibitors (ICIs): anti-cytotoxic T lymphocyte antigens (CTLA), anti-programmed cell death 1 (PD-1), anti-programmed cell death ligand 1 (PD-L1) antibodies and CAR-T cell therapy.
- PD-1 inhibitors: Nivolumab, Pembrolizumab, Cemiplimab
- PDL-1 inhibitors: Atezolizumab, Durvalumab, Avelumab
- CTLA-4 inhibitors: Ipilimumab
- CTLA-3 inhibitors: Relatinib
- CAR-T cell therapy: Groundbreaking immunotherapy by genetically re-engineered patient's own T-cells to produce CARs (chimeric antigen receptors) on their surface, allowing them to bind cancer cells and kill them.

**PD-L1 binds to PD-1 and inhibits T cell killing of tumor cell**



**Blocking PD-L1 or PD-1 allows T cell killing of tumor cell**



# Immunotherapy treatment in cancer

- Almost every cancer
- Melanoma
- Lung cancer
- Renal/urothelial cancer
- MMR Deficient Colorectal cancer/ upper GI cancers
- TN Breast cancer
- Hepatocellular Cancer

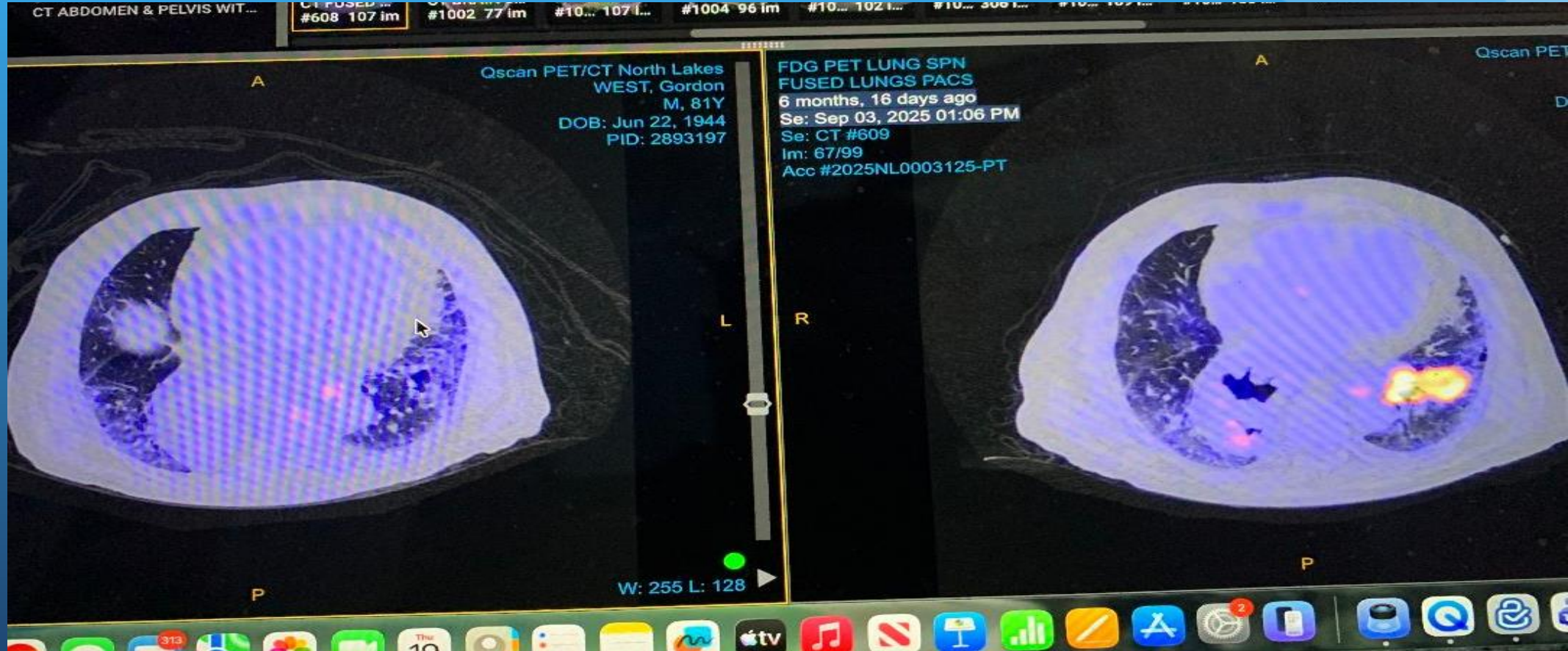
- Palliative intent
- Adjuvant
- Neoadjuvant

# Side effects

- Skin : Rash, vasculitis
- Bowel: Colitis
- Liver: Hepatitis
- Lungs: Pneumonitis
- Endocrine: Thyroiditis, Hypophysitis, adrenal insufficiency, Type I DM
- Rheumatological: Arthritis, Hyper activation of pre-existing auto immune conditions (RA, Lupus etc)
- Neurological: Encephalitis, aseptic meningitis, transverse myelitis, myasthenia gravis, peripheral neuropathy

# Side effect management

- Rule out infective cause for the symptoms
- Steroids mainstay of the treatment
- Low dose immunosuppressive therapy (MM, Methotrexate etc) for refractory cases
- Dose reduction doesn't improve the side effects
- Dose omission until improvement
- Some data supports reduce efficacy of IO with high dose of steroids







Patient name: James METRONORTH DoB: 10 Dec 1939

Request information

Request date: 9 Mar 2026

\* Request type: **New referral** | Update | Continuation | Request for advice

\* Reason for referral:  New condition requiring specialist consultation  
 Deterioration in condition, recently discharged from outpatients < 12 months  
 Other

\* Provider: **QHSR** | Private

Consents

\* Date patient consented to request: 09 Mar 2026

\* Patient is willing to have surgery if required? Yes | No | Not applicable

\* Condition and Specialty:  [HealthPathways](#)

Suitable for Telehealth?

\* Are you the patient's usual GP?

Request recipient:

\* Service/Location:

Specialist name:

Organisation details:

Investigations and imaging:

Standard clinical information:

Patient information:

Insurance information:

Referring GP's information:

Supporting documentation:

Select the most appropriate condition template for your patient



Patient name: James METRONORTH DoB: 10 Dec 1939

Request information

Request date: 9 Mar 2026

Request type: **New referral** | Update | Continuation | Request for advice

Reason for referral:
   
 New condition requiring specialist consultation
   
 Deterioration in condition, recently discharged from outpatients < 12 months
   
 Other

Provider: **QHSR** | Private

Consents

Date patient consented to request: 09 Mar 2026

Patient is willing to have surgery if required? Yes | No | Not applicable

Condition and Specialty: Medical Oncology [HealthPathways](#)

Suitable for Telehealth? Yes | No

Are you the patient's usual GP? **Yes** | No

Request recipient

Service/Location: Please select

Specialist name			
Organisation details	Medical Oncology	REDCLIFFE HOSPITAL	11.7 km
	Medical Oncology	THE PRINCE CHARLES HOSPITAL	16.7 km
	Medical Oncology	CABOOLTURE HOSPITAL	18.7 km
	Breast	ROYAL BRISBANE & WOMEN'S HOSPITAL	22.5 km
	Medical Oncology	ROYAL BRISBANE &	22.5 km

See the services closest to home for your patient (distance as the crow flies)

# Metro North Health

- [Home](#)
- [Refer your patient](#)
- [Hospitals & services](#)
- [Health professionals](#)
- [Research](#)
- [Get involved](#)
- [Careers](#)
- [About us](#)

[Home](#) / [Refer your patient](#) / Cancer Care Services

## Cancer Care Services

### Conditions

- [Brain tumours](#)
- [Breast Cancer](#)
- [Cervical Cancer](#)
- [Colorectal Cancer](#)
- [Endometrial Cancer](#)
- [Gastro-Oesophageal Cancer](#)
- [Head and Neck Cancer](#)
- [Hepatocellular \(Liver\) Cancer](#)
- [Lung Cancer](#)
- [Melanoma](#)
- [Ovarian Cancer](#)
- [Pancreatic-biliary Cancer](#)
- [Prostate Cancer](#)
- [Sarcoma \(Bone or Soft tissue\) Cancer](#)
- [Testicular Cancer](#)
- [Thyroid Cancer](#)

### Paediatric services

Referrals for children and young people should follow the [Children's Health Queensland referral guidelines](#).

### Emergency department referrals

Phone on call Oncology Registrar and send patient to the Department of Emergency Medicine at their nearest hospital.

Contact on call Oncology Registrar through:

- Royal Brisbane & Women's Hospital (07) 3646 8111
- The Prince Charles Hospital (07) 3139 4000
- Redcliffe Hospital (07) 3883 7777
- Caboolture Hospital (07) 5433 8888

View the [emergency contact details for referring General Practitioners \(PDF\)](#).

If any of the following are present or suspected, phone 000 to arrange immediate transfer to the emergency department or seek emergent medical advice if in a remote region.

- Symptoms of airway obstruction, SVC obstruction
- Severe gastrointestinal (GI) bleeding
- Bowel obstruction
- Febrile neutropenia
- Symptomatic hypercalcaemia
- Other organ failure/dysfunction
- Uncontrolled and disabling pain
- Massive haemoptysis and/or stridor
- Neurological signs suggestive of brain metastases or cord compression
- Very high calcium (3.0mmol/L)
- Severe dysphagia with dehydration
- Biopsy proven small cell lung cancer
  - Patients with symptoms of shortness of breath, deteriorating organ function
- Metastatic germ cell tumour (GCT) confirmed (biopsy) or suspect (tumour markers)
- Patients with severe symptoms, organ failure or life threatening complications
- Highly aggressive lymphoma
  - Burkitt's lymphoma
  - Lymphoblastic lymphoma
- Acute leukaemia

### Send referral

Hotline: 1300 364 938

Electronic:

- [GP Smart Referrals \(preferred\)](#)
- [eReferral system templates](#)
- Medical Objects ID: MQ40290004P
- HealthLink EDI: qldmnhhs

Mail:

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### Health pathways

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Login to Brisbane North Health

Pathways:

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### Locations

#### Medical oncology

[Redcliffe Hospital](#)

[Royal Brisbane and Women's Hospital](#)

[The Prince Charles Hospital](#)

#### Radiation oncology

[Caboolture Hospital](#)

[Redcliffe Hospital](#)

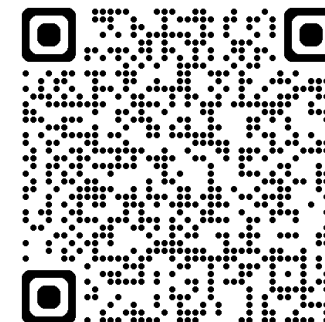
[Royal Brisbane and Women's Hospital](#)

[The Prince Charles Hospital \(consult only\)](#)

#### Haematology

[Royal Brisbane and Women's Hospital](#)

[The Prince Charles Hospital \(consult only\)](#)



ENT Head and Neck Surgery ▾

General Surgery ▾

Neurosurgery ▾

Ophthalmology ▾

Oral and Maxillofacial Surgery ▾

Orthopaedics / Musculoskeletal ▾

Surgery - Child ▾

Plastic and Reconstructive Surgery ▾

Urology ▲

Benign Prostatic Hyperplasia

Haematospermia

Haematuria in Adults

Postoperative Urologic  
Complications

Prostate Cancer ▲

Prostate Cancer - Screening

Prostate Cancer - Diagnosis

Prostate Cancer - Management

Renal Mass (Tumours or Cysts)

Renal Colic and Urolithiasis

Scrotal Pain, Lumps, or Swelling in  
Adults

Urethral Catheterisation

Urinary Incontinence in Women

Home / ... / Prostate Cancer / Prostate Cancer - Management

## Prostate Cancer - Management

This pathway is about the general practitioner's role in management of prostate cancer after diagnosis, alongside specialist treatment. See also [Prostate Cancer - Screening](#) and [Prostate Cancer - Diagnosis](#).

### Background

[About prostate cancer management](#) ▾

### Management

1. Assist the patient to make a decision about prostate cancer treatment:

- Consider [patient factors](#) ▾ and [disease factors](#) ▾.
- Discuss treatment options with the patient and whether treatment is intended to be curative (some patients [may not be suitable for curative intervention](#) ▾). Consider:
  - [Watchful waiting](#) ▾
  - [Active surveillance](#) ▾
  - [Surgery](#) ▾
  - [Radiotherapy](#) ▾
  - [Treatment of advanced prostate cancer](#) ▲

#### Treatment of advanced disease

Early referral to palliative care should be considered for all patients with advanced prostate cancer.

- Advanced prostate cancer is generally managed with one or a combination of [androgen deprivation therapy](#) ▾, chemotherapy, and other drugs (bisphosphonates, RANK Ligand inhibitors).
- Treatment options for symptom palliation include analgesics, chemotherapy, palliative radiotherapy, surgery, and bisphosphonates.

# HealthPathways for different cancers

[Home](#) / [Medical](#) / [Oncology](#) / [Optimal Cancer Care Pathways](#)



## Optimal Cancer Care Pathways

[About optimal cancer care pathways](#) ▾

### Available HealthPathways

The use of localised cancer pathways is recommended as these have been developed in collaboration with Brisbane North PHN and Metro North Hospital and Health Service. Localised cancer pathways include:

- [Breast Symptoms and Breast Cancer](#)
- [Colorectal Symptoms](#)
- [Prostate Cancer - Diagnosis](#)
- [Skin Cancer](#)
- [Suspected Lung Cancer](#)

### Cancer Council clinical guidelines and care pathways

In the absence of localised cancer HealthPathways, it is recommended that the [Cancer Council Optimal Care Pathways](#) are followed (also available in quick reference guides).

The Cancer Council also provides a set of [clinical guidelines](#).

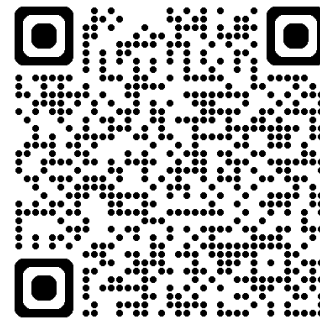
See also Cancer Council Queensland – [Health Professionals](#).

### Consumer information

A range of brief [consumer guides](#) by cancer type are available in several languages and can be imported into Best Practice or Medical Director by using [these instructions](#).

See also Cancer Council Queensland resources:

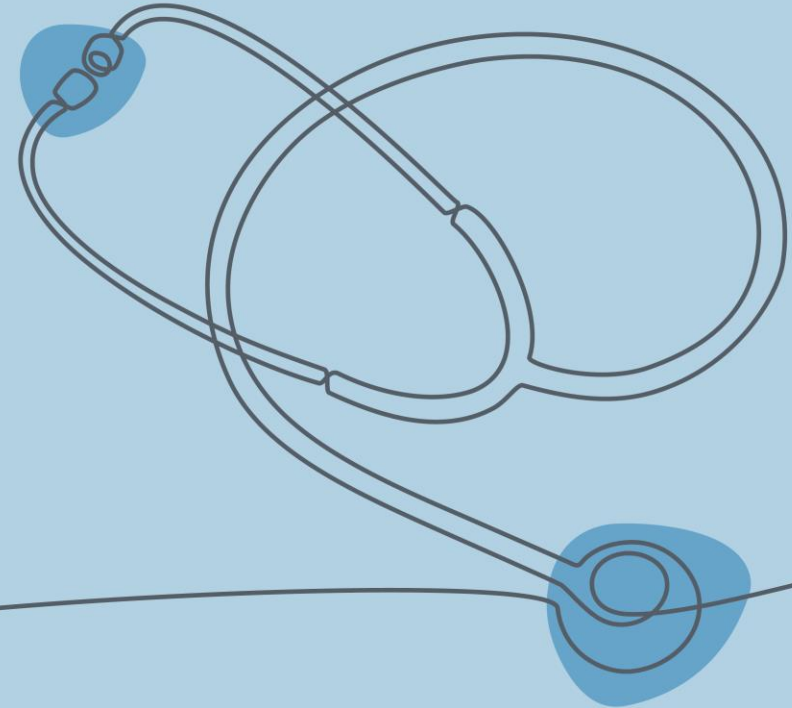
- [Support Services – How We Can Help](#): Phone 13-11-20
- [Information – Coping with Cancer](#)



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## How to: Request for Advice

Dr James Martin | GP Liaison Officer, Metro North Health & Brisbane North PHN





# METRO NORTH Clinical Advice

Providing local GPs with advice from specialist clinicians via

1. Phone 1800 569 099  
Monday – Friday 8:30am – 4:00pm
2. Written requests (GP Smart Referrals)

See current specialties offering non urgent clinical advice ▶



Metro North  
Health



Queensland  
Government

**GP Smart Referrals resource:**  
**How to: Request for Advice (RFA)**  
 GP Smart Referrals (GPSR) users can request advice from Metro North and other Hospital and Health Services (GPSR) for response. [Metro North GP Advice Program](#) | [Metro North Health](#) (Section 2) lists specialties and catchments for Metro North services currently accepting Request for Advice. This page is continuously updated as new services come onboard to offer advice. Phone advice is also offered for a number of specialties via the MN Clinical Advice Line (Section 1 of the same page).

