

Newsletter No.90

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Dear Colleagues

Discussion within WOC is never ending, sometimes heated, ever changing. This is in part due to the inequalities of orthopaedic need against ability and availability. I have written in these columns before about the value of the more experienced of our elder members in the management of conditions, prevalent in the West 40 years ago, to the present day problems of the Third World. The outcome of their visits is not to be measured in the number of cases seen or treatments completed but rather the change in scope and breadth of complexity of treatment provided during the years that follow. The essential concept of the “underdeveloped” is that it is “developing”. Nothing in nature stands still. Medical and surgical evolution happens before our eyes.

For these reasons those of us of mature years may feel obliged to travel further afield as the young surgeons in developing areas have learned and now seek the expertise of the younger specialist surgeons at the height of their achievement. They now seek the skills of arthroscopic surgery, replacement of major joints, spinal exploration and reconstruction.

The common arrangement is for a surgeon(s) with an anaesthetist, to be transported, (in economy class, paid for by charity) to the area of need. Local accommodation, often spartan, is arranged locally and the work is done unpaid. This does not mean “unrewarded”, as every volunteer repeats. The work is firstly to advise on possibilities for individual patients, secondly to operate safely and thirdly and most importantly to teach, inspire, warn, reassure and support the local surgeons. An old adage bears repetition: a visit simply to operate is uneconomical; the most that could be done in two or three weeks would be but a drop in the underdeveloped ocean of pathology.

The need now is for a team to comprise one mature and one young and vigorous surgeon....not of course that the young have a monopoly on vigour! One of the responsibilities for the mature surgeon is to know when he should discontinue operating. There is world wide experience of surgeons who tragically continue too long. The expressions of gratitude by a hospital in a poor country may seduce a “visiting fireman” into the belief that he is doing wonderfully well. Remember they will not be able to tell if things, of which they have but a limited experience, are going wrong. The main charitable bodies now demand (politely) that for a surgeon to operate, he must still be “in practical surgical work”. The Third World is the last place for a surgical complication to be abandoned.

In the penultimate contribution to Newsletter No 89, the new President of World Orthopaedic Concern (International) raised the prospect of a new Sub-Speciality of Third World Orthopaedics. **Dr Rajaskeran**, lately Secretary and now President Elect of WOC International, responded promptly as follows:

“Having trained in the UK and then travelled to many parts of the world, I have been impressed by how much the spectrum of orthopaedic disease and management varies from place to place. I am sure that as much as surgeons from the developing world need exposure to the state of orthopaedic surgery in well developed countries, there is a similar if not more need for orthopaedic trainees from the developed world to travel widely to the East and the South.

“Many centres in countries like India have high levels of clinical skill and treatment expertise and can provide exposure to conditions less often seen as yet in the West. This would include mutilating injuries to limbs, industrial accidents and neglected pathology such as advanced tuberculosis, tumours and untreated fractures.”

Dr Rajeskaran went on to discuss the possibility of starting a fellowship, which will allow registrars from the UK to travel to India for about 6 to 8 weeks for “hands-on” experience. Recently the British Association of Plastic Surgeons have approved a fellowship travel programme to India for such a period. WOC (India) would be happy to organise and host fellows recommended by WOC (UK). Dr Rajeskaran expresses his

conviction that such an experience would be invaluable and that funding for such a modest sabbatical could be raised through personal application.

Any who attended the SICOT meeting in San Diego last year would have seen adequate demonstration of the standard of work done in Rajeskar's unit in Ciombatore. This is a most valuable project for the young trainee who would see an abundance of primary pathology in contrast with the secondary or iatrogenic complications so frequently seen in special units in the West.

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Ken Tuson has replied to Raj reporting that he has had several letters in a similar vein, referring variously to "affordable" or "appropriate" orthopaedics. It is certainly applicable and accessible. The Journal of Bone & Joint Surgery have generously agreed to publish information about this project.

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Dr Satish Goyal, Jalna, India gives enthusiastic support that a new Sub-Speciality of Third World Orthopaedics be developed. He writes:

"I practise in a rural part of India where the patients cannot afford the expense of transport. We treat most of the patients with plasters, often because any delay in treating wounded patients doubles the danger of infection. Surgical practice from the West is difficult to follow in India because the demands of our patients are very different. Every town in India differs from every other.

