

World Orthopaedic Concern

Newsletter No 107 - May 2010

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Websites:- www.worldortho.com
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This Newsletter is circulated through the internet, through all WOC Regional Secretaries in the hope that they will be able to download and distribute it to those not connected through the "net."

Periodically revision is necessary; not least on the function of this Newsletter, and indeed even on the *raison d'être* of WOC itself. The last Newsletter, No 106, included much on the subject of the contribution of Orthopaedics in the face of major disasters, and we have a follow-up on the subject in this one. This office has received comment and criticism, so I wish to make one or two observations by way of explanation, and to invite contradiction.

WOC invites Charity, and informs on the subject of our Concern for Orthopaedics, World Wide. It has no International deposit of funds. It has no authority and no command organisation. Each part of the WOC world, runs its own Region, drawing funds for its own activities and communication, from its own members, for whom it provides a nominal umbrella for local and distant projects. Sometimes a region will receive funding from philanthropic bodies and individual donors. The Newsletter gives news of any orthopaedic activity as we hear of it. As a news-sheet, it rarely contains pictures; and any reproduced here are more often of important, recently deceased colleagues. The Newsletter is addressed to all and any who might wish to take part in individual projects. It does this by providing the "e" addresses of the organisers, and invites our readers to write to them. It is therefore a cross between an advertisement and an invitation, - acting as a sort of marriage broker - between those in need and those with an adventurous spirit and freedom enough to travel. (We do not generally display pictures of the

disparately deformed or disabled, with which our readers are (we presume) all too familiar.)

EARTHQUAKES Etc.

Two years ago, the recently past Secretary General of SICOT wrote to all members asking for the names and addresses of all who were prepared to respond suddenly to a major catastrophe. Many who are members of WOC, did so respond, but that is not the function of WOC. Such reaction must be individual, funded, and backed by logistical organisation, none of which WOC can offer.

Recent experience was splendidly described (in the magazine "British Orthopaedic News) by **Ricky Villar**, who was able to drop his clinical responsibilities and join a team organised by MERLIN, to Haiti. He wrote in graphic terms about the utter chaos of the destruction of buildings, the loss of life, of electricity, water, food and shelter. To this scene he depended upon the organisation and logistical skills of MERLIN to provide the wherewithal for the most elementary first aid surgery. Having no building still standing, they set up an emergency facility on a tennis court.

(It is in circumstances like these, that one comes to realise the value of a practical administrator, and see him as an ally, not an adversary. Ed.)

Emergency surgery is slow to organise and the vital entity of time, so vital according to the principles of ATLS, is beyond control. The flow of casualties is hampered by the destruction of roads, loss of communication and the absence of access to airfields -- in short -- infrastructure. The result was to place an entirely unfamiliar obstacle in the way of health care. Almost nobody received any surgical treatment within the "golden 48 hrs" of injury. It was, and still is, left to the second and third waves of volunteers to adapt to the orthopaedic necessities for those who have survived. After Ricky, the following report has been written by his senior trainee registrar, James Simpson.

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Fellowship Training & Disaster Surgery

MERLIN's decision for me to go was made 48 hours before I left. I had assembled some personal gear and halved it. My fellowship supervisor made sure I was well briefed on what to take, and to "keep it simple", taking no risks. On the 5th February I was dropped off, via Dominica, at a make-shift bus depot near the American Embassy in Port-au-Prince.

As night fell over the city I was taken to the tennis courts in Delmas 33, where a field hospital had been erected. The first 48 hours were fairly surreal and then gradually I became comfortable with the surgical environment. The “hospital” consisted of seven large tents, four acting as wards with eight beds per tent. The theatre tent had two surgical tables and was air-conditioned. Sterilisation was provided by two temperamental gas powered steam sterilisers. A further tent housed a mini C-arm for imaging.

The majority of the surgical work performed was managing crush wounds. These translated into relatively straight-forward wound debridements, external fixation and split skin grafts. The core MERLIN medical team consisted of one plastic surgeon, one orthopaedic surgeon, two anaesthetists, two theatre nurses, an A&E consultant and two ward nurses. Transitions between teams were staggered, to allow for face-to-face handovers, which meant that staffing numbers were periodically higher. The surgeons typically changed every two weeks, though some were able to stay longer. In addition we had MERLIN logistic and management personnel to support our activities. There was also a large team of local staff with nurses, drivers and “fixers”.

