



# theNotes

## Recent advances in the treatment of blood cell cancers



The London Clinic  
Newsletter  
Autumn/Winter 2006

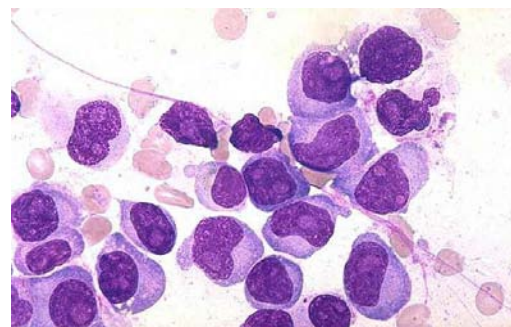
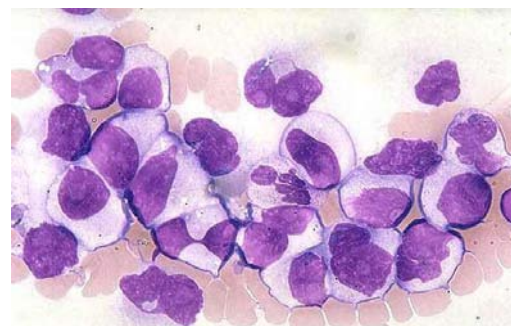
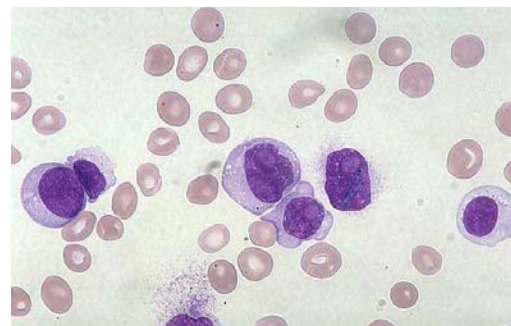
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*At The London Clinic we have a commitment to understanding the use of new drugs, using them effectively in the management of patients with cancers of the blood and lymph gland systems. By so doing we are starting to see major improvements in the outcome of patients with these disorders.*

Cancers of the blood and lymph nodes are tumours frequently seen in general practice. It is, therefore, important to have clear conceptual guidelines to make the appropriate diagnosis. In addition, it is becoming increasingly important to understand traditional treatments and how recent advances in small molecule and antibody treatments are impacting patient survival rates. We are also seeing different side effects of the newer therapeutic interventions which impact the supportive interventions in the GP setting.

The Haemato-Oncology Service at The London Clinic is expanding and using more novel treatments, which is improving survival of our patients. The impact is a greater propensity of GPs encountering such patients in the outpatient setting. At the Clinic, we have excellent inpatient facilities dedicated to these patients, enabling us to manage patients safely within a controlled environment. However, an increasing number of patients are being managed in the outpatient setting as these newer treatments are better tolerated than traditional chemotherapy.

Our understanding of molecular biology has led to a major advance in the development and use of targeted treatment for chronic myeloid leukaemia, CML. This molecular defect is called the Philadelphia Chromosome, and deregulates an oncogene called BCR/ABL which is a tyrosine kinase.



Images of leukaemic blast cells seen in the peripheral blood (top image) and in the bone marrow showing two different types of blast cell (bottom two images).

'The haemato-oncology service at The London Clinic is expanding and using more novel treatments. The impact is a greater propensity of GPs encountering such patients in the out-patient setting.'

Professor Gareth Morgan



## Recent advances in the treatment of blood cell cancers continued

We are able to specifically target this leukaemia abnormality with simple oral chemotherapy. This treatment switches off the molecular abnormality underlying CML leading to its resolution. Once remission is achieved, we are able to monitor disease levels using a sensitive molecular test. If minimal disease levels are achieved, this treatment can be associated with very long term survival and control of the disease. There are a number of other CML like genetic abnormalities for which we have diagnostic capabilities that enable us to administer effective treatments. In AML there is a specific abnormality called a FLT-3 IT which is associated with poor prognosis but now can be targeted using these tyrosine kinase inhibitor drugs with improved prognosis.