"The talk at National Orthopaedic meetings in India often dwells on major joint replacements and revision procedures, which 95% of our orthopaedic colleagues do not practice. We do not reject information about complex surgery but at the same time we must learn more about the common problems and the variety of modes in which they present, because they are numerically the major part of our work and therefore the area of greatest need."

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ETHIOPIA

Report from **Stephen Wood** who visited the Black Lion Hospital in Addis between the 1st and 28th February 2003. He sends a detailed review of the working of the department, its problems and hopes for the future. A summary of his recommendations includes the following list.

1. A booklet should be developed covering the basic management of common injuries.
2. A closer collaboration ought to evolve between the orthopaedic and radiology department so that follow up films can be provided regularly.
3. Close collaboration with the Plastic Surgical Unit at Yekatit Hospital would greatly improve the emergency management of compound fractures and thereby avoid some of the grosser complications.
4. The recently developed telemedicine link, although of great value, is proving unacceptably expensive and perhaps a "Healthnet" e-mail connection should be re-established in the cause of economy.
5. A close record of the use of the Operating Room ought to be kept because there are periods of great wastage through lack of communication.
6. The accounting system for the Orthopaedic Department needs to be reorganised preferably on the basis of a new bank balance requiring a single signature.

It is clear that many of the continuing difficulties of the department are associated with the recent loss of staff, one to America and one to Egypt, for protracted periods from which it is feared they may not return. **Dr Tezera** sends a desperate plea for volunteers to fill these new vacancies over the forthcoming months (see below). Steve Wood reports on his assessment of those in training as showing enthusiasm and energy but desperately in need of guidance. He picked out in particular **Dr Manyazewal** and **Dr Bedri**, Senior Residents, with a good overall grasp of orthopaedic problems. Amongst the more junior members of the trainee team, Drs Biruk and Elias also showed particular promise.

The Telemedicine link has been brought about largely by the donation of a digital camera and accessories from the Swinfen Charitable Trust (SCT) set up by the new patron of WOC UK to allow problem cases to be demonstrated in detail for advice from afar.

A review of the clinical work done at the Black Lion impressed Steve Wood. Compound fracture/dislocations of the ankle remains a serious problem, many of which require amputation but refuse it. The help of **Dr Einar Ericssen**, a Norwegian Plastic Surgeon, who has set up the new Unit in the Yekatit Hospital is keen to help with the management of difficult problems with skin cover and would like to be consulted at an early stage before contamination turns into infection.

The current treatment for grossly displaced supra-condylar elbow fractures is lateral traction. Similar problems might be covered if a handbook for local advice in relation to common injuries could be drawn up, perhaps by the residents with senior participation. The follow up care for fractures and control of reduction requires rather more collaboration from the x-ray department than is currently available.

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URGENT CALL During the six months between the 1st September 2003 and the 29th February 2004 the teaching staff at the Black Lion Hospital **Addis Ababa** will be reduced to 2 (from 4). To maintain the standard of instruction for the 9 trainee grade surgeons, help is needed in the outpatient department, wards and operating theatres. **Dr Tezera** invites immediate communication with him at orthkoped@telecom.net.et or with any of the recent visitors from the UK, Sue Fullilove at Suefullilove@doctors.org.uk or Stephen Wood at skwchf@compuserve.com

We are grateful to Geoffrey Walker who has sent the following report from **Dr Jose J Monsivais**, describing his Orthopaedics Overseas Volunteer Assignment in Ethiopia, May - June, 2002.

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“I was based at Black Lion Hospital in Addis Ababa, Ethiopia for a three week period between May and June 2002. Ethiopia is a land of abject poverty where many struggle daily simply to survive. It is a land where the need for medical attention is so great it is easy to become overwhelmed and frustrated by one’s inability to help on a grand scale. But the gratefulness of the people for the little that I was able to contribute during my time there certainly overrode those frustrations. My living quarters near the hospital

were very spartan - no radio, TV or microwave! - but it was kept clean by Wubi, the housekeeper, who also did laundry and prepared one meal a day.

“Much of the professional time was spent consulting on cases of fracture, bone tumour, osteomyelitis and congenital problems. One referral involved a young man who walked into the clinic holding a paperbag over his right hand. When he removed the bag, we saw a degloved dorsum of the hand with a crush injury of the extensor tendons and bony architecture. This had occurred three days before when his car rolled over his hand while he was working on it. He was only now seeking help.

