THE WYVERN GP BRIEF

WYVERN
Private Hospital

AUTUMN 2026

WELCOME

A MESSAGE FROM OUR CEO, ANNE SCOTT, AND CHAIRMAN OF THE BOARD, DR WILLIAM SEARS

Welcome to the first edition of the Wyvern Brief, a newsletter designed to keep you up to date with what's happening at Wyvern Private Hospital.

If you're not yet familiar with us, Wyvern is the Northern Beaches' newest private hospital, purpose-built to serve our community across a wide range of specialties and services. As a high-end surgical and rehabilitation facility, we are equipped to manage complex cases across all the specialties we offer. Designed in collaboration with clinicians, Wyvern brings together the latest diagnostic, surgical and rehabilitation services within an environment that prioritises patient wellbeing and the wellbeing of the people who work here.

As we continue to grow, we're committed to partnering closely with our local GPs to ensure patients receive the best possible care. In the months ahead, we'll share clinical updates, specialist education and practical tools to support your work. Alongside evening dinners and online CPD, we will host GP lunches and introduce new digital tools to make accessing Wyvern and our specialists even easier.

This inaugural edition features practical clinical insights across orthopaedics, neuro-spine surgery, plastic surgery and hand surgery.

We hope you enjoy this first edition of the Wyvern Brief.

Warm regards,

Anne Scott, CEO
Dr Bill Sears, Chairman & Neurosurgeon

WYVERN AT A GLANCE

Opened in December 2024, Wyvern is an 85-bed private surgical and rehabilitation facility specialising in the following disciplines and delivering end-to-end care (diagnosis, treatment, rehabilitation)

TOTAL ACCREDITED SURGEONS 70

TOTAL ACCREDITED DRS 248

SPECIALITIES

- Neuro- Spinal
- Orthopaedics
- Vascular
- General Surgery
- Pain
- ENT
- Plastics
- Cranial surgery *Coming soon*
- Cardiology *Coming soon*

FACILITIES

- 8 Operating Theatres *including cardiac catheter lab*
- 10 Day Surgery Chairs
- Inpatient Beds Two wards with 28 Surgical Beds Each *all single rooms with ensuite*
- 20 Rehabilitation Beds *all single rooms with ensuite*
- Six Bed ICU *capacity to expand to 9*
- Outpatient Physiotherapy Gym
- Three 23-hour Beds
- Hydrotherapy Pool

ANCILLARY SERVICES

- Wyvern Medical Imaging
- Pathology Managed By Laverty
- Pharmacy
- 148 Car Bay
- Consulting Suites
- Cafe

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WYVERN PRIVATE HOSPITAL

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A GP GUIDE TO THE

DIRECT ANTERIOR HIP REPLACEMENT

The direct anterior approach is a minimally invasive technique used to perform total hip replacement procedures. By accessing the joint from the front and operating between natural muscle planes, it can limit soft tissue disruption and may contribute to a smoother early recovery compared to traditional methods that involve splitting or detaching muscles.

HOW IT DIFFERS FROM OTHER APPROACHES

The prosthetic components used are identical; the difference lies in how the surgeon accesses the hip joint. The anterior approach may offer benefits such as reduced early postoperative pain, faster mobilisation, and shorter hospital stays for some patients. Registry data also indicate a potentially lower risk of dislocation with this technique in certain cases. However, anterior, lateral, and posterior approaches are all considered safe and effective when performed appropriately. The optimal choice depends on factors such as patient anatomy, surgical complexity, and any previous operations.

WHEN TO CONSIDER REFERRAL

Consider referral when hip pain is ongoing, function is deteriorating, sleep is affected, and mobility is limited, particularly if appropriate conservative measures, such as physiotherapy, exercise therapy, weights loss and simple analgesia no longer provide adequate relief.

Common features include groin pain, often radiating to the buttock and occasionally the knee, along with reduced range of motion, nocturnal pain, and progressive functional decline.

RED FLAGS FOR URGENT ASSESSMENT

Rapid deterioration, inability to weight bear, or suspected avascular necrosis with collapse of the femoral head warrants urgent review.