Another example of the effective use of laboratory techniques and specific therapeutic interventions is in acute leukaemia sub-type FAB M3, which allows us to treat patients with a drug ATRA, inducing differentiation of the leukaemic precursor. This therapeutic approach prevents the common coagulation problems seen with this disorder and improves patient survival.

In the area of the lymphomas, the advent of a specific antibody — Rituximab - has given us the opportunity to use combined chemo-immunotherapy. This strategy has greatly improved patient survival. For large cell lymphomas the classic chemotherapy combination has been CHOP, which when combined with Rituximab leads to significant

improvement in patient survival rates. Similarly, in chronic lymphocytic leukaemia (CLL), the combination with Fludarabine, Cyclophosphamide and Rituximab (FCR) is highly effective and extremely well tolerated by patients. In CLL another antibody, Campath 1H, is highly effective also and can induce remissions where classic chemotherapy treatments have failed. However, there is an increased need for specific monitoring and appropriate prophylaxis treatment for viral infections, in particular cytomegalovirus, CMV. Our expert understanding of these unique drugs means that we can optimise complex patient treatment safely and effectively.

In the area of myeloma there have been many advances. At least three new drugs are available and are used regularly. Velcade is a drug which targets a small structure within the cell called the proteasome. This drug stresses the myeloma cells and kills them. Thalidomide, has made a comeback in the treatment of myeloma and is highly effective in the treatment of patients leading to very high response rates with few side effects.

Both Thalidomide and Velcade have specific side effects like peripheral neuropathy which we need to manage appropriately. There is, however, a new agent Revlimid, which lacks the neurotoxic side effects of either thalidomide or velcade, and is better tolerated.

Stem cell technology is becoming increasingly understood and has a widespread use as part

of transplantation for blood cell cancers. We have years of experience in using patient's own and donor cells. Recent advances have reduced the toxicity of the procedure making it more applicable to older patients who would previously have been denied this treatment.

At The London Clinic we have a commitment to understanding the use of new drugs, using them effectively in the management of patients with cancers of the blood and lymph gland systems. By so doing we are starting to see major improvements in the outcome of patients with these disorders. At the same time we continue to develop the use of standard chemotherapy treatments and one of our aims to integrate new drugs with the standard approaches and proactively to improve outcomes. Stem cell transplantation procedures are a highly effective treatment modality which can cure patients with these cancers and recent advances are making this approach safer and more applicable.

**Professor Gareth Morgan**  
PhD FRCP FRCPATH  
Professor of Haematology  
Tel 020 8661 3672

### Haemato-oncology team

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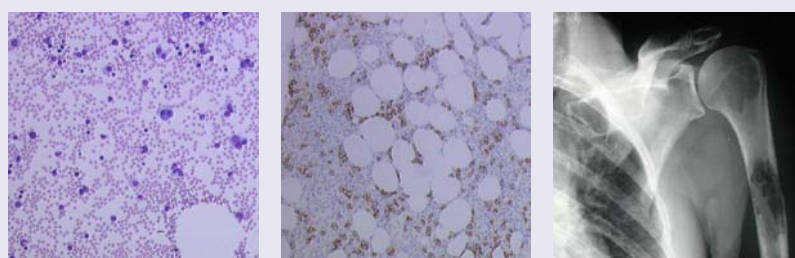


Image of bone marrow aspirate and trephine biopsy from a case of multiple myeloma. The final panel shows a large lytic lesion caused by the myeloma, located in the shaft of the left humerus.

'I am really looking forward to the excitement of conducting experiments high on Everest – our biggest challenge will be ensuring all our high-tech equipment works in such an extreme environment!'

Dr Denny Levett



Dr Denny Levett

*The London Clinic*

Dr Denny Levett is used to rising to a challenge in her role as Critical Care Fellow in the critical care unit at The London Clinic — but the words *high pressure* will take on a completely different meaning when she embarks on her next dizzying project.

Dr Levett is next March set to climb Mount Everest, as part of the research project *Xtreme Everest* which hopes to put a team of 10 doctors on the summit.

The Centre for Aviation, Space and Extreme Environment Medicine which is running the *Xtreme Everest* research expedition, uses extreme environments as a means of investigating critical illness and human physiology.