“I gave lectures on reconstruction including microsurgery, re-implantation and peripheral nerve repair with a focus on the brachial plexus. The ideal and the real are definitely at odds in this setting; what is desirable is often not possible due to lack of resources. One young boy had a fibrosarcoma of the forearm and treatment which would preserve the hand was not feasible because it would tie up too many resources and the quality of banked blood is unreliable.

“My in-country travels including Badahar, a 40 minute flight from Addis. I remember vividly the long uninterrupted lines of local people walking along the unpaved roads carrying 30 to 50 pound packs on their backs on their way to market. They were barefooted, ranging in age from childhood to the very elderly, and according to my guide they would walk 30 km in a day. We drove to the main origin of the River Nile as well as visiting churches and a monastery. From here we flew to Gondar and in addition to the sightseeing saw that the local “ambulance” service of a dozen family members taking turns to carry a patient. From here to Lalibela where, at the best hotel in town, hot water is available for one hour in the morning and one hour in the afternoon. Most of the time there was no water at all. The churches here contain many religious treasures in gold, silver and bronze that date back to 12th and 14th centuries. The rural people in this area are deeply religious and willingly and lovingly share what they have.

“I got the impression that I had passed through a “time window” and walked back two thousand years to the time of Christ; beggars, lepers and people with multiple deformities are everywhere, creating a heart-breaking scene. I also had the opportunity to visit the

ALERT Hospital where leprosy patients are cared for. Originally established by a Swedish University, the ALERT is staffed by doctors from all over the world. Proudly they claim the nation's only dedicated "Hand Service" to which patients journey from all over Africa.

"This experience was challenging and at times frustrating, but at all times I was aware of the work other volunteers have done before me. I left with a renewed appreciation for all that I have in my own life, and with a desire to return to Ethiopia to contribute a little more to where the need is overwhelming. Profoundly moving is the conviction that every contribution is met with a spirit of gratitude and appreciation, unlike anything I have ever experienced."

Dr Jose J Monsivias [handmicro@msn.com]

Just before Geoffrey Walker returned to London, **Michael & Margaret Turner** from Montana arrived at the Black Lion Hospital. Michael has sent his report to the HVO authorities, from which the following are edited extracts.

"The Black Lion Hospital, as the single referral centre for the entire country, receives an abnormal number of very complex cases. We noted a plethora of tumours, amongst them, osteosarcoma, synovial sarcoma, Ewing's tumour and several not diagnosed. Polio, TB, cerebral palsy and osteomyelitis were to be expected, but the number and severity of road accidents were not. I attributed the many road accidents and personal assaults to the availability of alcohol. Amongst the worst injuries were due to land mine explosions, gunshots and occasional bites from a hyena. The department is headed by **Drs Tezera and Tadesse** and we took part in the practical instruction of the 9 residents, some on rotation from general surgery."

Mick Turner noted the irregular imaging facility and the protracted delay between operative cases. The theatre equipment was incomplete and though there was an "AO" set, the residents require to be involved in its use in the theatre. As a result much of the fracture treatment is conservative and therefore expensive in terms of "bed-time". Much of the aftercare is provided by the residents, which in the US would normally be done by ancillary workers - wound care, traction balancing, plaster casting etc. Mick listed the

main requirements to be further volunteers to boost the teaching staff, and external fixators, and for the volunteer himself is required a sense of humour and patience and a capacity to adapt. Both Mick and Margaret reported that in their visit they hope that they have taught more than they themselves have learned, which was a considerable amount.

The living conditions were good with a very pleasant climate at 8000 feet on the Equator. Their evenings and weekends were free and they took every opportunity to admire the dramatic countryside and ancient buildings. In spite of several frustrations, the Turners expressed their appreciation and enjoyment, and have every intention of returning.

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One common denominator of all the reports that come from the Black Lion Hospital is the pleasure that the professional visitors took in helping with the work.

Sue Fullilove, Orthopaedic Hand Surgeon from Plymouth, reports on her month of December 2002 at the Black Lion Hospital in Addis. She also reported on the paucity of teaching staff at the Hospital and the urgent need for visiting helpers in that grade. She listed a number of requirements, which would be invaluable, including traction beds, tourniquets and a variety of surgical equipment. One of her current tasks is to devise a box of essential tools, a basic set for almost any eventuality.

