During May an amazing 5,000-plus delegates from diverse countries and backgrounds flocked to Florence, Italy, for the World Congress on Osteoporosis.

The congress was held from 5 to 8 May 2010. Its major strength was the emphasis on presentations with a strong clinical focus. Highlights included discussions on the management of osteoporosis in the very elderly, optimal dosing and extraskeletal effects of Vitamin D, assessing fracture risk with DEXA and other radiological technologies, and assessment of women's attitudes towards fracture prevention and osteoporosis treatment.

Meet-the-Expert Sessions were held twice daily and were well attended. Eight to ten topics were explored at each so the only difficulty was deciding which session to attend as the majority of topics had direct clinical relevance to my practice. Debbie Kesper and I developed a system where we would attend different sessions and then summarise the information to each other. Despite this there were still a number of topics that I was unable to access.

There were a few cutting edge plenary presentations. In particular Dr Ego Seeman from the Austin Hospital in Victoria gave a very elegant and well received presentation on region specific fracture management and response to therapy.

Future congresses are in Valencia, Spain, in 2011 and 2012 in Bordeaux, France. I plan to attend again in two or three years. In addition, the first Asia-Pacific osteoporosis congress is planned for Singapore in December 2010, but I have little information on this.

I have previously attended an international osteoporosis conference that is held annually in Washington DC, USA, but preferred the format of the Florence conference with its high level of clinical applicability and more global approach in terms of presenting speakers, information, and audience participation.

Ingrid McGaughey

Like many medieval bridges, the Ponte Vecchio (above) was lined by shops - originally occupied by butchers, they now house jewellers, art dealers and souvenir shops.

Debbie Kesper, Ingrid McGaughey and friends in Florence (left).
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Have your say!

We welcome letters to the Editor. You must provide your full name and address for verification.

The views expressed in any letter published are those of the individual writer and not necessarily endorsed by the Faculty.

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How often do we spend time really catching up with our professional friends?

Yes, I know that we are usually get on very well with our professional colleagues in our workplaces, but I am speaking of the smaller percentage of people, whose friendship with us has grown up in particular work or study circumstances, and continues over the years. The person who you might not see for a couple of years, or decades, and as you meet and start to talk, it is as if the intervening time had not been, and you pick up the friendship exactly where you left off. Chance meetings at recent conferences have set me thinking.

The recent Melbourne WCIM/College/Faculties meeting was wonderful. It started on the Sunday, with a properly planned trainees’ day, which led into a well-focused rehabilitation clinical stream with good quality special orations. Combined with some really outstanding medical sessions on specialist medical topics with concentrated boluses of clinical information, all within the one program, this made for a great smorgasbord of choice. Thinking about the intersection of climate alteration and social evolution, patterns of disease, and the opportunities that we encounter as individual practitioners to influence others for change, for example, was very challenging. Even better that at several times at the conference, my friends were sitting together and interacting and discussing ideas, many from outside the box of our pure rehabilitation context. It felt more like interactive time spent at university, time spent in learning-community mode with friends, and was quite unlike the focused rush of multiple brief speech and email contacts, characteristic of an ordinary day’s work.

1975, I did a student elective in Taiwan, and worked together with a young diabetes physician who had just returned from doing his English M.R.C.P. Twenty years later, in the 1990s, I was in central Taiwan developing extended care services from a large teaching hospital, and Dr Lin was the hospital D.M.S. In Melbourne, fifteen years after last working together and with only intermittent email contact since, we renewed the warmth of professional friendship in person.

I had not originally intended to join the AOCPRM meeting in Taipei last month, but an e-notice that a quorum of ISPRM Education Committee members would be present led me to change plans, notwithstanding the lack of a daylight direct Sydney-Taipei flight. A return to old stamping grounds is never the same – 15 years on, the galaxy of mobile road-side breakfast and lunch sellers and their attendant legendary traffic jams have all but disappeared. The marathon that often seems to coincide with a rehab conference showed that the air is much cleaner than it was, the “wild chicken” bus companies have disappeared, there is a metro that runs on time, and everything seems much more tame and ordered than before. While the conference venue remains very startlingly pink-tiled, it is clearly overshadowed by the nearby Taipei 101 office tower. I do not have a good head for heights, but the outlook from the top is amazing. The conference did how ever show case just how far rehabilitation practice has advanced in East Asia, in the last decade especially, with some very good original research papers on new modes of physical and electrical treatment modes. In his plenary, Gerold Stucki laid an excellent philosophical foundation for us, though I still have some trouble coping with the idea that all can be described in terms of single diagnosis ICF core-sets, when many of the patients I deal with have two or more conditions contributing to their need to be under my rehabilitation care.

But the combination of time in discussion with friends, over food, was the highlight of that time for me. A long and productive working breakfast around ISPRM educational matters was well worth the 5.30 am rising time. I waived the conference gala dinner in favour of a quick 45 minute (150 km) trip down the new bullet train line, out to and back from my old hospital in central Taiwan, and a wonderful time spent with previous professional colleagues. Universal health insurance coverage of hospital and ambulatory care services has been in place since 1993, and they are now, like here, placing emphasis on the importance of locally-based hospital governance, though having only one level of government to deal with.

No wonder photos from meetings usually feature groups of friends together.

Andrew Cole
Rehab in Rudd’s Brave New World

The Prime Minister has announced as part of the National Health Reform that hospitals will be expected to be efficient.

That is to be done by determining and paying an ‘efficient’ price for all hospital activities. Activity Based Funding (ABF) will apply to all hospital services across Australia. Different activities are classified by diagnosis (DRGs). An independent body will determine the efficient cost of each activity and local hospital networks will receive funding according to the cases they admit. ABF aims to reduce the cost of an episode of care (ie an admission) by reducing lengths of stay (Eagar 2010).

Simple ...

Rehabilitation and other subacute care services don’t quite fit this model. In our world, the patient’s treatment isn’t driven primarily by diagnosis but by functional abilities and rehabilitation goals (Eagar 2010). Classification needs to factor these in, so classification systems such as AN-SNAP have been designed which factor in impairment, age and functional status to determine efficiency. Sounds reasonable ...

So how efficient is your service? To a rehabilitation physician, a program enabling a patient to maximise his or her independence at a reasonable cost is efficient. To us, keeping a stroke patient for an extra two weeks in a rehabilitation unit to avoid nursing home placement is an efficient use of services. It’s a good investment from the point of view of the Federal Government too because it saves nursing home costs.

But local hospital networks are not concerned with the cost of community services or nursing home care. Efficiency to them means cost to their budget. It is exclusively measured in bed days within their part of the hospital system. A cheap service is an efficient service, regardless of health outcomes. How do rehabilitation services measuring their effectiveness by functional outcomes co-exist with managers who measure effectiveness by length of stay?

Does it all matter if you’re not a policy geek?

Well, we’re told efficient hospitals will thrive in the brave new world of National Health Reform. They can keep any profits generated by early discharge. Mr Rudd has also promised them extra funding. You can expect inefficient services and wards to be axed.

So it matters to us all.

Jennifer Mann and Kim McLennan

Reference:
Eagar, K. (April 2010): ABF Information Series: No. 1 ‘What is Activity Based Funding?’ and No. 6: ‘Subacute care’
University of Wollongong Centre for Health Service Development
http://chsd.uow.edu.au/activity_based_funding.html (This series provides a simple summary of Activity Based Funding.)
Dear Colleagues

This is the basis of the speech that I gave at the Annual Members Meeting in Melbourne in March of this year.

I thought that I would share with you some of my thoughts on taking up my current role. It is with humility and with some trepidation that I assumed the role of President of the Australasian Faculty of Rehabilitation Medicine. It is a privilege to acknowledge all those who have influenced me along the journey. In particular I would like to acknowledge Stephen Buckley, the immediate Past President. In the misty dawn of time I was Stephen’s registrar. At the time he encouraged me to undertake training in rehabilitation medicine. I recall his comment that “he had passed, why couldn’t I?” I have used this comment since then, several times, to encourage more people to undertake what I consider to be a sustaining and satisfying career. I would also acknowledge all the doctors, nurses, allied health professionals and, most importantly, the patients and their families from whom I learnt so much.