**Benefits of Request for Advice**  
 Request for Advice allows GPs to ask non urgent clinical questions to Metro North clinicians. Advice is usually returned within 5 business days. Request for Advice may be helpful for:

- avoiding the need for referral by provision of clinical information to support GP-led care
- obtaining specialty advice more rapidly than via standard referral
- advice on additional investigations to help streamline outpatient input if referral is required
- reassuring patients that referral is/isn't required.

**Creating a Request for Advice**  
 You can create a Request for Advice via the below screens in GP Smart Referrals:

1. Patient view screen by clicking **Request Advice**
2. Referral screen by clicking **Request for Advice** in the Request type

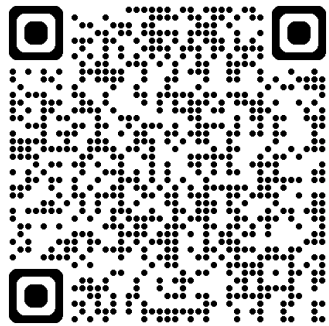
**Selecting a condition and finding a service**  
 Search for the specialty (e.g. Urology or Neurology) in the **Condition and Specialty** field. Based on the Condition/Specialty entered, the services offering Request for Advice will display in the **Service/Location** box.

Information about the Request for Advice service including any inclusion or exclusion displayed in the **Service/Location information** section.

Request for Advice for that specialty or condition in Metro North, for out of catchment services, these requests will not be accepted.

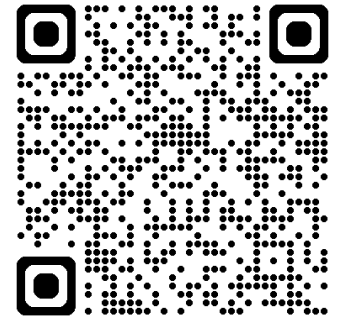
phn Queensland Government Metro North Health

V1.0 | Published: November 2025 | Review: November 2026



[Metro North GP Advice Program | Metro North Health](#)

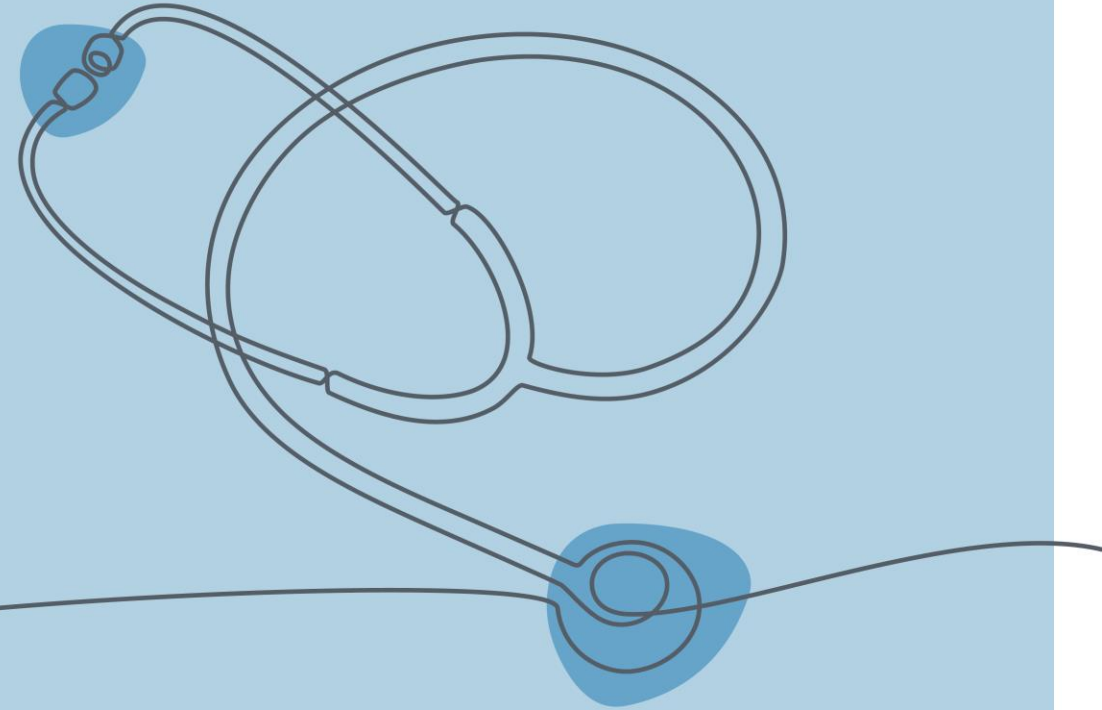
[Smart Referrals | Metro North Health](#)



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## Adult ADHD: diagnostic & management considerations

Dr Shuichi Suetani | Psychiatrist, UIH

# ADHD in Adults

Prof Shuichi Suetani

Psychiatrist



Championing Generalism – GP Workshop

21 March 2026

# Every man and his dog has an opinion...

aadpa | australasian ADHD professionals association

aadpa | australasian ADHD professionals association

ADHD Prescribing Guide For Australian Healthcare Professionals

Australian Evidence-Based Clinical Guideline For Attention Deficit Hyperactivity Disorder (ADHD)

1ST EDITION | 2024

1ST EDITION | 2022



IUIH Network Protocol

Attention Deficit Hyperactivity Disorder (ADHD) in Adults v2  
August 2023

- Given that there are so much subjectivity in ADHD, it's good to have/follow/be aware of guidelines
- But remember, guidelines are just that – *guidelines* – need to place them in your particular context

Australian Prescriber

VOLUME 49 : NUMBER 1 : FEBRUARY 2026

ARTICLE

## Pharmacological management of attention deficit hyperactivity disorder in adults

Shuichi Suetani

Psychiatrist<sup>1,2</sup>  
Professor<sup>3</sup>

Jaimie Hull

Clinical Pharmacist<sup>4</sup>

James G Scott

Psychiatrist<sup>2</sup>  
Professor<sup>4,5</sup>

### SUMMARY

Attention deficit hyperactivity disorder (ADHD) is a common neurodevelopmental disorder that is characterised by inattention, hyperactivity or impulsivity. It affects around 3 to 5% of adults.

The main pharmacotherapies for adults with ADHD include psychostimulants, such as methylphenidate and amphetamines (dexamfetamine and lisdexamfetamine), and non-psychostimulants such as atomoxetine.

Community HealthPathways

Brisbane North

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## ADHD in Adults

See also [ADHD in Children and Youth](#)

# Objectives

- Three “types” of ADHD in adults
- Diagnostic process
- Pharmacological therapy
- Non-pharmacological therapy

# Objectives

- **Three “types” of ADHD in adults**
- Diagnostic process
- Pharmacological therapy
- Non-pharmacological therapy



# ADHD in adults: 3 “types”

- **Pre-existing cases** (“Ron”)
- **Missed cases** (“Harry”)
- ***De novo* cases:**  
 (“Hermione”)



# ADHD in adults: “Ron”

- **Pre-existing cases:** Adults who grew up with a diagnosis of ADHD in childhood
  - Continuing care, or
  - Coming back after a break in treatment
- Usually diagnosed in primary school: “*can’t sit still, can’t stop talking, hyperactive, etc.*”
- M > F (by 2 – 4: 1)
- May have stopped medication for different reasons (e.g. didn’t want it, didn’t need it, couldn’t find a psychiatrist)



# ADHD in adults: “Harry”

- **Missed cases:** Adults who had been “missed” in childhood
- Missed for various reasons: *“he was smart, parents didn’t (or didn’t want to) think about it, a lot of other stuff going on, etc.”*
- But symptoms **were** there before the age of 12
- PBS needs: an in-depth clinical interview with/or obtainment of evidence from, a: (a) parent, (b) teacher, (c) sibling, (d) third party



# ADHD in adults: “Hermione”

- ***De novo* cases:** Adults who had **no** symptoms in childhood but developed them later in life
- Changes of life e.g. going to Uni, having children, retirement :“*Loss of scaffolding, masking, etc.*”
- But no convincing ***objective*** history of ADHD like symptoms in childhood
- This is **not** ADHD based on DSM (*yet... ???type 1 v type 2 ADHD*)
- *Note:* ADHD gender rate is almost 1:1 in adulthood



# Objectives

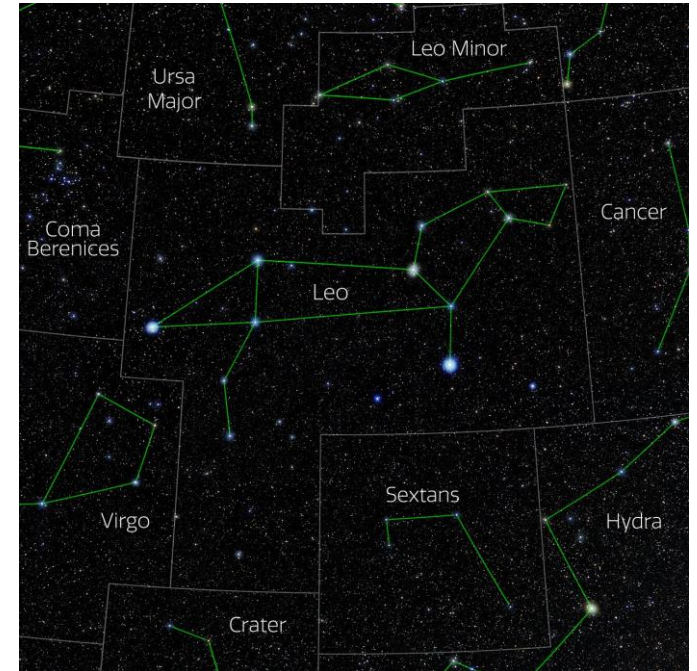
- Three “types” of ADHD in adults
- **Diagnostic process**
- Pharmacological therapy
- Non-pharmacological therapy



# Psychiatric diagnoses are like star signs

- Subjective
- Lack clear biological markers
- Significant overlap between different diagnoses
- Do not fully capture the individual's experience

***“Psychiatric diagnosis is seeing something that exists, but with a pattern shaped by what we expect to see.” – Prof Allen Frances***



# Psychiatric diagnoses are like star signs

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- Do not fully capture the individual's experience

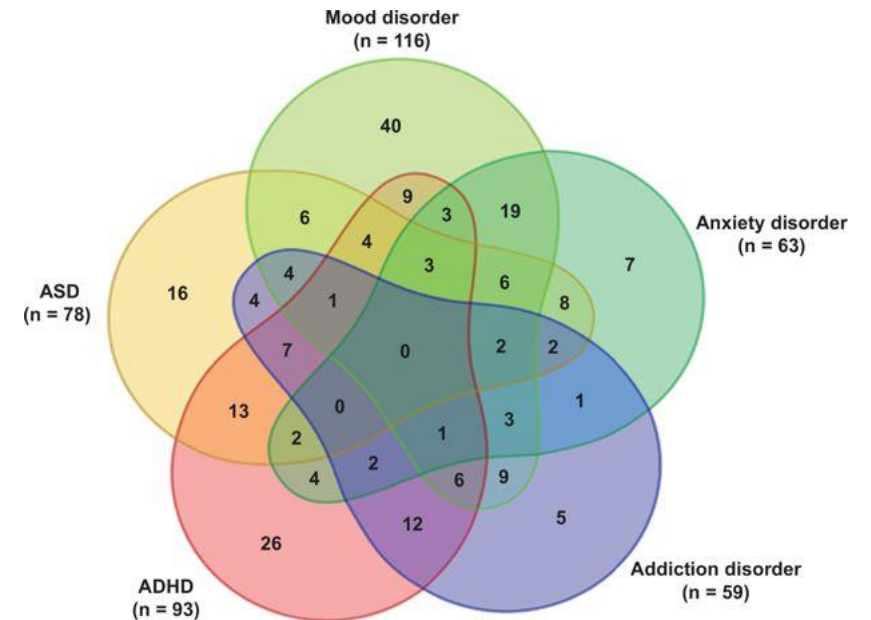
***“Psychiatric diagnosis is seeing something that exists, but with a pattern shaped by what we expect to see.” – Prof Allen Frances***

***But DSM/ICD is so much more robust that an opinion from an expert/influencer***



# Comorbidity is a rule rather than exception

- Psychiatric comorbidity up to 80%
- Lack of focus is very common
  - Transdiagnostic symptom, not at all pathognomonic
  - “Difficulty concentrating” present in 17 diagnoses in DSM 5
- Response to treatment is *NOT* diagnostic
- In practice:
  - Rule out the “reversible causes” (e.g. thyroid, iron, anemia, OSA, etc.)
  - Rule out the “potential contraindications” (e.g. substance use, psychosis, mania)



# First:

## A comprehensive psychiatric assessment

- Explore everything but ADHD:
  - Mood: Depression and mania\*/hypomania
  - Anxiety
  - Substance use\*
  - Psychosis\*
  - Trauma
- A lot of this, you may know already from previous interactions
- If obvious and disabling – consider treating them first to see if the symptoms persist
- \*Be clear about the limitations in pharmacological options

# Then:

## ADHD specific assessment

- Once you are confident that there are no other condition we need to treat first – then focus on possible ADHD symptoms
- Use semi-structured clinical interview tools (you don't *have* to, but I think it's useful – remember, we're trying to be objective)
  - ACE Plus version 2 (free but need to register)
  - DIVA-5 (about €10.00)
- Remember: onset, pervasiveness and functional impairment
- Ensure you have some collateral information for *current* symptoms (preferable) and in *childhood* (mandatory)

# Objectives

- Three “types” of ADHD in adults
- Diagnostic process
- **Pharmacological therapy**
- Non-pharmacological therapy



# Medication choices (The 2 x 2 x 2 rule)

- 2 types, 2 subtypes, and 2 agents
- Psychostimulants
  - Short acting:
    - methylphenidate (Ritalin SA) or
    - dexamfetamine
  - Long acting:
    - methylphenidate (either Ritalin LA or Concerta) or
    - lisdexamfetamine (Vyvanse)
- Non-psychostimulants
  - Atomoxetine - mane
  - Guanfacine – nocte

\*Note: Clonidine – not PBS approved and evidence in adults is small

# I wouldn't treat ADHD with stimulant if...

- Current symptoms of: psychosis, mania, acute suicidality or severe depression (treat these symptoms first)
- History of *clear* psychosis, ever (could consider atomoxetine)
- History of clear mania or bipolar disorder type I (could consider atomoxetine with care)
- Current (within the past 2 years) *regular* substance use including medicinal THC (could consider atomoxetine)



# I would seek opinion/guidance if...

- Epilepsy
- Cardiac issues\* see next slide
- Eating disorders (restrictive; e.g. anorexia nervosa)
- Bipolar type II (if convincing)
- Age over 55
- If you are not sure at all...



# Cardiologist referral:

**PEOPLE WITH ADHD SHOULD BE REFERRED FOR FURTHER ASSESSMENT BEFORE COMMENCING STIMULANT MEDICATION OR ATOMOXETINE IF ANY OF THE FOLLOWING IS PRESENT:**

- A history of congenital heart disease or previous cardiac surgery
- A history of sudden death in a first-degree relative under 40 years suggestive of a cardiac disease (usually a familial arrhythmia)\*
- Shortness of breath on exertion, compared to peers\*
- Fainting on exertion\*
- Palpitations that are rapid, regular, and start and stop suddenly\*
- Chest pain suggesting cardiac origin.
- A heart murmur (not including innocent heart murmurs in children)

\* These signs and symptoms may be indicative of a familial arrhythmia. When present, a 24-hour ECG is recommended and referral to a cardiologist for an opinion is suggested.

