SIMON BONNINGTONS 'S ZAMBIAN E DIARY

Simon Bonnington has been off on sabbatical, working for the past six weeks at Mpongwe Mission Hospital in rural Zambia. Here are some extracts from his e-diary

"I started work properly with a Ward Round with Dr Okoko. 19 patients on Female Ward, 6 have known HIV. One had had a hysterectomy 3days ago and now looks septic. We can do an FBC and differential, also ESR and Blood Film for malaria. ALT is available but K+ and Na+ are not. There are plain film XRs and USS, but no ECG. I asked Dr Okoko if it would be helpful to have one, knowing that Yeovil Surgeries replace old equipment. Yes, he said, but then we would need to know what to do with the findings! Blood transfusions are given below Hb of 5, or 6 if symptomatic. There appears to be a reasonable supply of needles, fluids etc, but few Nurses. Notes are somewhat disorganised, as are Xrays, which are stored in one pile, but eventually you can locate the right pieces for each patient."
"**Wednesday was a particularly heavy day – I saw 75 patients but no electricity and then no water in the evening**. The next day three cases for theatre. One was a revision of a debridement of an infected foot in a very poorly controlled insulin dependent diabetic. Should have been Nil By Mouth but had felt hungry, so he ate a bowl of nsima (ground maize porridge). The procedure needed doing, so I did it, necessarily without much sedation. It hurt. I asked the Student Clinical officer assisting me to explain to him that a Below Knee Amputation would be the inevitable result if we did not attend to the wound properly. The patient gritted his teeth. "Surgical sets are devoid of drapes to establish a sterile field and the I&D set has no scalpel handle. So I am becoming proficient at requesting exactly what I need from the Theatre Orderly who runs the autoclave. I am therefore scrub nurse, anaesthetist, ODA, surgeon and then recovery nurse whilst the ward nurse finds a trolley to take the patient back to the ward. Transferring the patient from the table to the trolley involves a heave on the patient's clothing. The impact tends to help to wake them up a bit!"

"Tuesday is Theatre Day. We have a pulse oximeter, though it is not always used. Anaesthetic is again Diazepam, Atropine and Ketamine. The first case was climbing on the table when I arrived - a bilateral tubal ligation. Dr Okoko was taking his time to arrive but the medical licenciate was all set to administer the anaesthetic. All that was required was a surgeon. Blow it! I've done this loads of times before, albeit thirteen years ago, let's crack on. Transverse lower abdominal incision, through the rectus sheath, blunt dissection of the peritoneum, find the left tube, clamp, clamp, catgut to tie & tie, cut and cut to resect the mid section Manchester technique. Or is it Pomeroy? Or is that something totally different? Anyway, who cares what it is called. Same for the other side. Then out again, peritoneum, nonabsorbable for the rectus sheath, interrupted silk to skin, one wet, one dry, et voila!" "Next Dr Okoko and I tackle a very tricky hysterectomy. We continue with the aspiration of a large ovarian cyst and finally a repeat laparotomy for post-op peritonitis and sepsis following a C-section two weeks ago. No lunch, but Dr Okoko assured me that if he stopped he would never be able to get the list restarted again! We use the same room for Pre-op and Recovery, so the next patient knows what is coming." "**On Female Ward we have a steady stream of odd infections that turn out to be HIV +ve. On Thursday the Clinical Officer admitted a lady with a two week history body wide eruption of small lumps. It looked like Von Recklinghausen's but with barely any gaps between lesions now discharging pus and blood I gave her a trial of Cloxacillin and sent her for Pre-Test Counselling for HIV. Yesterday she was no different, and she was found to be "reactive" (the euphemism here for HIV +ve). I scratched my head. In my recent CME study notes I had come across a question**

about a woman with skin lumps and a positive Acid-Fast stain of a skin smear. Could it be? I checked in the Oxford Handbook of Tropical Medicine… and the lab can do the test. "Doctor, you are very clever!" comes the reply No, it was just a very fortunate guess: leprosy. With a 6 month course of medication, it should come under control."

"Jungle Doctor meets Scrapheap Challenge. On Saturday I see a girl of seven who had a fractured midshaft left femur. The X-ray showed very obvious displacement. I remember being taught that you should never see an X-ray of a fractured femur that isn't already in a Thomas splint. Mpongwe has no such appliance. Because of her age I wasn't happy to simply consider weeks of traction leaving her with an inevitably shortened leg, and thought that internal fixation to the proper length at Ndola Hospital was required. Dr Okoko agreed, but there was no transport to take her and no Thomas splint. We could provide her mother with funds to transfer her to Ndola (presumably by bus!) but what to do in the meantime? Dennis and a colleague were stripping some sort of engine down and a pile of scrap metal lay behind the carpentry shop. Broken beds, wheelchairs, bits of bicycle and obscure antediluvian medical devices were heaped up. Half an hour later, after a nifty bit of scavenging, using an angle grinder, two bolts, assorted washers, a hefty hammer and the vice, I was finished. Proper job! Padded with cotton wool gamgee and bandages from Theatres, a rope from a dusty cupboard, copious amounts of sticky strapping tape and the limb was immobilised and in traction. Possibly the most seful thing I have done here. **After this, the resetting of the forearm was a bit of an anticlimax**."

"The medical work is challenging and stimulating; without paperwork, meetings, budgets or endless diktats from local or national control. **If you can do it, you do, if you can't, you don't, or you 'make a plan' to try to do it differently.** Very simple, with no space for argument and a population that accepts the status quo without grumbling.

Every day I have had the opportunity to really improve health and even directly save lives – not rely upon statistical significance to probably affect an outcome.

I fear that as a result returning to work in the NHS will be even more challenging for me. On the other hand I have also found it far too easy to drift into the accepted standards and sub -standard (from a European perspective) practices at Mpongwe. Initially horrified that a heavily sedated patient under Ketamine with an unsecured airway is neither monitored nor necessarily watched whilst a minor surgical procedure is undertaken, I am now very happy to knock them out and crack on, glancing occasionally at the chest to make sure it is still moving. The UK Government want more procedures done in GP surgeries and fewer in Hospitals; I've now got some rather good ideas.