Dr Levett and colleague Dr Daniel Martin, also from the critical care unit at the Clinic, will form part of a 30-strong team who will attempt to place a research team on the summit of Everest. The team will also study 200 healthy volunteers from the general public who will trek to Everest Base Camp between March and June 2007.

The *Xtreme Everest* Team will be studying the human response to low oxygen levels (hypoxia). They hope that lessons learnt on the mountainside at the limits of human survival can be brought back to the bedside to help in the care of critically ill children and adults.

Dr Levett, who is also the deputy director of CASE, says:

**“Low oxygen levels (hypoxia) are an almost universal problem in critically ill patients on breathing machines. However, it is difficult to study the effects of low oxygen levels on their own in the Clinic as patients have so many other health problems occurring at the same time. Studying healthy individuals in an extreme environment will increase our understanding of the effects of hypoxia and enable us to use this knowledge when caring for patients affected by it back at home.”**

All team members work in anaesthesia, intensive care or remote medicine in their professional lives. Dr Levett, in particular, has previously taken part in a number of marine biology expeditions in Tanzania, Oman and Fiji. She is an experienced diver and has also taken part in mountaineering expeditions in remote locations worldwide.

Dr Levett adds: I am really looking forward to the excitement of conducting experiments high on Everest — our biggest challenge will be ensuring all our high-tech equipment works in such an extreme environment!

If you are interested in volunteering please see the *Xtreme Everest* website [www.xtreme-everest.co.uk](http://www.xtreme-everest.co.uk)



## Noted

### Onwards and upwards!

We are continuing to expand our services at The London Clinic and this includes the increasing use of more progressive and novel treatments. In this issue, Professor Gareth Morgan talks to us about recent advances in the treatment of blood cell cancers and the effective use of some newer drug treatments.

We're also physically expanding, with the opening of our new state-of-the-art consulting rooms at 5 Devonshire Place this month. The new purpose-built facility houses 25 modern consulting suites and a number of out-patient clinical services such as endocrinology and cardiology. This hospital development also sees an expansion of our women's services, including two new rapid access, consultant-led services: colposcopy and early pregnancy scanning.

Someone who literally is travelling upwards is Dr Denny Levett from our critical care unit who tells us about her planned expedition to Mount Everest. The research project, sponsored by The London Clinic, aims to study the human response to low oxygen levels (hypoxia) to help improve our understanding of these effects on critically ill patients on breathing machines. We wish the team the best luck with their expedition and we'll keep you posted on their progress.

Your feedback on our newsletter is always welcomed. If you do have any suggestions regarding what you'd like to see in here in future editions, please feel free to send an email to us at [info@thelondonclinic.co.uk](mailto:info@thelondonclinic.co.uk)

Karen Bullivant

*Marketing Director, The London Clinic*

Osteoporosis is very common. In the U.K., one in three women and one in twelve men over the age of 50 years suffer from osteoporosis. It is an enormous financial burden to the National Health Service and UK government costing over £5 million each day not counting the human costs.

An osteoporotic fracture occurs every 3 minutes. The commonest such fracture is spinal fracture with an incidence of 120,000 fractures per year outnumbering osteoporotic hip fractures. The commonest osteoporotic spinal fractures are vertebral body compression fractures.

When treating patients with osteoporotic vertebral body compression fractures, clinicians are confronted with the osteoporotic disease, the back pain, and the spinal deformity. Significant advances have been made in the treatment of osteoporosis and pain control. The elderly patient population, and risks of major open spinal surgery had resulted in reluctant acceptance of the spinal deformity, and conservative treatments using body bracing and prolonged bed rests. Spinal deformity can lead to further spinal pain and vertebral fractures. It has been shown that each thoracic spinal kyphotic deformity results in 9% loss of lung function, and that spinal deformity adversely affects body balance with increased muscle fatigues and gait disturbance causing recurrent falls and fractures.

Recently, balloon kyphoplasty, as approved by the National Institute of Clinical Excellence (NICE), has been gaining clinical acceptance as an effective treatment for painful osteoporotic vertebral body compression fracture as well attempting fracture reduction restoring some of the lost vertebral body height, and preventing further local progressive vertebral body collapse. To date more than 240,000 vertebral fractures in 210,000 patients worldwide have undergone balloon kyphoplasty mainly in the USA and Europe.