She came to the same conclusion as every other visitor that these surgical visits must continue although all felt that the hospital must not rely upon them indefinitely. She hopes the visits explained and underlined the need in Addis and that the national government must see its way to supporting the hospital financially. Sue is already planning her next visit for the month of March 2004.

EAST AFRICA

Michael Beverly from Ealing Hospital writes about the recent trip organised by the Association of Surgeons of Great Britain and Ireland to East Africa. The group of four surgeons comprised Bob Lane, (general surgeon from Winchester) John Rennie (colorectal surgeon from Kings) Russell Lock (bowel surgeon from Whipps Cross) to Michael Beverly (orthopaedic surgeon from Ealing) with a senior theatre sister. WOC

contributed towards Mike Beverly's travel and the equipment required was generously donated by Ethicon and Johnson & Johnson. In addition various NHS hospitals contributed suturing materials and gloves.

Short intensive courses were arranged in Dar Es Salaam (Muhimbili University) and Kampala (Makarere University). The arrangements depended upon local organisation, which was excellent. The local abattoirs contributed animal material, usually goats, to practise the management of skin wounds, tracheostomies, chest drainage and the repair of bowel and other hollow viscera. The candidates were a mixture of new interns, SHOs and junior registrars. The material from the abattoirs was also ideal for practising the repair of blood vessels, tendons and nerves. Abdominal surgery was simulated with the goats abdominal wall distended over a balloon. Occasional lapses in care resulted in explosions!

Between the two courses, the surgeons were well entertained on the beaches of Zanzibar and on rafts in the Upper Nile. It is clear from Mike's report that the trip was warmly welcomed by the host professors and is to be repeated, possibly at other venues.

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NIGERIA

The National Orthopaedic Hospital, at Dala Kano, was established in 1959. The commercial city of Kano is located in the heartland of Northern Nigeria and has an estimated population of over four millions, predominantly Hausa - Fulani muslims.

The hospital was established by the then Northern Nigerian Government largely as a result of the efforts of the late **Arthur Frank Bryson** OBE FRCS and with some assistance from the British Government. It was and is named The Orthopaedic Hospital, Dala-Kano, and was absorbed under the care of the Federal Government in 1980. In the early years, doctors and nurses were seconded from the Royal National Orthopaedic Hospital, London in two rotations. Continuous consultant cover was provided by Ginger Wilson, Charles Manning, Sir Herbert Seddon, Robin Denham, Geoffrey Walker and Lorden Trickey in rotation, and with them a senior trainee, including Chris Colton,

Malcolm Swann, Cyril Monty and many others. It remains the only orthopaedic hospital in the entire northern states of Nigeria serving a population of over 60 million.

Currently there are 180 beds in seven wards, five qualified orthopaedic surgeons and one plastic surgeon provide the consultant cover. In the year 2001, 4560 new cases and 674 major operations were performed. The workload is mainly trauma with the predominant surgical procedures including internal and external fixation. An image intensifier is available and functional. Facilities are available for total joint replacement and an average of 10 hips are replaced annually. All the appropriate ancillary services are present but many require improvement.

The Hospital runs a residency training programme in orthopaedic surgery, which is accredited by the National Postgraduate College, Nigeria and the West African College of Surgeons. A Post-Basic Orthopaedic Nursing School was started in 1965 and 1200 nurses have been registered.

Amongst the major clinical problems for the hospital are the increasing frequency of road traffic accidents in the community and the late presentation of patients to the hospital, because many of them initially go to traditional healers for treatment. Some of the equipment in use is obsolete, difficult to maintain and in need of replacement. Government funding falls short of requirement and much of the equipment has to be imported.