We did “keep things simple” and worked hard. The occasional more complex cases were managed with team discussions and team decisions. We were all aware that we were performing without the usual safety net. We had neither HDU nor ITU facilities on site and it was only later that these became available in some of our partner organisations. At night the hospital was left exclusively to our local team, as security concerns were too great to allow us to linger much after nightfall. We only performed one below knee amputation during my trip and this was in a patient where attempts at limb salvage by two previous MERLIN teams, had sadly failed and it was clear to all, including the patient, what was required.

The question over whether too many amputations were performed early on is difficult to answer. It took a significant time for adequately equipped surgical units to be available, and we had no renal dialysis service. Managing open fractures with anything other than amputation in these circumstances is a high risk stratagem. Much of the early management was compromised by a lack of equipment and an inability to provide adequate follow-up due to the initial overwhelming number of

patients. Complications were therefore more likely to occur, and not to be identified early. Latterly the surgeon who replaced me reported an increasing workload of patients with infected metal-work from internal fixation performed at other centres. An infected ankle ORIF in Haiti probably means a delayed amputation. A malunited ankle may be a preferable option particularly in a country where the most basic health care is lacking and long term prosthetics will be relatively expensive.

The work was hugely rewarding. Leaving was difficult and the return to western medicine, frustrating. I gained a group of friends and colleagues with whom I hope, and plan, to work again.

I would pass on the following tips:-

- Seek out the advice of those you trust that have done this type of work before.
- Insist on speaking to the surgeon you are replacing as soon as you know you are going. Identify what equipment is available, and what is not. Find out all about available help, and the possibility of patient evacuation.
- Consider taking a set of loupes and a battery powered surgical head light. When you get a bleeder down a deep dark hole you will be thankful of the assistance they provide! And be prepared to “pack” and revisit the wound on another day.
- Adhere to the “K.I.S.S.” principal at all times.

James Simpson, jm.simpson@rcsed.ac.uk

Reprise. It is worth taking further stock at this point and adding up-to-date, local colour. The State of Florida stands 700 miles from Haiti, and already had a medical link through the Miller School of Medicine in Miami, with Port au Prince, dating back to 1994. They have been training doctors and nurses and running remote health centres on the Island. Within 24 hrs doctors and nurses were on site, but without equipment, First Aid was of the most primitive kind. Eagerness to help was immediate, but transport depended upon airfields; it was all too late for those losing blood.

Immediate help could only come from those already there, the Haitians. Food handouts commenced within hours of the catastrophe. “We don’t believe in dry food hand-outs,” was quoted, “our people have dignity.” The “invasion” of Western NGOs cannot be immediate. Few Haitians, outside the city, speak any language but Creole; not even French. This

was an opportunity for émigré Haitians to come home, which they did in great numbers, during the second and third weeks. The country is now well into the second phase of recovery, in which the long haul of Rehabilitation has begun. It is likely to need two years of funding. External prosthetists have responded from England (Blachfords, whose factory sent hundreds of prostheses from India) and Scotland (Finniestons, who have an office in Miami.) They are involved with the training of Haitian technicians. This chronic problem is not going to go away.

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The above information and comments are typical of acute traumatology, an aspect of orthopaedics which receives scant attention in modern Texts. The problems are those imposed by the time factor and compounded by poverty. They warp classical orthopaedics and significantly affect any definition of “Excellence”. These are factors which seldom reach the podium of Grand Meetings, but numerically they pose the greatest tests of surgical ingenuity

Personal Appreciation

WOC wishes to express its debt to the late **Professor Chares Sorbie**, who died so suddenly two months ago. For so long he championed the work of WOC and its vital place in the training of those colleagues who perpetuate the principles of safe, sound, classical orthopaedics under straightened circumstances in the developing world.