Balloon kyphoplasty is a radiologically-guided minimally invasive percutaneous vertebral body augmentation procedure that can be performed under either local or general anaesthesia, and involves the placement of bone cements in the fractured vertebral body. Two deflated balloons are introduced into the fractured vertebral body, which are then inflated, deflated, and removed leaving behind two voids within the vertebral body (fig 1). The viscous bone cement is then placed in the bony voids under no or very little pressure. During the inflation of the balloons, fracture reduction with vertebral body height restoration is attempted. The balloons are inflated using opaque contrast medium, and the bone cements are also radio-opaque allowing the whole procedure to be monitored and guided radiologically. In addition, bone biopsy can be taken at the time of the procedure if necessary.



Figure 1

Figure 1  
Schematic diagram showing two balloons placed in the vertebral body.

# Balloon Kyphoplasty and Osteoporotic Vertebral Compression Fracture

The indications for balloon kyphoplasty are painful or progressive osteoporotic vertebral compression fractures. Patients' history and examinations are taken to establish the clinical diagnosis. Dual Energy X-ray Absorptiometry (DEXA) scan is useful in confirming vertebral osteoporosis. Spinal plain radiographs are effective in monitoring fracture progression, and spinal sagittal MRI STIR (short tau inversion recovery) scan which is sensitive to vertebral body fracture oedema, is valuable in confirming the painful vertebral bodies particularly when multiple vertebral collapses are identified on the plain radiographs. In patients who cannot have MRI scans, bone scan may be helpful. Spinal CT scan is useful in assessing complex fracture configurations, and technically challenging cases. In addition, radiological investigation is helpful in ruling out non-osteoporotic causes of vertebral fractures such as infection and neoplasms. The contraindications/cautions for balloon kyphoplasty include infection, unstable fractures, uncorrected coagulopathy, pregnancy (due to the x-ray radiation during the procedure), and fractures causing neurological deficits.

In our series of over 200 balloon kyphoplasty procedures, more than 90% of the patients have back pain improvement or resolution. About 40% of the patients stop analgesic usage, and a further 40% of the patients have reduced analgesic usage. The pain improvement is associated with improved functional outcome. The onset of pain relief is generally immediate if not within 24 hours of the procedure.

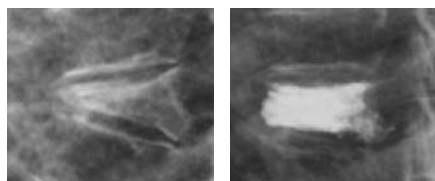


Figure 2 (a) (b)

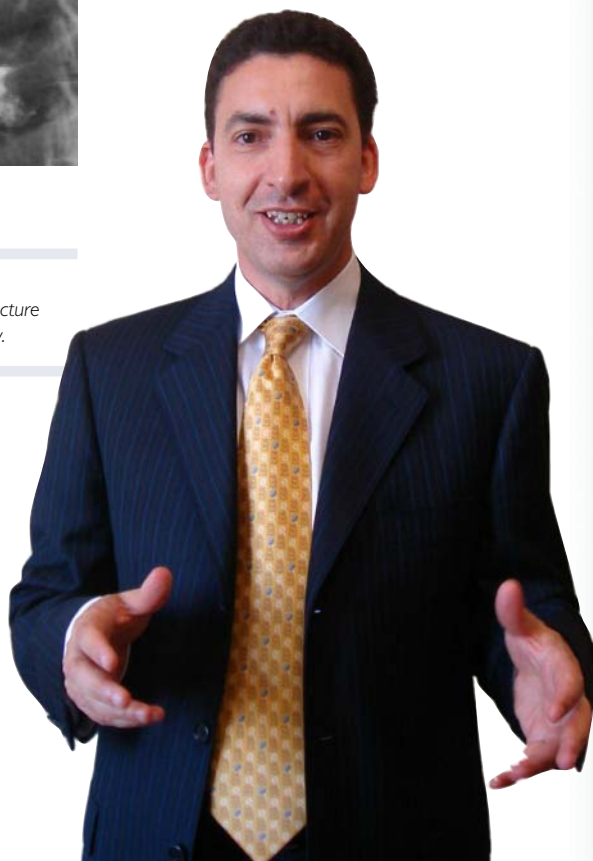
Figure 2  
Osteoporotic vertebral body compression fracture before (a), and after (b) balloon kyphoplasty.