I chose to study medicine as it was the longest degree and I thought, if I didn’t like it, I would have plenty of time to transfer to another course. However, once I reached the clinical years I found that I had a passion to make a difference and to improve my patient’s quality of life. This passion remains undimmed but is now tempered with wisdom. When I was a newly minted intern doing after hours calls I had occasion to attend to a man in his mid eighties who had end stage renal failure on haemodialysis. He became septic. I started to do the standard septic workup, but as usual my procedural skills were less than proficient. My patient became naturally quite angry when I had my third go at trying to find a vein to take blood. He pleaded angrily to be left alone and commented on my fringe that was falling over my eyes. The man died an hour later and I have always taken this comment since then, several times, to encourage more people to undertake what I consider to be a sustaining and satisfying career. I would also acknowledge all the doctors, nurses, allied health professionals and, most importantly, the patients and their families from whom I learnt so much.

Stephen Buckley has achieved so much during his time as President that he sets a very high standard. Garry Pearce achieved the, at times insurmountable, goal of an inclusive collaboration with Divisions, Faculties and Chapters at Board level. He did this quietly and with determination and probably even stubbornness to achieve this. The Faculty is not the office, it’s not the letterhead, it is the Fellowship. All of us are the Faculty and each one of us has the opportunity to grow our Faculty and to spread the contagion of passion tempered with wisdom. The end result will be that everyone has good rehabilitation when they need it.

I have the honour of acknowledging Dr Stephen Buckley’s term as Faculty President.

Stephen Buckley has achieved so much during his time as President that he sets a very high standard.

Garry Pearce achieved the, at times insurmountable, goal of an inclusive collaboration with Divisions, Faculties and Chapters at Board level. He did this quietly and with grace, setting the stage for the next step as presaged by the Taverner Research.

During his term Stephen Buckley turned the Faculty’s view to external challenges. I recall many times when he was musing on what next to do, and turned these thoughts into actions and then results. He was responsible for seeing through the development of what became known as the Role of the Rehabilitation Physician Statement, through the hard work of Craig Davenport and those who attended the vibrant workshop. This
provides the answer to that conversation stopper – so, what do you actually do?

Stephen then was instrumental in developing the AFRM National Rehabilitation Strategy. This has been disseminated and widely acknowledged.

Stephen has followed his own good advice and been persistent and persuasive. He recounts how he had 30 seconds to talk with the Honorable Nicola Roxon, Minister for Health. He stated that Rehabilitation Medicine was “the backdoor of the hospital”. This was later repeated to him by a senior NSW politician without realising that it was his own phrase. This persistence has paid off by the establishment of regular quarterly meetings with the Subacute Care Policy Section of the Department of Health and Ageing.

Perhaps a fitting tribute to his Presidency is the formation of the ‘Alliance’ – which brings together all the major professional bodies of Allied Health and Nursing who, with Rehabilitation Physicians and the patient, make up the multidisciplinary rehabilitation team. This alliance has developed a draft multidisciplinary National Rehabilitation Strategy that was presented to the Department of Health and Ageing in March this year.

Much of Stephen’s achievements were at one time just wishful thinking. It was his drive, his persistence and his quiet determination that turned wishes into action and more so into giant steps forward for Rehabilitation Medicine. In his spare time he continued the good work of Garry Pearce by progressing the successful integration into ‘one College’ and is one of the RACP representatives on the University Partnership Project. Once a person steps down – often as time goes by, the person is forgotten over the years as colleagues also retire. However, the successful outcomes are remembered – by their deeds shall you know them.

Thank you for expressing your confidence in electing me President of the Faculty.

Kath McCarthy

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**Private Practice Opportunity**

Our Rehab physician is leaving and we need to find someone urgently to either:

- provide a locum service until we can recruit to the role, OR
- make the most of this opportunity and establish a permanent private practice in partnership with Murray Valley Private Hospital.

**Murray Valley Private Hospital (MVPH),** a comprehensive Rehabilitation and Oncology Hospital located in Wodonga in North Eastern Victoria, is seeking a Rehabilitation Physician (FAFRM) to establish their private practice in partnership with the hospital.

**BENEFITS:**

1. Financial assistance with relocation
2. Rent free consulting rooms for 3 months with rooms located on-site
3. Practice management assistance provided
4. Assistance with marketing your practice to GPs in the community to help establish your referral base
5. Joint appointment with public hospital, providing financial security whilst establishing your private practice.

**ABOUT US ...**

MVPH is licensed for 48 beds, with an 11 bed Day Chemotherapy Unit, for cytotoxic and related treatments and four procedure room beds, utilised for related minor procedures. The 33 Inpatient beds consist of 20 Rehabilitation beds, ten Oncology beds and three beds for the Sleep Disorder Centre. On-site facilities include specialist medical consulting rooms, pathology service, radiation oncology and a clinical psychologist. Acute medical care is also provided.

MVPH also has on-site accommodation for up to 55 outpatients and their carers. The Support Units offer comfortable motel style accommodation and eliminate the worry of finding accommodation for patients and carers, who may need to travel some distance for treatment and do not require in-patient care.

**INTERESTED?**

Please contact Kerrie Gallaway, Director of Clinical Services/Facilities Manager at Murray Valley on 02 6055 3251; m: 0439139757 or email: gallawayk@ramsayhealth.com.au to find out more.
Book Review

The Amputee Coach
by Cathie Howells with Sandra McFaul

Global Publishing Group, 2009
Phone 03 9736 1156 to order

This is an interactive book written in a chatty style by Cathie Howells with the help of Sandra McFaul. Cathie Howells is a very capable physiotherapist who has been treating lower limb amputees for more than 20 years. She has been a lecturer at the University of New South Wales prosthetic course for most of those years. She has trained paralympians as well as the average amputee. Thus she brings a wealth of experience to her writing.

The aim of the book is to teach amputees to walk well, be fit, and to enjoy life. It has questions for amputees to answer and a text below to help them solve the problem, e.g. “Write down your frustrations and anger” and then how to deal with it. Amputees are directed on how to achieve greater levels of ability and performance. It is sprinkled with pithy sayings which we can all apply to our lives, e.g. “A goal without a plan is just a wish”.

The first six chapters are aimed at inspiring the amputee to become more active. The nitty gritty starts in Chapter 7 which tells the amputee how to fall-proof the home, with illustrations on how to get up from a fall. Illustrated balance exercises are included in this chapter. Other chapters include core stability, stretching, and how to improve walking patterns.

There are inspiring stories of people who have gone on to ice skating on a transfemoral prosthesis, or to become paralympians. There are stories of ordinary people who have been lifelong prosthetic users.

The most unusual was the story of a man who became a transfemoral amputee at the age of 16 in 1955. His father measured his stump dimensions and posted off for a leg to be made in England. Prosthetics in Australia is now a different place from then! In his retirement he has self-funded a C-leg. Cathie says he retrained and got a good outcome with this prosthesis.

I would recommend this book to all rehabilitation physicians. It is a great read and will be of value to the able bodied as well as the disabled.

Lorraine Jones

Update in Rehabilitation Medicine Day

A fascinating and informative day was enjoyed by all who attended the Victorian Branch’s 7th annual Update in Rehabilitation Medicine Day on Saturday 27 February, organised by Prof Fary Khan and her team at the Royal Melbourne Hospital. In fact the Lovell Theatre was packed to capacity with clinicians from all fields of rehabilitation, with nursing, allied health, and rehabilitation Fellows mingling in a social environment whilst enjoying updates from leaders in various spheres of rehabilitation medicine on a day that emphasised the importance and expansion of research in rehabilitation medicine.

Prof Khan, an extraordinarily driven and dedicated clinician and researcher, dazzled all with the sheer volume of her publications as she updated us on the current evidence base in the field of multiple sclerosis rehabilitation, as well as highlighting the current gaps in our knowledge and the vast opportunities for ongoing clinical research. Dr John King, a highly respected neurologist from the Royal Melbourne Hospital with a special interest in MS, led a detailed discussion on the importance of early diagnosis and treatment in slowing disease progression in MS, the role played by MRI lesion number and volume in determining the likely clinical course, and the efficacy of currently available medications, and exciting future directions. Prof Ian Baguley made the trip down from Westmead Hospital in Sydney to provide an interesting update on spasticity management, highlighting the importance of careful patient selection when seeking to improve function through spasticity reduction.