He always took a considerable interest in the activities of WOC, and always strove to include the developing countries in the activities of Sicot and of its Committees. He liked to have as many candidates for the SICOT Diploma as possible from resource-poor areas, and he appreciated the need for the examiners to ensure that questions were relevant to the orthopaedic problems found in these parts of the world. (*We quote from the obituary published in the SICOT Newsletter as follows:*)

He was Canadian National Delegate of SICOT from 1977 to 1987. In 1990 he was Congress President for the highly successful XVIII SICOT Congress in Montreal. The proceeds from this enabled him to establish the Canadian Scholarships which provided funds for a visiting professor to travel to an orthopaedic training establishment anywhere in the world to assess facilities and standards and provide a report. It could be said

that of all the guiding principles of the founding fathers of SICOT, Charlie was most concerned with Education. He introduced the SICOT Training Manual based on the Core Curriculum of the Canadian Orthopaedic Association and was heavily involved with the establishment of SICOT Training Centres around the world. He was co-examiner with Tony Hall from the inauguration of the SICOT Diploma Examination in 2003 and was responsible for the written paper each year. He was President of the Canadian Orthopaedic Research Society from 1975 to 1976, President of the Canadian Orthopaedic Association in 1986-87 and President of SICOT from 1996 to 1999.

QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.

Through his leadership of the academic committees of S I C O T, he gave constant encouragement to all who disseminate the hard won lessons of modern surgery, to the parts of the world with the longest waiting lists. His energy and charm will not be forgotten by all whom he inspired.

MYANMAR

Professor **Alain Patel** was in Myanmar for a month before Christmas. It is rare for us in the English speaking world to hear news from this secret part of the world, but Alain has for years maintained his French team working with the Burmese Orthopaedic community. He writes, :-

“All is running well. I no longer perform operative surgery, but continue

to teach, advise and instruct. It is gratifying to see how well the new surgeons are coping and making clinical judgments between conservative and surgical treatments.”

In **Mandalay**, the second city, in the North, a new Orthopaedic hospital of 200 beds has been opened, largely equipped from Alain’s charity, (AMFAA) which has provided the hardware for OT, Sterilization, ICU and X-ray. Now the Burmese surgeons are running the place efficiently and to a high standard, The Children’s Hospitals are doing good work too. Alain’s team of regular visitors are closely involved in 3 of them and in 16 distant dispensaries. The AMFAA workshop is running efficiently for the past three years and Burmese technicians are able to maintain and repair the equipment. (Alain also comments that the car, left there by Geoffrey Walker, is still in working order!)

Alain has no news from Hopital Amitié in Vientiane, but he was recently in Thailand and South Laos, where he was able to arrange scholarships from the Thai Ministry of Foreign Affairs, for Burmese specialists in training.

Alain Patel (amfafrance@netcourier.com)

Professor Patel has been the driving force in Myanmar, which for years has been the province of his French charity, and reliant upon his teaching for the development of Burmese orthopaedics. He has been scrupulous in maintaining a strictly apolitical position. Those who might wish to contribute personally, should surely speak French.

INDONESIA - SUMATRA

Ger Olyhoek writes:-“ our team is just back from Sumatra after a long period of working and teaching in Pematang Siantar and in Medan. We have been doing this work for 20 years now; next year will probably be the last time I go to do operative work. Teaching and advising and training will of course continue.

“The problems at Sumatra, in the aftermath of not one, but two major earthquakes, are serious. We still see far too many infections and badly managed fractures; I have submitted a paper for the Gothenburg SICOT Meeting. Sadly the subject is not thought to be “New” – but certainly it is true. The harsh lesson has to be learned and learned again, and again!

“Herein lies a monumental problem, requiring to be regularly repeated. At the SICOT meeting in Thailand, fracture treatment was discussed and debated. But although the fundamentals were thought to have been adequately covered by “internet” communication, in my experience, “e” learning stops when electricity fails!

It is tempting to take a “preventative” attitude to the problem of “Honda” disease – caused by small over-powered motor-bikes, on bad roads. But as the roads get better, the accidents occur at greater speed. The worse the fracture, the more destructive the infection that follows surgery. And both make increasing demands on personal and national economies. “In my view the only thing we should do, is to go back to the early principles of Watson Jones. If the “chiefs” idealise operative surgery, what else can the resident do, but follow?

