

**Newsletter No. 95 - January 2005**

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Dear Colleagues

The editors of the world's media have been inundated with the shattering photographic images and harrowing metaphors from the fringes of the Indian Ocean, bringing death to life, so vividly as to move their readership to donate more generously than their governments. My personal reaction was a desperate wish to be of some physical help to what must essentially be thousands of ordinary fractures. Within hours or at most a few days, the complex and complicated will have been resolved, probably tragically.

The days that followed December 26<sup>th</sup> - the "golden hours of traumatology" (ref: ATLS) - during which life-saving action is to be taken, passed with absolutely no facility, no physical assistance, no medical help. Even the most modest First Aid was swept from the face of the Indian Ocean shores. No transportation, to where, for what?

How often have we, in the comfort of an organised Health Care, complained with cynical comment about the "Administrators"? Seeing the images from Sumatra, Sri Lanka, Thailand, causes us to adjust our perception. Before the niceties of fracture management can be even considered, basic work is necessary, the logistics of finding survivors, bringing to them water, food and shelter, setting up crude prefabricated structures for medical care and finally, bringing in the nurses and doctors. Facilities would be those of 200 years ago; the scene of a battlefield. It is easy to see why military doctors (including naval) were always referred to as "surgeons!"

How long will it be before ordinary orthopaedics can possibly be practised? Your correspondent has made enquiries. The replies were few and late. It is a time to stand back while the Military mobilises. Except that is, for our noble Honorary Secretary, **Ger Olyhoek**, whose native Netherlands has historic associations with the East Indies and whose regular visits to Sumatra (on behalf of WOC) have been reported in these Newsletters.

Ger found an instant response from his fellow countrymen and enthusiastic support from the Dutch Orthopaedic Association and the Dutch Red Cross. As I write, on January 6<sup>th</sup> 2005, he leads a team of two orthopaedic surgeons, two plastic surgeons, a general surgeon, an anaesthetist and a theatre sister, already in flight from Amsterdam, bound for Sumatra. All are full of years (60++), ingenuity and experience. Their colleagues at home will continue to organise what must be regular replacements as the months (possibly years) continue. There is a unique basis of community confidence built over many visits during which personal friendship has been forged. Their linkmen in Amsterdam are **Professor Van Dijk** and **Dr Chris van der Togt**, whose phone numbers are respectively 0031 655 747 591 and 0031 653 520 802, (but your correspondent is ahead of you in the queue!) I hope to be able to bring news from Banda Aceh as soon as we hear from Ger.

## **MESSAGES from the REGIONS**

### **AFRICA**

**Scott Innes** writes from Sacramento CA. In September 2004, he visited the Black Lion Hospital, **Addis Ababa**, on an Orthopaedics Overseas - Orthopaedic Research and Education Foundation (OO/OREF) travelling fellowship. This is open to all US senior residents; applications are accepted on a rolling basis. The fellowship covers travel and lodging and even includes visas and miscellaneous expenses. (Info from hvousa.org)

“The Black Lion is the perfect institution to visit as a resident. It has one of the few orthopaedic training programmes in Africa. I enjoyed spending time with colleagues of a similar age and state of training, and with similar interests to my own. The hospital now has an image intensifier, newly delivered and first used by us on a fractured hip. The residents are extremely friendly, inquisitive and eager to share their country with the foreigner, not only its orthopaedic pathology and special style, but also its physical beauty and amazing antiquity. It has been a most broadening education which I hope others will read about in this letter.” ([scott.innes@ucdmc.ucdavis.edu](mailto:scott.innes@ucdmc.ucdavis.edu))

As **Geoffrey Walker** has often reported, the Black Lion provides for the visiting trainee, an intimacy with musculoskeletal disease and a feel for the natural process of healing, not only for fractures but long standing chronic infective conditions. These are processes which are often obscured in the West by complicated inert implants.

By contrast, **Dr Alonge Temitope** writes from **Nigeria** with words of appreciation for the contents of these Newsletters, but takes your correspondent to task over his use of the expression “Third World Surgery”. Alonge prefers to call it “Surgery as practised in the Third World”. It is a nice point. He urges that the outcome of surgery is not necessarily a function of where it is carried out. He asks “who represents WOC in Nigeria?” I was sad not to be able to inform him because Nigeria was one of the earliest centres of WOC UK activity. Perhaps Dr Temitope has found a job for himself! ([alonge2003@yahoo.com](mailto:alonge2003@yahoo.com))

**Tim Board**, Specialist Registrar, writes from Booth Hall Children’s Hospital, Manchester, having returned from a five weeks visit to **Malawi**, as part of a WOC-Treleors/Gauvain travelling fellowship, with sponsorship from Stryker, DePuy, Rotary and the DFID. The members included **Steve Mannion** (consultant), Drs **Kandise Jackson** and **Qamar Siddiqi** (senior house officers from Blackpool) and **Henry Dowlen** (medical student from Imperial College London) and himself.