The patients are allowed home once fully recovered from anaesthesia. The extent of the vertebral height restoration and kyphotic angle correction depend on the age of the fracture and the extent of the vertebral body collapse. Fractures within one week, and possibly up to two weeks, generally can be reduced significantly while height restoration is generally not possible in cases of complete collapse (vertebral plana) (fig. 2). The procedure normally takes 40 minutes for the first vertebral level with further 20 minutes for each additional level done. Adverse cement extravasation rate for balloon kyphoplasty is about 0.3% per vertebral level which compares favourably with that of vertebroplasty of 3.7% quoted in medical literature.

In summary, balloon kyphoplasty seems to be an effective and low-risk minimally invasive percutaneous vertebral body augmentation procedure in the treatment of painful or progressive osteoporotic vertebral compression fractures. The outstanding feature of balloon kyphoplasty is patient-friendliness viz. comfort, short hospital stay, and short recovery time. Furthermore, the concept of creating vertebral bone voids with controlled safe placement of materials, and the balloon technology offer exciting therapeutic futures.

**Mr Habib Ellamushi**  
FRCS(Ed) FRCS(SN)

Consultant Neurosurgeon  
Tel 020 7234 2163 / 020 7377 7209



**CONSULTANT PROFILE**

Dr Frances Lawlor qualified from University College Dublin in 1972. Her pre-membership medical posts were carried out in Ireland with the exception of some months spent in Nigeria looking after adults and children.

She spent one year as a paediatric SHO and six months as Obstetric SHO. After becoming a member of the College of Physicians of Ireland, Dr Lawlor worked as dermatology SHO both in Galway and Liverpool, before becoming dermatology registrar in Sunderland and Senior Registrar in Coventry.

After accreditation as a dermatologist, she spent three years as Research Fellow working on the Physical Urticarias in Professor Greaves department at the St Johns Hospital for Diseases of the skin, St Thomas Hospital. Dr Lawlor was appointed consultant at Newham University Hospital in 1990 and continued as honorary senior lecturer in dermatology at UMDS for some years. She is now Consultant Dermatologist at Newham University Hospital and Honorary Consultant at St Thomas in the Urticaria service.

Dr Lawlor has a wide experience with inflammatory diseases, coloured skin and paediatric dermatology. She has a particular expertise in Urticaria.

Dr Lawlor is a member of the British Association of Dermatology, a Fellow of the Royal Society of Medicine, a Fellow of the American Academy of Dermatology and a Fellow of the European Academy of Dermatology and Venerology. She has published extensively.

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Consultant Dermatologist

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Tel 020 7616 7693 / 020 7363 8004

'Post operative care is an important part of plastic surgery, be it constructive or aesthetic.'

Mr Mark Ho-Asjoe



## Post-operative care following plastic surgery

Mr Ho-Asjoe discusses some common post-operative complications that general practitioners may be presented with following a patient's plastic surgery procedure.

### Post-operative wound care

Surgery encompasses the whole entity from consultation until the wound has healed. Post-operative wound care is an important part of surgery, particularly with Plastic Surgery, be it reconstructive or aesthetic. Bruising, oedema and mild discomfort are common after surgery and are to be expected. However, excess pain can be a sign of infection, seroma formation or fat necrosis.

Wound dehiscence is probably the most common complication during the wound healing process. The majority are minor and only require daily cleaning and dressing such as Tullgra, Inadine or a simple dry dressing. In a more sloughy wound, there may be a requirement for a de-sloughing agent such as Aquacel, Intrasit or Vacutex. There are many other dressings available in the market with some being very specific for certain types of wound and others being chosen due to personal preference.

### Aesthetic breast surgery

In general, following breast surgery, the patient should wear a supportive bra continuously for a period of time after surgery. The duration is variable and will range from 2-6 weeks. A sports bra is usually recommended. It is not recommended to perform any strenuous upper body exercise for at least 6 weeks.