# Under PBS, your options depend on the *timing* of your diagnosis...

- Childhood diagnosis: All
- Retrospective diagnosis in adulthood: Stimulants (all except for Concerta) but not non-stimulants
- Does not meet the full diagnosis (i.e. symptoms suggestive of ADHD without childhood evidence): None



# If ADHD is diagnosed in childhood (Ron)

## 1. LA Psychostimulants

- Either Lisdexamfetamine (Vyvanse) or
- Ritalin LA (need to test with Ritalin IR first) or
- Concerta (need to test with Ritalin IR first)

## 2. The other LA psychostimulants (2 options)

## 3. (?Consider short acting if appropriate/if you feel confident)

## 4. Non-psychostimulant

- Atomoxetine (probably more robust evidence in adults) or
- Guanfacine (nocte, sedation; need psychiatry input for initiation)

## 5. Think about why it is not working (coming up)



# If ADHD is diagnosed retrospectively (Harry)

1. LA Psychostimulants
  - Either Lisdexamfetamine (Vyvanse) or
  - Ritalin LA (need to test with Ritalin IR first)
2. The other LA psychostimulant
3. (?Consider short acting if appropriate/if you feel confident)
4. Non-psychostimulant (off PBS)
  - Atomoxetine (probably more robust evidence in adults) or
  - Guanfacine (much more expensive)
5. Think about why it is not working (coming up)



# If ADHD is NOT diagnosed (Hermione)

1. Non-psychostimulant (off PBS)
  - Atomoxetine (probably more robust evidence in adults) or
  - Guanfacine (much more expensive)
2. Think about why it is not working (coming up)

I would *not* use psychostimulants *off* label



# What if it's not working?

## Box 1 Factors to consider when there is a lack of response to drugs for attention deficit hyperactivity disorder<sup>15</sup>



### Is the diagnosis correct?

Ensure that ADHD-like symptoms are not primarily driven by another psychiatric or medical condition.

### Has an appropriate titration occurred?

Ensure that the maximum tolerable dose has been reached.

### Are the appropriate symptoms being targeted?


Psychostimulants may be more effective for the core symptoms of ADHD (i.e. inattention, hyperactivity, impulsivity) but less effective for the non-core symptoms of ADHD such as executive dysfunction and emotional dysregulation.

### Are there other psychosocial issues to consider?

Ensure that other psychosocial issues are appropriately addressed.

### Have relevant comorbidities been addressed?

Explore, identify and manage other comorbidities (e.g. depression, anxiety, substance use) appropriately.

- 
- for dexamfetamine—40mg a day; or
  - for lisdexamfetamine—70mg a day; or
  - for methylphenidate—80mg a day.

When you have a hammer  
- everything looks like a nail.



When you have a hammer  
- everything looks like a nail.

If everything looks like a nail  
- you probably have a hammer.

# Jan 2026



Royal Australian and New Zealand College of Psychiatrists (RANZCP)

14,142 followers

2w

#Vyvance is now the fastest-growing drug on the #PharmaceuticalBenefitsScheme, raising concerns about "diagnosis on demand" and possible overprescription.

#Psychiatrists say safe #ADHD care depends on comprehensive, clinically informed assessments that look at the whole picture, as ADHD symptoms can overlap with a wide range of psychiatric and physical conditions.

“People need to understand that stimulant medications are not without risk. They do lead to side-effects, psychiatric and physical. They can lead to cardiac problems, even psychosis, and they need to be properly monitored.”

Dr Astha Tomar  
RANZCP President



# Objectives

- Three “types” of ADHD in adults
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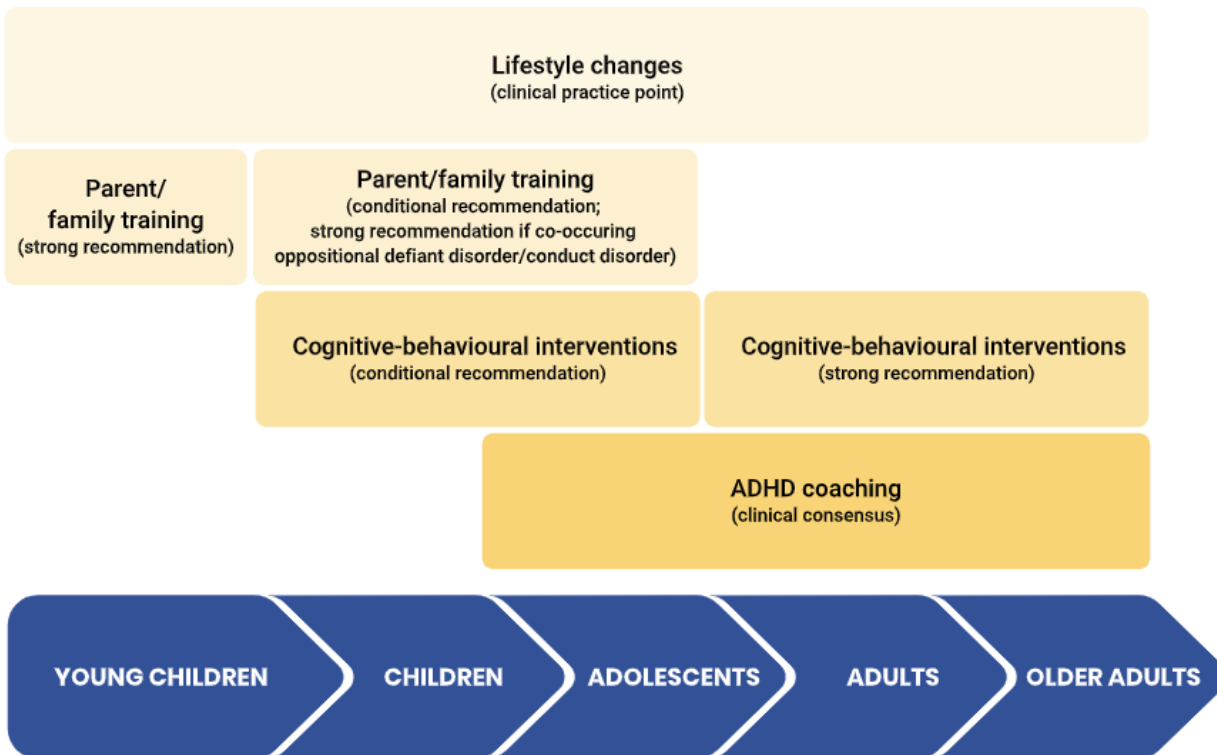
# Non-pharmacological treatment options

## Pharmacological treatment:

- Primary outcome: symptom reduction
- Secondary outcomes: improved functioning and wellbeing

## Non-Pharmacological treatment:

- Primary outcome: improved functioning and wellbeing
- Secondary outcomes: symptom reduction



- Some evidence for CBT but not much evidence base for others, *but*;
  - Lifestyle interventions (e.g. exercise, diet, sleep hygiene) would be helpful to most people with or without ADHD
- The cost – benefit balance with the cost being mainly financial and time for most people

# Take home message

- **First, do no harm (*Primum non nocere*)**
- ADHD may be a life *changing* diagnosis – but it's not a life *threatening* condition
- I am very excited but also a bit anxious about;
  - Shifting goal posts in diagnosis: societal and political drive
  - If it's too good to be true, it probably is (e.g. Opioid, benzos, medicinal cannabis)

**Sometimes (more often than you think), in psychiatry, we do more harm by trying to help someone than not doing anything at all.**



*Do No Harm*



## ADHD in Adults

See also [ADHD in Children and Youth](#)

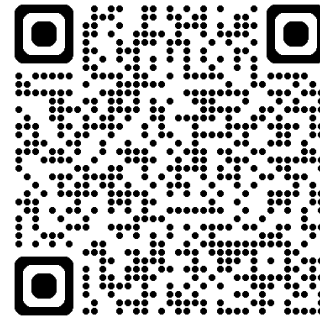
### Assessment

A thorough assessment is required to make a diagnosis of ADHD and requires a team approach. <sup>1</sup>

- Consider screening for ADHD in [high-risk groups](#) ▼, particularly if these patients:
  - are not responding to treatment of their high-risk condition and/or are having trouble adhering to treatment.
  - regularly miss appointments.
  - have symptoms of ADHD not explained by the alternative diagnosis which are causing functional impairment. <sup>1</sup>
- Take a history. Ask about:
  - symptoms of [inattention](#) ▼, [hyperactivity, and impulsivity](#) ▼. Be aware that these symptoms must have [essential features](#) ▼ for a diagnosis of ADHD.
  - the patient's strengths and self-identified factors that they may be using to minimise the symptoms and their impact.
  - [childhood symptoms](#) ▼.
  - [other psychiatric disorders, co-morbidities, and associated factors](#) ▼.
- Consider using a [self-report symptom checklist](#) ☑ to rate symptom severity.
- Examination:
  - Perform a [mental state examination](#) ▼.
  - Check blood pressure and pulse.
  - Measure height, weight, and [BMI](#) ▼.
  - Perform cardiovascular examination, if considering stimulant medication.
  - Look for features of hyperthyroidism – tremor, tachycardia, arrhythmia, thyroid eye disease
  - Consider the need to look for evidence of intravenous drug use.
- Arrange investigations:
  - Blood tests – FBC, thyroid function tests (TFTs), E/LFTs, lipids
  - ECG – if considering stimulant medication and there are [cardiac risk factors](#) ▼.
  - Random urine drug screen – if concerned about substance use.
- Consider [differential diagnosis](#) ▼.

### Management

- Establish a diagnosis.
- Manage any [co-morbid mental health conditions](#) ▼:
- Provide [written information](#) ☑.
- Discuss treatment options:
  - [Lifestyle interventions](#) ▼
  - [Psychological therapy](#) ▼
  - [Pharmacological therapy](#) ▼
- If considering referral for initiation of stimulant based medication and the patient has any [cardiac risk factors](#) ▼, request [non-acute cardiology assessment](#).
- Refer based on the patient's needs and preference:
  - Request [private psychiatry assessment](#) for diagnosis and initiation of pharmacological treatment.
  - Consider requesting [private psychology assessment](#), ideally from a clinical psychologist with experience in ADHD, for diagnostic clarification and suitability for cognitive behavioural therapy (CBT).
- Provide ongoing care of patients using pharmacological ADHD treatment.
  - Understand the [plan and restrictions of prescribing stimulant based medication](#) ▼.
  - Be familiar with the medications used to treat ADHD.
    - [Stimulant medications](#) ▼
    - [Second-line medications](#) ▼
    - [Third-line medications](#) ▼
  - [Review the patient](#) ▼ at regular intervals (at least every 6 months).
  - [Review effectiveness of medication](#) ▼.



# How Medicare Mental Health can help

When it comes to managing or improving your mental health, it can be difficult to know what to do or where to go.

[Medicare Mental Health Centres](#) and [Kids Hubs](#) can connect you with a range of mental health professionals for support, whatever your situation.

Find a location near you, or make a free call to the national phone service on **1800 595 212** (weekdays 8:30am-5:00pm, excl. public holidays).

You can also browse a range of resources and services on this website to support yourself or someone you care for.

Find support

Call 1800 595 212

Coming soon (end of March 2026):

## Medicare Mental Health Check In

Medicare Mental Health Check In will provide free guided digital support to help you build practical skills to take better care of your mental health and wellbeing early. It's completely free for people living in Australia, no referral or diagnosis is needed. [Learn more on this page.](#)

Visit website

medicare

Mental Health  
Check In



### Free service

Medicare Mental Health is funded by the Australian government and is free to access.



### Easy access

You do not need a referral or Mental Health Treatment Plan to use our services.



### For everyone

Whether you've had ongoing challenges or are reaching out for the first time, everyone is welcome.

# Medicare Mental Health Check In

Medicare Mental Health Check In will provide free guided digital support to help you build practical skills to take better care of your mental health and wellbeing early. It's completely free for people living in Australia, no referral or diagnosis is needed. [Learn more on this page.](#)

Visit website

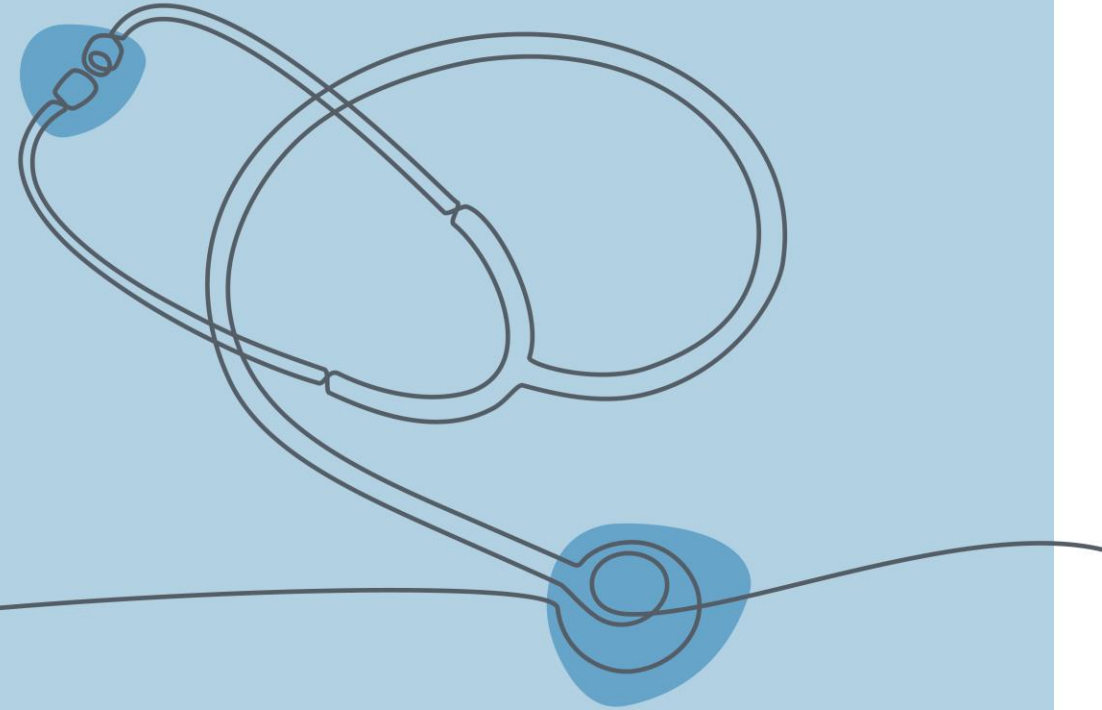
*medicare*

**Mental Health  
Check In**

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



## Turning pain into gain: Persistent pain management approaches

Dr Zoe Vella | Staff Specialist, Tess Cramond Pain and Research Centre, RBWH





# Turning Pain into Gain: Persistent Pain Management Approaches

DR ZOE VELLA

FANZCA, FFPMANZCA

TESS CRAMOND PAIN AND RESEARCH CENTRE



How to optimise primary care  
management of persistent pain  
based on available evidence



How tertiary persistent pain  
management services can support  
you and your patients

# Key Messages

Treatment is different for persistent pain

Medical treatments can help; but should not be used alone

Medical treatments have both risks & benefits

Patients in pain may be vulnerable when making choices about treatment options

Patients have both rights & responsibilities

Medical treatments should improve more than just pain

# What is persistent pain?

- ▶ What is pain?