USEFUL GP WORKUP

Plain radiographs of the hip is usually sufficient for diagnosis of hip arthritis. In the referral, include symptom duration, pain location, walking tolerance, conservative measures undertaken, relevant comorbidities, current medications and any relevant previous surgeries.

TRAINING AND CASE SELECTION

The direct anterior approach requires dedicated training. Dr Lin completed advanced fellowship training in Baltimore and Seattle and now uses the anterior approach for most primary hips, selecting alternative approaches when clinically appropriate, for example complex revisions or challenging acetabular reconstruction.

INTRODUCING DR CHARLIE LIN

ORTHOPAEDIC HIP AND KNEE SURGEON

Wyvern Private Hospital is pleased to work with Dr Charlie Lin, an experienced orthopaedic surgeon specialising in hip and knee replacement, reconstruction and revision surgery, as well as complex trauma care. He is known for his calm, thoughtful approach and his commitment to evidence based, patient centred treatment.

After completing his orthopaedic training in Sydney, Dr Lin was awarded Fellowship of the Royal Australasian College of Surgeons in 2011. He then undertook advanced subspecialty training at internationally recognised centres, including the Rubin Institute of Advanced Orthopaedics in Baltimore and Harborview Medical Center in Seattle, where he gained expertise in hip and knee reconstruction and complex pelvic and acetabular trauma. He later completed a further fellowship at Royal North Shore Hospital.

A pioneer in robotic assisted joint replacement in Sydney, Dr Lin was among the first surgeons in the city to adopt robotic arm assisted partial and total knee replacement and is accredited in MAKO technology for knee and hip procedures. He is also one of the few surgeons offering the minimally invasive direct anterior bikini incision approach for total hip replacement.

Dr Lin established his private practice in Wahroonga in 2012 and continues to provide specialist care across the upper and lower North Shore and Northern Sydney.

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MEET WYVERN'S GERIATRICIAN TEAM

Wyvern's new Geriatric Perioperative Unit is now fully operational and already strengthening care for our older patients. Our highly experienced team, Dr Marion Matheson, Dr Ming Loh & Dr Albert Kwok have worked together for almost five years, forming a cohesive unit deeply familiar with the Northern Beaches communityworking at Northern Beaches Hospital Delmar, Manly Waters and Sydney Adventist Hospital.

The team provides daily coverage, including weekends, ensuring older patients feel supported throughout their entire surgical journey. They work closely with surgeons, GPs, allied health, discharge planners, rehabilitation teams and pain services, creating a seamless pathway from pre-operative planning through to postoperative recovery and transition back to community care.

A key strength of the service is continuity of care. The same physician may be involved before surgery, during admission, in ICU if required and through rehabilitation providing reassurance for complex patients, their families and their treating surgeons.

For GPs and patients, the benefit is simple: a holistic, end-to-end perioperative model delivered by clinicians who understand local services and the needs of older adults on the Beaches.

This integrated approach enhances safety, supports clinicians and ensures our older patients receive coordinated care.

FROM NEW YORK TO AUSTRALIA: LESSONS FROM A FELLOWSHIP AT THE HOSPITAL FOR SPECIAL SURGERY

What drew you to undertake a fellowship at the Hospital for Special Surgery in New York?

I undertook a Complex Adult Spine Fellowship at the Hospital for Special Surgery (HSS) in New York in 2023, following the reopening of international borders after the COVID-19 pandemic. HSS has long been recognised as one of the world's leading centres for orthopaedic and spine surgery, and the opportunity to train in such a high-volume, academically driven environment was enormously appealing. Australia undoubtedly has a world-class health system; however the reality is that the majority of scientific progression stems from within the United States right now, so to be in the heart of it was unlike anything I had seen or experienced before.

I was particularly drawn to the opportunity to work under the mentorship of Professor Alex Hughes and to observe the work of several world-leading spine surgeons across the United States, including Dr Lawrence Lenke and Dr Greg Mundis. The fellowship provided exposure to an extraordinary breadth of complex spinal pathology and allowed me to further develop advanced techniques in minimally invasive anterior and lateral surgery, robotic and augmented-reality navigation, spinal endoscopy, and complex revision and deformity surgery.

What did you see there that was different from practice in Australia?