Following a rowdy morning tea break, Prof John Olver from Epworth Rehabilitation and Monash University updated the mob in several key areas of traumatic brain injury rehabilitation, including genetic markers and the role of Apo-E4, the current recommendations for seizure prophylaxis following TBI, a fascinating recent study on the role of botulinum toxin therapy for lower limb spasticity in shifting patients into higher functional walking categories with consequent enhancement on quality of life, and the role of exercise and pharmacotherapy in combating post-ABI fatigue. A very informative update on the role of rehabilitation physicians in the management of intellectual disability, particularly as such patients age, was provided by Prof Lyn Lee from the Concord Hospital and Sydney.
Abrahamson presented a fascinating update on the role of online, all 1,227 pages of it! And finally, Dr Sarah Canadian-produced SCIRE resource which is available spinal cord injury rehabilitation, highlighting the fantastic presented an important update in the evidence base for In line with the evidence-based theme of the day, Dr becomes quite enjoyable!

The afternoon session focussed further on the expanding importance of research in rehabilitation medicine, which was particularly useful for the rehabilitation registrars contemplating their clinical research modules. Informative talks from Dr Jen Alviar, a visiting Fellow from the Philippines, about the process of conducting research, followed by the extremely important topic of writing up research papers and submitting them to appropriate journals for publication, presented by Dr Marina Demetrios, a Fellow at the Royal Melbourne. An energising talk from Dr Louise Ng then compared the ordeal of writing a Cochrane Review to having babies – even though one inevitably says “never again” after the first one, more follow and it actually becomes quite enjoyable!

In line with the evidence-based theme of the day, Dr Peter New, head of spinal rehabilitation at Alfred Health, presented an important update in the evidence base for spinal cord injury rehabilitation, highlighting the fantastic Canadian-produced SCIRE resource which is available online, all 1,227 pages of it! And finally, Dr Sarah Abrahamson presented a fascinating update on the role of rehabilitation in the management of autism spectrum disorders – it’s not often that a scientific presentation includes analyses of Borat, Andy Warhol and Napoleon Dynamite!

On behalf of all attendees, I would like to thank Prof Fary Khan and her energetic team at the Royal Melbourne Hospital for arranging such an informative and entertaining update.

Top tips & tricks

- If a hand is bunched up from spasticity and you want to get it out straight, hyperflex the wrist and amazingly the finger flexors relax so you can get the rest of the hand out flat!
- In TBI research, modafenil has not been demonstrated to show any difference in fatigue; in fact, only exercise has been shown to have any benefit on fatigue.
- There is Level 1 evidence that exercise prevents depression in spinal injured patients.
- MRI performed early in the diagnosis of multiple sclerosis predicts the course of this disease. There is a ‘window of opportunity’ for treatment early in the course of MS.
- Include a cover letter addressed to the editor of your chosen journal – this is your chance to ‘sell’ your article for publication!

Richard Bignell & Dionne Rourke

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**AACRM Prize**

The prize is valued at $1,000 plus travel expenses to attend the award presentation.

The cash prize and an award certificate are presented during the Annual Meeting of AFRM Fellows, usually held during the Annual Scientific Meeting.

The nomination form is to be signed by a proposer and a seconder, who could be Rehabilitation Physicians, therapists, patients, mentors or colleagues. It is available on the Faculty website. Please note that nursing and allied health professionals may be nominated as well as Fellows of the Faculty.

Nominations must be sent to the Faculty’s Senior Executive Officer before the end of August each year.

Richard Bignell & Dionne Rourke
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as at 21 May 2010

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Rhaia June 2010
Vale

Peter Anderson

Orthopaedic Surgeon
Vietnam Veteran
Rehabilitation Specialist

Peter Anderson was born in Britain, the son of an eminent Sheffield urologist. He studied medicine at Cambridge University and came to Australia as a qualified surgeon.

In Australia he completed the F.R.C.S. Australia and took up practice as an orthopaedic surgeon. Service in public hospitals was in an honorary capacity in those days, and Peter served as a consultant at Royal Perth Hospital and also at Princess Margaret Hospital for Children.

Peter's kindly and friendly approach was the start of many lifelong friendships. For many colleagues his dedication and gentleness was always a feature of his work, both in Australia and overseas.

Peter served two six-month terms in the Australian Army as a front-line surgical officer. That day in July 1969 when man walked on the moon was a day Peter remembered well. It was a day an Australian platoon was mined and ambushed and nearly totally wiped out. There were many casualties. In their song I was only 19, the band Redgum sang: “Frankie kicked a mine, the day that mankind kicked the moon”.

Peter worked round the clock to stabilise those who survived and undertook emergency surgery in the field hospital tent before they were airlifted back to Australia. This must have been an incredibly stressful time for him. He felt for the Vietnam veterans when their service to their country was insufficiently recognised and they felt tainted. In an interview with the West Australian he said, “I came back tainted with the brush of the My Lai massacre. Some of my professional colleagues didn’t want to know about me at all. I had no work when I came back to Australia”.

Peter’s experience and interest in rehabilitation lead him to head the Melville Commonwealth Rehabilitation Service until it closed.

Peter’s Vietnam experience was also valuable in establishing that Vietnam veterans suffered disabilities related to their war service. His grasp of legal requirements helped many veterans both medically and in establishing their claims. He was quick to point out that working for medico legal consultants compromised your opinion and it was difficult to give an unbiased report. He spoke out about this and the issue was raised in a local paper. His opinion was not necessarily popular but he was not afraid to voice what he felt. Peter has served the medical fraternity in the specialties of orthopaedic surgery and rehabilitation over a full and distinguished career.

In April 2008, Lt-Col Anderson (Ret’d) received the Australian Defence Medal.

He had a strong Christian faith and he worked at all times in the service of our Lord. He used his talents to benefit those around him and I am confident that the rejoinder “Well done, good and faithful servant” sits well on his shoulders.

He died suddenly on November 21, aged 80. He left a wife, six children, and grandchildren Natasha, Andrew, Timothy, Jessica and Annabelle.

To his wife Mary and all his family members may we extend our gratitude for a life well lived, for the support you gave Peter and we express our great sympathy on your loss.

It was a great privilege to have learnt from him and a great privilege to have him as a friend.

Edited eulogy, courtesy of Bob McWilliam.
When I started medical school I had tattooed on my back primum non nocere. 'What does that mean?' asked almost everyone who saw it, including my medical student colleagues. And at graduation there was an optional Hippocratic Oath ceremony after the formal ceremony, which was attended by only a handful of people, myself not included (blame champagne and excited relatives if you would be so kind). The study of traditional ethics was obviously not an area of keen interest among my peers.

In my experience, the principles of medical ethics have been regularly discussed and explicitly referred to in guiding management mostly in my RMO palliative care terms, but I still think they are the fundamental principles for our practice in rehabilitation medicine, and important for all of us to keep in mind. The four prima facie principles are beneficence, non-maleficence, respect for autonomy, and justice.

Primum non nocere: first, do no harm. Our primary consideration should be to cause no injury to the people we look after. We must be well informed of potential side effects of the treatments we prescribe. One of the benefits of regular rotations as trainees is the opportunity to observe a wide variety of approaches from our consultants, from those who extensively utilise prescription medications and high-tech equipment, to those who seem to feel that time and understanding are the great healers.

Salus aegroti suprema lex: roughly translated, the well-being of the patient is most important (More literally: the patient’s health is the supreme law). We should act in the best interest of the patient. Rather self-explanatory. We must be sure that the benefits we promote are accurate, by keeping ourselves up to date with new evidence and best practice. And we must carefully consider what is most right for each individual, not just what is most right or most convenient for ourselves.

Voluntas aegroti suprema lex: the patient’s will is most important. Our patient has the right to choose or refuse, to make decisions about their own future. We should use our experience and knowledge to offer all practical possibilities, and be able to explain likely outcomes, advantages and risks in a way that our patient can understand. Then, it is up to them. Informed consent and confidentiality also fall under this principle.

Justice: fairness and equality regarding the distribution of scarce resources, and prescribing appropriate treatments to appropriate patients. It also means respect for people’s rights and for the law. One example that readily comes to mind is our role in moving people out of our beds when there is potentially someone who will benefit more from the inpatient program. Easier said than done, I know. But we can assist by consistently guiding our patients through their journey so that hopefully they can achieve an acceptance of their new impairment and be prepared to incorporate changes into their lives, rather than endlessly circulating through our system in search of a cure that cannot be found.