“Pain is an unpleasant sensory and emotional experience associated, or resembling that associated with, actual or potential tissue damage”

- ▶ Pain is a protective mechanism
- ▶ It is present when the CNS senses danger
- ▶ Persistent pain is evidence of CNS ‘training’
- ▶ Persistent pain management relies on CNS ‘retraining’
- ▶ Medical treatments can be used to assist this process

Medical treatments can help; but should not be used alone

Medications

Interventional pain procedures

Surgery

Aims of medical treatment:

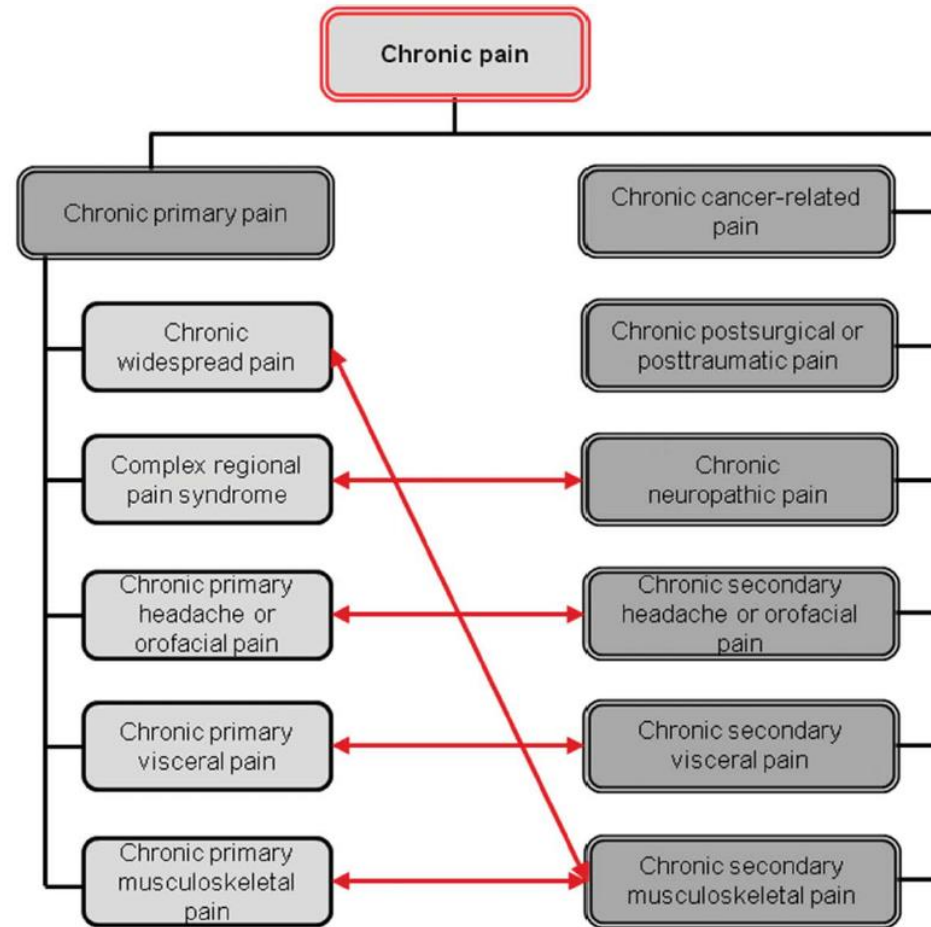
- To reduce distress to a bearable level
- To help patients function as well as possible
- To minimise the adverse effects of treatment

# Medical treatments

Informed by  
Pain diagnosis

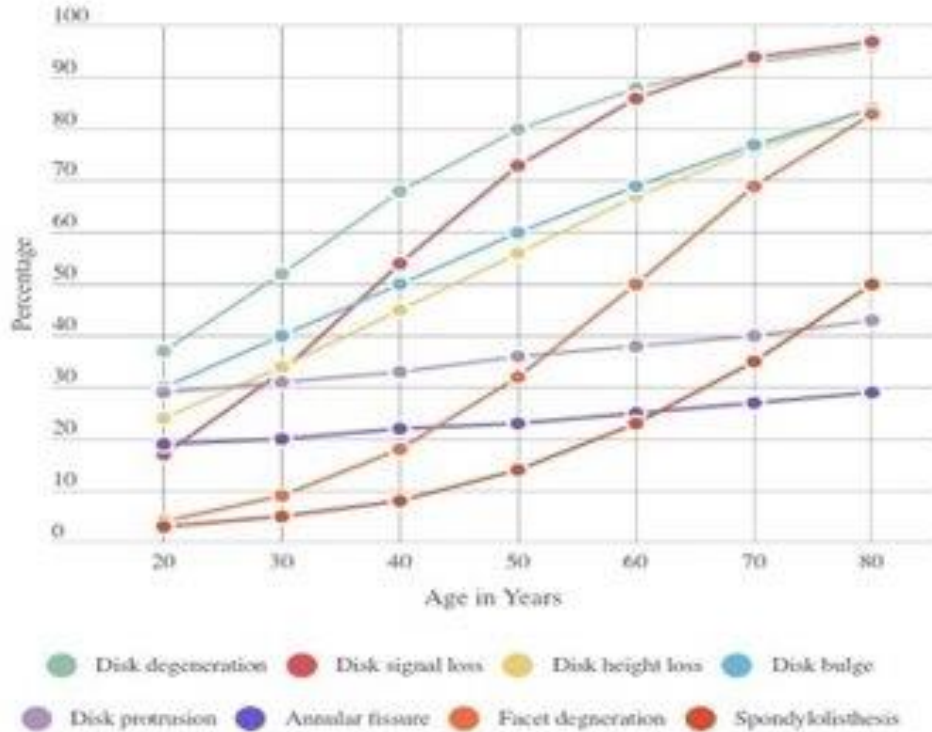
Pain diagnosis  
informed by  
ICD-11 criteria

# Pain Diagnosis



Chronic secondary pain syndromes

# Imaging Findings in the Backs of Pain-free People



Brinjikji, W., Luetmer, P. H., Comstock, B., Bresnahan, B. W., Chen, L. E., Deyo, R. A., et al. (2015). Systematic literature review of imaging features of spinal degeneration in asymptomatic populations. *American Journal of Neuroradiology*, 36(4), 811-816.

# Imaging

(Brinjikji W et al, 2015)

# Pharmacological Management

No currently available 'cure' for persistent pain

Great interindividual response to medications

Every drug has the potential to cause harm

Drugs are pain management 'tools' – they can be used well or used poorly

Only use medications where the benefit outweighs the potential harm

## RECOMMENDATIONS

# Faculty of Pain Medicine, ANZCA

Recommendations from the Faculty of Pain Medicine, ANZCA on chronic pain, neuropathic pain and low back pain. The Faculty of Pain Medicine is a faculty of the Australian and New Zealand College of Anaesthetists and is the professional organisation for specialist pain medicine physicians (Fellows) and specialist pain medicine physicians in training (trainees). The Faculty is responsible for the training, examination and specialist accreditation of specialist pain medicine physicians and for the standards of clinical practice for pain medicine in Australia and New Zealand. Formed in 1998, the Faculty is the first multidisciplinary medical academy in the world to be devoted to education and training in pain medicine.



# Medication recommendations

## Avoid

Avoid prescribing opioids (particularly long-acting opioids) as first line or only therapy for chronic pain

## Do not continue

Do not continue opioid prescription for chronic pain without ongoing demonstration of functional benefit, periodic attempts at dose reduction and screening for long term harms

## Avoid

Avoid prescribing pregabalin and gabapentin for pain which does not fulfil the criteria for neuropathic pain

# Medication recommendations

## Do not prescribe

Do not prescribe benzodiazepines for low back pain

## Do not refer

Do not refer axial lower lumbar back pain for spinal fusion surgery

## Do not prescribe

Do not prescribe currently available medicinal cannabis products to treat chronic non-cancer pain (CNCP) unless part of a registered clinical trial

# Opioids

Risk of adverse events increase with long term use

- ▶ Opioid induced hypoventilation
- ▶ Adverse mood effects
- ▶ Impaired cognition
- ▶ Impaired coordination or driving ability (especially in combination with benzodiazepines and gabapentinoids)
- ▶ Diffuse musculoskeletal, neuroendocrine and urinary symptoms
- ▶ Osteoporosis
- ▶ Immunosuppression

# Opioids

Insufficient evidence of opioid efficacy in the long term

- ▶ Opioids have a limited role in chronic pain because of a lack of evidence for their long-term benefit.<sup>1</sup>
- ▶ If opioids are started, generally recommended to limit trials of opioids to 4 weeks, after exploring all other treatment options, both physical and psychological.
- ▶ Look for measurable improvements in quality of life (sleep, mood) and function (activities) to gauge the effectiveness of opioids during the trial phase.
- ▶ If a functional improvement is not seen within 4 weeks, longer-term use of opioids is not recommended.

# Assessing response to opioid therapy

- ▶ **Activities**
- ▶ **Analgesia** – to assess the change in the pain level, a visual analogue scale (VAS), a numeric rating scale (NRS), or questionnaires as such as the brief pain inventory (BPI) can be used.
- ▶ **Adverse effects**
- ▶ **Aberrant behaviour** – unsanctioned dose escalation, reported missing scripts, possible inappropriate use, diversion and overuse/overdose
- ▶ **Affect**
- ▶ **Adequate documentation**

# Opioids

Central sensitisation and tolerance can occur within 4 weeks

- ▶ Central sensitisation refers to the phenomenon where **pain shifts from a peripheral sensory experience to a central nervous system response**
- ▶ It can result in increased response to painful stimuli, experience of pain in response to stimuli which are not normally painful, or spontaneous pain
- ▶ Opioid-induced hyperalgesia is a type of central sensitisation induced by opioid medication

# Opioids

Central sensitisation and tolerance can occur within 4 weeks

- ▶ Tolerance is a progressive lack of a response to a drug
- ▶ Tolerance and central sensitisation reduce the effectiveness of opioids over time, which limits the usefulness of opioids as a clinical intervention
- ▶ Tolerance can be overcome (at least for a time) by dose escalation of the primary analgesic; however, this is not always effective and can lead to increased adverse effects

# Medication recommendations

## Avoid

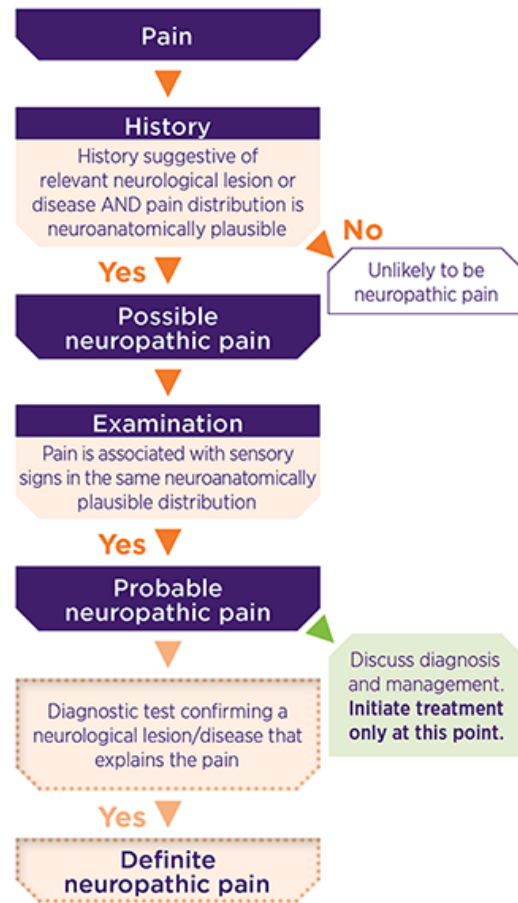
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## Avoid

Avoid prescribing pregabalin and gabapentin for pain which does not fulfil the criteria for neuropathic pain



Grading system for diagnosis of neuropathic pain

# Neuropathic Pain

---

## Pharmacotherapy and non-invasive neuromodulation for neuropathic pain: a systematic review and meta-analysis



Nadia Soliman\*, Xavier Moisset\*, Michael C Ferraro, Daniel Ciampi de Andrade, Ralf Baron, Joletta Belton†, David L H Bennett, Margarita Calvo, Patrick Dougherty, Ian Gilron, Aki J Hietaharju, Koichi Hosomi, Peter R Kameron, Harriet Kemp, Elena K Enax-Krumova, Ewan McNicol, Theodore J Price, Srinivasa N Raja, Andrew S C Rice, Blair H Smith, Fiona Talkington†, Andrea Truini, Jan Vollert, Nadine Attal\*, Nanna B Finnerup\*, Simon Haroutounian\*, NeuPSIG Review Update Study Group



### Summary

**Background** There remains a substantial unmet need for effective and safe treatments for neuropathic pain. The Neuropathic Pain Special Interest Group aimed to update treatment recommendations, published in 2015, on the basis of new evidence from randomised controlled trials, emerging neuromodulation techniques, and advances in evidence synthesis.

*Lancet Neurol* 2025; 24: 413–28

This online publication has been corrected. The corrected version first appeared at [thelancet.com/neurology](https://www.thelancet.com/neurology) on July 16, 2025

# Neuropathic pain

First-line, second-line, and third-line recommendations for the drugs or drug classes or neuromodulation treatments for neuropathic pain based on the GRADE classification

	Daily dosages and dose regimen *	Recommendation
<b>Strong recommendation for use</b>		
$\alpha 2\delta$ -ligands	<p>Gabapentin 1200–3600 mg in three divided doses</p> <p>Gabapentin ER 1200–3600 mg in two divided doses</p> <p>Pregabalin 150–600 mg in two divided doses</p> <p>Mirogabalin 10–30 mg in two divided doses</p>	First line
SNRIs	<p>Duloxetine 60–120 mg once a day</p> <p>Venlafaxine 150–225 mg once a day or in two divided doses</p>	First line
Tricyclic antidepressants †	25–150 mg once a day or in two divided doses	First line

# Neuropathic pain

Weak recommendation for use		
Lidocaine 5% plasters ‡	1–3 plasters to the painful area for up to 12 h per day	Second line for peripheral neuropathic pain
Capsaicin 8% patches ‡	1–4 patches to the painful area for 30–60 min with a minimal application interval of 60 days	Second line for peripheral neuropathic pain
Capsaicin cream ‡ §	Usually 0·075% one to three times per day	Second line for peripheral neuropathic pain
Botulinum toxin type A ‡	50–300 units to the painful area every 3 months	Third line for peripheral neuropathic pain
rTMS (10–20 Hz targeting M1) §	1200–3000 pulses per session	May be used in selected patients
Opioids § ¶	Usually <120 mg morphine equivalent in two divided doses  Tramadol 200–400 mg in two extended releases or three divided doses	May be used in selected patients

# Neuropathic pain

**Panel: Drugs or drug classes or neuromodulation treatments for neuropathic pain with inconclusive recommendations or recommendations against use based on the GRADE classification**

**Inconclusive evidence for use\***

- Carbamazepine–oxcarbazepine†
- Lacosamide
- Lamotrigine
- NMDA receptor antagonists
- Selective serotonin reuptake inhibitors
- Transcranial direct current stimulation
- Transcutaneous electrical nerve stimulation
- Spinal cord stimulation
- Topiramate

**Recommendations against use**

- Cannabinoids
- Valproate
- Levetiracetam
- Mexiletine‡

\*The remaining interventions which were assessed as inconclusive due to insufficient evidence are listed in the appendix pp 23–43. †For trigeminal neuralgia, these two drugs are recommended as first-line for long-term carbamazepine (200–1200 mg/day) or oxcarbazepine (300–1800 mg/day) in three divided doses.<sup>25,26</sup> ‡For the treatment of inherited erythromelalgia (300–600 mg/day in three divided doses) this drug may be of benefit.<sup>11</sup>

# Neuropathic pain

# Gabapentinoids

- ▶ Guidelines currently do not recommend use in lumbar spinal pain with sciatica
- ▶ Prescription rates have increased dramatically since 2013
- ▶ High rates of serious harm associated with use
- ▶ Deaths related to pregabalin rose from 16 in 2013 to 121 in 2016
- ▶ Check for history of substance use disorder and signs of abuse or dependence before prescribing pregabalin or gabapentin.
- ▶ Start with a low dose, increase slowly
- ▶ Trial deprescribing every 3-6 months to assess ongoing benefit and reduce risk of adverse effects

# Medication recommendations

## Do not prescribe

Do not prescribe benzodiazepines for low back pain

## Do not refer

Do not refer axial lower lumbar back pain for spinal fusion surgery

## Do not prescribe

Do not prescribe currently available medicinal cannabis products to treat chronic non-cancer pain (CNCP) unless part of a registered clinical trial

# 'Medicinal' cannabis

Prescription is via the Therapeutic Goods Administration (TGA) online system.

5 main categories of conditions for which doctors can legally prescribe medicinal cannabis products

Epilepsy

Chemotherapy induced nausea and vomiting

Palliative care

Multiple sclerosis

**Chronic non cancer pain**

# 'Medicinal' cannabis

Cannabis remains unregistered with the TGA

It has not undergone the strict chemical, pharmacological and toxicological assessment that is required for all registered medicines in Australia

Potential to cause significant harm in terms of respiratory and cardiovascular function, mood and psychotic symptoms, and cognitive impairment

Available scientific evidence remains insufficient to justify its clinical use

# 'Medicinal' cannabis

- ▶ Across all chronic pain conditions, cannabinoids were more likely than placebo to produce a 30% reduction in pain
- ▶ The NNTB was 24
- ▶ There was no significant evidence that cannabinoids reduced pain by 50% compared to placebo
- ▶ Cannabinoids overall were associated with a larger reduction in pain intensity than placebo. This was calculated to be a reduction of about 3mm on a 0-100mm scale

(Stockings et al, 2018).

