Women’s Health GP Conference

The Royal College of General Practitioners

Saturday 22nd April 2017
Gynaecology in a Women’s Hospital

Diagnostics
- Imaging – US/MRI
- Urodynamics
- Pathology and histology
- Excellent colposcopy facilities

Gynae Consultant subspecialists
- Minimal access surgery
- Endometriosis
- Urogynaecology
- Outpatient hysteroscopy
- Strong link to HCA’s cancer networks

- Dedicated gynaecology nursing team in outpatients, theatre and wards

- Specialist women’s health physiotherapy team
Why refer to the Portland?

- At an average London and Home county GP practice, approximately one in every 5 families will have their children covered on their Medical Insurance Policy.

- Quick access to London’s top Specialists who undertake a true MDT approach.

- Three operating theatres, one emergency operating theatre on the labour ward and an onsite Adult High Dependency Unit, Neonatal Intensive Care Unit, Special Care Baby Unit, Transitional Care Unit and Paediatric Intensive Care Unit.

- Patient care is tailored to the individual.

- All rooms have ensuite facilities where one parent/partner can stay at all times.

E: portlandgp@hcahealthcare.co.uk            T: 0207 390 6057           F: 0207 390 6069
GP Liaison Team

- Same day and next day appointments available Monday to Saturday

- Audiology, Imaging and Therapy departments accept referrals directly from GPs

- Education programme – Conferences, Evening Seminars in the Portland Boardroom and Evening Paediatric Seminars at The Shard

T: 0207 390 6057  F: 0207 390 6069
E: portlandgp@hcahealthcare.co.uk  W: www.theportlandhospital.com
Polycystic Ovarian Syndrome

What we understand and how we can help

MISS MEG WILSON
CONSULTANT OBSTETRICIAN AND GYNAECOLOGIST
History

- Stein and Leventhal 1935

Diagnosis

- Rotterdam criteria – Two of the three criteria
  1. PCOS on USS
  2. Oligo or anovulation (less than 6 periods each year)
  3. Hyperandrogenism
Diagnosis – ovarian morphology

- PCO ultrasound appearance in 22% of normal population

- PCOS is present in
  - 7% of women
  - 32% of women with amenorrhea
  - 87% of women with hirsuitism/acne
  - 73% of women with anovulatory infertility
Managing Symptoms
Obesity

- Supportive strategies for weight loss and diet.
- Consider Metformin
- Bariatric surgery
Hirsuitism and Acne

- Weight loss
- Cosmetic methods
- Oral contraceptive pill – consider Yasmin as it has an antiandrogenic action. Avoid norethisterone and levonogestrel as these are androgenic and worsen hirsuitism.
- Dianette (Cyproterone acetate)
- Eflomithine (Vaniqa cream)
- Spironolactone
- Flutamide
- Finasteride
Menstrual irregularity

- Weight loss if high BMI
- Oral contraceptive pill (avoid androgenic pills)
- Mirena IUS
- Aim to have at least 4 period each year
Subfertility

- 10% weight loss in high BMI women is more successful than IVF.
- Metformin
- Clomiphene citrate (Clomid) – with follicular tracking.
- Ovarian drilling.
- IVF – need BMI less than 30
Long-term health

- Gestational diabetes risk
- Insulin resistance and Type 2 diabetes
- Cancer risks – endometrial cancer
- Cardiovascular risks
- Sleep apnoea
- Depression
Take home messages

- PCO affects 1 in 4 women however PCOS affects 1 in 10.
- Confirm the diagnosis
- Treat the presenting symptoms
- Consider longterm health risks
- www.rcog.org – Polycystic Ovarian Syndrome; Long term consequences
- NICE – PCOS Metformin in women not planning pregnancy
- The Polycystic Ovarian Syndrome. Position statement from the European Society of Endocrinologists 2014
- Verity.co.uk – Patient support
Women’s Health Physiotherapy

What can we do for you?
22nd April 2017
Objectives

Women’s Health Physiotherapy – What exactly do we do?