Medical ethics must be carefully considered in the case of Body Identity Integrity Disorder, which is the subject of this edition’s Clinical Corner. If you have come across any interesting cases, tell us about them for next time. Trainees, we are calling on you to contribute to this trainee subsection. This month, one new registrar says goodbye to his junior years in a poem, but we do need to hear from more of you. Short articles or long, photos or poems, quotes or requests, this is your magazine to make of what you wish. Send your articles to jgil2726@gmp.usyd.edu.au at any time.

Good luck to those of you studying for exams. It is not my turn this year, but it will be soon enough!

Jasmine Gilchrist

Trainees and SIGs

Did you know trainees can join the Faculty's Special Interest Groups? SIGs are part of the Education Committee, and welcome trainees and specialists with a special interest or expertise in an area of rehabilitation medicine.

The ten rehabilitation SIGs are:
- Developmental and Intellectual Disability
- Mind
- Musculoskeletal Medicine, Pain and Occupational Rehabilitation
- Neurological Rehabilitation
- Paediatric Rehabilitation
- Prosthetics and Orthotics
- Rehabilitation and Older People
- Rural and Remote
- Spinal Cord Injury
- International Classification of Functioning, Disability and Health.

They provide trainees with a way to get ahead in the fields they are interested in, and influence the content and method by which we are taught.

SIG functions include collecting information and data relevant to the sub-specialty, disseminating material, developing clinical practice guidelines, providing peer support and networking opportunities, and contributing to Annual Scientific Meetings and our training curriculum.

Each SIG has its own section on the AFRM website http://afrm.racp.edu.au, providing information and forums for discussing matters of interest.

If you would like to join one of the SIGs just send an email to afrm@racp.edu.au or phone 02 9256 5420. It costs nothing to join, you can belong to more than one group, and full membership is open to trainees as well as Fellows.

Jasmine Gildchrist

First-Year-Out

Flashback, ah! Finally a breath
Snap off the tourniquet
Tiny triumph, shortly lost to
Two more charts
Three forms
Four summaries
Origins of scrawl
A good pick-up
She lives
A young man arrests
Tears shared
Another form
Lugubrious afternoon rounds
To follow
Abandoned drollery anticipates
The weekend and my pillow

Rabin Bhandari

2010 New Fellows

... celebrating the end of their trainee years

Jenson Mak

Yuriko Watanabe
Clinical corner

Body Identity Integrity Disorder

Body Identity Integrity Disorder is a psychiatric condition that may gain entry into DSM-5. It describes people who experience an emotional discomfort with a functioning body part (usually a limb), feeling so strongly that it should not be there that day-to-day functioning is impeded.

Such patients may injure their own limbs irreversibly, request amputation of healthy body parts, or more rarely ask to be made blind or deaf, or given a spinal cord injury.

There is some debate in the literature about whether such requests should be granted. It is a debate between autonomy and the potential improvements in quality of life that supposedly cannot be achieved in any other way, versus non-maleficence, finding other ways to treat psychological distress, and the question of whether surgery would in fact solve the underlying issue.

One of the arguments in favour states that we allow people to mould themselves via cosmetic surgery to the ‘irrational ideals’ of images portrayed in the media, so why not allow amputation, etc. The argument against realises that even though such a patient promises to ‘pay their own way’, statistically people with disabilities are less able to earn an income through the lifespan and these cases will likely end up posing an extra burden on the health and welfare systems. (Ed: In the current state of medical knowledge, amputation is irreversible, unlike much augmenting cosmetic surgery.)

Have a look at websites such as www.ampulove.org and www.transabled.org for a peek into the disturbing world of devotees, pretenders and wannabes. We may not like what we see but in our practice we could come across cases like these. Write in and tell us what you think.

Jasmine Gilchrist

Trainee Committee Report

The Trainee Committee continues to meet regularly via teleconference to discuss trainee matters. This year I am privileged to accept the position of chairman and trust that the committee will continue to represent your views. We are always interested to hear your thoughts both positive and negative!

I would like to take this opportunity to thank Leah Vos who is stepping down from her position of Queensland trainee representative to take maternity leave. We wish her all the best. At our most recent meeting we welcomed Dr Lasitha Delungahawatte and Dr Francoise Joseph as newly appointed members of the committee.

Recent committee discussion has included ensuring accredited training positions offer appropriate supervision and support and reflect the training curriculum. We are also continuing discussions regarding assessment and feedback especially for trainees who are experiencing difficulty, and the needs of trainees balancing work and family responsibilities. We have been working with the Faculty in the development of a mentoring service for those trainees juggling the demands of young children and training and are grateful to those Fellows who have volunteered their time.

Also on the agenda this year, we are hoping to work towards developing a more structured approach to ensuring trainees have access to accredited FIM training in their early years of training.

Dr Gounden (NSW Representative) is pursuing the development of a MSK course with the assistance of the MSK SIG that we hope will be useful for both junior trainees and those preparing for the Fellowship examinations.

After a few teething problems last year the bi-national Wednesday training sessions are running again and will continue to offer a valued learning opportunity as well as the all important catch up over afternoon tea!

There continues to be vacancies for trainee representation on a number of committees. We are extremely lucky that trainee representation and involvement is encouraged by the Faculty. I urge all trainees to be involved - be it by serving on a committee, attending CME events, or joining a SIG.

To those trainees who recently sat for the Written Fellowship Examinations and for those preparing for Module 2, we wish you “Good Luck and Enjoy”!

Alexis Berry
Chair
Is YourCPD and OurCPD going in the right direction?

Firstly, it’s almost that time of the year again. Your CPD submissions are due by 30 June every year. Until 2009 inclusive if you missed the cut off date, then we did not necessarily accept your submission. As of 2010, we have changed the rules; if your online submission is not in by 30 June 2010, you have another three months, but you will only receive the minimum number of points regardless of how many more points you have submitted, ie only 60 points (unless you did not achieve that level), and you will be audited. This means you have three extra months in which to do your submission but you will be audited! That means you will have to provide all documentation to support your CPD claims or risk missing out on certification of your involvement in a CPD program. If you do not know what is required as documentation read my previous articles!

Over the past couple of months I have had the opportunity to do some thinking about OurCPD. As your representative on the RACP Expert Advisory Group on Continuing Professional Development (CPD EAG), I had the opportunity to attend the 2nd International Forum on CPD Accreditation which was held at the College offices in Sydney just before the WCIM in Melbourne. Apart from many Australians, not only representing all branches of the College of Physicians, but also all the other colleges, there were doctors and medical administrators who are involved in teaching and continuing professional development for medical practitioners from all over the world. There were some outstanding thinkers present speaking on a number of topics to do with future CPD programs, the role of accreditation of programs, issues of credentialing and relicensing, etc. There were a number of workshop sessions but the entire program of 1½ days was interactive and enjoyable. It allowed me to reflect on what we are doing and how we may be able to do it better.

Subsequently, the CPD EAG has met and reviewed the World Federation of Medical Education (WFME) global standards for continuing professional development of medical doctors, and currently that committee is looking to adopt these standards.

In the meantime, we need to think about whether our CPD program in the AFRM is going to be able to meet those standards. As well, we need to consider if our online program meets the needs of those of us who use it (which this year should be everybody). Over the next few issues I will be writing more about the need to progress our program to meet the standards and may ask you what you think of our current online program.

Dr Barry Taylor, the current Chair of the EAG, has recently documented the values and principles that were the basis for the development of the RACP MyCPD program, and I have paraphrased these below.

The qualities essential for the program are that it should be:
- simple to use
- relevant to practice
- facilitate adult learning
- make the best use of current information technology
- integrate with the College’s future education platform.

The following principles were adopted to guide the development of MyCPD:
- learning is best when it is related to needs
- a person is unable to identify all their learning needs so peer input is essential
- learning is more effectively applied to practice when it is followed by reflection
- background learning remains important
- learning should cover the range of a person’s practice.

Furthermore, the CPD program should ensure:
- an integration of continuing professional development and professional practice
- a change in the mindset of Fellows away from a recording of events to a tool for learning through needs assessment, planning and reflection
- ready access for physicians in remote locations to CPD resources.

The Expert Advisory Group for CPD has determined that these values and principles should continue to govern the development of the CPD program within the College, and recommends their application to all Faculties and Chapters.