One of the most striking differences was the sheer scale and subspecialisation of practice. At HSS, surgeons often focus very narrowly on specific areas of spinal pathology—such as adult deformity, complex revision surgery, or minimally invasive lateral approaches. This level of specialisation allows teams to refine techniques to an exceptional degree.

Another difference was the high degree of integration between technology and surgical planning. Robotic navigation, advanced imaging platforms, and augmented-reality systems were used routinely to enhance precision and workflow in the operating theatre.

Finally, the multidisciplinary infrastructure was remarkable. There was seamless collaboration between surgeons, physiotherapists, pain specialists, rehabilitation physicians, and research teams, all working within a highly coordinated system focused on optimising outcomes.

What were the most valuable lessons you brought back to your own surgical practice?

The most valuable lesson was the importance of thoughtful patient selection and surgical planning. At HSS, significant time is devoted to understanding the exact pain generator and ensuring that surgery is targeted precisely at the underlying pathology.

Technically, the fellowship reinforced the benefits of less invasive approaches where appropriate. Minimally invasive anterior and lateral techniques can allow excellent restoration of spinal alignment and stability while minimising muscle trauma and facilitating faster recovery.

Equally important was the emphasis on data-driven practice. Outcomes, complications, and patient-reported measures are continuously monitored and analysed, which helps refine surgical decision-making. Research, data, and outcome assessment have now become cornerstones of my own practice.

How did that experience shape the way you assess, operate on or communicate with patients?

The experience reinforced the importance of clear expectation setting with patients. A significant part of successful spine surgery is ensuring that patients understand what surgery can realistically achieve—and what it cannot. I now place even greater emphasis on correlating imaging findings with clinical symptoms, and ensuring that the proposed procedure addresses the specific source of the patient's pain or neurological deficit.

From a surgical perspective, the fellowship strengthened my focus on precision and efficiency, using modern technologies and minimally invasive strategies where appropriate to optimise outcomes. It was also reassuring to learn that what we are doing here as spine surgeons is right alongside the best in the world!

Were there any approaches to recovery, rehab or multidisciplinary care that you have applied here?

One area that stood out was the structured approach to early mobilisation and rehabilitation. Patients were encouraged to mobilise early, often within hours of surgery, with physiotherapy integrated from the outset. There was also strong emphasis on coordinated peri-operative care, including pain management strategies that minimise opioid dependence and maximise functional recovery. Wyvern as a facility allows me to incorporate aspects of this approach in Australia to ensure continuity of care.

Has the fellowship changed which patients you think benefit most from surgery, and when?

If anything, the experience strengthened the principle that surgery should be offered to the right patient at the right time. Many patients improve with conservative management, and surgery should generally be reserved for those with persistent pain, neurological compromise, or structural pathology that clearly explains their symptoms.

At the same time, the fellowship highlighted that well-selected patients can achieve remarkable improvements with modern surgical techniques, particularly when the pathology is clearly defined and the operation is carefully planned. Spine surgery is a discipline that has come a long way in a relatively short time.

What is one practical insight from HSS that local GPs may find useful in day-to-day care?

One practical insight is the importance of carefully correlating imaging findings with clinical symptoms. Degenerative changes on MRI are extremely common, even in patients without pain. Thus, despite having more advanced imaging modalities at our fingertips than ever before, I still rely most on my own clinical bedside tests which have been performed for many decades!

For GPs, identifying true nerve compression symptoms or progressive neurological deficits is often the key trigger for specialist referral.

Dr Timothy R. Lukins

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INTRODUCING DR TIMOTHY R. LUKINS

Dr Timothy R. Lukins is a Consultant Neurosurgeon with subspecialty expertise in minimally invasive neuro-oncology, complex adult spine disorders and endoscopic skull base surgery, including tumours and chordomas. He practises at St Vincent's Public and Private Hospitals, the Mater and Wyvern Private Hospital. Dr Lukins completed his medical degree at UNSW, undertook neurosurgical training in Australia and gained Fellowship of the Royal Australasian College of Surgeons. He completed fellowships in neuro-oncology and minimally invasive spine surgery at St Vincent's Sydney, followed by advanced adult spine training at the Hospital for Special Surgery in New York. He is a Conjoint Lecturer at UNSW and remains actively involved in research and education.

SPINE PATHOLOGY:

WHEN SHOULD GPS CONSIDER SURGICAL REFERRAL?

