ELECTIVE (SSC5c) REPORT (1200 words)

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

Conditions most frequently presenting in the emergency department at Rabwah are remarkably similar to the conditions presenting in the UK. However, their frequency is quite different. Epigastric pain is extremely common here as is presentation with a fever, often the focus is the gastrointestinal tract and clinicans are constantly on the lookout for features of tyhpoid, bacterial gastroenteritis and food poisoning. Sometimes a focus is not found and then the key question becomes one of whether the patient has had any rigors or sweating. Here, the most likely differential is malaria and investigations are sent to diagnose this common disease. The use of emperical treatment is rife here, often due to costs and availability of investigations. Therefore, a patient presenting with a fever is given antibiotics and anti-malarials, often without investigations. Additionally, a significant proportion of presentations are due to underlying anxiety disorder, sometimes presenting with the classical clinical picture of hyperventilation, headache, chest pain and tingling in the hands and feet whilst, at other times presenting as epigastric pain, severe headache, generalised weakness and patients describing a feeling of impending doom. One of the reasons for this is because of the multiple societal ills that plague this country. Girls have it the worst here, with almost zero propects and no gaurantee of a future with security, safety and happiness. Girls are often, without consent, married to boys they have never seen or met, who may or may not be educated or employed. As they themselves are often uneducated, they are unable to secure any future for themselves by finding a job. At the same time, she lives in a house shared by the boy's family inclouding brothers, sisters, mother and father whom she has to look after, sometimes single handedly.

Aother very common presentation is one of renal colic. A very surprising feature of this presentation is the young age at which patients present, sometimes even teenagers. Given the epidemic proportion of viral hepatitis here, a common presentation is one of haematemesis, malaena or jaundice. Malnutrition is rife here and so is anaemia, both microcytic and megaloblastic; I have also seen hypocalcaemic tetany here, which is very rare in the UK. It would be an understatement to say that presentation to the emergency department with road traffic accidents is extremely common here. There are no footpaths in this city and the roads are shared by pedestrians, cyclists, motorcyclists, cars, horse-carriages, vans and trucks. Soft tissue injury, lacerations requiring stitches and fractures are extremely common. One of the primary reasons for this is that the hospital is adjacent to a major road which functions as a highway, carrying traffic from adjacent towns and cities. However,its size is small and drivers are often frustrated resulting in a huge number of collisions, which are all brought to this hospital. Domestic abuse and child abuse also seems to be common, so much so that doctors often just treat the injuries and send patients home without questioning the mode of injury. Only when the patients condition suggests a murder attempt is the polic involved. Simiarly, suicide is illegal in this country, so the hospital refuses to treat/admit anyone with a suicide attempt due to the inevitable involvement in medico-legal proceedings. So the patients are often referred to a different hospital to get treatment.

Prehospital care is also remarkably different to what is available in the UK. There is a 1122 service in the local region that responds to emergencies. For the most part, the role of the ambulance is one of merely transporting the patient to the hospital. At best, the crew is able to take some vitals but is unable to record a basic thing like an ECG. Additionally, there is often only one person in the ambulance who is driving it, so there is no one available to start CPR if the patient should arrest. The use of the ambulance service is relatively rare. Even the sickest patients are often brought in by relatives who have driven them large distances. Fazal e Omar hospital is famous in the area, and often the patients say that they brought their relative into this hospital because they feel the patients are treated better here. On occasion, patients who had already been admitted into a different hospital were brought in without hospital transport, at a very high probability that the patient would die in the middle of their journey, so that they can get treatment from this hospital. As mentioned above, RTA's are very common. When patients are brought in, there is no one there to stabilise the C-spine, and if someone has a broken leg, they would most likely hop in to the emergency department. Due to poor pre-hospital services, I have had to adjust how I treat certain conditions. For example, whilst it would be normal policy to wait 5 minutes before terminating a febrile convulsion, here it is treated as soon as the patients are brought in. This is because when the patient is brought in with a convulsion, it is most likely that this has been going on for at least 20 minutes.

The use of imaging is similar in some respects but remarkably different in other. For example, when someone is suspected of having pneumonia, bowel obstruction, or bowel perforation, an x-ray is ordered. However, as

healthcare is not free in this country, it is up to the patient to go to the radiology department to get their x-ray done, if they are able to afford it. There is no facility to arrange portable x-rays, so if a fracture is suspected, the patients have to go the emergency department to get the x-ray done. Often, the hospital acts very charitably and discounts a significant proportion of the cost so that the patients get the x-ray done. Additionally, some practices differ. For example, abdominal x-ray or CT is done for renal colic in the UK. Here, abdominal ultrasound scans are utilised a lot more for this presentation, which is far less sensitive for picking up nephrolithiasis, but does pick up complications such as hydronephrosis. The use of CT scans here is rare, and there is no on-site radiologist to comment on these scans. Whilst the hospital staff are very charitable, the costs of the CT scan shoots up because the scans are sent to and reviewed by external doctors who are quite expensive. In cases where there is clinical equipoise in cases of head injury, sometimes a CT is done free of cost to the patient, in order to decide whether to keep the patient or refer depending on the finding. Anything that requires neurosurgical intervention is referred.Therefore, all the investigations here have to have strong justifications for their request. MRI scans are not available in this hospital. Since there is no system of maintaining patients notes, even if patients have had previous scans, you are not aware of the results and patients often get angry if you request it again, even though it's their fault that they didn't bring in previous notes.

It is unfortunate for me, though fortunate for patients, that shock is a rare presentation in the emergency department. I am most surprised at the lack of septic shock, given that infectious diseases are rampant in this area. However, the reason for this is that a lot of quack medicine is practiced here. Patients present very quickly here, often going to a local doctor, who may not be qualified as a doctor at all, sometimes within one or two hours of developing a fever. By the time, they come to the emergency department, they have already seen 2-3 "doctors" who would have prescribed 2-3 different antibiotics for the patient. Hence, the development of septic shock is rare. Nevertheless, I did see one case, which was taken very quickly to ICU and treatment was not initiated in the Emergency department. Unfortunately, the patient refused admission on the basis of expense, and it is not known what the outcome was; the prognosis was bad. Given the number of RTA's, it is also quite surprising that hypovolaemic shock is rare; this often presents due to dehydration from diarrhoea and vomiting, although it is better to say that hypovolaemia presents rather than shock. As mentioned before, pulmonary embolisms are rare so obstructive shock also doesn't present. As all cardiac emergencies are not seen in Fazal e Omar hospital, due to their referral to the neighbouring Tahir Heart Institute, cardiogenic shock is also not seen, though I have seen patients with hallmark signs of CCF, including raised JVP, bilateral pleural effusions and noisy breathing.