# 'Medicinal' cannabis

- ▶ Efficacy of drugs is often expressed as the number needed to treat.
- ▶ Based on a minimum of a 50% reduction in pain intensity
- ▶ In trials over 8–16 weeks, drugs with different mechanisms (**tramadol, opioids, antidepressants, gabapentin and pregabalin**) have been found to be similarly effective for chronic pain.
- ▶ The numbers needed to treat for 50% pain reduction ranged from **2.6 to 6.4**

(Cohen, 2013)

# 'Medicinal' cannabis

- ▶ Chronic pain patients who received a cannabinoid had 2.3 times the odds of experiencing an adverse event compared to placebo.
- ▶ The NNTH for any adverse event was 6.
- ▶ There were no significant impacts upon physical or emotional functioning, and low-quality evidence of improved sleep and patient global impression of change.
- ▶ **“It appears unlikely that cannabinoids are highly effective medicines for chronic non-cancer pain”**

(Stockings et al, 2018)

# Interventional Pain Procedures

- ▶ Diagnostic nerve blocks
- ▶ Peripheral nerve blocks
- ▶ Facet joint LA + steroid injection
- ▶ Thermal and pulsed radiofrequency neurotomy
- ▶ Epidural steroid Injection
- ▶ Neurolytic procedures for cancer pain
- ▶ Spinal cord Stimulation
- ▶ Intrathecal opioid pumps
- ▶ Lidocaine infusion
- ▶ Ketamine infusion



# Medical treatments have both risks & benefits

- ▶ Aim for lowest effective dose of any pharmacological treatment
- ▶ Combination therapy can reduce overall dose requirements; BUT
- ▶ Caution with drug interactions
- ▶ Combining pharmacological and non-pharmacological therapy can reduce dose requirements
- ▶ Procedures can be associated with significant risk
- ▶ Ideally, medications and procedures will be **temporary** interventions to facilitate pain 'retraining' with exercise or psychological techniques

# Patients in pain are vulnerable when making choices

Beware the  
'cure all'

Treatments for  
persistent pain  
rarely work in  
isolation

# Patients have both rights & responsibilities

- ▶ Discuss and understand benefits and risks of medical treatment
- ▶ Take medication only as instructed
- ▶ Never provide anyone else with your medicine
- ▶ Have only one prescribing doctor
- ▶ Return unused medicine to pharmacy
- ▶ Be responsible for safety of self and others
- ▶ Know when your next prescription is due
- ▶ Attend review appointments

Medical  
treatments  
should  
improve more  
than just pain

Improvement in ability to  
function

Completion of household tasks  
and activities of daily living

Increased enjoyment



How to optimise primary care  
management of persistent pain based  
on available evidence



How tertiary persistent pain  
management services can support you  
and your patients

# Tess Cramond Pain and Research Centre

- ▶ Established 1967 by Emeritus Professor Tess Cramond
- ▶ Tess Cramond Pain and Research Centre is one of five adult pain management services for Queensland and northern New South Wales
- ▶ Based at STARS, remains a RBWH service
- ▶ Team consists of medical, nursing, allied health and administration staff



# Medical

- ▶ Every patient seen by Pain Medicine Specialist or Rehabilitation Physician or Psychiatrist with an interest in Pain Medicine at initial appointment
- ▶ Level 1 Training Unit for FPM
- ▶ Medical staff have specific areas of interest - at triage patients streamed to specialised pathways, e.g. pelvic pain, craniofacial pain, adolescent and young adult
- ▶ Before proceeding to allied health treatment, all patients are discussed at multidisciplinary case conference to determine best treatment pathway

# Allied Health Therapy

## Individual

- Physiotherapy (no hydrotherapy!)
- Psychology
- Occupational Therapy

## Group Programs

- LIFE
- CONNECT

# Interventional Pain Procedures

- ▶ Diagnostic nerve blocks
- ▶ Peripheral nerve blocks
- ▶ Facet joint LA + steroid injection
- ▶ Thermal and pulsed radiofrequency neurotomy
- ▶ Epidural steroid Injection
- ▶ Neurolytic procedures for cancer pain
- ▶ Spinal cord stimulation
- ▶ Intrathecal opioid pumps
- ▶ Lignocaine infusion
- ▶ Ketamine infusion



## Adult Persistent Pain Management Service

PPMS's are for patients with complex persistent pain who require a multidisciplinary approach for the management of their pain. PPMS expect patients to take an active role in learning self-management techniques and to have a general practitioner who remains central to the supervision of their care.

Please consider if the goal of referral to a PPMS is aligned with the treatment goals of persistent pain management. These are specifically to improve management of pain, improve function and improve quality of life overall. The approach is primarily a rehabilitative approach.

PPMS are not primarily diagnostic services.

### All patients being referred to this service should:

- have persistent pain resulting in functional impairment from physical disability and/or psychosocial issues
- have persistent pain that has been thoroughly investigated; and
- have referrals accompanied by all relevant investigations and specialist reports
- all patients being referred to this service should be able to provide valid consent or have a substitute decision maker who can do so on their behalf if needed.

### Patients who may not benefit include those:

- accepted under an insurance claim e.g., Workcover/having treatment in the private system
- for whom litigation may be a barrier to rehabilitation
- where there is a clear statement by a PPMS that there are no further or new therapeutic options.

# Referral

## Minimum Referral Criteria

### Category 1

(appointment within 30 calendar days)

- Cancer pain where the patient's specialist treating team is requesting Persistent Pain Management Service (PPMS) input
- Patients on a palliative care pathway where the patient's specialist treating team is requesting PPMS input
- New onset neuropathic pain of less than 6 weeks duration relating to a recent diagnosis of a condition for example:
  - herpes zoster (risk for post herpetic neuralgia)
  - ischaemic pain
  - trigeminal neuralgia
  - brachial plexopathy
  - diabetic neuropathy
  - multiple sclerosis
  - spinal cord injury
  - post stroke pain
- Worsening post-surgical/procedure pain or complication e.g. pleural tap of less than 3 months duration (where a post-operative complication has been excluded)
- Newly diagnosed or suspected new onset (3, months) of [complex regional pain syndrome](#) (CRPS) based on the Budapest criteria

# Referral

# Complex Regional Pain Syndrome (CRPS)

- ▶ Symptoms (3 or more)
- ▶ Signs (2 or more)
  - ▶ Sensory (allodynia, hyperalgesia, sensory alteration)
  - ▶ Motor/Trophic (wasting, reduced ROM, skin/hair/nail changes)
  - ▶ Sudomotor (sweating)
  - ▶ Vasomotor (colour, temperature alteration, swelling)

## Category 2

(appointment within 90 calendar days)

- Sub-acute pain (defined as lasting 6 to 12 weeks) with moderate to high risk of functional deterioration
- Exacerbation of neuropathic pain from pre-existing conditions as listed in Category 1
- Patients with frequent emergency department / primary care presentations for exacerbations of persistent pain despite attempts at management
- Adolescents and young adults who are at risk of non-attendance at school/study/work, or elderly and frail adults experiencing, or at risk of, declining quality of life
- Complex pain presentation resulting in marked psychological distress (note that patient must also be under the care of a mental health clinician where there are escalating risk concerns)
- Pain with onset less than 6 months ago that is resulting in psychological and/or functional impairment, that is not responding to primary care management
- Functional impairment as a result of severe or complex side effects from pain medications that are not able to be managed in primary care
- Individuals at risk of work cessation due to persistent pain

# Referral

### Category 3

(appointment within  
365 calendar days)

- Pain with onset more than 6 months ago that is resulting in psychological and/or functional impairment, that is not responding to primary care management

# Referral

# Connected Community Pathways Programs

2 distinctly different partnership programs

## Persistent Pain Service for Mob

TCPRC and IUIH partner for co-design, co-delivered Persistent Pain Service for Aboriginal and Torres Strait Islanders



---

## SPAN Pathway

TCPRC and PHN partner to establish a community-based allied health pain management program for lower acuity patients referred to the TCPRC



# Persistent Pain Service: A Caring Pathway for Mob



- ▶ TCPRC/Institute for Urban Indigenous Health Partnership
- ▶ Co-designed, Co-delivered Persistent Pain Service weekly at Caboolture MATSICHs
- ▶ TCPRC Pain Medicine Specialist + TCPRC and MATSICHs Nursing and Allied health team
- ▶ Culturally informed and responsive model of care
- ▶ Culturally safe physical environment

# Outcomes



Positive client feedback – 98% report culturally safe care and satisfaction

*“They made me feel seen and heard, which is exactly what I needed.”*

Travel time/costs reduced by >13,000km in first year

*“I feel relaxed, its good... it's a relaxed atmosphere ... If I didn't like it, I wouldn't come back here ... I'm not just a number... all the staff are really interested in how I am going and just having a yarn”*

High rates of uptake of the service

- 95% attendance for new appointments
- 90% attendance overall

# SPAN Pathway

- ▶ Metro North funded Partnership between Tess Cramond Pain and Research Centre (TCPRC) and Brisbane North Primary Health Network (BN PHN) commissioned provider (PainWISE)
- ▶ Connecting tertiary persistent pain services with primary care providers
- ▶ Low acuity patients that are best suited to coordinated pain education and community-based MDT approach
- ▶ Goals- Care sooner, closer to home, build community capacity increase capacity for most complex patients to be seen at TCPRC

# SPAN-PHN Pathway

- Community based service commissioned by PHN (PainWISE)
  - ▶ Provide care coordination
  - ▶ Pharmacy led medication review
  - ▶ Group pain education
  - ▶ Needs based individual allied health with special interest and experience in persistent pain
- Underpinned by:
  - ▶ Regular MDT Case Conferencing between
    - ▶ TCPRC,
    - ▶ Commissioned Service provider (PainWISE) and
    - ▶ Community-based allied health clinicians
  - ▶ Clinical Advice Line
    - ▶ Pain medicine specialist to support GP
  - ▶ Building community of practice and relationship building between all clinicians

Tess Cramond Pain and Research Centre (TCPRC)

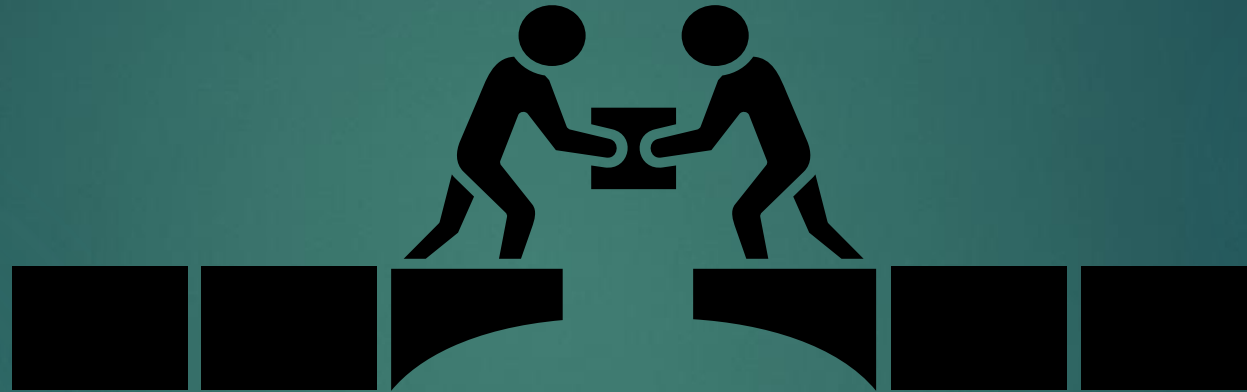


Case conferencing - Pain Specialist and allied health

Clinical advice line



TCPRC send suitable low acuity patients



Commissioned Community provider- PainWISE



Group pain education  
Pharmacy  
Individual allied health



Support from TCPRC with escalation pathway to return to tertiary pain service as required

# Early outcomes of SPAN

- ▶ Average of 600km per patient saved
- ▶ Parking costs were eliminated
- ▶ Time to care for SPAN patients was reduced from ~510 days to less than 30 days.
- ▶ Attendance improved from 93% to 98%,
- ▶ 95% of patients reported that they were satisfied with their experience through the PainWISE program
- ▶ Improvement in pain specific outcome measures
- ▶ De-centralised persistent pain services for non-urgent patients, allowing tertiary services to focus on urgent most complex patients.

# Clinical Advice Line (CAL)

Monday to  
Friday

1 800 569 0999  
0900 - 1200

# Clinical Advice Line (CAL)

- ▶ Patient of TCPRC had been rotated from oral opioid medication to buprenorphine patch
- ▶ Presented to GP appointment stating wanted to go back on oral opioids due to skin reaction from patch, concerned about other adverse effects
- ▶ GP phone call to CAL during patient appointment
- ▶ TCPRC pharmacy follow up arranged
- ▶ Patient reported great success with recommendations provided at CAL call, improved pain relief on patch, very pleased with outcome of rotation

## Other resources

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[www.noigroup.com](http://www.noigroup.com)

---

[Noigroup Clinical Discussions - YouTube](#)

---

[Home | Pain Revolution](#)

---

[Home | Retrain Pain](#)

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[Online Treatment for Chronic Pain | MindSpot](#)



# Noigroup Clinical Discussions

@NOIClinicalDiscussions · 2.76k subscribers · 57 videos

A channel for clinicians learning how to confidently apply Explain Pain and Noigroup concepts...more

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Popular

Oldest



How to Explain Pain Without Losing Your Patient

438 views · 12 days ago



Where Do I Even Start? A Practical Introduction to Pain Science

525 views · 2 weeks ago



Behind the curtain of good pain education: values, vulnerabilities, strengths and...

1.7k views · 1 month ago



What to Say When Patients with Pain Ask 'What's Wrong With Me?'

1.8k views · 1 month ago

## Ready to prescribe with more clarity and confidence?

Opioid management course  
6 modules



### Better Pain Management Program (All 12 modules)

The complete 12-module Better Pain



### Pain management in the clinical setting (6 modules)

Apply your existing pain management



### Better Pain Prescribing. Clarity and confidence in opioid management: 6 module package

Develop clearer decision-making in opioids



### Introduction to the pain experience (3 modules)

The first steps in understanding a contemporary

## Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain

### Preamble

- A. The Faculty of Pain Medicine (FPM) recognises the lack of definitive evidence supporting the long-term effectiveness of opioid analgesics in people experiencing chronic non-cancer pain (CNCP) and the substantial evidence for potential harm.
- B. The FPM recognises that opioids are widely and often inappropriately prescribed for CNCP despite the lack of clear evidence of efficacy.
- C. The FPM also recognises the changed regulatory environment introduced in Australia by the TGA<sup>1</sup> in 2020, specifically<sup>2</sup>:
  - “[Modified-release opioid product] is indicated for the management of severe pain where
    - other treatment options have failed, are contraindicated, not tolerated or are otherwise inappropriate to provide sufficient management of pain, and
    - the pain is opioid-responsive, and
    - requires daily, continuous, long-term treatment.
  - “[Modified-release opioid product] is not indicated for use in chronic non-cancer pain other than in exceptional circumstances.”
- D. The FPM interprets “exceptional circumstances” in this context to denote:
  - Severe pain,
    - for which other treatment options have failed, are contraindicated, not tolerated or are otherwise inappropriate to provide sufficient management,
    - and
    - which has been shown to be opioid-responsive
- E. In New Zealand, Medsafe has not taken an overarching regulatory approach. The indications for each drug are listed in its data sheet.<sup>3</sup> Some but not all products mention criteria such as opioid-responsiveness, failure of conservative methods of analgesia, and absence of psychological contraindication, drug-seeking behaviour or history of drug misuse. CNCP is not necessarily specified.
- F. This document describes the current position of the FPM regarding the prescription of opioids in CNCP, presented as a series of principles and a synopsis of the evidence and reasoning on which they are based.



## Opioid Calculator

The Faculty of Pain Medicine of the Australian and New Zealand College of medical students, nurses and allied health practitioners engaged in the care of morphine equivalent daily dose (oMEDD). It is available as a free smart ph



## Membership

Membership is open to anyone with an interest in improving persistent pain healthcare for Queenslanders.

Our members include:

- health professionals who work in primary care
- researchers and academics
- patients and community members.

We also have representatives from health interest groups, professional bodies and non-government organisations.

As a member, you'll be involved in working groups where you can share your experiences, expertise and feedback. You'll have access to member resources, news and updates, and be invited to network events.

### Co-chair

#### **Kym Boon**

Staff Psychiatrist and Pain Medicine Specialist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service

### Co-chair

#### **Bede Ashley**

Allied Health Team Leader, North Queensland Persistent Pain Management Service, Townsville Hospital and Health Service

[Join the Queensland Persistent Pain Clinical Network →](#)



Questions?

# References

- ▶ Brinjikji W, Luetmer PH, Comstock B, Bresnahan BW, Chen LE, Deyo RA, Halabi S, Turner JA, Avins AL, James K, Wald JT, Kallmes DF, Jarvik JG 2015. [Systematic literature review of imaging features of spinal degeneration in asymptomatic populations](#). AJNR Am J Neuroradiol. Apr;36(4):811-6.
- ▶ Cohen M 2013. Principles of Prescribing for Persistent Non Cancer Pain. Australian Prescriber, 1 August. <https://www.nps.org.au/australian-prescriber/articles/principles-of-prescribing-for-persistent-non-cancer-pain>.
- ▶ Fishman, Ballantyne & Rathmell 2010. Bonica's Management of Pain 4e. <https://www.nps.org.au/news/chronic-pain>
- ▶ [Faculty of Pain Medicine, ANZCA - Choosing wisely](#)
- ▶ Gourlay DL, Heit HA, Almahrezi A. Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. Pain Medicine 2005;6:107–12. [Search PubMed](#)
- ▶ [Grading system for diagnosis of neuropathic pain - NPS MedicineWise](#)
- ▶ [Persistent Pain Management | Clinical Prioritisation Criteria](#)
- ▶ <https://www.tga.gov.au/alert/pregabalin-and-gabapentin>
- ▶ Treede R-D et al. 2019. Chronic pain as a symptom or a disease: the IASP Classification of Chronic Pain for the International Classification of Diseases (ICD-11). Pain. 160: 19-27.
- ▶ Soliman N et al. 2025. Pharmacotherapy and non-invasive neuromodulation for neuropathic pain: a systematic review and meta-analysis. Lancet Neurology. 24 (5): 413-428.