Many patients with back or neck pain can be managed safely and effectively in primary care. This guide outlines when conservative care is appropriate, when referral is recommended, and which red flags require urgent action.

WHO CAN USUALLY CONTINUE WITH CONSERVATIVE MANAGEMENT?

Many common spine presentations, including mechanical back pain, age-related degeneration and mild sciatica, improve with physiotherapy, exercise therapy, analgesia, anti-inflammatories or targeted injections. Mechanical back pain in isolation, particularly when symptoms vary with movement or posture and there are no neurological features, is usually not a surgical presentation. Patients with leg pain from disc bulge or spinal stenosis can often continue conservatively unless the pain is severe, persistent or worsening. If symptoms remain manageable and there is no neurological deficit, non-operative care for up to six weeks is often appropriate.

WHEN TO START THINKING ABOUT A SURGICAL REFERRAL

Consider a surgical opinion when symptoms significantly impair mobility, sleep or quality of life despite conservative care, or when radicular pain persists beyond six weeks. Referral is also appropriate when there is diagnostic uncertainty, or when imaging and clinical findings need specialist interpretation. Progressive scoliosis, spinal deformity, tumour or infection should also prompt referral. These conditions may not always require surgery but do require specialist assessment.

RED FLAGS REQUIRING URGENT IMAGING OR REVIEW

Urgent assessment is recommended for bladder or bowel dysfunction, myelopathy including hand clumsiness, loss of fine motor control, impaired balance or gait disturbance, sudden inability to walk, marked reduction in walking capacity, profound weakness, rapidly worsening numbness, proprioceptive change, severe abrupt functional decline, or suspicion of tumour or infection. These features may indicate spinal cord or nerve compression and warrant urgent imaging and specialist review.

MRI is most helpful when soft-tissue or neural pathology is suspected. Because MRI is performed supine, an upright X-ray or EOS image is often useful to assess functional alignment.

SCIATICA AND DISC PROLAPSE: WHEN TO PERSIST AND WHEN TO REFER

Continue conservative care if symptoms are present for less than six weeks, pain is manageable and there is no motor weakness, progressive sensory change or other neurological deficit. Refer when pain is severe or disabling, when neurological deficits are present, or when symptoms persist beyond six weeks with significant impact. Evidence suggests surgery may provide faster relief for this subgroup.

WHAT TO INCLUDE IN A GP REFERRAL

For effective triage, include symptom duration, distribution of pain, any weakness or sensory change, impact on walking or hand function, bladder or bowel symptoms, prior imaging, conservative treatments attempted, and the effect on daily function. Patients with sudden, severe neurological compromise may be directed for rapid specialist assessment where appropriate. Over the years, I have been increasingly impressed by the quality, clarity and sophistication of GP referrals I receive.

Dr Davor Saravanja,
Orthopaedic and Spine Surgeon

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INTRODUCING DR DAVOR SARAVANJA

ORTHOPAEDIC HIP AND SPINE SURGEON

Dr Davor Saravanja is an Australian-trained Orthopaedic and Spine Surgeon with additional advanced fellowship training in Canada. He specialises in the management of degenerative spine conditions, disc herniation, radiculopathy, cervical spine conditions, spinal deformity and spinal tumours.

After completing his orthopaedic training in Sydney in 2007, Dr Saravanja undertook an 18-month fellowship in Complex Spine Surgery at Vancouver General Hospital, working with internationally recognised surgeons including Dr Marcel Dvorak, Dr Charles Fisher and Dr Brian Kwon. He also completed dedicated paediatric spine training at British Columbia Children's Hospital.

INTERESTED IN A VMO LUNCH VISIT?

CLICK HERE TO REQUESTS A GP WYVERN VMO LUNCH VISIT

WHEN TO WATCH AND WHEN TO REFER: DUPUYTREN'S IN GENERAL PRACTICE

Dupuytren's disease typically begins with a painless lump or cord in the palm, most often affecting the ring or little finger. Early on, patients may notice a small nodule, thickened cord, or subtle tightness. As the condition progresses, flexion contracture of the finger can occur, making it difficult to lay the hand flat or fully extend the digits.

MONITOR OR REFER?