Their main centre was the Lilongwe Central Hospital from which they made week long trips to the Northern districts including the Nkharta Bay and Rumpee Hospitals. He describes the work often done by Orthopaedic Clinical Officers (OCO) whose training covers two years and brings them to a level of technical skill essential for the provision of basic fracture care. The visiting surgical team was able to add expertise in the surgical management of malunions, paralytic polio, purulent arthritis and congenital deformity. He describes the work of the Malawi Club Foot Project, based on serial manipulation and plaster splintage.

While there, the team contributed to a Course on Ankle Fractures, designed for the OCOs of whom 21 attended. All modes of management were discussed for this injury, which is seen rather less frequently than in the West. The reason for this may be related to the greater fitness of people less dependent upon transport, and the simplicity of footwear.

Three research projects were set up during the visit.

- 1) A prospective audit of an unusual (but possibly very old) technique of covering long-standing and extensive skin defects, by “moralised full thickness skin grafts”. The technique needs no specialised knife (e.g. the Humby) but takes a piece of skin, about 4 cms x 8 cms, completely “defats” it and cuts it up into tiny

fragments about 1 mm square. The moralised fragments are spread crudely over the area where they “seed” themselves quite quickly.

- 2) An audit of the use of “sugar dressings” to control wound odours. Sugar is held in position with petroleum jelly or glycerine as a paste. The disappearance of smell might be attributable to either the preservative antimicrobial effect or the osmotic effect on a wet wound.
- 3) A prospective audit of Ankle Fractures, to be treated at Lilongwe according to the guidelines drawn up during Course on the injury as it presents in Malawi.

The results of all projects will be reviewed throughout the forthcoming year. Tim Board plans to make at least one further visit to Malawi to follow-up the promising early results.

### **ASIA - NEPAL**

The latest in the series of bi-annual surgical camps took place in November 2004, somewhat in spite of concern about the domestic political disturbance (Maoist). The team comprised three surgeons, one of whom is a trainee registrar, together with a paediatric anaesthetist, **Graham Bell**, from the Glasgow Children’s Hospital. Most of the surgery, 48 procedures, was carried out at the relatively new Medical School Hospital, outside the town of **Nepalgunj** in Western Nepal.

The format followed the usual pattern. Advance announcement attracted a huge number of the disabled, from which the resident surgeon selected 290 requiring either surgical treatment or a definitive opinion regarding diagnosis and advice, usually as to why surgery was positively to be avoided. These latter cases included many cases of post-encephalitic athetoid inco-ordination. There were also many of the more common cases of cerebral palsy (reflecting obstetric delays), eleven cases of very late-to-present Talipes Equina Varus, teenagers walking on their talus, with the foot “upside-down”. This is the sort of case never seen in the West and, according to the resident doctors in Nepalgunj, only seen there when a visiting foreign team is announced. These, together with gross cases of paralytic polio and cases of long delayed joint dislocation, proved the most testing operative challenges. Other classical conditions included pseudarthroses of the tibia, osseogenesis imperfecta, disphysial aclasis, a variety of tumours, mainly benign, and septic arthritis of the hip and knee (TB tests pending).

The second week in the Kathmandu Valley was filled with visits to several out-of-town hospitals where surgical facilities were seen to be improving rapidly (joint replacement and Ilizarov!). Finally a whole day symposium was held on Trauma to Children, at which the visitors contributed at least one paper each.

As usual it was a tour concentrating essentially on instruction with operative participation by the resident surgeons. The team included **John Fixsen** (Great Ormond Street) whose enormous experience of paralytic conditions of infancy provided the final opinion on what is surgically possible and what is to be avoided, and why. **Archie Hawken** (SpR from Wessex) took a full part in the surgery, as did your correspondent.

This tour was an opportunity to review the programme over ten years during which IMPACT (UK) has contributed to the travelling expenses (in conjunction with WOC-UK). The hosts, now members of the flourishing Nepalese Orthopaedic Association, have expressed their appreciation of the input from their colleagues from the UK, and hope that the visits should continue with another sponsor to take the place of IMPACT (UK), who have had to withdraw.

**Dr Robert Stein** writes from Nashville, TN, describing his pioneer work in setting up the orthopaedic programme in **Bhutan** on behalf of Orthopaedics Overseas in 1991. He speaks warmly about his trainee, **Dr Tshewang Thinley**, the first and so far the only native Bhutanese orthopaedically trained surgeon, having completed his statutory residency in Bangkok in 1999. Dr Thinley now looks to advance his expertise through a specialist fellowship in spinal surgery. Rob is concerned about the number of cases of spinal injury, with or without neurological complication, arising from falls from a height or from motor accidents. These are well known to be, at best, uncertain in their outcome. They are furthermore extremely expensive to investigate and to treat! Their best chance of care in the domestic sense is from their own family who will never be able to travel great distances with their relative for treatment.