- Evidence-based practice
- Part of the MDT
- Antenatal and Postnatal care
- Musculoskeletal
- Uro-gynaecological
- Assessment and treatment options
Evidence-Based Practice

Clinical guidelines, research evidence, clinical governance, audit and outcome measures

- NICE
- RCOG
- RCM
- WHO
- Chartered Society of Physiotherapy (CSP) & Pelvic Obstetric and Gynaecological Physiotherapy (POGP)
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Organisation/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives and Obstetricians</td>
<td>GUM clinics</td>
</tr>
<tr>
<td>Gynaecology / Urology</td>
<td>British Association for Sexual Health and HIV (BASHH)</td>
</tr>
<tr>
<td>Colorectal</td>
<td>Mothers with Anal Sphincter Injuries during Childbirth (MASIC) Foundation</td>
</tr>
<tr>
<td>Endometriosis CNS</td>
<td>Psychology</td>
</tr>
<tr>
<td>Urology CNS</td>
<td>Dietetics</td>
</tr>
<tr>
<td>FGM clinics</td>
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</table>
Obstetric Physiotherapy

**Antenatal Physiotherapy**
- Pelvic Girdle Pain (PGP), sciatica, lumbar spine
- Rib flare pain
- Carpal tunnel symptoms (CTS)
- Continence issues
- Pelvic organ prolapse (POP)
- Rectus Abdominis Diastasis

**Postnatal Physiotherapy**
- PGP, sciatica, lumbar pain
- Rib pain, CTS, abdominal diastasis
- Post OASI / Episiotomy
- POP & Continence issues – faecal, flatus, urinary
- Sexual dysfunction & dyspareunia
Physiotherapy

Musculoskeletal Physiotherapy
- Coccyx and sacral pain
- Pudendal Nerve pain
- PGP (non-pregnancy related)
- Return to exercise
- Pilates-based core exercise

Physiotherapy for Uro-gynaecological and Pelvic pain
- Pre & post-operatively
- Pelvic floor muscle weakness
- Continence (bladder and bowel)
- OAB / habitual issues
- Advice UTI / cystitis / IBS / constipation
- Colorectal & evacuation disorders (inc. pain)
- Pelvic organ prolapse
- Chronic pelvic pain – Vulvodynia, dyspareunia, sexual dysfunction, liaison with endometriosis CNS
- FGM – bladder issues, pain, post-deinfibulation
Physiotherapy Assessment and Treatment

Physiotherapy Assessment

- Full Subjective - complete history

- Objective Musculoskeletal - abdominals, pelvic alignment, spinal positioning, gait and biomechanics, posture, leg-length etc.

- Objective Pelvic Floor examination – skin condition, external musculature, digital vaginal and/or anal examination, (muscle bulk, power and endurance grading, POP, structural deformity, scarring, pain) pudendal nerve palpation
Physiotherapy Assessment and Treatment

Physiotherapy Treatment Options

- Exercise advice, core progression, downtraining for overactive muscle groups
- Diet / fluid advice / bladder training
- Bowel management – technique / laxatives / probiotics advice / irrigation systems / plugs
- Electrical assessment EMG biofeedback, neuromuscular electrical stimulation
- Wi-Fi- technology e.g. Elvie & Pericoach products
- Advice sexual dysfunction – lubricant advice, dilator therapy
- Manual Therapy (inc. pelvic floor muscles, pudendal nerve, joint mobilisations)
- Acupuncture
Case Study

49 year old female c/o constant urinary leakage since 1\textsuperscript{st} child 8 years ago (SVD)
Occasional stress urinary incontinence additional with ADL, worse since 2\textsuperscript{nd} child
(ELCS) 4 years ago

Employed full time (desk work) fit & healthy – minimum 1 hour walking per day, high-intensity training. Nil of note PMH.

4/12 ago vaginal hysterectomy with TVT for POP cystocele

- Incomplete voiding every time requiring regular self-catheterization, if not emptied leads to urgency and urge incontinence
- Surgery lessened SUI slightly
- Remains with constant leakage – permanently damp, needing liner pads day and night
- Has reduced fluids+ as concerned about issues
Case Study

No bowel issues, no dyspareunia, no UTI, video urodynamics shows residual of 200mls.

Referred with “obstructed flow and considering having a tape cutting procedure which will likely result in complete incontinence. Patient has asked if she can see a physiotherapist to learn pelvic floor exercises first”

Objective Physiotherapy Assessment:
Contractions graded 3/5 left-sided PFM, grade 4/5 right-sided PFM
8 second hold time, 8 repetitions, 10 fast contractions possible
No visible / palpable POP, no pain symptoms produced, no atrophy

Provisional diagnosis:
• Good pelvic floor structure, fair muscle power and endurance.
• Incomplete emptying ? Structural / positional
• Poor fluid intake likely leading to urgency?
Case Study

Aim of treatment:
Good voiding habits / teach double void / give more time to void / good fluid intake
Aim for emptying more fully every void with good positioning and technique
Reduce incomplete emptying and need for self-catheterization by 50% of time