Dupuytren's can be monitored when symptoms are mild and function is unaffected. Referral is appropriate when a patient is concerned about finger position, a contracture begins to limit hand function. A simple screening test for primary care is the tabletop test. If a patient cannot place their palm flat on a table, referral is recommended.

WHAT CAN MIMIC DUPUYTREN'S?

Conditions that may resemble Dupuytren's include painful palmar lumps, lesions in younger patients and nodules in locations that are not typical for the disease. Any lump outside the ring or little finger should prompt consideration of alternative diagnoses.

WHO IS MORE LIKELY TO PROGRESS?

Faster progression is more common in patients with a family history of aggressive disease, radial side involvement of the hand, Dupuytren's diathesis (e.g., associated Peyronie's disease, knuckle pads) or a younger age at onset.

ROLE OF CONSERVATIVE MEASURES

There is no proven role for splinting or hand therapy before referral. Vitamin E cream has limited evidence, but some patients feel it helps slow early progression.

TREATMENT OPTIONS

Once function is affected, surgical release is the mainstay. Collagenase injections are no longer available in Australia.

Helpful information in a GP referral

Please include:

- Rate of progression
- Degree of contracture, especially PIP joint involvement
- Impact on daily activities
- Early referral is preferable when PIP joints are affected, as surgical results are less predictable.

REASSURANCE FOR PATIENTS

If the lump or cord fits the pattern of Dupuytren's and function is preserved, reassure patients that monitoring is appropriate.

A COMMON MISCONCEPTION

That Dupuytren's surgery is a simple local procedure. Nerves and vessels must be carefully dissected, and referral to a specialist hand surgeon is important.

INTRODUCING DR ANNA WATSON

ORTHOPAEDIC HAND SURGEON

Dr Anna Watson is an Australian-trained Orthopaedic Hand and Wrist Surgeon with extensive local and international experience. Originally graduating in physiotherapy from the University of Queensland in 2001, she completed her medical degree in 2005 and gained her FRACS in Orthopaedic Surgery in 2015. Dr Watson has undertaken advanced fellowship training in hand, wrist and microsurgery in Sydney, London and Switzerland. She is a member of the Australian and New South Wales Hand Societies, the Royal Australasian College of Surgeons and the Australian Orthopaedic Association. As well as operating at Wyvern, Dr Watson consults and operates at Northern Beaches Hospital, St Luke's Private Hospital and Sydney Hospital.

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Orthopaedic Hand Surgeon

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‘BURSITIS’ - ROTATOR CUFF RELATED PAIN:

COMMON PRESENTATIONS, CONSERVATIVE MANAGEMENT, AND WHEN TO REFER

As an orthopaedic shoulder surgeon practising in Australia, I am frequently referred patients presenting with shoulder pain often labelled as “bursitis.” This term typically refers to subacromial bursitis, which commonly overlaps with rotator cuff tendinopathy, subacromial impingement syndrome, or subacromial pain syndrome. Rotator cuff pathology is a continuum of disease encompassing tendinopathy (with or without calcifications), partial thickness tears, full-thickness tears and cuff tear arthropathy. Rotator cuff pathology is one of the most common musculoskeletal complaints in primary care, particularly affecting middle-aged adults and those involved in repetitive overhead activities such as tradespeople, swimmers, or recreational athletes. It often arises from degenerative changes, overuse, or minor trauma, with prevalence increasing with age.

COMMON PRESENTATIONS

Patients with rotator cuff pathology usually describe anterolateral shoulder pain that may radiate to the deltoid insertion or upper arm. Pain is often exacerbated by overhead reaching, lifting, or activities behind the back, such as putting on a jacket. Night pain is classic, making it difficult to sleep on the affected side, alongside a dull ache, stiffness, or perceived weakness during arm elevation. A painful arc between 60° and 120° of abduction is common.

On examination, you’ll likely find positive impingement signs like Neer’s or Hawkins-Kennedy tests, tenderness over the subacromial space, and pain or weakness on rotator cuff-specific tests (e.g., empty can for supraspinatus or external rotation lag for infraspinatus). Passive range of motion is typically preserved, helping differentiate from conditions like frozen shoulder (adhesive capsulitis). Subacromial bursitis often coexists with rotator cuff tendinopathy, where the bursa becomes inflamed or thickened between the rotator cuff tendons and acromion. The rotator cuff—comprising the supraspinatus, infraspinatus, teres minor, and subscapularis—stabilises the humeral head in the glenoid. Dysfunction can lead to superior humeral head migration, narrowing the subacromial space and irritating the tendons and bursa.

