


# What the new three year old check involves

This November, the Federal Government has introduced the Medicare Healthy Kids Check, an opportunity for parents of children between their third and fourth birthday to have a comprehensive assessment and check up by their GP.

The consultation can take up to an hour, often involving the practice nurse as well as the GP. This doesn't mean that parents concerned about any aspect of their child's development or health should wait till they're three. Their child can have a full assessment by the GP no matter what their age. The idea behind the three year old check comes from the Thriving Kids initiative, which aims to provide early detection and early action should a child aged eight and under need support and help. From 1 January 2028, parents will no longer be able to qualify their child for the NDIS if the child has what are defined as low to moderate support needs for diagnoses such as autism spectrum disorder. Those supports will be delivered through Thriving Kids by whichever state or territory the family lives in.

The hope of the three year old check is to be able to detect vulnerable kids or those who'd benefit from supports and interventions before problems become more serious or entrenched. So it's a preventive program.

## What to expect in the check-up

This is more than just a chat and a couple of questions. Parents will be asked about any concerns they have, along with specific questions about the child's development, behaviour and social skills. It's really an attempt to get to know the child and their strengths as well as any vulnerabilities. In more than one in five children, at least one vulnerability may be found, but that doesn't mean it's serious. If support or an intervention is necessary, the practice will endeavour to find the right service for the child's needs. For the majority who are found to be fine, the check up has the advantage that the GP will have a lot of data on how they were faring at age three in case anything changes.

If you want to dig deeper, here's a paper in the AJGP which advises GPs on what the process could look like.

**References**

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# Prostate cancer testing has changed

There is no screening program for prostate cancer. That's because the PSA blood test which doctors have relied upon has been controversial and accused of encouraging overtreatment. That in turn has meant men needlessly experiencing complications such as erectile dysfunction and urinary incontinence, not to mention infections from prostate biopsies.

But things have changed and while there is still no official screening program, new guidelines help men and their doctors make better informed decisions. The guidelines also reduce the need for biopsies and in some men, safely delay or avoid treatments such as surgery to remove the prostate (radical prostatectomy) or radiation therapy.

The first thing is for men to know their risk and at each stage for their doctor to fully inform them of the benefits and risks to aid their decision making. Men with a brother with prostate cancer, or whose father had prostate cancer below the age of 65, or who had two or more second degree relatives who died from prostate cancer, or who carry the cancer gene BRCA2, or who have Black sub-Saharan African ancestry should be offered two yearly PSA tests from the age of 45.

In other men, routine PSA testing is not recommended under the age of 50, but two-yearly testing should be offered from 50 to men who decide to be tested. If the PSA is raised for a man's age, it should be repeated between one and three months later. If it's still raised, then a referral to a specialist should be offered. And here is where things have changed a lot. In the old days there weren't many alternatives to jumping in and doing a biopsy. MRI scanning of the prostate has made a big difference. It allows the urologist to see what if anything is going on inside the prostate. In many cases that avoids a biopsy and if there is something, it tells the surgeon where to biopsy in the gland. The biopsy itself should be done through the skin between the scrotum and the anus (the perineum) rather than from inside the bowel, which risks a blood infection.

Sometimes the biopsy shows that it's safe to wait and watch carefully, because sometimes an early cancer doesn't progress. This is called active surveillance and is tailored to what the biopsy found, the PSA testing and the man's preferences. Such surveillance does reduce the need for surgery or radiation, but if intervention is needed it can occur in safety.

The bottom line is that prostate cancer testing and early detection is complex and needs thought on the part of doctors and their patients so that the best decisions can be made.

**References**

Prostate Cancer Foundation of Australia. 2026 Guidelines for the Early Detection of Prostate Cancer in Australia. St Leonards, NSW: PCFA; 18 May 2026. https://www.prostate.org.au/resources/clinical-guidelines-for-the-early-detection-of-prostate-cancer/

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# Does a robotic knee replacement make a difference?

Knee replacements are among the commonest operations done in Australia with tens of thousands each year. Many orthopaedic surgeons now use robotics to help them. This is different from what you may have seen with other robots in surgery such as prostatectomy where the surgeon manipulates robotic arms and tools inside the person's abdomen or pelvis.

Robotics in knee surgery is about highly sophisticated imaging which is used to program the way the bones are cut and the new joint is placed between the femur and tibia, the two bones above and below the knee joint.

Surgeons like it because they feel they get more accurate joint placement, and that makes recovery better and reduces the likelihood of revision surgery.

However, despite this hope, a British study of nearly 700,000 knee replacements between 2018 and 2024 has found that robotics has not changed the revision rate over five years following the surgery when compared to the surgeon doing the operation without robotic assistance. There were also no differences in surgical complications. Recovery rates didn't seem to differ either.

One of the authors accepts that robotics might be indicated in some circumstances, for example where the surgery is going to be complicated.

The bottom line for patients is that they wouldn't choose their surgeon based on whether or not the surgeon uses robotics. They really need to know the surgeon's revision and infection rates, their general approach, how many knee replacements they do and the reputation of the hospital where they work. In general the hospital counts for a lot, as does the volume of work the surgeon performs.

Declaration: By the time you read this I'll have had a robot assisted knee replacement!

**References**

Mohammad HR, Judge A, Griffin XL, Murray DW. Early national comparison of robotic versus conventional knee replacements for arthritis using National Joint Registry data: target trial emulation study. BMJ. 2026;394:e100691. https://www.bmj.com/content/394/bmj-2026-100691

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