Advice offered session 1:
Pelvic floor exercises with ‘Knack’ to contract with ADL and cough / sneeze etc.
Fluid advice with bladder diary
Toilet positioning taught, double void, rocking, take time to void, relaxation

Session 2:
ASYMPTOMATIC and very happy!
Stopped pad use, no dampness, no need for another surgery
Patient feels all advice regarding toilet positioning and technique has helped
Advice offered for long-term care POP, PFExs, sports etc, core exercise
To Summarize

There are multiple sources encouraging physiotherapy input for women with pelvic health issues – NICE Guidelines, RCOG, POGP, WHO

If one quarter of your caseload consists of women’s health, 1 in 3 women develop urinary incontinence in pregnancy, and between 1-10% of adults are affected by faecal incontinence…

… a referral to a Women’s Health Physiotherapist could lessen your caseload, reduce onward referrals to secondary care, and change a woman’s quality of life forever…
Managing Contralateral Breast Risk
Team Based Approach to Prophylactic Mastectomy

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Clinical Senior Lecturer and Consultant Oncoplastic Breast Surgeon
Department of BioSurgery and Surgical Technology at Imperial College London
The Breast Unit at Imperial College Healthcare NHS Trust

Presentation at Women’s Health Conference, Portland Group, Portland Hospital for Women and Children, 22nd April 2017
ABS Statement regarding Mr Ian Paterson

Mr Ian Paterson FRCS, a general and breast surgeon, who worked at the NHS Solihull Hospital, Little Aston and Solihull Spire private hospitals, was suspended by the General Medical Council (GMC) in 2012 for performing ‘unnecessary’ and ‘inappropriate’ breast surgery on large numbers of women over many years.

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Jury retires in trial of breast surgeon Ian Paterson

A jury has retired to consider its verdicts in the trial of a breast surgeon accused of carrying out "completely unnecessary" operations.
Increasing Rates of Bilateral Mx

Increasing Incidence of Bilateral BC?

“Angelina Jolie effect”

- Increasing use of RRM in high risk—ie, BRCA mutation carriers with a primary cancer
- Not account for the overall increasing use of the procedure
- Numbers in this patient group have remained static for the past two decades
Contralateral Mx in Sporadic Unilateral Breast Cancer

![Graph showing the percent of women selecting CPM over the years from 1999 to 2007. The graph shows an increase in the percentage of women selecting CPM from 2002 onwards.]

What Drivers for Contralateral Mx?

Misperception regarding risk and prognosis

“Screen cripple” and challenge of multiple Bx

Desire for reconstructive symmetry

Anxiety of a contralateral relapse
## Risk of Contralateral Disease Low

<table>
<thead>
<tr>
<th>Years since diagnosis</th>
<th>Sporadic</th>
<th>BRCA1</th>
<th>BRCA2</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3.5%</td>
<td>19%</td>
<td>12%</td>
</tr>
<tr>
<td>15</td>
<td>10.5%</td>
<td>36%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Low risk sporadic patient = 0.5-1% / annum, = 13% lifetime patient diagnosed age 50 years [historical data and probably over-estimates – NACT, hormone thx which modify C/L risk)

Contralateral Mastectomy Offers No Significant Survival Advantage

- No high quality data
- C/L RRM improves survival in sporadic unilateral BC
- Impact non-cancer survival likely due to confounders

Risk Relapse Index Cancer Higher
Risks of C/L RRM and Reconstruction

Mastectomy reconstruction substantial and irreversible

NMRA 4/7 average LOS
LOS: 4/7 Implant and 9-11/7 Autologous

6% severe pain and 12-18% complication

Flap loss rare ~1% significant impact

Return to theatre and re-operative 5%

Cost (psychological and economic – £10K)
MDT Approach to RRM

Genetics Clinics in North East Thames
Escalation in requests for risk reducing mastectomy in gene carriers and contralateral mastectomy in patients with sporadic breast cancer

Regional Multidisciplinary Team meeting (RRM-MDT) was established at our Centre toward improving the quality of decision-making

Our aim was to review cases discussed at RRM-MDT with specific focus on referral patterns and justification for acceptance or rejection of risk-reducing surgery
RRM-MDT Patient Pathways

- **Gene Carrier**
  - Risk Reducing Mx
  - Genetics
  - Surgeon
  - Psychologists
  - BRA support group meeting
  - RRM-MDT

- **Sporadic Cancer, Contralateral Mx**
  - Surgeon
  - Formal risk assessment
  - Psychologists
  - BRA support group meeting
  - RRM-MDT
Attended by women considering immediate or delayed reconstruction