So, does the AFRM MyCPD program meet all these criteria? Could our CPD online program be better? Something for you to ponder! I would be grateful to receive your thoughts on the direction of OurCPD program. You can email me at Ruth.Marshall@health.sa.gov.au or email Natali Vlatko, our CPD Administrator, at Natali.Vlatko@racp.edu.au. I look forward to receiving your comments.

YourCPD “lead”, Ruth Marshall
Education Committee Report

Based on the report given to the annual meeting of Faculty Fellows by the Chair of the Faculty Education Committee (FEC) in March 2010.

The Education Committee (FEC) of the AFRM met on five occasions between July 2009 and March 2010 with three face-to-face meetings and two teleconference meetings. Procedures have also been developed for making urgent decisions, such as Fellowship recommendations, using electronic communications.

The current FEC membership is:

Dr Stephen de Graaff  Chair
Dr Toni Hogg  OTPs & Honorary Secretary
Dr Geoff Abbott  Accreditation
Dr Michael Chou  Assessments
Dr Genevieve Kennedy  Teaching & Learning
A/Prof Peter Flett  Paediatric Rehabilitation
Dr Lee Laycock  Special Interest Groups
Dr Jennifer Chapman  Scientific Program
Dr Ruth Marshall  CPD
Prof Ian Cameron  Academic Rehabilitation Medicine
A/Prof Andrew Cole  Co-ordinator of Education
Dr Samir Anwar  New Zealand Fellow
Dr Lasitha D. B. Delungahawatte  Trainee Representative
Dr Kath McCarthy  AFRM President, ex officio
Mrs Sybil Cumming  AFRM Administrator
Ms Rebecca Forbes  AFRM SEO.

Most of the positions on the FEC were declared vacant on 31 December 2009 and expressions of interest were called for from the Fellowship. In each case those members who had just completed their first two-year term of office were re-appointed for another two-year term. However, after many years of dedicated service to the FEC, Dr Jurriaan de Groot decided not to renominate and the position for a Representative from New Zealand has now been filled by Dr Samir Anwar. The Trainee Representative position was filled earlier this year by Dr Lasitha Delungahawatte.

Education workshops

A/Prof Andrew Cole continues in the role of Coordinator of Education for the AFRM. As Chair of the RACP Physician Educator Expert Advisory Group he leads the College initiatives for the training of Physician Educators. In October last year he coordinated an education workshop for Faculty supervisors in Brisbane. The session titled “Learning at work - goals and plans” was then repeated in Victoria in November. A similar session is being planned for Adelaide on 4 September 2010. The FEC also held a workshop for supervisors in Sydney in May 2009 and a Long Case Assessment Calibration workshop was held in Melbourne on 21 March 2010.

Rehabilitation Medicine Specialty Training Programs

At the time of this report there were 136 trainees (127 adult and 9 paediatric) registered with the Faculty for 2010.

The Bi-National Training Program has entered its second year with regular monthly videoconferences recommencing between February and November. The three-year program of topics (based on clinical subjects from the curriculum) includes Illness and Injury in the Elderly, Stroke, Orthopaedics, Burns, Pulmonary Rehabilitation, and Paediatric Rehabilitation for 2010. It is the responsibility of each state and New Zealand to follow the same monthly theme and provide local sessions to supplement the monthly videoconferences.

Paediatric Rehabilitation Sub-committee

A/Prof Peter Flett and his committee have been continuing their work on the draft of a new curriculum for advanced training in Paediatric Rehabilitation Medicine with the help of the College Deanery staff. The College has agreed that the three-year program due to be launched in January 2011 will be administered by the AFRM, and that successful trainees will be awarded the dual qualification FRACP FAFRM. Following a full consultation process the draft curriculum will be presented to the College Education Committee for endorsement later this year.

Assessments

32 candidates sat for the Fellowship Clinical Examination on 15 August 2009 in Sydney. With 20 passing successfully the pass rate was 63%. The next Fellowship Clinical Examination will be held in Melbourne on 14 August 2010. The Fellowship Written Examination this year was held on Tuesday 11 May 2010. A requirement of the Faculty Training Program is that trainees in their first or second years are required to
successfully pass written and clinical modular assessments in order to proceed to the third year of training. During 2009 Module 1 Written Assessments were held in March and September with a total of 27 candidates passing of the 41 trainees who presented (66%).

31 candidates presented for the last Module 2 Clinical Assessment in June. The pass rate was 77% with 24 candidates passing. The next Module 2 will be held in Sydney on 19 June 2010.

Faculty Executive has asked the FEC to conduct a strategic analysis of the External Training Modules during 2010. A survey has just been drafted for new Fellows and trainees to complete by mid-year to provide feedback on the good and bad points of the current modules, and to comment about their learning experiences and their perceptions about other essential learning areas that could be covered through similar self-directed learning activities.

Accreditation Sub-committee
Dr Geoff Abbott was reappointed to chair this group for another two years. He is also a member of the College’s Accreditation Expert Advisory Group (EAG) which has now formulated a College policy on accreditation of training ‘settings’ and developed College standards for site accreditation. The Faculty accreditation criteria are currently being reviewed to align with these College standards.

Ninety-five settings have now been accredited or reaccredited as suitable environments for Rehabilitation Medicine training until January 2011, when the next reaccreditation cycle begins. Faculty reviewers conducted five virtual site visits during 2009.

There are now 140 AFRM supervisors who have been accredited or reaccredited until 1 July 2011.

Continuing Professional Development Sub-committee
Dr Ruth Marshall has been reappointed as the Chair of this sub-committee and accordingly retains membership on the CPD Expert Advisory Group of the RACP. The policy to introduce mandatory CPD has now been endorsed by the College Board. From 2011 Fellowship retention will be linked to active participation in a recognised CPD program. The FEC and CPD Committees are investigating options for Final Year Trainees to accumulate CPD points to ensure that...
Medical Board requirements for registration are met once Fellowship is achieved.

The participation rate for 2008 AFRM CPD Program returns was 86% of eligible Faculty Fellows (269/313).

The end of June this year is the closing date for acceptance of 2009 CPD returns for participants in the Faculty’s CPD program. You are reminded that only online submissions will be accepted and processed this year.

Scientific Program Sub-committee

Dr Jennifer Chapman continues to chair this sub-committee, which is responsible for the forward planning of the Faculty’s Annual Scientific Meetings. Faculty Council has supported the proposal that after this year, when the ASM is fully integrated into the RACP Physicians Week, the AFRM will be organising its own annual conference featuring a Rehabilitation Medicine clinically oriented program. Whenever possible this annual conference will be held jointly with a national meeting from a related association, especially those involving the allied health professionals or with another national rehabilitation society.

Tentative plans are now in place for organising these joint annual conferences until 2015:

- In 2011 as well as joining the Physicians in Darwin in May, there will be a joint conference with ANZCoS in Brisbane on 13-17 September, with Spinal Rehabilitation and Pain being featured topics.
- The 20th ASM is being held conjointly with the World Congress of NeuroRehabilitation in 2012 in Melbourne. The dates are 16-19 May 2012.
- Proposals for other ASMs are Sydney in 2013, Darwin in 2014, and Wellington, NZ, in 2015.

Chairs of Special Interest Groups (SIGs) Sub-committee

This group, chaired by Dr Lee Laycock, was asked by Faculty Council to conduct a strategic review of the role of the SIGs. The review process has resulted in some amendments to the Terms of Reference and administrative procedures for the SIGs. Among the changes is the requirement for SIG membership lists to now be reviewed every two years. Annual meetings of members are now optional and all Office Bearers are elected for two-year terms.

Following its annual members’ meeting in 2009 the Traumatic Brain Injury (TBI) SIG no longer had a Chair or Honorary Secretary and was therefore disbanded in November 2009.

Most of the ten remaining SIGs prepared and submitted Business Plans for 2010 in order to secure funding. More regular teleconference meetings and more journal clubs and workshops have been planned. While a few SIGs remain relatively inactive, all are considered to be valuable assets to the Faculty and are still a potential resource when specific issues arise.

Academic Rehabilitation Medicine Sub-committee

Under the chairmanship of Professor Ian Cameron this group has been focusing on raising the profile of research in Rehabilitation Medicine. They have been investigating ways to establish networks or centres of research excellence to get multi-centre research happening in an organised way. To try to extend the research capacity of the Faculty the members have undertaken to present research sessions or workshops, usually at the time of the AFRM conference. A very successful research workshop with the Rural and Remote Special Interest Group (R & R SIG) of the Faculty took place in Terrigal in October last year.