[O. Popoola FRCS, Medical Director]

The quarterly magazine of the Leonard Cheshire Organisation has been received with a full article on the Flyspec project, from which I quote the following:

John Jellis established Flyspec in 1982 as an outreach programme from the orthopaedic unit of the University Teaching Hospital in Lusaka. Their light aircraft, a 34 year old Beechcraft, is flown and maintained by John himself who at the latest count has attended to 1049 patients and operated on 254 of them. He and his plastic surgical colleague **Dr Goran Jovic** (+/- a visiting surgeon) make the long journeys to government and mission hospitals because there is no way in which the disabled and deformed can make their way to the city; and anyway facilities in Lusaka are in a poor state at the moment. Their

casemix includes club feet and cleft palate, both of which, in the conditions that prevail, are likely to be life threatening. Few untreated disabled children reach adulthood! The harsh rural conditions condemn such patients as the “unfittest” and they do not survive. This elevates the sort of surgery high above the semi-cosmetic. There is no system of referral. A ten day walk with a poor prospect of being seen let alone treated, disinclines the most able.

The service is supported from charitable funds including the surgeon’s own private practice at the Zambian-Italian Hospital and the Orthopaedic Research Trust. Any children requiring surgery too major for the distant little hospitals, are brought back to Lusaka and taken care at the Lusaka Cheshire Home from which they are operated on at the Italian Orthopaedic Hospital at the expense of the Cheshire Home. Leonard Cheshire International regularly makes supporting donations to the safety of the aircraft.

The magazine also describes the Cheshire Home in Khartoum which has set up a new operating theatre specifically for orthopaedic deformity within the grounds of the Cheshire Home in Khartoum. This new development is generously supported from the Christoffel Blindeminnison International, which also supports Chris Lavy in Malawi.

The Leonard Cheshire International West Africa Region contributes a broad view of the aftermath of ten years of civil war in Sierra Leone. Displaced people are spread across the country and their condition made the more pathetic because they have been deliberately maimed in the conflict. The need here is not so much reconstructive orthopaedic surgery as prosthetics. Perhaps more than anything they suffer the sense of shame that has such a profoundly depressing effect upon the amputee. What always was one of the poorest nations in the world is now completely devastated in its infrastructure, its economy and its people. In such economic conditions, those who are unable to make a contribution to the GNP are low in the pecking order. As a result of the terror campaign, 40% of the population have been “displaced”.

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IMPACT

The Newsletter from IMPACT is aimed essentially at the numerous donors, including the major United Kingdom banks. It conveys the extent of their investment. Besides many enchanting personal stories are photographs from rural Nepal, from Vavuniya district in Sri Lanka and the Mollarhat District in Bangladesh. Their various projects continue with remarkable energy and achievement, particularly the Lifeline Express, so prettily painted with flowers and a rainbow, now has extra coaches generously donated by Indian Railways. These include a new operating theatre on wheels. The floating hospital, "Jibon Tari" to which John Lurie, David Jamieson-Evans and Malcolm Swann have been participants, has recently been on the move again leaving behind many who have been successfully treated and most importantly an improved community sense about how most disabling conditions are to be avoided.

NEPAL

The first surgical camps to rural Nepal in 2003 took place between March 9th and 24th. Contributors included the surgeons **David Jones** and **Mike Laurence**, with **Dr Graham Bell**, anaesthetist from the Children's Hospital, Glasgow supported as usual by **Dr Mahesh Shrivastava** and two trainees from Kathmandu. The task was to run two operating camps at venues that had not been previously visited. They presented quite different projects.

The first was in the small town of Damak at the very eastern end of the Terai, close to the border with Bhutan. The town hospital is small with a compact but airy outpatient lean-to. During the first two days a total of more than 300 outpatients were seen. The majority suffered from conditions of no great severity (back pain predominated) but there were many cases of muscular dystrophy and cerebral palsy, for whom a confirmation of the diagnosis and the impossibility of surgical cure, was of value. The problem for the town is that the excellent hospital staff does not include an orthopaedic surgeon. One does visit on a regular basis from Kathmandu but only once a month and for a few days. The second feature, which is different from any similar community in Nepal, is the close proximity of a huge refugee camp for displaced Bhutanese. In all some one hundred thousand had fled or been forcibly expelled from over the border during the previous ten years. The UNHCR were responsible for looking after them and had funded a new hospital which it was our job to open with the first surgical lists. This was no mean task

starting from bare rooms and zero equipment. Some we brought with us, some we borrowed from the town hospital, which enabled us to complete 13 surgical procedures, including 2 damaged and disabled hands, 2 femoral osteotomies from polio and mal-union of a fracture, 2 corrective procedures on the elbow and a radical correction of a club foot.