Women who have had breast reconstruction attend

Two meetings / month

Informal and relaxed environment

BCN on hand to answer questions and address concerns

Opportunity to discuss and find out more about available options for breast reconstruction

For RRM-MDT patients, attendance mandatory before reconstructive surgery is contemplated
Quarterly meeting
Standard proforma
Registers patient
Aide memoire and a formal document
Hard copies held in office
Multi-referrer (unit and sub-specialty)
Longitudinal record
# Breast cancer risk category

<table>
<thead>
<tr>
<th>Lifetime risk from age 20</th>
<th>Near population risk</th>
<th>Moderate risk</th>
<th>High risk(^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than 17%</td>
<td>Greater than 17% but less than 30%</td>
<td>30% or greater</td>
</tr>
</tbody>
</table>

| Risk between ages 40 and 50 | Less than 3% | 3–8% | Greater than 8% |

\(^1\)This group includes known *BRCA1*, *BRCA2* and *TP53* mutations and rare conditions that carry an increased risk of breast cancer such as Peutz-Jegher syndrome (*STK11*), Cowden (*PTEN*) and familial diffuse gastric cancer (*E-Cadherin*).
Methodology

- A retrospective review of patient records was conducted extracting the following information:
  
  (a) Family history and genetic mutation status  
  (b) Data pertaining to prior breast cancer(s)  
  (c) Request for bilateral or contra-lateral risk-reduction  
  (d) RRM-MDT outcome decision  
  (e) Justification(s) for rejection
## Patient Demographics

**TABLE 1 Personal history of breast cancer and genetic mutation status for all patients discussed by MDT**

<table>
<thead>
<tr>
<th>Personal History of Breast Cancer</th>
<th>N= (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No prior history</td>
<td>21 (13.9)</td>
</tr>
<tr>
<td>Genetic mutation and positive history of breast cancer</td>
<td>71 (47.0)</td>
</tr>
<tr>
<td>Sporadic prior breast cancer (gene tested negative and gene test pending)</td>
<td>55 (36.4)</td>
</tr>
<tr>
<td>Unknown prior history</td>
<td>4 (2.6)</td>
</tr>
</tbody>
</table>
**TABLE 2 Summary of MDT decision-making outcomes in requests for prophylactic mastectomy**

<table>
<thead>
<tr>
<th>MDT Decision</th>
<th>N= (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved</td>
<td>80 (53.0)</td>
</tr>
<tr>
<td>Declined</td>
<td>51 (32.5)</td>
</tr>
<tr>
<td>Decision Pending</td>
<td>18 (11.9)</td>
</tr>
<tr>
<td>Unknown</td>
<td>4 (2.6)</td>
</tr>
</tbody>
</table>
Results: RRM Approved
Results: RRM Declined

Justification for Declining Patient Request for Prophylactic Mastectomy

- Low CBC/LR Risk: 45%
- Patient Declined: 25%
- Medically Unfit: 15%
- Request driven by cosmesis: 10%
- Family History Unsubstantiated: 5%
- Patient "Did Not Attend" BRA group meeting or OPD: 5%
- Psychological status: 5%
## Accepted vs Rejected

<table>
<thead>
<tr>
<th>Socio-demographic and Disease Parameters</th>
<th>PM Request <em>Rejected</em> at RRM-MDT</th>
<th></th>
<th>PM Request <em>Accepted</em> at RRM-MDT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[n= (%)]</td>
<td></td>
<td>[n= (%)]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive / Yes</td>
<td>Negative</td>
<td>Unknown / no documented evidence</td>
<td>Positive / Yes</td>
</tr>
<tr>
<td>Personal breast cancer history</td>
<td>24 (47.0)</td>
<td>27 (52.9)</td>
<td>-</td>
<td>33 (41.3)</td>
</tr>
<tr>
<td>Nodal involvement</td>
<td>8 (15.7)</td>
<td>17 (33.3)</td>
<td>26 (51.0)</td>
<td>22 (27.5)</td>
</tr>
<tr>
<td>Metastases</td>
<td>21 (41.2)</td>
<td>0</td>
<td>30 (58.8)</td>
<td>22 (27.5)</td>
</tr>
<tr>
<td>ER status</td>
<td>18 (35.3)</td>
<td>8 (15.7)</td>
<td>25 (49.0)</td>
<td>18 (22.5)</td>
</tr>
<tr>
<td>HER2 status</td>
<td>3 (5.9)</td>
<td>21 (41.2)</td>
<td>27 (52.9)</td>
<td>7 (8.8)</td>
</tr>
<tr>
<td>BSO</td>
<td>16 (31.4)</td>
<td>25 (49.0)</td>
<td>10 (19.6)</td>
<td>21 (26.3)</td>
</tr>
<tr>
<td>Tamoxifen received</td>
<td>16 (31.4)</td>
<td>24 (47.1)</td>
<td>11 (21.6)</td>
<td>22 (27.5)</td>
</tr>
<tr>
<td>Aromatase inhibitor received</td>
<td>6 (11.8)</td>
<td>32 (62.7)</td>
<td>13 (25.5)</td>
<td>4 (5.0)</td>
</tr>
<tr>
<td>Radiotherapy received</td>
<td>20 (39.2)</td>
<td>27 (52.9)</td>
<td>4 (7.8)</td>
<td>30 (37.5)</td>
</tr>
<tr>
<td>Chemotherapy received</td>
<td>18 (35.3)</td>
<td>29 (56.9)</td>
<td>4 (7.8)</td>
<td>37 (46.3)</td>
</tr>
</tbody>
</table>
10-Year Prognosis Comparison