Patient name: James METRONORTH DoB: 10 Dec 1939

Request information

Request date: 9 Mar 2026

Request type: **New referral** | Update | Continuation | Request for advice

Reason for referral:  New condition requiring specialist consultation  
 Deterioration in condition, recently discharged from outpatients < 12 months  
 Other

Provider: **QHSR** | Private

Consents

Date patient consented to request: 09 Mar 2026

Patient is willing to have surgery if required? Yes | No | Not applicable

Condition and Speciality: Pain Management - Persistent pain (Persistent Pain Managemen [HealthPathways](#)

Suitable for Telehealth? Yes | No

Are you the patient's usual GP? **Yes** | No

HealthPathways | Metro North

- [Medications in Chronic Non-cancer Pain](#)
- [Chronic Non-cancer Pain](#)
- [Complex Regional Pain Syndrome \(CRPS\)](#)
- [HealthPathways home page](#)

Request recipient

Service/Location: Please select

Specialist name: Please select

Organisation details: [icon]

Condition specific clinical information

Investigations and imaging

Standard clinical information

Patient information

Insurance information

Referring GP's information

Select the most appropriate condition template for your patient

Links to appropriate HealthPathways for assessment & management support

[Home](#) / [Refer your patient](#) / Persistent Pain Management

## Persistent Pain Management

### Conditions

- [Persistent Pain – Adult](#)

### Emergency department referrals

The Persistent Pain Management Service for Metro North is based at the Surgical, Treatment and Rehabilitation Service (STARS). For urgent referrals phone on call Persistent Pain Registrar via Royal Brisbane & Womens' Hospital switch – (07) 3646 8111

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Patients with acute pain (and no provisional diagnosis)
- Patients with acute pain and new neurological symptoms eg Cauda Equina Syndrome (CES)
- Patients requiring acute mental health services
- Concerns pertinent to any medical/surgical condition which raise the possibility of serious underlying disease (malignancy or infection) should be reviewed by the appropriate specialty either via emergency department or high priority outpatient appointment.

### Persistent Pain Management Service

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All patients being referred to this service should:

- have persistent pain resulting in functional impairment from physical disability and/or psychosocial issues
- have persistent pain that has been thoroughly investigated; and
- have referrals accompanied by all relevant investigations and specialist reports
- all patients being referred to this service should be able to provide valid consent or have a substitute decision maker who can do so on their behalf if needed.

### GP Persistent Pain advice

GPs can now access advice from a Pain Medicine Specialist for medical advice and clinical questions regarding patients with persistent pain via the [Clinical Advice Line](#) (1800 569 099), Tuesday – Friday 9:00am – 12:00pm. Please see [Clinical Advice Line](#) for patient eligibility details.

Please prepare the required information prior to your call:

- Patient name and date of birth
- Significant history, co morbidities, and medications
- Presenting complaint, relevant examination findings
- Reason for enquiry

If you have an urgent request outside of these hours, please call the RBWH switch board (07) 3646 8111 and ask to speak with the Persistent Pain Management Service on-call registrar or consultant.

GPs can also seek non urgent advice from a Pain Medicine Specialist via the Request for Advice function in GP Smart Referrals please see [Clinical Advice Line](#) for details regarding patient eligibility.

### Send referral

Hotline: 1300 364 938

#### Electronic:

[GP Smart Referrals \(preferred\)](#)  
[eReferral system templates](#)  
 Medical Objects ID: MQ40290004P  
 HealthLink EDI: qldmnhhs

#### Mail:

Metro North Central Patient Intake  
 Aspley Community Centre  
 776 Zillmere Road  
 ASPLEY QLD 4034

### Health pathways

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email: [healthpathways@brisbanenorthphn.org.au](mailto:healthpathways@brisbanenorthphn.org.au)

Login to Brisbane North Health Pathways:  
[brisbanenorth.healthpathwayscommunity.org](https://brisbanenorth.healthpathwayscommunity.org)

### Locations

[Surgical, Treatment and Rehabilitation Service \(STARS\)](#)

### Resources

[General referral criteria](#)

#### Clinical information

[Referral pathway tool: Which service to refer to?](#)

[PPMS eReferral form \(PDF\)](#)

[Persistent Pain Management Guide for GPs \(PDF\)](#)

[General patient screening and referral guide \(PDF\)](#)

[Discharge Planning and Communication guide \(PDF\)](#)

#### Patient resources

[Information brochure, Queensland Health \(PDF\)](#)



# METRO NORTH Clinical Advice

Providing local GPs with advice from specialist clinicians via

- Phone 1800 569 099  
Monday – Friday 8:30am – 4:00pm
- Written requests (GP Smart Referrals)

See current specialties offering non urgent clinical advice 



Metro North Health



## Tess Crammond Pain and Research Centre offers:

- Phone advice**  
*Monday – Friday 9:00am – 12:00pm*  
*Patients over 16 years of age*
- Request for Advice**  
*Patients over 16 years of age*



## Chronic Non-cancer Pain

### Background

About chronic non-cancer pain

### Assessment

1. Take a detailed history:

- Pain features
- Pain impact
- Previous treatments
- Co-morbidities

2. Assess:

- psychosocial factors – this is essential
- personal beliefs about pain
- behavioural responses requiring modification

3. Consider risk factors for serious pathology and investigate accordingly.

4. Examine the patient.

5. Identify any pain syndromes or co-morbidities requiring specific management.

6. Consider investigations only when there is a specific clinical question in mind or additional information is required to confirm a diagnosis or exclude serious pathology.

### Management

Management for patients with chronic pain is complex, and requires a collaborative, multidisciplinary approach to minimise harm from inappropriate treatment.

1. Once serious pathology is ruled out:

- Offer education and reassurance.
- Discuss self-management – help the patient to set goals and develop a pain-management plan.
- Discuss and reinforce the use of non-pharmacological measures if appropriate.
- Provide advice about returning to work and consider financial assistance if required.

2. Consider online pain management.

3. Optimise management of any co-morbidities including depression, anxiety, or substance misuse.

4. Consider requesting:

- occupational therapy, physiotherapy assessment, or exercise physiology for assistance with exercise therapy, rehabilitation, and ergonomics.
- psychology assessment for cognitive behaviour therapy (CBT) and biofeedback, particularly in patients with psychosocial risk factors, depression, or anxiety.
- dietetics if assistance is required to correct any nutritional deficiencies or weight issues.

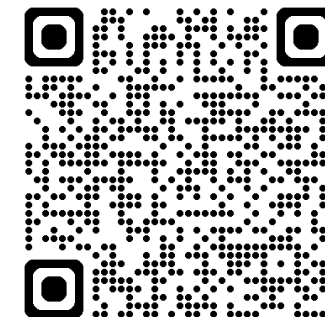
5. Consider preparing a General Practice Chronic Condition Management Plan (GPCCMP) and/or a mental health treatment plan if appropriate.

6. Manage specific pain types according to relevant pathway (if available), or request other specialist assessment according to the specific condition causing the chronic pain.

7. Consider medications for chronic non-cancer pain.

8. Schedule regular follow-up, assess progress, and modify treatment accordingly.

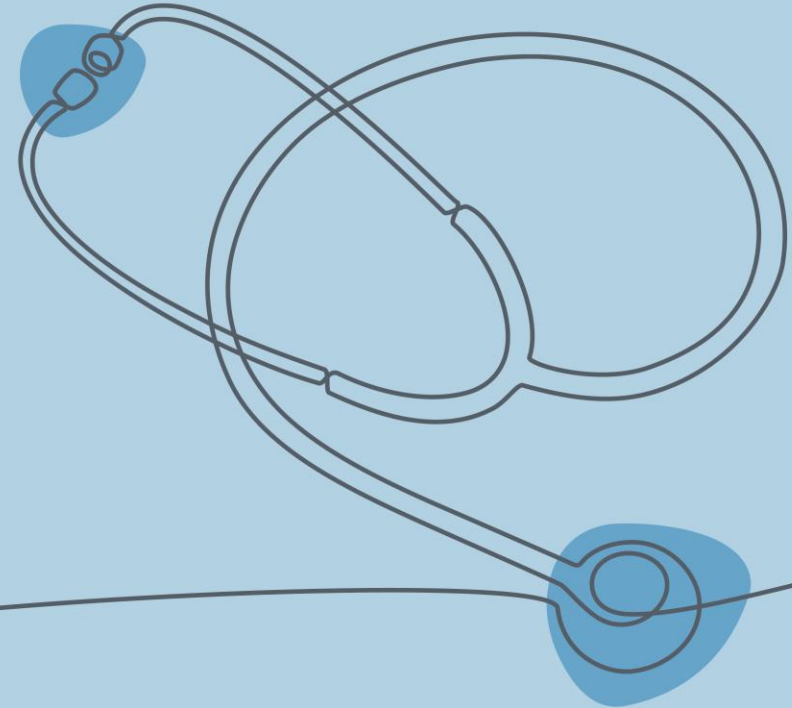
9. Consider requesting non-acute pain management assessment if:



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



## What's in the future for medical AI?

Professor Catherine Jones | Radiologist, I-MED

**phn**  
BRISBANE NORTH  
An Australian Government Initiative

 **Queensland** Government  
Metro North Health



# AI in health – the past and the future

Prof Catherine Jones

GP event Brisbane North, March 21<sup>st</sup> 2026

## Global digital health market, 2018-2030 (US\$M)

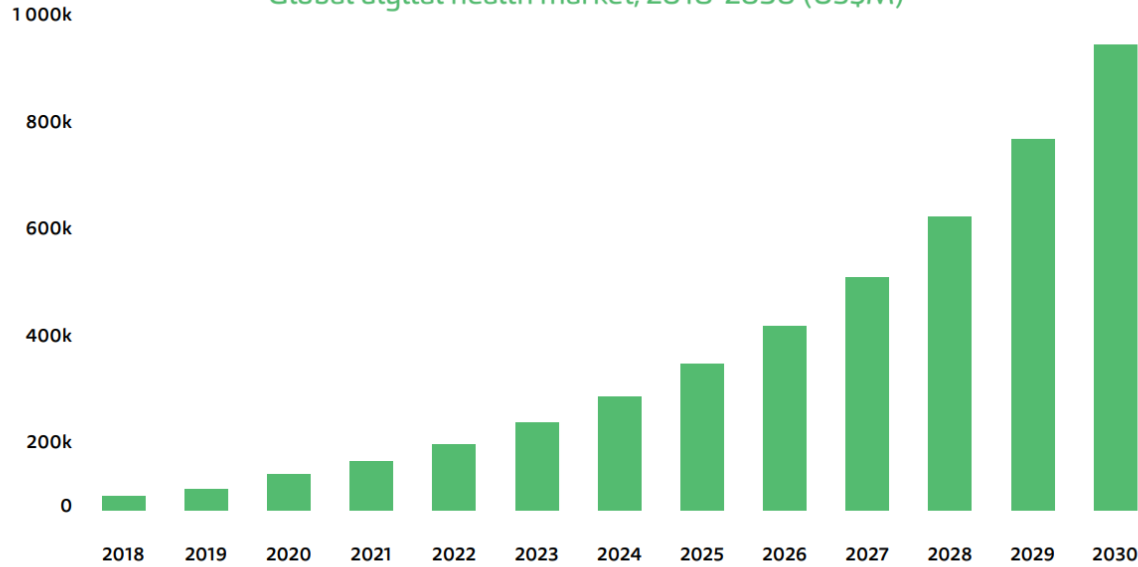


Figure 4: Global Digital Health Market Revenue (In USD). Adapted from Grand View Research Digital Health Market Size And Share Report 2024.<sup>32</sup>

## Digital Health Pipeline Growth 2017 - 2024

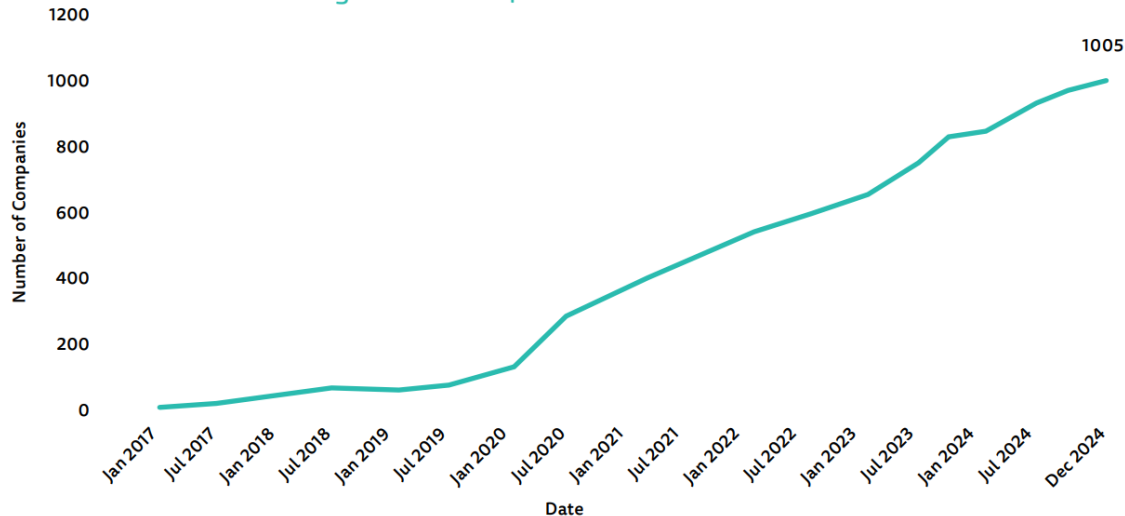


Figure 5: Australian Digital Health companies & technologies assessed against ANDHealth's proprietary stage of development matrix | Companies assessed at December 2020 (n=146), March 2022 (n=520) and December 2024 (1005)

## Highlights from *The Rising Giant*



**1005**

operating SMEs in ANDHealth's pipeline of digital and connected health (DCH) companies



**76%**

compound annual growth rate (CAGR) since 2022



Victoria is home to **422** DCH companies, growing **106%** since 2022

Since 2020, early-stage companies have increased **38%**

**65%** CAGR increase in mid-stage companies

Late-stage companies increased **66%**



**75%**

identified health practitioners as their combined end user



Clinical decision support is the **#1** primary and combined purpose



**15%**

of companies are primarily focused on mental health



**47%**

of companies are developing AI/ML technologies



**44%**

of companies are creating solutions to be used in the home



**28%**

identified health providers as their primary paying customer



# Where can AI help?

## Pre-scanning

- Clinical Decision Support
- Request form processing
- Allocation of human resources
- Patient booking and reminders

## Scan Acquisition

- AI-driven automated scanning protocols
- Reduced radiation dose, scan time
- Improved image quality

## Radiologist interpretation

- AI-driven triage
- Segmentations
- Interpretation assistance
- AI-assisted voice recognition
- AI-generated report

## Post-radiologist

- AI-driven report distribution
- Coding/billing
- Urgent finding communications
- AI follow up of recommendations
- Peer review



# Image reconstruction and quality

- **Noise reduction**

- AI to reduce noise initially produced over-smoothed images
- Newer algorithms produce de-noised images which remain clinically interpretable

- **Reduced radiation, contrast and time**

- Used across CT, MRI, PET
- High quality PET images produced from low dose scans (99% reduction in radiation)<sup>1</sup>
- 200-fold reduction in required radiotracer with maintained image quality<sup>2</sup>

1. Ouyang, Jiahong, et al. "Ultra-low-dose PET reconstruction using generative adversarial network with feature matching and task-specific perceptual loss." *Medical physics* 46.8 (2019): 3555-3564

2. Xu, Junshen, et al. "200x low-dose PET reconstruction using deep learning." *arXiv preprint arXiv:1712.04119* (2017)



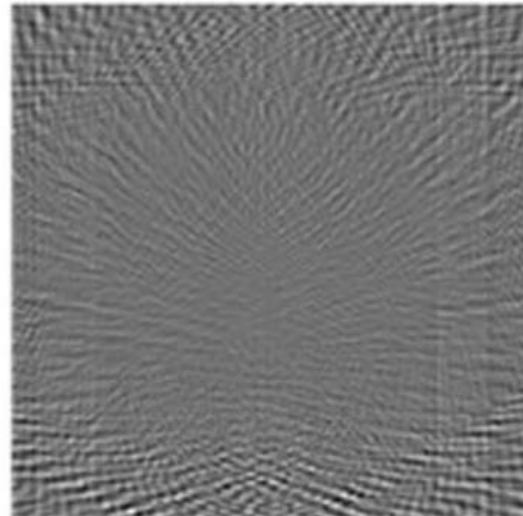
# Low dose CT artefact

- Low dose CT uses reduced tube current and/or voltage, with reduced image quality due to increased noise
- This artefact can be removed by AI algorithms → low dose CT without the noise