Diagnosis is primarily clinical; routine early imaging like X-rays (for acromial spurs) or ultrasound/MRI (for tendon or bursa changes) isn’t always necessary, as findings may not correlate with symptoms and ultrasound accuracy varies. A 2003 study in Sydney demonstrated a very poor accuracy rate of 0.38 for diagnostic ultrasound examination (Goldberg et al). Imaging is best reserved for cases with red flags or poor response to initial management.

CONSERVATIVE MANAGEMENT

Current guidelines strongly support non-operative treatment as the first-line approach for rotator cuff pathology, with success rates of 70-90% over weeks to months. The 2025 AAOS Clinical Practice Guideline on rotator cuff injuries emphasises conservative strategies for non-full-thickness or partial-thickness pathology, while the British Journal of Sports Medicine highlights exercise as superior for long-term function.

Key components include:

Exercise Therapy: This is the cornerstone. Recommend a structured, progressive program for at least 12 weeks, focusing on eccentric strengthening of the rotator cuff (particularly external rotators), scapular stabilisation, thoracic and cervical mobility, and core exercises. Supervised physiotherapy improves adherence and short-term outcomes, though home-based programs can be effective. Address any contributing tightness or weakness to reduce impingement.

Activity Modification and Education: Advise temporary avoidance of aggravating overhead activities, promote posture awareness, and set realistic expectations. Emphasise self-management to prevent over-reliance on medical interventions.

Pharmacological Options: Short-term oral NSAIDs can help with pain and inflammation, but use them judiciously given gastrointestinal and cardiovascular risks.

Corticosteroid Injections: Consider a single ultrasound-guided subacromial injection with local anaesthetic for severe pain, night pain, or acute flares not responding to initial measures. This provides short-term relief (weeks to months) but avoid repeated injections due to potential risks like impaired tendon healing, especially if surgery may be needed later.

Evidence from the Journal of Shoulder and Elbow Surgery and Shoulder & Elbow journal indicates that exercise outperforms subacromial decompression alone in many cases, with no added benefit from surgery over conservative care for pure impingement or bursitis. In Australia, we align with these international standards, ensuring cost-effective care through Medicare-supported physiotherapy.

WHEN TO REFER

Most patients improve with conservative management, but timely referral to an orthopaedic shoulder specialist is crucial for those who don’t. Refer for further assessment (e.g., MRI) and potential intervention if:

- There’s no improvement after 12 weeks of structured conservative management, with persistent pain, weakness, or functional limitations.
- Acute traumatic onset with significant weakness suggests a full-thickness tear—early referral optimises outcomes, especially in younger or active patients.
- Suspected large or massive tear, progressive symptoms, or imaging showing significant pathology.
- Red flags are present: profound sudden weakness, unrelieved night pain, trauma history, or alternative diagnoses like instability or cervical radiculopathy.
- Patient preference or diagnostic uncertainty persists.

Isolated subacromial decompression is no longer routinely recommended for uncomplicated impingement or bursitis, as outcomes are comparable to exercise alone. For full-thickness tears, surgery (e.g., repair) may be considered after failed conservative trials, particularly if the tear is repairable and symptomatic. In my experience, early evidence-based conservative care in general practice—tailored to the patient’s needs—maximises outcomes, minimises unnecessary surgery, and aligns with guidelines from bodies like the AAOS and BJSM. If you’re managing a case and unsure, feel free to discuss it with me for collaborative input.

INTRODUCING DR MARCUS CHIA

SHOULDER AND ELBOW ORTHOPAEDIC SURGEON

Dr Marcus Chia is a fellowship-trained Shoulder and Elbow Orthopaedic Surgeon with expertise in minimally invasive and advanced techniques for arthritis, instability, rotator cuff tears, fractures and complex upper limb conditions. Originally a physiotherapist, he graduated from the University of Sydney and worked with rugby, netball, soccer and water polo teams before pursuing medicine. He completed his medical degree with Honours, followed by Orthopaedic Surgical Training in Sydney. Dr Chia then undertook international fellowships in France, the UK, South Africa and the United States, refining his skills in advanced arthroscopic and open shoulder and elbow surgery. He operates at Sydney Adventist Hospital, Northern Beaches Hospital and Wyvern Private Hospital.