![Bar chart showing 10-year PREDICT Survival (Median) for Request Accepted and Request Rejected categories. The chart displays a comparison between the lowest and highest survival rates, with the highest survival rate significantly higher than the lowest for both accepted and rejected requests.](image)
Psychological Indication for Surgery?

- **C/L RRM Case Accepted for Psychological Indication**
- 64y.o., Essex County
- 2010 (L) BC – mucinous and HG DCIS
- 2010 (L) Mx and ANC
- 2011 Adjuvant AI
- **Geneticists**: pop risk of LR (0.5-0.7% p/a) – recommend reject
- **Psychologists**: Emotionally unable to cope with everyday life given possibility of another BC diagnosis
- **RRM Decision**: Accept
- **Procedure**: (R) RRM and DIEP Flap reconstruction
Low Risk of Contralateral Disease

- C/L RRM refused C/L risk not deemed to be high enough
- 49 y.o.
- Multifocal (L) BC, 16mm+13mm G3, IDC, ER+, HER2-, LN-, (L) Mx and LD+Expander
- Geneticists: Low risk lifetime C/L = 22%, 10y mortality from prior Bc = 20-25%
- Psychologists: Patient perceives risk to 85% and is unshakable in her belief of her own C/L risk
- Plastics: Nil procedures offered
- RRM-MDT Decision: Declined
Multifactorial Low Risk and Comorbidity

- **C/L RRM refused comorbidity and genetics**
- 55y.o. Southend
- **Anaesthetists**: Crohn’s and Morbid Obesity
- Breast cancer WLE & RT
- **Psychologists**: suitable
- **Genetics**: 0.7% p/a risk of C/L disease – suggest decline
- **Plastics**: Concerned re-comorbidity
- **RRM-MDT Decision**: Declined
Poor Prognosis from Index Breast Cancer

- **RRM declined due to poor prognosis from index**
- 54y.o. Epping
- (L) BC 2010
- 41mm, G3, Node+, IDC, adjuvant chemo, DXT
- **Oncologists**: High risk of relapse and distant metastases
- **RRM-MDT Decision**: Declined
Questionable Family History!

- Considered to be extremely high risk (FHx – paternal bilateral BC)
- BSO locally
- Decided to see VR for RRM-Recon d/c
- RRM-MDT processes actioned
- **Geneticists:** No FHx BC – father had **bilateral gynaecomastia surgery**!
- **RRM-MDT Decision:** Declined
Economic Impact of RRM-Refusal

- Assuming our data - refuse 30% of C/L or Bilateral Mx
- 2011 data from BMJ open ~600 patients underwent Bilateral Mx as first procedure
- Assume none of these cases had bilateral ca
- 185 patients would be spared Mx
- Assume £10,800 HRG
- Saving: ~£1,998,000
Impact of RRM Refusal

- Unilateral Sporadic BC
- C/L risk estimates below threshold
- RRM-MDT declined
- Patient returns 3 years with contralateral breast cancer
- Medico-legal implications
- Risk may be small
- Risk is still real i.e. 10% at 15 years will get a C/L cancer
- How do we approach these patients if they have been declined RRM?
RRM-MDT facilitates cross-specialty interrogation of requests for risk reduction, helps to justify reasons for rejection and restricts surgery to those likely to derive maximum benefit
A multidisciplinary team approach minimises prophylactic mastectomy rates

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