[Ger Olyhoek golyhoek@hotmail.com]

VISIT TO ETHIOPIA AND SOMALILAND. Australian Doctors for Africa

8th March 2010 to 21st March 2010

The pattern of work at the Black Lion Hospital commenced with the daily 8.00am trauma meeting, and then involved us in the subsequent fracture clinics, referral clinics, talipes clinics, theatre operating sessions and teaching sessions with the residents. Dr Fintan Shannon was visiting at the same time and we were careful to coordinate our involvement with him. The teamwork amongst the consultants at the Orthopaedic Department at the Black Lion Hospital remains at a high standard, thanks to the leadership of Dr Woubelam. It is perhaps understandable that she has to take the opportunity to work on committees and other pressing administration business when visitors are present to shoulder some of the clinical load.

There are eight new first year residents who have joined the orthopaedic programme and the quality of these residents is the best for some long time. In particular there are four who represent outstanding potential; and the others are sound. This represents a wonderful opportunity to train young orthopaedic surgeons over the next four years.

The small theatre adjacent to the emergency department is planned to be handed over to the orthopaedic department, with anaesthetic cover for debridement under anaesthesia, simple manipulations and reduction of dislocations.

The next large project is to convert the available space in the new rehabilitation block to three orthopaedic theatres. This represents a significant capital expenditure but will give the orthopaedic department control of clean/sterile theatres with adequate operating time. For the interim the Saturday operating sessions are going well with the generous support of the orthopaedic consultants and residents.

The next visit of Australian Doctors for Africa has been scheduled for 26th August 2010 which will be led by Dr Tony Jeffries. He will take Dr Tim Fletcher, orthopaedic registrar as well as Paul Maloney, orthopaedic technician and Victoria Gibson with another experienced theatre nurse. The main effort here will be to work on upper limb surgery and also progress the knowledge of sterile technique in theatre by the nurses, residents and consultants.

During this current visit **Graham Forward** travelled via Djibouti to **Hargeisa in Somaliland**. The purpose of this was to make preparations with Dr Ereg, the Dean of the Hargeisa Medical School for the visit of teaching doctors from Australia. The Edna Aden Hospital was visited to help clarify the dwindling water supply and make plans for possible assistance from Australia. A comprehensive visit to the Hargeisa Group Hospital, the main public hospital for Somaliland, was made. A commitment was given for Australian Doctors for Africa to work to renovate the laundry room with the assistance of the Taakulo Somaliland Community.

Hargeisa Group Hospital would benefit from a planned orthopaedic visit and the supply of small fragment sets, circlage wires and other instruments to allow relatively simple fractures to be dealt with. At this stage no date has been fixed for such a visit but Australian Doctors for Africa will now search for a suitable orthopaedic surgeon to make that visit and couple this with a teaching visit to the University of Hargeisa Medical School.

Forward [grforward52@hotmail.com]

Dr. Fintan Shannon visited the Black Lion Hospital In Addis Ababa, for six weeks through March and April 2010. He reports on the high standard of work, but also lists the impediment felt in the operating facilities, having to deal with the enormous workload. While he was there, some 300 surgical procedures were carried out; none of them trivial! Fintan himself operated on 30 cases comprising DDH, CTEV, septic arthritis and assorted contractures from delayed fractures and dislocations. Emergency admissions averaged 7 per night. Many normally requiring admission had to be sent home with traction splints for surgery later. This shortage of bed space has a significant effect on the definition of an “Emergency”. Rarely is it possible to admit cases of malignant tumour, infected fracture or congenital deformity. An average of 5 patients were “held” in the back section of the Emergency Dept, waiting for a bed. The new Rehabilitation Dept. is not yet in operation, still awaiting commission.

Fintan reports significant improvement in the “productivity” of the operating theatres, with the provision of battery-operated drills, an Image intensifier, the equipment for “SIGN” Intramedullary Nailing, and the BLH external fixateur, (a local design.)

In the analysis of his six week stay, Dr Fintan makes the following recommendations: The trauma load demands an operative session each day, in order to cope with the “emergencies”. This is emphasised by the fact that the trainees need help, supervision and direction in their surgery, if they are to learn from their experience. Furthermore, Dr. Fintan suggests that the morning surgery sessions should start at 8.30 am. And he wished that the physiotherapy and orthotic services could be integrated with the orthopaedic work, and that the orthopaedic teams be reorganised into four or more separate units. Fintan feels that the wealth of clinical work at the Black Lion, has the potential to produce the greatest training service.

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Lack of space requires that reports from Cambodia, Bangladesh et al. be postponed until the next newsletter in August

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