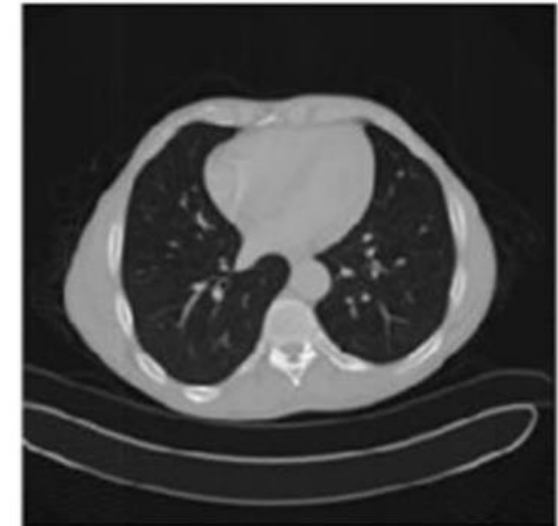
Sparse-view  
reconstructed images



Artifact residual map



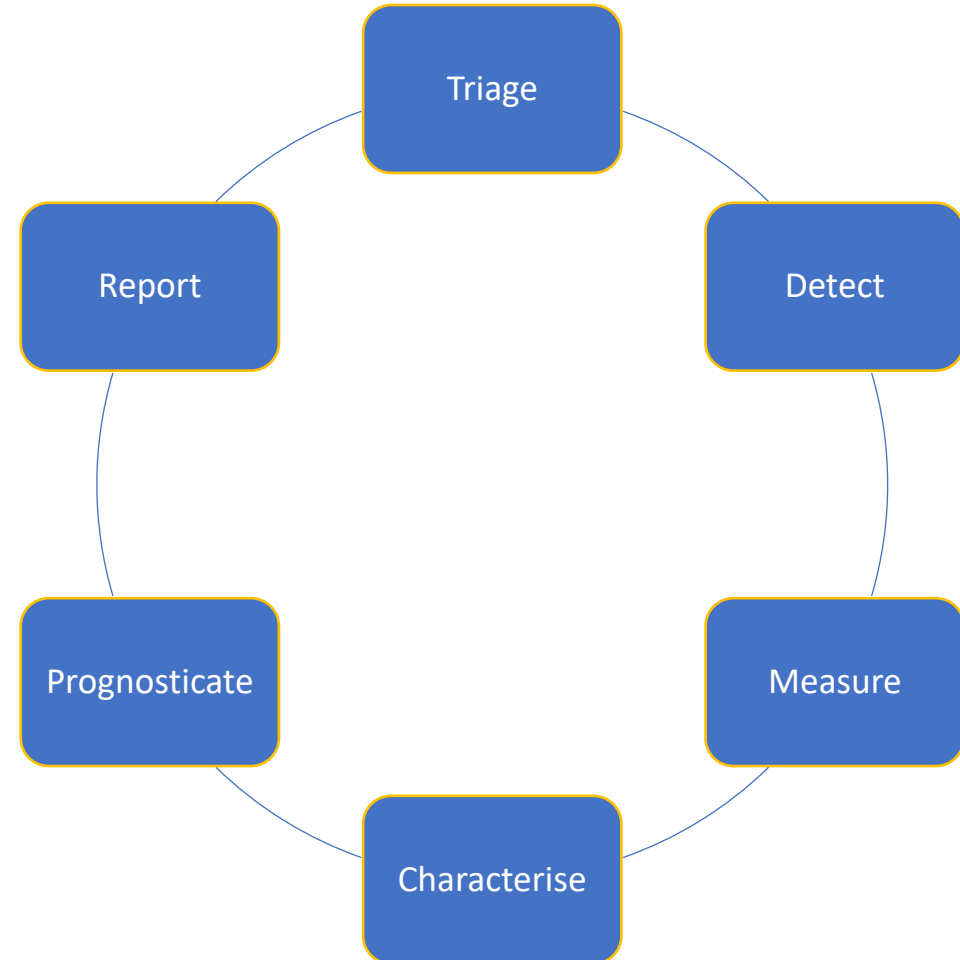
CT recovery images



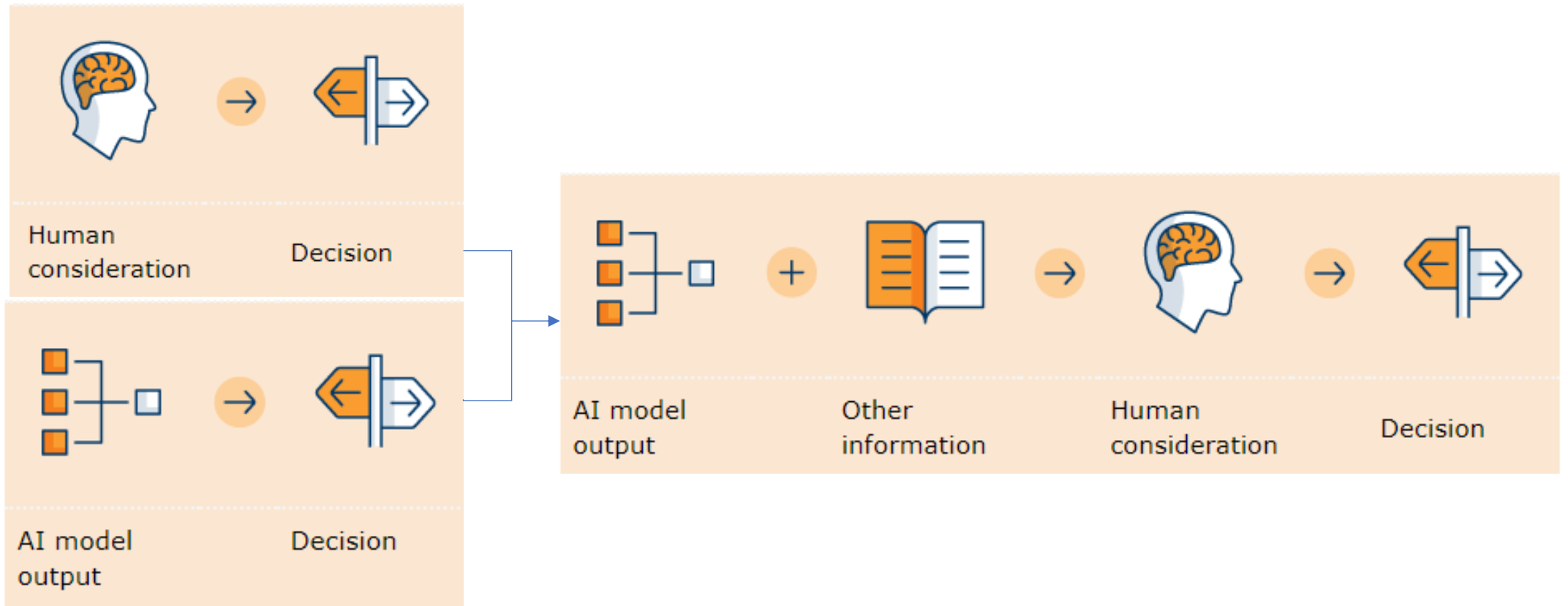
# Radiologist reporting

We are using AI to help us do:

- **What we already do, but better and faster**
  - Triage
  - Detect
  - Measure
  - Dictate
- **What we CANNOT already do**
  - Prognosticate
  - Measure



# Decision making in health care



# AI-driven triage



## Current clinical triage – based on:

Referral information  
'URGENT' written on the form  
Referral source eg emergency department  
Radiographer observations



## Problems:

Urgent pathology may be waiting in the 'non urgent' pile  
*When everything is urgent, nothing is urgent*  
Turnaround KPIs > clinical priority



## Artificial Intelligence Tool for Detection and Worklist

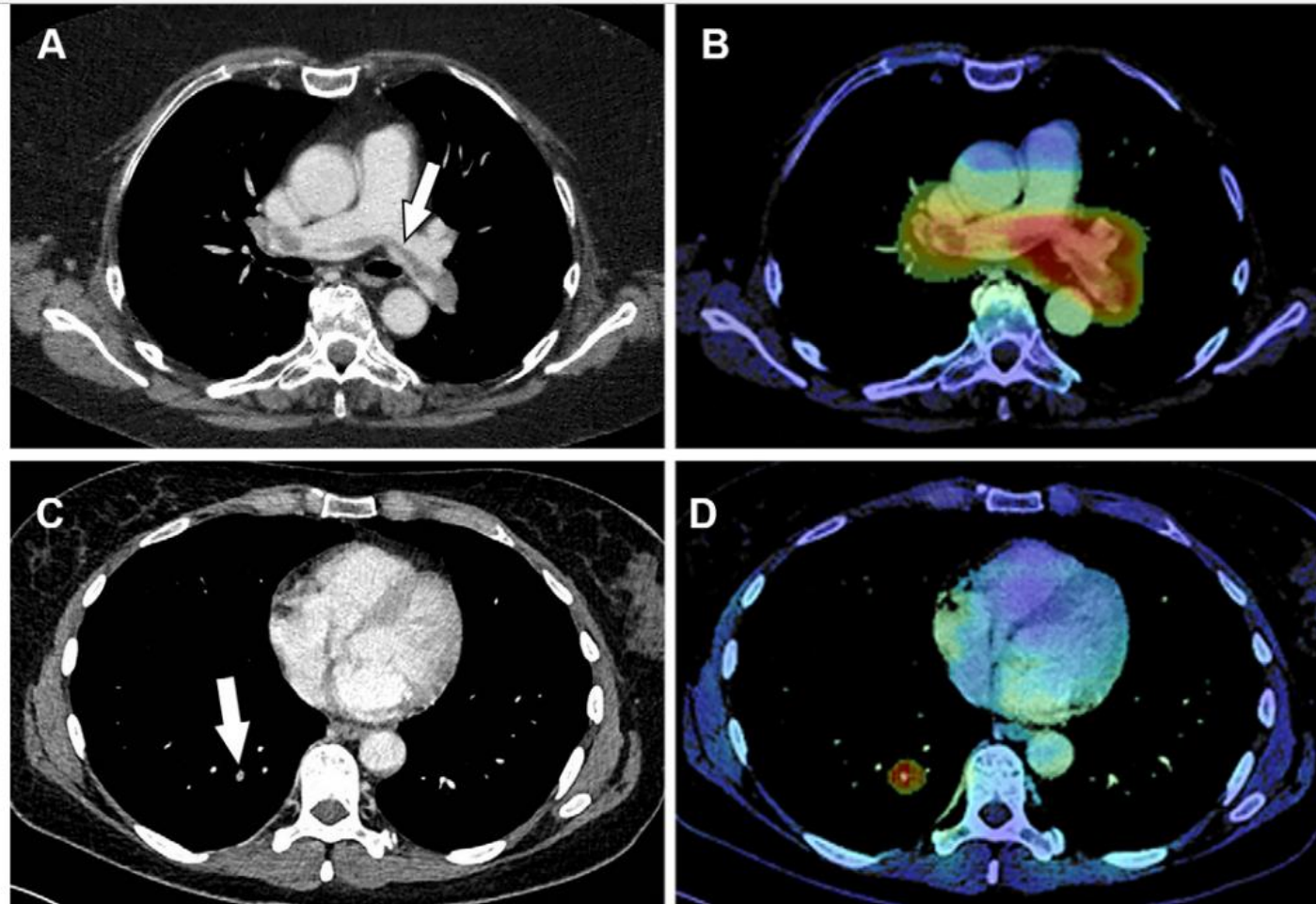
**Purpose:** To evaluate the diagnostic efficacy of artificial intelligence (AI) software in detecting incidental pulmonary embolism (IPE) at CT and shorten the time to diagnosis with use of radiologist reading worklist prioritization.

**Materials and Methods:** In this study with historical controls and prospective evaluation, regulatory-cleared AI software was evaluated to prioritize IPE on routine chest CT scans with intravenous contrast agent in adult oncology patients. Diagnostic accuracy metrics were calculated, and temporal end points, including detection and notification times (DNTs), were assessed during three time periods (April 2019 to September 2020): routine workflow without AI, human triage without AI, and worklist prioritization with AI.

**Results:** In total, 11 736 CT scans in 6447 oncology patients (mean age, 63 years  $\pm$  12 [SD]; 3367 men) were included. Prevalence of IPE was 1.3% (51 of 3837 scans), 1.4% (54 of 3920 scans), and 1.0% (38 of 3979 scans) for the respective time periods. The AI software detected 131 true-positive, 12 false-negative, 31 false-positive, and 11 559 true-negative results, achieving 91.6% sensitivity, 99.7% specificity, 99.9% negative predictive value, and 80.9% positive predictive value. During prospective evaluation, AI-based worklist prioritization reduced the median DNT for IPE-positive examinations to 87 minutes (vs routine workflow of 7714 minutes and human triage of 4973 minutes). Radiologists' missed rate of IPE was significantly reduced from 44.8% (47 of 105 scans) without AI to 2.6% (one of 38 scans) when assisted by the AI tool ( $P < .001$ ).

**Conclusion:** AI-assisted workflow prioritization of IPE on routine CT scans in oncology patients showed high diagnostic accuracy and significantly shortened the time to diagnosis in a setting with a backlog of examinations.





**Figure 2:** True-positive detection of incidental pulmonary embolism (PE) by the artificial intelligence (AI) software. **(A, B)** Images in a 68-year-old woman who underwent routine CT with intravenous contrast agent for outpatient follow-up of melanoma. **(A)** Axial CT image shows a large filling defect straddling the bifurcation of the pulmonary trunk (arrow) and extending into both pulmonary arteries, compatible with an incidental saddle PE. **(B)** Corresponding AI heatmap highlights the detected abnormality (red), thereby prioritizing the case in the radiologists' worklist. **(C, D)** Images in a 58-year-old woman with a history of rectal cancer undergoing outpatient follow-up. **(C)** Axial restaging CT image with intravenous contrast agent shows a small incidental subsegmental PE in the right lower lung lobe (arrow). **(D)** Corresponding AI heatmap enables the radiologist to localize the finding (red).



# AI Diagnostic tools – Questions to ask

- Does the AI address a clinical problem?
- Is it accurate?
- Does the AI actually improve my performance?
- Does the evidence reflect real world practice?
- Is the evidence applicable to our own practice population?