New President Kath McCarthy with Past President Stephen Buckley

Retiring President Stephen Buckley with College Medal winner Thomas Woolard
Fellowship matters

Between May 2009 and March 2010 the following 22 doctors satisfactorily completed the Faculty’s assessment requirements and have been awarded Fellowship of the AFRM. The new Fellows are:

- Toni Auchinvole
- Antoinette Botman
- Michael Carroll
- Tik Shun Chan
- Kate Hall
- Fanborz Jashnany
- Saleem Khan
- Ee Wei Lim
- Jenson Mak
- Kim McLennan
- Julia McLeod
- Kerry O’Meara
- Victoria Peeva
- Prasannan Ponganamparambile
- Sachin Shetty
- Brenda Slee
- Swee-Ling Toh
- Victor Voerman
- Anna Ward
- Yuriko Watanabe
- Kevin Young
- Nina Zhang.

Advanced Training Portal

Over recent months the Faculty staff have been working with staff from the College Deanery’s e-Learning team to develop a project plan specifying the tasks and timelines to set up a Rehabilitation Medicine Advanced Training Portal. This portal will provide trainees with an online site where they can access information and lodge forms, interact with supervisors, submit assignments and undertake evaluations, enabling them to be more in control of their own training programs. A lot of the front end design and development has already been completed, so most of the work to be completed during 2010 will be with IT developing/adapting the tools. In order to use the tools already developed the AFRM Clinical Syllabus’ learning objectives are currently being reformatted.

AMC Accreditation 2010

The College is scheduled for reaccreditation by the Australian Medical Council (AMC) this year. The final submission, which will include the AFRM and its training programs, is to be forwarded to the AMC in early July.

Stephen de Graaff
Chair

Prize winners

Congratulations are extended to the following prize winners:

- **Basmajian Prize** for 2009 (awarded to the candidate with the top score in the Fellowship Clinical Examination)
  Shared equally by *Dr Amanda Johns* and *Dr Julia McLeod* who attained the same score.

- **Adrian Paul Memorial Prize** for 2009
  *Dr Polly Tsai* for a prospective study on the effects of group circuit classes in improving the balance and mobility in the outpatient setting.

- **Ipsen trainee poster prize for a neurological presentation** (July 2009 ASM, Queenstown, New Zealand)
  *Dr Josephine Braid* for dysautonomia following traumatic brain injury and the effect of Gabapentin: a pilot study.

New Fellows with Stephen Buckley and Stephen de Graaff (back row) & Thomas Woolard (front row left)
Victoria & Tasmania

Our branch held the 2010 Annual Meeting in February at the Courthouse Restaurant. The event was well attended and Prof John Olver spoke about his new position and future directions for Rehabilitation Medicine. The 2010 Branch Committee was elected with the following Fellows successful in the election:

- Dr Mary Lou Leach Chair
- Dr Ronald Leong Hon Secretary
- Dr Michael Chou Hon Treasurer
- Dr Brian Anthonisz
- Dr Sandra Farquharson
- Dr Senen Gonzalez
- Dr Nathan Johns
- Dr Kerry O’Meara
- Dr Michael Ponsford
- Dr Kwong Teo
- Dr Rob Weller

With Prof John Olver and Dr Stephen de Graaff as ex-officio members.

Dr Senen Gonzalez is to continue to co-ordinate the Teaching and Learning Sub-committee in 2010, after successfully facilitating the registrar program last year.

Dr Kerry O’Meara has agreed to take on the role of CPD Co-ordinator and has already organised (with Dr Chris Baguley) the first CPD evening for the year which was held on 31 March 2010.

Dr Brian Anthonisz will continue to coordinate the Annual Registrar Research Presentation evenings and Dr Nathan Johns will again co-ordinate the Careers Expo for interns and HMOs.

Dr Rachael Nunan has agreed to facilitate Registrar Selection in 2010, and we are grateful for her Queensland-honed skills as Dr Leong will be difficult to replace.

Dr Farquharson, Ponsford and Teo remain tireless in supporting the education sub-committees.

The AFRM ASM was this year integrated with the World Congress of Internal Medicine from 20-25 March. This was capably coordinated by Dr Rob Weller and his team of assistants. The Melbourne Exhibition and Conference Centre proved to be a terrific venue for holding a conference of this size. There was excellent attendance at all the Rehabilitation/AFRM sessions and they appeared to be well received by non-AFRM attendees.

From July 2010, FIM will be the inpatient reporting outcome measure to the Victorian Department of Health, replacing the Barthel, on which the current CRAFT funding model is based. It is hoped that over time, the DH data will be made compatible with AROC reporting data, with all data fed directly to AROC from the Victorian DH.

As this goes to press, we are awaiting the outcome of the COAG meeting in Canberra to see how the face of healthcare will look, not only in Victoria but throughout Australia.

Mary Lou Leach
Chair

New Zealand

Annual members’ meeting

The Annual Meeting of the New Zealand Branch was held on 5-6 March at the Waipuna Conference Centre in Auckland. The program included a National Rehabilitation Strategy Planning Workshop, which was attended by Professor Kath McPherson of Auckland University of Technology (AUT), and a session dedicated to peer support. The presence of Dr Stephen Buckley, President of the AFRM, and Dr Kath McCarthy, President Elect, greatly contributed to the success of the meeting.

 Election of officers

Dr Jurriaan de Groot was re-elected as Chair, Dr Robin Sekerak as Secretary, and Dr Richard Seeman as Treasurer. Dr Samir Anwar replaces Dr de Groot as New Zealand Representative on the Faculty Education Committee, and whilst the position of Branch Training Coordinator remains vacant, Dr Anwar has kindly agreed to remain in an acting role until a new Fellow may be in a position to fulfil this role in the near future. Dr Will Taylor will be representing the New Zealand Branch on the CPD and Academic Sub-committees.

Administrative support

Discussions have commenced between our branch and Ruth Anderson, New Zealand Manager of the RACP, regarding administrative support for our branch. Secretarial support, such as taking minutes would be available on the proviso that Branch Committee meetings by teleconference are held during office hours, and the Branch would need to consider holding future
annual members’ meetings in Wellington in order to avail ourselves of such support.

**Fellowship matters**

The New Zealand Branch extends a warm welcome to Dr Ei Wei Lim, paediatric rehabilitation Fellow, who has joined the services of the Wilson Centre and Starship Hospital in Auckland. We also welcome Dr Raj Singhal, who is based at the Burwood Spinal Unit in Christchurch.

**Training**

New Zealand currently counts seven trainees. All training centres now have access to the monthly Bi-National Training Program teleconference link sessions. A series of local training sessions focussed on examination preparation, including mock-O'SCE examinations, is in preparation.

**Strategic issues**

The development of a National Australian Rehabilitation Strategy is followed with great interest by members of the New Zealand Branch, and previous workshops have been attended by our Branch Chairman, as well as Professor Kath McPherson, Chair of Rehabilitation Studies, AUT. Although we have a mature rehabilitation workforce, and there is multidisciplinary interaction at different levels, eg through the New Zealand Rehabilitation Association (NZRA), the current political health focus in New Zealand is on cost-containment within the public hospital setting. As a result, a number of rehabilitation units are under threat of reduction of services. Future opportunities to educate the public and politicians regarding the benefits of organised rehabilitation as well as the development of regional cooperation on rehabilitation service initiatives between District Health Boards need to be explored. The focus will need to be on developing a message which will ‘stick’, and underpin this with evidence such as can be derived from AROC, now most units in New Zealand have joined.

**NZRA**

It is of interest that our Australian colleagues are working towards setting up a similar multidisciplinary forum in the form of an ‘alliance’ as we currently have with the NZRA. A further local NZRA conference is planned to be held in 2011, whilst New Zealand is hoping to bid for the 2015 AFRM ASM to be held again in conjunction with the NZRA/NZIRR.

Jurriaan de Groot
Chair

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**New South Wales & Australian Capital Territory**

Meetings for 2010 have commenced and the branch has welcomed Chris Katsogiannis as the first official ACT representative on the committee which will now be known as the NSW/ACT Branch Committee.