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PLASTIC SURGERY REFERRALS:
WHAT HELPS US ASSESS YOUR PATIENT

GP referrals are most helpful when they provide a clear picture of both the clinical issue and the patient's goals. A strong referral should outline the reason for referral, duration of symptoms, relevant medical history, prior treatments, current medications, comorbidities, smoking status and any biopsy or pathology results. As plastic surgery is a visual specialty, photographs (without patient identifiers) are extremely valuable for triage.

It is also helpful to note whether the concern is reconstructive, functional or cosmetic, as this can influence urgency and pathway. For cosmetic surgery, Australian regulations require referral from an independent GP or a specialist who does not perform that procedure. This ensures the patient is appropriately assessed and referred to a surgeon with the correct qualifications. A brief summary of the patient's concerns and expectations can further streamline care.

Useful questions for the GP visit include:

1. What is bothering you most?
2. How long has this been a concern?
3. What are you hoping will improve?

Optional considerations (not required in the referral but useful clinically):

1. Has the patient had previous surgery or cosmetic procedures?
2. Has another practitioner declined treatment?

INTRODUCING DR JOHNNY KWEI

Dr Johnny Kwei is one of Wyvern's highly skilled Plastic, Reconstructive and Aesthetic Surgeons and a Fellow of the Royal Australasian College of Surgeons. He also holds significant leadership roles as Honorary Secretary of the Australian Society of Plastic Surgeons and Assistant National Secretary for the International Society of Aesthetic Plastic Surgeons. Despite these appointments, Dr Kwei remains exceptionally approachable and down-to-earth.

Originally from Perth, he completed his medical degree at the University of Western Australia before moving to Sydney for specialist plastic surgery training. His career then took him overseas for advanced fellowships, including at Queen Elizabeth Hospital in Birmingham and further training with world-leading surgeons in New York, Paris and Seoul. These experiences helped broaden his surgical perspective and refine his technique.

Dr Kwei operates at North Shore Private, Castlecrag Private and here at Wyvern, and is committed to surgical education through his role as NSW Director for Surgical Skills and Education Training. Outside the operating theatre, he enjoys Bikram and hot yoga, often practising at Australia's oldest hot yoga studio in Brookvale.

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WHAT IS A UNICOMPARTMENTAL KNEE REPLACEMENT?

A unicompartmental knee replacement (UKR) is an operation where only the worn part of the knee is replaced (usually medial, or inner side of the knee). This differs from a total knee replacement where all the compartments; medial, lateral (and typically the patellofemoral) compartments are replaced.

What are the main advantages of a partial knee replacement compared with a total knee replacement

A UKR is a less invasive operation. This results in a shorter hospital stay, faster recovery and fewer medical complications. Also, because only the worn compartment is resurfaced, normal knee kinematics are preserved leading to better functional outcomes.

Which patients are the best candidates for a partial knee replacement

Typically patients with isolated single compartment osteoarthritis, a stable knee and minimal deformity with a good range of motion will be suitable candidates. Each individual patient's functional demands and expectations also play an important role in decision making.

When should a GP refer a patient with knee osteoarthritis for surgical opinion

Knee osteoarthritis is a common condition in the community, particularly among older adults. Typically patients will first present with pain and swelling after activity. Initial non operative management would include analgesia such Paracetamol and anti inflammatories, physiotherapy and weight loss. If symptoms continue despite non operative management then referral for a surgical opinion is indicated. Night time pain and worsening functional impairment are often symptoms of worsening disease.

What information makes a GP referral most helpful to you

In most cases a plain film xray of the knee is all that is required for the diagnosis of osteoarthritis and should be the first investigation for any patient presenting with knee pain. Occasionally an MRI may be indicated where the diagnosis is unclear or a non arthritic condition (such as meniscal tear) is suspected.