These thoughts make clear sense of the plan to have such expertise in the eastern Himalayas. There are of course many excellent centres in the USA and the UK, but I would recommend that a more appropriate experience would be had from one of the

Indian centres of excellence, for example Mumbai, Delhi, Ciombatore, Chennai or, less far away, Calcutta or Patna. ([resbread@mindspring.com](mailto:resbread@mindspring.com))

**Roderick Duncan** writes from Glasgow about a child he saw on a visit to Cambodia who suffered from osteogenesis imperfecta with gross femoral bowing. Both bones have been “rodded” and one is infected! Clearly a case into which one would like not to have got. But there might be even greater risk in removing the nail if the femur is ununited. This is the sort of case requiring a great deal of time, and time itself may be the most expensive item if such a case is to transported a long distance.

## ANNOUNCEMENTS

**Ron Huckstep** writes from Australia: The internet website - [www.worldortho.com](http://www.worldortho.com) - now includes the last 23 Newsletters, between January 1997 and October 2004. It also contains comprehensive texts on all aspects of poliomyelitis, including the techniques of operative correction and the manufacture of splints and callipers. Ron goes on to quote disconcerting reports of the resurgence of Acute Poliomyelitis in areas thought to have been free of the disease; 22 countries are listed (reference: BMJ 26/6/04 p 1513).

Professor Huckstep goes on to report the continuing programme of training provided in Australia for surgeons from Cambodia, Vietnam, Indonesia, the Solomon Islands and Samoa. These are organised by Bill Cumming et al. A seminar at the Combined Meeting at Sydney, October 2004, included papers on the Tonga Foot Club programme, Hand Surgery in Myanmar, Orthopaedics in Bali and the International Centre of Orthopaedic Education. ([huck333@ozemail.com.au](mailto:huck333@ozemail.com.au))

**Professor David Morley** draws our attention to the series of free CDs, TALC, addressing teaching points specifically relevant to tropical surgery without being exclusively orthopaedic. ([david@morleydc.demon.co.uk](mailto:david@morleydc.demon.co.uk))

**Claire Hicks**, IMPACT’s chief executive, describes the situation she found on a recent visit to Kathmandu. Everywhere military checkpoints are to be seen in the capital. Foreigners are strongly advised not to travel outside Kathmandu. Many people have been killed on both sides of the conflict. There is virtually no effective parliament. America is arming the army while the Maoists extract a modest ransom from any tourist. The worst atrocities are perpetrated on the farming community which is driven from the

countryside, filling the towns with refugees. These observations have caused IMPACT to curtail some of its Nepalese programme. But support for the Nepal Medical College continues. The recent camp visit conveyed to the College, surgical equipment to the value of \$1000, from WOC-UK.

**Nancy Kelly**, the executive director of health Volunteers Overseas, writes and sends their latest newsletter. In this is recorded the OO awards for Leadership and Volunteer Work to Drs **Richard Fisher** and **Michael Gross**.

The Congress devoted exclusively to External Fixation is announced - Lima, Peru, May 26<sup>th</sup> - 28<sup>th</sup> 2005 ([info@externalfixation2005.com](mailto:info@externalfixation2005.com))

Two orthopaedic vacancies are announced:- Ethiopia; the Black Lion Hospital, Addis Ababa, for 3-4 weeks; and a two week assignment at an (unnamed) teaching hospital in Manila, Philippines. (info: [info@hvousa.org](mailto:info@hvousa.org))

**CONCLUSION** As will be noticed, this Newsletter depends absolutely upon the reports from the regions, anecdotes from those actually doing the work. This is not only out of gossipy curiosity, but those providing financial support to the projects need to know what exactly they are supporting...and then because what is being done is really very interesting indeed!

Please mark this address for your story: **Michael Laurence** at [mllaurenc@netcomuk.co.uk](mailto:mllaurenc@netcomuk.co.uk)

#### **POSTSCRIPT**

Several short messages have been received from "WOC's man in Sumatra". Ger Olijhoek describes the difficulty of getting into the island. Already nine days after the catastrophe, the small airfields in North West Sumatra are heavily committed with the paucity of facilities. One imagines a short and narrow airfield, probably no lights, unable to take cargo craft of any size and restricted in time while the last plane clears the field. They managed to get their team into Meulabo which is one of the most seriously damaged areas. Ger found a scene recalling the devastation of the Great War battlefields in Northern Europe (14/18). Once they made their way to Banda Aceh, the slow trail of injured were beginning to block approaching roads, and yet in the town itself nothing remained with which to perform any meaningful surgical treatment. It seemed at first if they had

brought with them too well staffed a team. But within days the emotional dust began to settle and the trickle of fractured femora and tibia rapidly built into a flood.

Tetanus was a significant first complication for which anti-toxin was in extremely short supply.

Very few of the population had had the benefit of active immunisation. Ger's latest message is to report that very many doctors have presented themselves in Sumatra, but few have tropical experience. His team is already too busy. He promises to keep us (and through us, you) informed of his endeavours.