We returned to the Nepal Medical College in Kathmandu to take part in an academic symposium on the management of neglected club foot. This included two radical surgical procedures, continuously displayed from the theatre onto video screens before an audience of 30 to 40 young surgeons in training. Following this, papers were read on the principles of management of the condition, in particular one by Graham Bell on the control of post-operative pain. This video-taped presentation remains in the archive of the College for future use.

The second camp was held in Birgunj, due south of Kathmandu, a large town on the main road to India. There the most experienced orthopaedic surgeon to the town, **Dr B K Prasad** had already collected 30 of the most challenging cases from his practice, for further opinions and possibly surgical treatment. In all 10 patients with untreated club foot were operated upon that week, together with 3 bony tumours, 1 femoral osteotomy, 1 humeral osteotomy and a case of contracture following burns.

On our return to Kathmandu we took part in the weekly clinical conference at the Tribhuvan University Teaching Hospital's Orthopaedic Unit. A formal lecture was given by one of us on congenital deformity at the knee. Cases presented by our hosts included fulminating infection, an unusual presentation of tuberculosis and a malignant giant cell tumour in the spine.

Those taking part in the camps felt that a significant contribution had been made both to the demonstration and performance of surgical treatment and to the training of the young surgeons of Nepal who show such enthusiasm and ability year by year.

Workshops in Nepal

An analysis of the outcome from Orthopaedic Workshops for the village practitioners in rural Nepal has been drawn up by **Dr Ram K Shah, Professor Robert Owen** and **Mr David Jones** in a paper to be published by the journal, "Education for Health". The programme in Okhaladhunga District collaborates with traditional bone setters and is supported by the Nepal Medical College in Kathmandu. The impossibility of providing effective orthopaedic primary care across a country so impoverished with regard to infrastructure and therefore transportation, often results in catastrophic iatrogenic disease.

Any critical appraisal of the rural, traditional healers and bone-setters is perhaps inappropriate because of the lack of communication with them. Any organised orthopaedic advice at the first aid level is gladly received. It is cheap to provide but requires the provision of basic splinting material with the important warnings about its misuse (strangulation from tight bandaging etc) with the result that even simple injuries become complicated and limbs are lost.

The object of these workshops is to understand and build upon the skill and knowledge of the traditional bone-setters (TBS), and to warn them of the dangers, particularly to the circulation and peripheral nerves. Improved relationship between TBS's and organised health provision will prevent many disasters. The training sessions last 3 days and 56 participants attended a recent one. The teaching sessions included lectures, discussions, practical demonstrations and various handouts.

The area of Okhaldhunga District covers a population of 160,000 souls, with a population density of 130 per sq km. The average literacy rate is 31.7%. The only hospital is one of the United Missions of Nepal and has 31 beds. The area was served by 194 traditional healers.

In subsequent conversation, Dr Shah commented upon how very much the people of Nepal owed to the Missionary Hospitals widely distributed about the Kingdom. They form a unique basic service which state medicine has not been able to replace.

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COMMENT

Surgeons confined in the UK, to domestic (Western) orthopaedics, receive the excellent trade journal, Orthopaedic Product News (OPN) in which all the newest devices are displayed and promoted. The February issue contained an interesting contribution from Dr Pieter de Bruijn who visited Kathmandu on behalf of Health Volunteers Overseas and supported by the Rotatory Club of Tiel, Netherlands. Dr de Bruijn spoke in Harrogate recently describing his experience at the Tribhuvan University Teaching Hospital in Kathmandu where he was “confronted by appalling surgical conditions (which) both patients and medical staff endure. Cross contamination is a major problem and equipment is sparse, old and unhygienic”.

This correspondent was surprised and very disappointed by this report. WOC regularly sends teams (March and November) to the Kingdom of Nepal, mostly to provincial towns, rather than to Kathmandu. Sparseness of sophisticated equipment should not surprise but to describe it as unhygienic is somewhat insulting. We too attended the TUTH (reported elsewhere in this Newsletter) and our visits over the past eight years impress us with the dedication and assiduous attention to the basics of surgery. Moreover our early surprise at how *little* cross contamination we observed, is often explained by the fact that half of the children of Nepal do not reach the age of 4 years (a sobering reference to LD50). As a result, natural selection has (perhaps cynically) produced a population with amazing immune systems, wonderfully protecting them against cross infection. We believe that this somewhat rogue report does not reflect the experience of members of WOC (Netherlands) or WOC (Nepal) and that the impression of our visits has always been one of profound admiration. A major part of WOC's work in training is the safe use of appropriate orthopaedic equipment so that Industry which advertises in OPN will see its products used successfully.