What should GPs tell patients about recovery and expectations after a partial knee replacement

Generally the recovery after a partial knee replacement is faster than a total knee replacement. Patients can expect to walk the same day after their surgery and spend only a few days recovering in hospital. The first two to three weeks are focussed on recovery with some mild pain and swelling to be expected. Most patients can return to light duties including driving around four to six weeks with a full recovery expected by three months.

INTRODUCING TRISTAN RAPPO

We're pleased to welcome Dr Tristan Rappo. He is a fellowship-trained surgeon specialising in hip and knee arthroplasty and sports knee injuries. Dr Rappo completed his medical degree at the University of Sydney and gained Fellowship of the Royal Australasian College of Surgeons in 2019. He then undertook advanced subspecialty training in hip and knee reconstruction with the Peninsula Orthopaedic Research Institute, with a particular interest in robotic hip and knee replacement. Dr Rappo consults at Peninsula Orthopaedics within Northern Beaches Hospital and operates at both Northern Beaches Hospital and Wyvern Private Hospital. He is known for his approachable manner and commitment to helping patients return to comfort, mobility and confidence.

Dr Tristan Rappo,
Orthopaedic surgeon, Hip and Knee

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INTERVENTIONAL RADIOLOGY

AT WYVERN PRIVATE HOSPITAL

Wyvern Private Hospital is pleased to offer comprehensive interventional radiology services delivered by two highly experienced specialists, Dr Brendan Steinfort and Dr Ken Faulder. Both clinicians have over twenty years of consultant experience and hold fellowships in interventional neuroradiology as well as general interventional radiology.

A wide range of minimally invasive, image guided procedures, with twice weekly CT guided lists are available at Wyvern. These sessions cover both straightforward and more complex procedures, providing timely access for patients who may benefit from targeted, low risk interventions.

While much of their recent work has focused on spinal injections, Drs Steinfort and Faulder are very happy to review patients with other conditions suited to minimally invasive radiology techniques. Their expertise provides an excellent alternative for patients who may not be candidates for surgery or who would benefit from a less invasive approach.

REFERRAL AND CONTACT DETAILS

Dr Steinfort and Dr Faulder can be contacted via:

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CT GUIDED PROCEDURE BOOKINGS

Bookings can be made through Wyvern Medical Imaging:

(02) 8428 2500 | wmireception@wyvernhealth.com.au

WYVERN MEDICAL IMAGING: ADVANCED DIAGNOSTICS CLOSE TO HOME

Wyvern Medical Imaging provides GPs and patients with seamless access to a full suite of modern diagnostic services, all located within Wyvern Private Hospital. Equipped with state-of-the-art technology , including CT, MRI, ultrasound, low-dose digital X-ray, fluoroscopy, weight-bearing CT and True-to-Scale spine imaging , the service delivers fast, accurate results to support timely clinical decision-making.

Open five days a week, the department offers imaging for both inpatients and outpatients, with appointments outside standard hours available by arrangement. Any patient with a valid GP referral is welcome to use the service. Convenient underground parking and direct access from the lower-ground carpark make visits straightforward for patients with mobility challenges.

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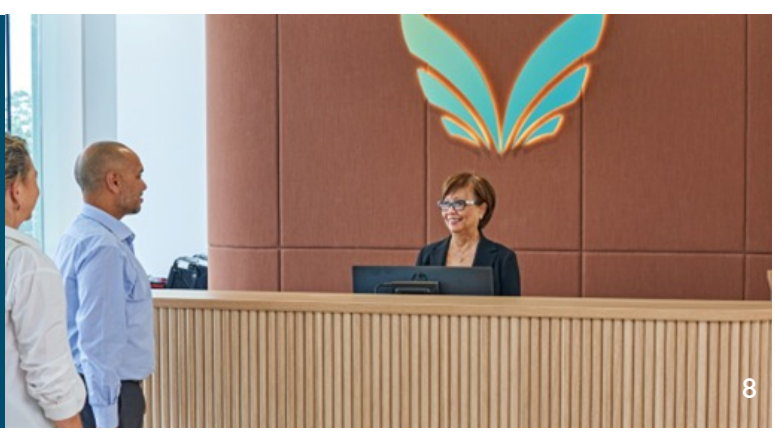
INTERESTED IN GP EDUCATION?

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