Our aims for 2010 include:

- Continue participation in the Bi-National Training Program and conduct additional local teaching sessions in conjunction with the videoconferenced sessions and clinical sessions for trainees on Saturdays.
- CME evenings are planned through to the end of 2010, including a weekend CME event in Canberra later in 2010, and the second trainees research presentation evening, which proved a successful innovation in 2009, will be held late in 2010.
- In 2009 we commenced dialogue with NSW Health regarding a rehabilitation re-design project and we plan to continue that dialogue in 2010 with plans to have a working party established with the department. Time will tell how the new Federal Health Reforms will affect this project!

As requested by the Government Relations and Models of Care EAG we are collecting information regarding how the COAG Subacute Enhancement Funding has been implemented across the NSW and ACT. We haven’t yet heard from all parts of NSW and ACT but there is certainly great variation in how much of this funding has been allocated to rehabilitation, ranging from news of significant progress on implementation of programs to comments such as ‘what money?’ We are keen to hear from other Fellows across the state regarding how the money is being used (or not used!) in their services.

Jennifer Mann
Chair

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Victoria Peeva

Anantha Prasannan Ponganamparambile
Spinal Cord Injury (SCI) SIG

The Annual Meeting of the Spinal Cord Injury Special Interest Group was held following the World Congress of Internal Medicine on 25 March 2010. Dr Peter New and Dr Monica Ling were re-elected unopposed to the positions of Chair and Secretary respectively.

There are a number of highlights for the SCI SIG regarding achievements and milestones over the recent months. The curriculum that the SCI SIG revised a number of years ago has been acclaimed by ISCoS and the International Society of Physical Medicine and Rehabilitation. These organisations are currently in the process of developing a formal SCI curriculum and are using our curriculum as a framework.

A very successful workshop for Fellows and trainees was held preceding the Annual Meeting on the ASIA Impairment Scale, with approximately 25 attendees. It is anticipated that this workshop will become an annual event, at least for a number of years. This is necessary to improve the ASIA Impairment Scale examination skills necessary for AROC data collection as well as to provide competency and expertise for registrars and Fellows in this challenging area.

Our first teleconference journal club was held in March. Additional teleconference journal clubs are planned for 17 June and September. This offers another important learning opportunity and interaction modality for Fellows and trainees interested in SCI.

Looking ahead, exciting opportunities and challenges for the coming year include participation in the Bi-National Training Program and the combined AFRM/ANZCoS annual meeting in September 2011.

All Fellows and trainees interested in the rehabilitation of patients with spinal cord injury or damage are encouraged to join the SCI SIG via the Faculty website.

Peter New, Chair

Musculoskeletal, Pain & Occupational Medicine (MSK) SIG

The MSK SIG committee is planning a busy 12 months ahead, starting with a MSK workshop for trainees over the long weekend in June. We are organising further spinal injection workshops and workshops on MSK ultrasound examinations.

There is ongoing support for the ‘health benefit of work’ and Bone and Joint Decade discussions.

Given the good feedback from last year’s computer based workshop we are considering another workshop, maybe on occupational rehabilitation, so watch this space!

We have approached a few overseas speakers and are negotiating with the 2011 ASM organising committee either as part of the main program or as a pre-conference activity.

Clive Sun, Chair

Mind SIG

The Mind SIG has had an active start to the year. At our first teleconference we familiarised ourselves with the new online conferencing facilities offered by the RACP and discussed the planning of workshops for this year and next. Our second teleconference featured a presentation by Dr Lyndon Wall on his experiences at the Mind Conference in Sydney in December 2009.

We’re still welcoming new members and looking forward to some interesting speakers as part of our teleconference link-ups as the year progresses.

Jane Malone, Chair
Paediatric Rehabilitation SIG

The Paediatric Rehabilitation SIG has been busy over the last year. Many of us met at the Australasian Academy of CP and Developmental Medicine meeting in Christchurch NZ in March 2010. A very collegiate and informative conference. The next AusACPDM meeting is to be held in Perth in 2012.

Meetings have commenced with AROC for all Paediatric Rehabilitation Units in Australia and New Zealand to compile a minimum data set for Paediatric Rehabilitation. There is representation from all states and centres, with the multidisciplinary group being led by Frances Simmonds from AROC. Watch this space!

The intrathecal baclofen users group, led by Dr Gavin Hutana, a WA trainee, has compiled a minimum data set and handbook for prospective data collection of outcomes and adverse events following intrathecal baclofen pump implantation. Ethics approval is currently being obtained in each state and data collection will commence as from this year.

Dr Stephen O’Flaherty at CHW, NSW has compiled a database for prospectively collecting data on adverse events following botulinum toxin injections for children with cerebral palsy. This will provide a formal pooling of data in the future to report on significant adverse events. The database has been offered to all the paediatric botulinum toxin injecting services.

Dr James Rice, SA, successfully organised a two day training workshop for paediatric trainees in Sydney in February 2010. All nine paediatric trainees attended thanks to the availability of travel grants from Allergan Australia. It is planned that there will be another two day training weekend in 2012 in Brisbane led by Dr Lisa Copeland.

This first paediatric and rural and remote journal club was held on 30 April and was well attended. Dr Kate Langdon of WA presented a paper on stem cells, Dr Simon Paget, a NSW trainee, on inpatient weeFIMs and computer modelling, and Dr Kate Rodwell, a Queensland trainee on Melatonin use in persons with intellectual disability a meta analysis. It was noted that Melatonin is now available on PBS and so more easily prescribed.

The Bi-National Training Program will have a session on paediatric rehabilitation on 24 November when Dr Lynne McKinlay will talk on Cerebral Palsy, Dr Mary-Clare Waugh on intrathecal baclofen and Dr Kate Langdon on transition issues.

All in all, a busy time for everyone.

Mary-Clare Waugh, Chair

Rehabilitation & Older People SIG

The SIG is meeting by teleconference and a number of activities are in progress.

A preliminary analysis of AROC data comparing older people admitted to private and public rehabilitation hospital wards has been completed. It shows that there are differences in background characteristics between older patients in these two settings, and rehabilitation following hip or knee arthroplasty is a much more common reason for admission to private rehabilitation wards than in the public sector. Further analyses are being performed to more clearly understand differences between the groups, particularly with reference to rehabilitation outcomes.

The Position Statement Driving and Dementia has been revised on behalf of the Australian and New Zealand Society for Geriatric Medicine. It is available from: www.anzsgm.org/documents/PS11DrivingandDementiaapproved6Sep09.pdf

The Austroads Guidelines have been in the process of revision for many months. There has been input into the sections relevant to driving by older people with dementia and other medical conditions.

The SIG will not have a face-to-face Annual General Meeting in 2010, but will convene by teleconference.

Ian Cameron, Chair

New Paediatric Fellows

Jennifer Ault & Stephen Buckley with new Paediatric Rehabilitation Fellows
Antoinette Botman, Kim Mclennan, Kate Hall and Anna Ward
## Calendar of Events