Obituary

Dr Ayaz Ahmed Khan 1949-2002. Geoffrey Walker sends us sad news of the death of one of his closest friends. The editor has received messages of friendship for Dr Ayaz from Geoffrey Walker and Ginger Wilson. His contribution to Bangladeshi Orthopaedics has been considerable for all its tragic brevity.

Bangladesh Orthopaedic Surgery has suffered a great loss in the death from colonic cancer of Dr Ayaz Ahmed Khan on the 20th March 2002 at the tragically early age of 53 years. He was born in a respected Muslim family in Dhaka. He graduated from the Medical College of Dhaka University in 1973 and obtained the Diploma of Orthopaedics in 1977 and M.S.Ortho. Surgery in 1980. He joined the government service in 1973 and served in different capacities in Mymensingh Rajshahi Sir Salimullah Medical College and Hospital and finally at the National Institute for Traumatology and Orthopaedic Rehabilitation (NITOR) as Associate Professor. He also served The Bangladesh Orthopaedic Society as founder member and as Secretary General from 1983 to 1986. He leaves behind a wife and two daughters, and beloved students, colleagues and innumerable admirers.

He was a very popular and inspiring teacher with a legendary warmth towards students, colleagues and patients alike. His empathy with patients and devotion to the profession were a model for so many whom he influenced.

Professor Ruhul Haque writes: “I first met Ayaz during one of my early teaching visits to the Rehabilitation Institute and Hospital for the Disabled, now known as NITOR. Soon after his higher qualification he, together with Dr Aminul Hassan, virtually ran the clinical activities of the director’s unit as Dr Surujal Islam, who had taken over on Dr Ron Grast’s retirement, was almost totally burdened by administration. These were happy days at the RIHD with students eager to learn and a pleasure to teach. During later visits Ayaz always took a close and personal interest in my own welfare and comfort in Dhaka and soon we became the closest of friends. He was usually too busy to be a regular letter writer but we did manage to keep in touch and it was always a very great pleasure on my many return visits to Dhaka to be greeted in exciting manner and to know that I was going to be so well attended during the few weeks that I could escape from the UK Health Service.

“With my son I attended his wedding to Nazneen, an Ophthalmologist, and then followed the birth and development of his two daughters, Noureen and Sabreen, both of whom are now splendidly grown up. Ayaz always valued close contact with his patients and demonstrated the value of careful clinical examination, traits which he always strove hard

to teach to his students. His early death leaves a major gap amongst the many colleagues in the developing world who have become our close friends.”

Forthcoming meetings

The British Orthopaedic Association will be meeting in Birmingham in September 2003 in which the Annual General Meeting of WOC UK will be held. A debate was planned in which the arguments for and against the development of a Speciality devoted specifically to the needs of the Third World would be widely discussed and in particular Dr Rajeskaran’s invitation to a visit to Ciombatore (see above).

At a recent WOC committee meeting plans were being laid for the 2004 scientific meeting of the British Orthopaedic Association at which WOC will make a significant contribution. The plenary lecture, eponymously in the name of Lipmann Kessel, will be given by **Dr Kanda Pillay** who has very kindly agreed to come to Britain for that. A major symposium will be given under the title of “Indian Summer” with contributions from both the Subcontinent and those that visit it, on the work characteristic of Indian orthopaedics.

The visit of Kanda Pillay to the UK will give to all his friends a particular pleasure in anticipation, knowing as we do, the domestic strain under which he has suffered since the tragic and sudden death of his wife. Those who come to Britain will look forward to the opportunity to conveying their personal special greetings and condolences.

The SICOT Meeting will be held in Cairo, September 8th - 11th 2003. The Committee is making available a number of gratis registrations for WOC members, which should be mentioned on application.

The function of this Newsletter is to convey some picture of the need in all its breadth and simplicity and complexity. I am conscious however that many of our quotations in the Newsletter are from British volunteers, but they certainly do not comprise the majority of workers in this field. This is a plea for further reports from further away.

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