With breast reduction and mastopexy, wound dehiscence is not uncommon and can be related to tension, infection, haematoma or seroma. Most do not require anything more than a short period of dressing.

Occasionally, pinhole size wounds may appear a few weeks after the wound has healed.

This is most likely to be related to the subcutaneous dissolvable suture that either is being discharged or it may be the formation of an inflammatory abscess. Neither of these conditions requires antibiotics. Simple reassurance, showers and dressing are the best treatment.

With breast augmentation, the implant is usually palpable around the edges especially in slimmer patients. This is most common in the inferior pole. Despite patients being informed prior to surgery, they often do return with concerns about a palpable lump once the oedema settled.

A palpable lump may also be present in a patient after breast reduction or mastopexy surgery. This is most likely to be due to fat necrosis. Patients are usually reassured and the hardness will settle with time.

Scar maturation is an important issue. It is important to minimise stretching as scar tissue is weaker in tensile strength in comparison to normal tissue. Until the inflammatory process settles, it is important to protect the scar with sun block as UV can induce hyperpigmentation. Regular moisturisation and massage is recommended after the wound has healed. If there are signs of hypertrophic changes or keloid scar formation, massage, silicone gel and pressure garments may be tried before steroid injection.

**Mr Mark Ho-Asjoe**  
MB Bch FRCS FRCS(Plast)  
Consultant Plastic, Reconstructive  
and Aesthetic Surgeon  
Tel 020 7079 0057

## NEW Early Pregnancy Scanning Service

The London Clinic and a team of consultant obstetrician and gynaecologists have worked in partnership to develop an Early Pregnancy Scanning Service based in our new modern facilities at 5 Devonshire Place.

Mr Davis, Mr El-Refaey, Mr Iskaros and Professor Jauniaux approached the clinic with their vision of a fast access, high quality consultant led early pregnancy service. Every patient will be seen by a consultant who will perform their scan and provide immediate advice on their results. If a complication is identified, the early detection will allow the consultant to manage the condition at any early stage with the full back-up facilities of The London Clinic.

The service is recommended for women in their first 12 weeks of pregnancy, who have concerns from bleeding, vaginal discharge and / or abdominal pain in this pregnancy, or have encountered problems in previous pregnancies. It is also available for women who seek reassurance that all is progressing well with their pregnancy.

A consultant will be available for appointments everyday between Monday—Friday from 10am-12noon. To make an appointment, GPs or patients should contact The London Clinic on 020 7034 6329

**Early Pregnancy Scanning appointments**  
**020 7034 6329**

## Consultants granted admitting /practising privileges

from May 2006  
to September 2006

### Cardiology

**Dr Simon Woldman**  
MBCLB FRCP CBNC MRCP BSE MD  
*Consultant Cardiologist*  
NHS Post(s): University College Hospital  
020 7573 8888

### Endocrinology

**Dr Maurice Katz**  
MB ChB  
*Consultant Endocrinologist*  
NHS Post(s): University College Hospital  
020 7383 7911



**Malcolm Miller**  
*Chief Executive, The London Clinic*

### General Surgery

**Mr Raj Bhutiaini**  
MB BS MS FRCS  
*Consultant General Surgeon*  
NHS Post(s): North West London Hospital  
020 8872 3872

**Mr Paris Tekkis**  
B Med Sci MBBS MD FRCS  
*Consultant Surgeon*  
NHS Post(s): Imperial College  
020 7886 1935

**Mr Peter Veitch**  
B Med Sci MBBS FRCS  
*Consultant in Renal Transplant and GI Surgery*  
NHS Post(s): Royal Free Hospital  
020 7794 0500

### Neurosurgery

**Mrs Anne Mitchener**  
Bsc (Phy) PhD MB Bchir FRCS FRCS(SN) CCST  
*Consultant Neurosurgeon*  
NHS Post(s): Charing Cross Hospital  
020 8846 1234

### Neurology

**Dr James Rakshi**  
MB ChB MRCP MD  
*Consultant Neurologist*  
NHS Post(s): Royal Free Hospital & Barnet and  
Chase Farm NHS Trust  
020 7794 1323