### 2010

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
<th>Website</th>
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<tbody>
<tr>
<td>30 June – 3 July</td>
<td>International Neuropsychological Society Mid-year Meeting</td>
<td>Krakow, Poland</td>
<td><a href="http://www.the-ins.org">www.the-ins.org</a></td>
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<tr>
<td>6 – 8 July</td>
<td>Identities, Care and Everyday Life, British Society of Gerontology</td>
<td>London, United Kingdom</td>
<td><a href="http://www.bsg2010brunel.org.uk">www.bsg2010brunel.org.uk</a></td>
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<tr>
<td>9 – 11 July</td>
<td>6th International Stroke Summit</td>
<td>Nanjing, China</td>
<td><a href="http://www.stroke.net.cn">www.stroke.net.cn</a></td>
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<tr>
<td>10 – 15 July</td>
<td>International Conference on Alzheimers Disease</td>
<td>Honolulu, Hawaii</td>
<td><a href="http://www.alz.org">www.alz.org</a></td>
</tr>
<tr>
<td>26 – 27 July</td>
<td>Smart Aged Care - The E-Health Revolution, Health Informatics Society of Australia</td>
<td>Terrigal, NSW, Australia</td>
<td><a href="mailto:smartstrokes@conferenceaction.com.au">smartstrokes@conferenceaction.com.au</a></td>
</tr>
<tr>
<td>29 August – 3 September</td>
<td>13th World Congress on Pain</td>
<td>Montreal, Canada</td>
<td><a href="http://www.iasp-pain.org">www.iasp-pain.org</a></td>
</tr>
<tr>
<td>1 – 3 September</td>
<td>Annual Scientific Meeting of the Australian and New Zealand Spinal Cord Society</td>
<td>Adelaide, Australia</td>
<td><a href="mailto:anzcos2010@sapmea.asn.au">anzcos2010@sapmea.asn.au</a></td>
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<tr>
<td>6 – 8 September</td>
<td>8th Australian Conference on Safety and Quality in Health Care</td>
<td>Perth, Australia</td>
<td><a href="http://www.aaghc2010.org">www.aaghc2010.org</a></td>
</tr>
<tr>
<td>28 September – 1 October</td>
<td>2nd World Parkinson Congress, Glasgow, Scotland</td>
<td><a href="http://www.worldparkinsoncongress.org">www.worldparkinsoncongress.org</a></td>
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<tr>
<td>29 September – 1 October</td>
<td>6th Congress of European Union Geriatric Medicine, EUGMS</td>
<td><a href="http://www.eugms2010.org">www.eugms2010.org</a></td>
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<tr>
<td>10 – 13 October</td>
<td>Best of Both Worlds – Mind and Body</td>
<td>Melbourne, Australia</td>
<td><a href="mailto:rehab2010@dcconferences.com.au">rehab2010@dcconferences.com.au</a></td>
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<tr>
<td>13 – 16 October</td>
<td>7th World Stroke Congress</td>
<td>Seoul, Korea</td>
<td><a href="http://www.isqua.org">www.isqua.org</a></td>
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<tr>
<td>25 – 27 October</td>
<td>National Forum on Safety and Quality in Health Care</td>
<td>Canberra, Australia</td>
<td><a href="http://www.isquacoS.org">www.isquacoS.org</a></td>
</tr>
<tr>
<td>9 – 12 November</td>
<td>7th Interdisciplinary World Congress on Low Back and Pelvic Pain</td>
<td>Los Angeles, USA</td>
<td><a href="http://www.worldcongresslbp.com">www.worldcongresslbp.com</a></td>
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<tr>
<td>29 November – 3 December</td>
<td>Lower Limb Prosthetics, Prince of Wales Hospital, Randwick N SW</td>
<td><a href="mailto:flor.Hajjar@sesiahhs.health.nsw.gov.au">flor.Hajjar@sesiahhs.health.nsw.gov.au</a></td>
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2011

5 – 8 December
22nd Annual National Forum on Quality Improvement in Health Care, IHI. Orlando, USA. Website: www.ihi.org/IHI/Programs/ConferencesAndSeminars/22ndAnnualNationalForumonQualityImprovementinHealthCare.htm

9 – 12 December
7th International Congress on Mental Dysfunction and other Non-motor Features in Parkinson’s Disease and Related Disorders. Barcelona, Spain. Website: www.kenes.com/mdpd

10 – 13 December
IOF Regionals 1st Asia-Pacific Osteoporosis Meeting. Singapore. Website: www.iofbonehealth.org/singapore-2010

5 – 8 December
22nd Annual National Forum on Quality Improvement in Health Care, IHI. Orlando, USA. Website: www.ihi.org/IHI/Programs/ConferencesAndSeminars/22ndAnnualNationalForumonQualityImprovementinHealthCare.htm

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2011

23 – 26 March

14 – 17 April
7th International Association of Gerontology and Geriatrics – Euro Region Congress. Bologna, Italy. Website: www.iaggbologna2011.com

12 – 15 June
6th World Congress, ISPRM. San Juan, Puerto Rico. Website: www.isprm.org

20 – 23 June
6th World Physical Therapy Congress 2011. Amsterdam, Netherlands. Website: www.wcpt.org/congress

13 – 17 September
2011 AFRM/ANZSCoS Annual Conferences. Brisbane, Queensland. Email: spinalrehab2011@tcc.co.nz

19 – 23 September

22 – 25 September
Translating Evidence into Practice – 10th International IACFS/ME Research and Clinical Conference. Ottawa, Canada. Website: www.mefmaction.net

2012

15 – 19 May
World Congress for NeuroRehabilitation. Melbourne, Australia. TBA

17 – 19 May
3rd Conference of Asia-Oceanian Society of Physical and Rehabilitation Medicine, AO SPRM. Bali, Indonesia. Email: aosprimbali@pharma-pro.com

27 May – 1 June
Spineweek. Amsterdam, Netherlands. Website: TBA

2 – 7 September

23 – 27 October
27th Annual Meeting, North American Spine Society. Dallas, USA. Website: www.spine.org

2013

16 – 20 June
7th World Congress, ISPRM. Beijing, China. Website: www.isprm.org

2011 Combined Annual Conferences of AFRM and ANZSCoS

Striking AcCord - succeeding through team work

The Australasian Faculty of Rehabilitation Medicine (AFRM), and the Australia and New Zealand Spinal Cord Society (ANZSCoS) invite you to join them in Brisbane for their combined annual conferences in 2011.

where The Sebel & Citigate King George Square Brisbane
when 13-17 September 2011
For further information contact The Conference Company
phone +64 3 365 2217
email spinalrehab2011@tcc.co.nz

Rhaia June 2010
Allergan - Committed to excellence in spasticity management

Before prescribing, please review Approved Product Information available on request from Allergan.

**BOTOX®** (botulinum toxin type A) purified neurotoxin complex is a prescription medicine containing 100 units (U) of botulinum toxin type A for injection. **Indications:** Strabismus; blepharospasm associated with dystonia, including benign blepharospasm & VIth nerve disorders (hemifacial spasm) in patients 12 years & older; cervical dystonia (spasmodic torticollis); focal spasticity of the upper & lower limbs, including dynamic equinus foot deformity due to spasticity in juvenile cerebral palsy patients 2 years & older; severe primary hyperhidrosis of the axillae; focal spasticity in adults; spasmodic dysphonia; upper facial rhytides (glabellar lines, crow’s feet and forehead lines) in adults. **Contraindications:** Hypersensitivity to ingredients; mast-cell-stimulating agents; benign essential blepharospasm & Ocular symptoms (chalazion, diplopia) associated with ocular myasthenia gravis. **Precautions:** Botulinum toxin effects may be observed beyond site of local injection with symptoms consistent with mechanism of action and reported hours to weeks after injection. Symptoms may include muscular weakness, ptosis, diplopia, blurred vision, facial weakness, swallowing and speech disorders, constipation, aspiration pneumonia, difficulty breathing and respiratory depression. Risk of symptoms is greatest in children with spasticity, but can also occur in adults particularly those on high doses. Swallowing/breathing difficulties can be life threatening and there have been reports of death (relationship to BOTOX® not established). Use with aminoglycosides or drugs that interfere with neuromuscular transmission; peripheral motor neuropathic diseases or neuromuscular junctional disorders; inflammation at injection sites; excessive weakness in target muscle; pregnancy & lactation. Generalised weakness & myalgia may be related to systemic absorption. Different botulinum preparations are not therapeutically equivalent. Exercise extreme caution should substitution with another botulinum preparation be necessary. **Blepharospasm:** Reducing blinking following injection of the orbicularis muscle can lead to corneal pathology. Caution with patients at risk of angle closure glaucoma, including anatomically narrow angles. **Strabismus:** Inducing paralysis in extraocular muscles may produce spatial disorientation, double vision or past pointing. Use in chronic paralytic strabismus only in conjunction with surgical repair to reduce antagonist contracture. **Spasticity:** Not likely to be effective at a joint affected by a known fixed contracture. **Cervical Dystonia (spasmodic torticollis):** Possibility of dysphagia or dysphonia. May be decreased by limiting dose injected into the sternomandibular muscle to <100U. 

**Primary Hyperhidrosis of the Axillae:** Consider causes of secondary hyperhidrosis to avoid symptomatic treatment. **Spasmodic Dysphonia:** Laryngoscopy in diagnostic evaluation is mandatory. Avoid treatment in patients due to have elective surgery. Use in general paralysis of the insane. **Equinus foot deformity & upper limb spasticity in children with cerebral palsy > 2 years (continued into adulthood)**

For more detail on criteria for availability, please refer to [www.pbs.gov.au](http://www.pbs.gov.au)

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