ELECTIVE (SSC5a/b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Objective 1

Describe the most common paediatric conditions requiring hospital treatment in rural Tanzania? How do they compare with commonly encountered conditions in the UK?

The inpatient paediatric facility at Dareda Hospital consists of 5 bays with 6 beds in each bay. Typically children are seen in the outpatients department and are admitted into the unit or they get admitted directly onto the ward. The most common cause for admission to hospital is pneumonia which is typically diagnosed clinically based on history and examination. In the UK, pneumonia is an important cause for paediatric hospital admission however it is much less frequently encountered unless a child has a primary lung pathology, long admission in hospital or are immunocompromised. On a typical ward round roughly half of the children will hold the diagnosis of pneumonia in Dareda. The second most common condition encountered is malaria. This is rarely seen in the UK and if is encountered is as a result of recent foreign travel and never due to exposure from within the UK. There is often some diagnostic doubt between malaria or pneumonia due to limited availabilty of investigations and consequently it is common to see children treated for both. Another condition which is relatively more common here than in the UK is malnutrition. This is graded depending on the percentage of ideal body weight and is treated with a ten step protocol and the use of special feeds high in protein and other lacking nutrients. Currently it is more common to see the reverse problem in the UK where children are increasingly suffering with obesity and its sequelae. A condition that is common to both Tanzania and the UK is the relatively high rates of diahorrea and vomiting with similar treatment between the countries. I have also encountered osteomyleitis and septic athritis at higher rates than I have previously seen however it is well documented that children are at higher risk of these conditions.

Objective 2

How are surgical services organised in terms of resources, staff and daily service in rural Tanzania? How does this compare to surgical provision in the UK?

There are many similarities in principle between surgery in the UK and in Tanzania. Here there is a separate theatres building as would be found in the UK with an anaethetist, doctor, scrub nurse and other theatre staff. The doctors who operate here are not necessarily specialty trained surgeons which is a major difference from the UK where surgeons undergo separate training to physicians and are further sub-specialised into particular branches of surgery. The role of the scrub nurse also deviates from that seen in the UK. The scrub nurse prepares and deliver the instruments to the surgeon but in addition to this role he/she also takes on the role as the first assisant surgeon - suctioning, clearing any bleeds with gauze and assiting the surgeon with suturing. The bread-and-butter of the surgical workload in Tanzania are caesarean sections. Other procedures I have seen have included insertion of a supra-pubic catheter and insertion of a balloon into the cervix to assist cervical dilatation for delivery. The theatre list will typically involve some elective caesarean sections and whatever other elective procedure is needed, and then any emergency cases which are often cases of trauma. This is very different to that which is seen in the UK where individual surgical specialties have their own theatre lists conducted by separate specialty surgeons and typically in individual surgical theatres. The role of

the anaesthetist is primarily the same as that in the UK. Here they too administer anaesthetic and monitor the patient intra-operatively but with fewer parameters such as blood pressure and heart rate. The use of different types of anaesthesia is somewhat different. Caesarean sections are conducted with the use of spinal anaethesia only and for local procedures local anaethetic is used solely when further agents or sedatives might also be added in the UK. A further difference from the UK is the fact that here scrubs, masks and caps are all reusable and are sterilised by washing only.

Objective 3

Describe an interesting clinical case highlighting a condition not commonly encountered in the UK. How did the patient present, what investigations were undertaken and how was the patient managed?

In the outpatients department I encountered a 15 year old adolescent girl who had a presenting complaint of loss of consciousness followed by "shaking of the limbs" and then a subsequent history of personality change and confusion of 3 days duration. The girl had previously been fit and well with no past medical or psychiatric history of note and no previous seziures. On examination the patient was comfortable at rest with no dyspnoea, pallor, jaundice and apyrexic. I was limited by the language barrier however the doctor I was with informed me that the patient was talking fluently but the content of her speech was bizarre. The patient believed that her recent presumed seizure was the work of the devil and she had the devil inside her. Her accompanying relative informed us that what she was saying was completely out of character and that she was very concerned. I found this case very interesting and unusual. Based on the history including the sudden nature, the doctor believed that the patient suffered a seizure and that the most likely explanation for this seizure was malaria causing an encephalitis. The patient was then reviewed by a senior collegue who advised admission with a complete set of observations and treatment with anti-malarials. The encephalitis could explain both the seizure component of her clinical presentation and the subsequent change in personality and abnormal thoughts. This case was particularly interesting because in the UK there is no malaria so malaria would not be included in the differential diagnosis although other infective causes would be.

Objective 4

Describe a situation where you have found the difference in culture/ language challenging and what you did to overcome or manage the difficulty

One of the major challenged I have faced in the hospital is the barrier of language. Although the hospital staff are all proficient in English as this is the language medical and nursing training is conducted in, the patient population as a general rule is not. The main language spoken here is Swahili, however there are also individual languages from the different tribes that occupy this region. One particularly common group here is Iraqui. A particular occasion where language proved challenging was at a HIV outreach testing afternoon at a nearby monthly market. My role was to speak to the patients who came to the HIV testing van and explain what I was about to, that it would hurt and what would happen with the results. To deliver this information effectively clearly requires good command of the local language, which I did not have, particularly so early on in my stay in Tanzania. This was also more challenging because of the nature of what was being tested for. HIV, here as in everywhere, has a huge stigma attached to it and recruiting people for testing in a public place such as a market made reassurance and language even more important. Although initially daunted by the task that lay ahead, I used the support of the community outreach team who were very kind and helped me get to grips with the relevant phrases I needed. This meant that I could communicate the relevant messages about pain and what to

do once the test was done. I also was quick to see how although language is very important, a great deal of communication can be achieved through other means such as facial expressions, demonstrations and intonation. Of primary importance was making the patient comfortable and relaxed and with the help of a few key phrases I was able to make a useful contribution to the workload that afternoon.