### Oncology

**Dr Susan Cleator**  
BA BMBCh MRCP FRCR PLD  
*Consultant Clinical Oncologist*  
NHS Post(s): St Mary's Paddington  
020 7886 1132

### Ophthalmology

**Miss Rajni Jain**  
MBBS MRCOphth FRCOphth  
*Consultant Ophthalmologist*  
NHS Post(s): Western Eye Hospital  
020 7935 7177

### Pathology

**Professor Bernard Portmann**  
MB BS MD MRCPPath FRCPath  
*Consultant Histopathologist*  
NHS Post(s): King's College Hospital  
020 7346 3734

### Plastic Surgery

**Mr Walid Sabbagh**  
MB ChB FRCS MSc  
*Consultant Plastic Surgeon*  
NHS Post(s): Mount Vernon Hospital  
020 8420 1818

### Radiology

**Dr Adrian Lim**  
MD FRCR MBBS BMedSci  
*Consultant Radiologist*  
NHS Post(s): Hammersmith Hospital  
020 8846 1858

**Dr Samantha Read**  
MBBS MRCS FRCR  
*Consultant Radiologist*  
NHS Post(s): University College Hospital  
0845 155 5000

**Dr Michael Michell**  
BA MA MB Bchir(Camb) DMRD FRCR  
*Consultant Radiologist*  
NHS Post(s): Kings Cross Hospital NHS Trust  
020 7346 3875

### Urology

**Mr M Shamim Khan**  
MBBS MCPS FRCsed FRCUrol FEBU  
*Consultant Urologist*  
NHS Post(s): Guy's and St Thomas' NHS Trust  
020 7188 6795

**Mr Palaniappa Raju**  
MBBS FRCS  
*Consultant Urologist*  
NHS Post(s): Mayday University Hospital  
020 8401 3331



Matron continues to bring some insight into issues affecting the Clinic in her regular feature

**Amanda Hallums**

*Matron/Director of Clinical Services, The London Clinic*

# Notes from Matron

The London Clinic works closely with consultants to bring excellence in individual care to our patients. In the past few months, we have launched two new clinical services: a Blackout Clinic and a colposcopy service.

## **Blackout Clinic**

Along with the expertise of Dr Rose, Consultant Neurologist, we have developed a specialist Blackout Clinic to help diagnose the nature of a patient's blackout, rule out any associated brain disorder and offer advice on the future management of their condition.

## **Who should be referred?**

The assessment is designed for patients who have experienced a blackout or near blackout that was:

- a witnessed convulsive seizure
- a witnessed episode without convulsions, but with features to suggest possible partial seizure
- not witnessed or an uncertain episode with any of the following:
  - unconsciousness
  - injury
  - tongue biting
  - incontinence
  - not unconscious, but with confused behaviour
  - headache post attack

Our Blackout Clinic assessment involves a series of blood tests, ECG, MRI scan and a consultation with a Consultant Neurologist. Prior to referral, general practitioners are requested to complete a referral form including details of their patient's blackout episodes and their suitability for undergoing an MRI scan.

This service is open to both insured and self-pay patients. If your patient is covered by private medical insurance, it's essential that they contact their provider to confirm that the assessment will be covered.

## **Colposcopy service**

Run by consultant gynaecologists Mr Carl Chow, Mr Thomas Ind and Mr Tim Mould, our new outpatient colposcopy service will be available from early October at our new premises at 5 Devonshire Place.

The London Clinic will provide a daily colposcopic consultation service. Biopsy results, if applicable, will usually be available within a week.

For further information about either of these new services, or for referrals, please call our appointments and information office on 020 7616 7693

## **Note on PPP patients from Sanjay Shah, Chief Financial Officer**

Following discussions with PPP, please be advised that, for a PPP subscriber holding a policy where private treatment is only covered if they cannot be treated on the NHS within six weeks, the Clinic will regard this patient as self-paying until PPP make a formal authorisation for their management plan in writing. Additionally, PPP has also confirmed that no private cancer treatments will be approved as it is their understanding that the NHS can treat all these patients within the six weeks period.

Please feel free to contact Lisa Ciccone, our Patient Administration Manager, on 020 7935 4444 ext 3652 if you have any questions.