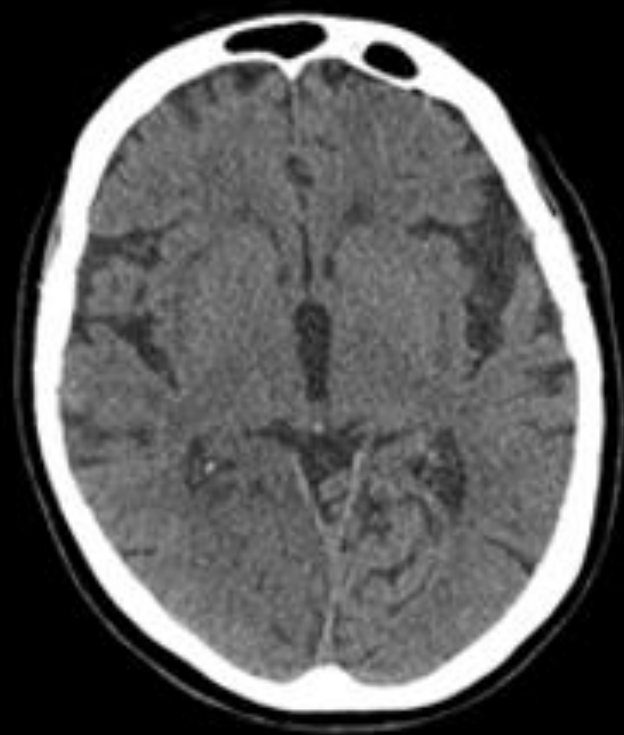


# Case example: Annalise CT brain

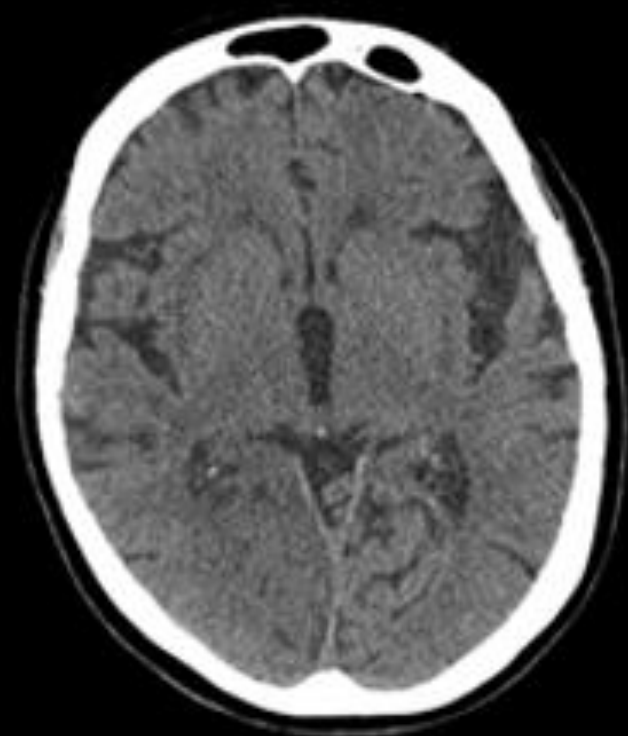
- **Prioritise CT scans with urgent brain findings**
  - Brain bleeds
  - Fractures
  - Stroke
  - Tumours
- **Improves radiologist detection of subtle findings**
- **Reduced reporting times (-10%)**
- **Reduced turnaround times for urgent cases**
- **Using AI to extend the scope of what we can see on the scan**



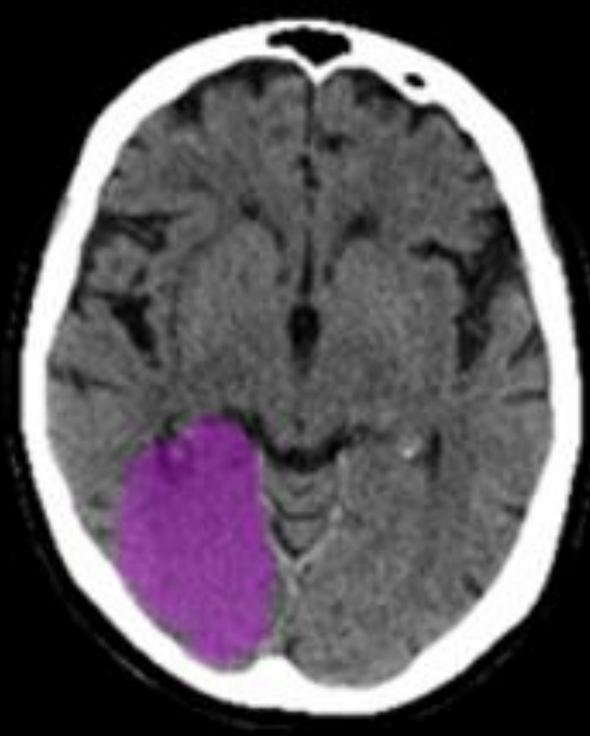
Non-contrast CT scan



Non-contrast CT scan



Model output

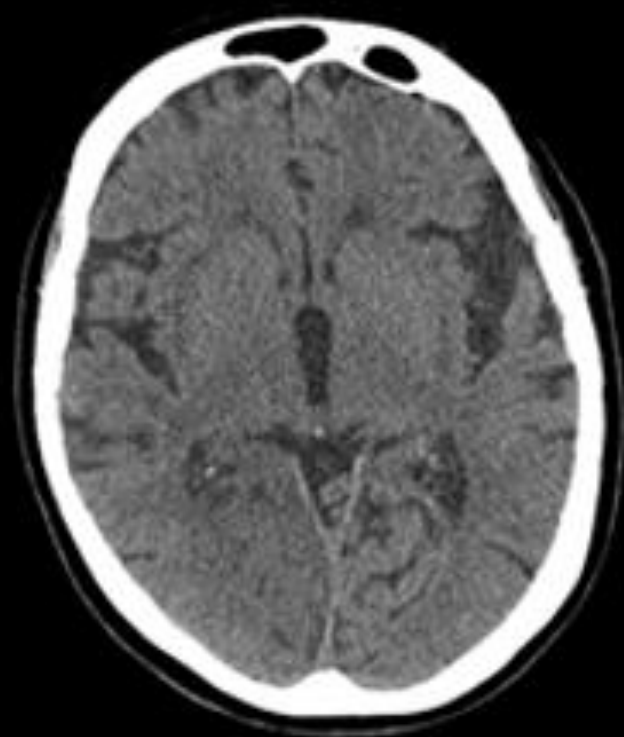


Acute cerebral infarct

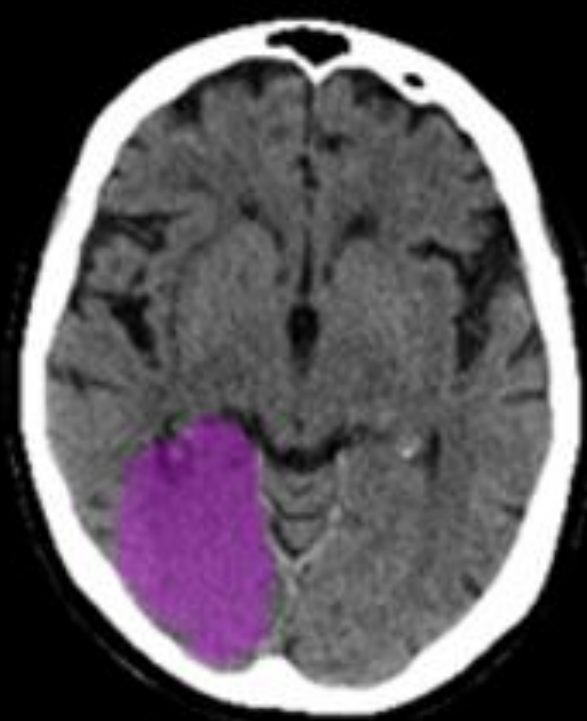
Show Hide



Non-contrast CT scan



Model output



Acute cerebral infarct

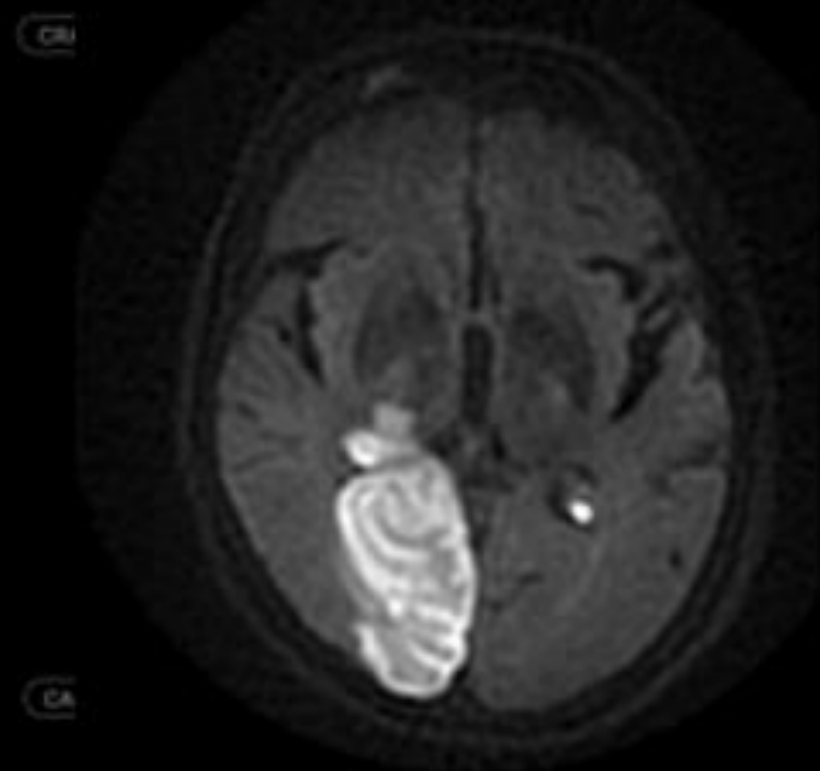


ABSENT



PRESENT

DWI

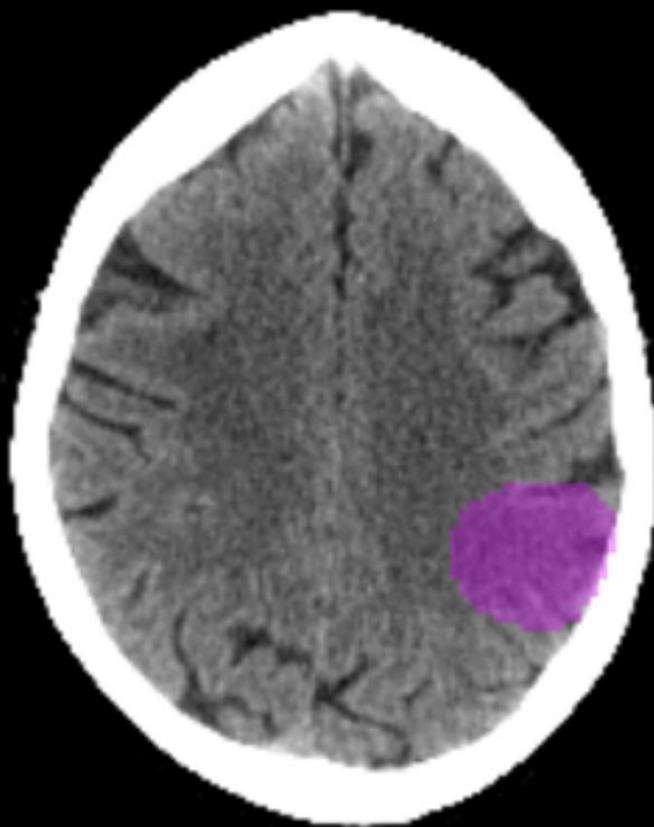


Non contrast CT



Non contrast CT

Model output



Show

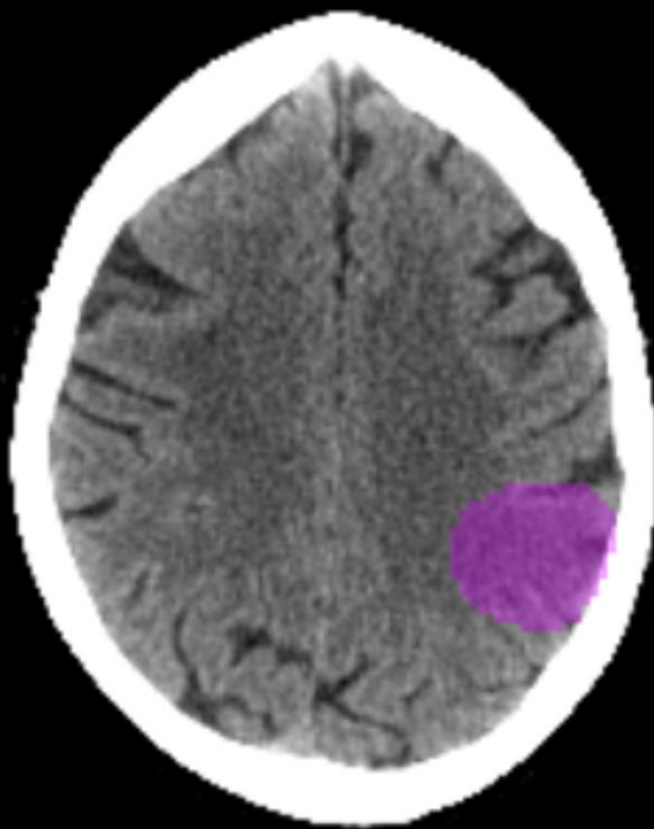
Hide



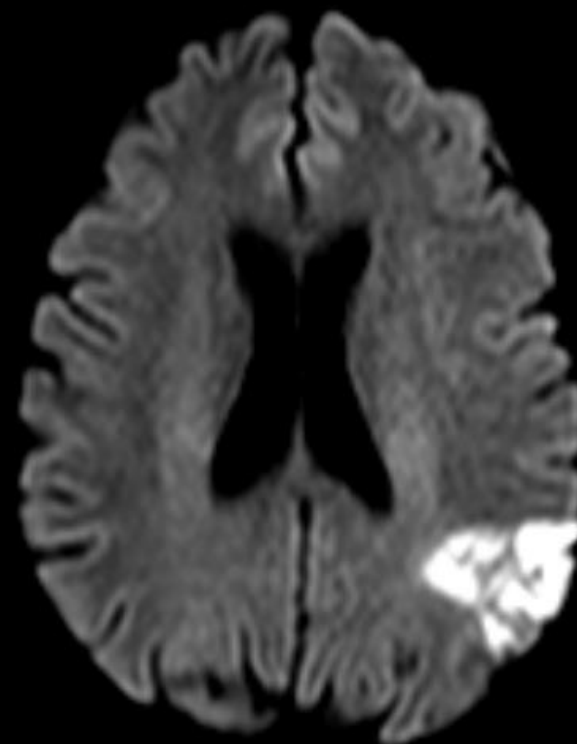
Non contrast CT



Model output



DWI



Show

Hide



# AI – Scribe tools – Questions to ask

Accuracy:	How accurate is the AI in transcribing medical terminology?
Implementation:	What is the learning curve for implementation?
Speech Patterns:	How does the AI handle different accents and speech patterns?
Security:	What security measures are in place to protect patient data?
Integration:	Can the AI integrate with existing systems?
Customisation:	How customizable is the AI to specific medical specialties?



# Example advice – Avant

[<https://avant.org.au/resources/ai-scribes-a-checklist-of-things-to-consider>]

## Medical purpose

Generative AI large language models such as ChatGPT were developed for general use rather than for medical purposes whereas AI medical scribes have been developed for use in a clinical context. Before you start using an AI scribe, consider these questions:

- Was the AI designed for a medical purpose?

*This is the most important question to ask. We recommend you do not use AI in a clinical context if it was not developed for a medical purpose or for use in healthcare.*

- Can you test the AI scribe's outputs to ensure that they are accurate, fit for purpose and make clinical sense?

*AI scribes are not subject to regulatory oversight so you need to satisfy yourself that the AI scribe you are considering is helpful, appropriate and safe to use in the clinical context in which you work*



# Compliance with Australian Privacy Laws

- Is any data collected or retained by the AI provider?

- Is data identifiable or de-identified/redacted?

- If data is retained:

- is it encrypted?
- can you access it?
- how long is it held?
- is it stored on servers within Australia or overseas?

*If data is sent and stored overseas, you may have additional privacy obligations (see the OAIC's [APP 8 Cross-border disclosure of personal information](#)).*

- Are there any proposed secondary uses of the data?

*Find out if the AI provider will use the data for any other purposes, such as for research, education or machine learning. Can any third parties access the data for these or other purposes? Specific patient consent may be required for the AI provider to use data for other purposes.*



# Understanding the product

Consider these questions:

- Does the AI provider have information you can give to patients about how the AI scribe works?
- Does the AI scribe incorporate a prompt to ensure consent is obtained at each consultation?
- Is there a notation in the record produced that patient consent has been obtained for use of the scribe?
- If asked by a patient, or a regulator, can you and your staff explain why you are using the AI scribe in your practice



# Administrative automation

- **AI-driven call centres**
- **Automated booking processes**
- **AI-triage of calls requiring human interaction**
- **Clinical decision support tools (AI to customise to the patient)**
  - Up to 10% of tests are not clinically appropriate<sup>1</sup>
  - Rates of inappropriate referrals drop when a CDS is implemented
- **AI-models to predict patient no-shows**

1. Tadavarthi et al, Radiology: Artificial Intelligence 2022; 4(2):e210114. <https://doi.org/10.1148/ryai.210114>



# Administrative automation

- **Coding/billing based on AI findings and chart review**
- **Communication of urgent findings**
  - Variety of methods eg phone app, email distribution list, text messages
- **Follow up of urgent recommendations**
  - Integration with EHR
  - Reminder messages to clinician/outpatient clinic/patient
- **Peer review processes**
  - Quality control tool



# Risks to AI health transformation

## Complexity

- Difficulty in establishing use case
- Challenge in assessing ROI
- Lack of political support/political change
- Technical challenges
- Lack of interoperability
- Scalability

## Strategy

- No high level strategy across health systems
- Local practices vary and strategic alignment is limited
- Lack of integration of technology innovation (such as digital health and AI) with overall health system strategy

## Regulations

- Fragmented, confusing rules on AI
- Medical device, or not a medical device?
- Changing goalposts

## Distrust

- Public and sector distrust
- Publicised case failure
- Initial adoption failure due to inadequate training or technological limitations
- Concerns over cost vs benefit





# Conclusion

- **AI will help address the healthcare crisis**
- **AI is changing reeeeeally fast**
- **Be open to new ideas**
- **Don't have a plague of pilots!**





**Thank you**

# Thank you!

## *Generalism*

NOUN

**a philosophy of care distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs.**