QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

FURTHER STATEMENT OF GERARD JOSEPH FITZGERALD

1. I, Gerard Joseph FitzGerald, c/- Queensland Health Level 18, 147-163 Charlotte Street Brisbane, acknowledge that this written statement by me is true to the best of my knowledge and belief.

2. This further statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

3. I have been requested to provide advice on the conduct of the operations of esophagectomies and Whipples procedures. I need to reaffirm that I am not a surgeon or an oncologist and therefore bring no particular expertise to my comments except that of an experienced medical administrator.

Oesophagectomy

4. Oesophagectomy is undertaken as the principal surgical treatment of cancer of the oesophagus. Cancer of the oesophagus is a relatively uncommon illness with an estimated incidence in Queensland of 3.5 per 100,000 per annum. It tends to be associated with smoking, alcohol ingestion and obesity related gastric reflux.

5. The prognosis of patients with cancer of the oesophagus is poor with only 5%-25% of patients surviving five years after the diagnosis.

6. The principal treatment is oesophagectomy supplemented by radiation therapy and chemotherapy. Oesophagectomy involves removal of the affected portion of the oesophagus and surrounding tissues with subsequent anastomosis of the remaining portion of the oesophagus to the stomach. Traditionally this was done by opening the abdomen to resect the stomach and the end of the oesophagus then entering the thorax to transect the oesophagus above the level of the tumour and then sewing the remaining oesophagus to the stomach. Recently new techniques have been developed which use laparoscopic devices to undertake the surgery.

7. Post operative mortality is relatively high cited in Harrison's textbook at 5-10% of patients. The reasons for this high mortality is that the disease affects older persons who have other illnesses that may increase the risk of surgery. Thus there is a need to ensure that the pre-operative preparation of the patients is extensive to appropriately stage the disease, exclude the presence of secondaries and the presence of other pathology that may lead to a poor outcome for the patient. I

would expect a team based approach to the assessment of the patient in which the surgeon and oncologist work in partnership to determine the best treatment able to be offered to the patient and should a surgical approach be considered appropriate then the involvement of the anaesthetist would be appropriate to determine the risks to the patient of a general anaesthetic. Following such a major surgery, the patient is most likely to require intensive care for several days.

Whipple's Procedure

8. Whipples procedure (pancreaticoduodenectomy) is a surgical procedure used to treat cancer of the head of the pancreas. In the second part of the duodenum, the pancreatic duct and the common bile duct empty into the duodenum at the Ampulla of Varta. Cancer in this area thus involves all three structures.

9. A Whipples procedure involves removal of the head of the pancreas, the common bile duct and the pancreatic duct and the duodenum with reconnection of the common bile duct to the intestine, pancreatic duct to the intestine and stomach to the intestine. This is an extensive operation involving several hours of surgery.

10. Patients undergoing this procedure generally are quite ill initially as they have liver failure and pancreatic failure resulting form the obstruction. Thus the risks of surgery are considerable.

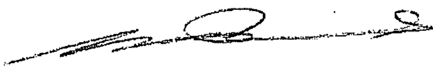
11. These procedures should be undertaken by someone who is performing the procedure on a regular basis. Experience shows they have the best results. In addition the procedures should only be performed where there is sufficient support in terms of equipment, facilities and other expertise. Thus a patient with such an operation will generally need to be managed in intensive care post-operatively.

12. The care of these patients should be undertaken by a multidisciplinary team involving the oncologist, intensivist, anaesthetist and physicians. They will need access to a range of other investigative equipment such as CAT Scanners etc. In addition because of the risks of complications following such surgery, good practice demands that patients should be managed in a facility which has the capacity to manage the complications as well as the original surgery.

13. For these reasons it would not in my view be appropriate to conduct these operations at Bundaberg Hospital. Bundaberg Hospital has a level 1 ICU which is suitable only for short term ventilation of patients. The ICU is supervised by anaesthetists not specialists in ICU and therefore it lacks the appropriate expertise to manage the post-operative care of such patients.

14. In addition the hospital does not have ready access to the other clinical expertise required to properly assess the patient and prepare the patient for such major surgery. Finally it is unlikely that any of the surgeons at Bundaberg would have the number of cases which would maintain appropriate expertise in such complicated procedures.

Signed at Brisbane on 23 June 2005.



Dr Gerry FitzGerald
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Queensland Health