ELECTIVE (SSC5c) REPORT (1200 words)

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

Conditions that presented into the paediatric ICU were common to those conditions that present in the UK. A very common condition that needs to be ruled out in almost all neonates is sepsis. A grading system of rule-out sepsis, probable sepsis and confirmed sepsis is used to determine the likelihood of sepsis based upon clinical and laboratory findings. Subsequent treatment is then based upon this, for example, neonates with a diagnosis of probable sepsis would be started on broad spectrum antibiotics, until cultures are confirmed. Culture specific antibiotics would then be started for ten days. I became familiar with this system early on as I was given the task to examine the neonates in the stable section of the paediatric ICU (similar to the level of care provided by the special care baby unit, SCBU, in the UK) and the majority of patients in this section had a diagnosis of sepsis.

However, unlike certain conditions that presented in the paediatric ICU, some conditions that presented in the paediatric ward were very different to those that commonly present in the UK. Like paediatrics everywhere, diseases are seen in different seasons throughout the year. During my time here, in the warm weather, a common condition was acute watery diarrhoea. A vast majority of young infants would present to the paediatric ward with loose stools for a number of days and many would even come presenting with marked dehydration. These children would need urgent fluid management as well as subsequent treatment with antibiotics, zinc, probiotics and in many cases, would need to switch to lactose free milk due to prolonged diarrhoea. The vast majority would make a full recovery.

Another common presentation here is a child presenting with a fever. Apart from conditions commonly seen in the UK such as pneumonia or an upper respiratory tract infection, malaria is something that has to be considered. Unlike Africa, the frequent strains are plasmodium ovale and vivax which are easily treatable with a simple course of chloroquine. Three doses are all that is required. Due to the widespread nature of malaria, many people would treat themselves empirically if they developed a fever for a few days and this would also be the case in many children where the focus of infection could not be found.

Another infectious disease, common here and very rare in the UK, that must be ruled out in a child with a fever, is typhoid fever. Due to poor sanitation, poverty and poor hygiene typhoid is an endemic in Pakistan. Antibiotic resistance is a problem here and most cases are treated with ceftriaxone .

The diseases mentioned above are ones that I expected to see. What I was surprised to see were cases of mumps. Like the UK, all children are vaccinated against mumps but it seems that either the vaccine is not effective or the uptake of the vaccine in some areas is poor. Though repeatedly stressed by our consultant in charge not to admit children with mumps into the ward because of the risk of infection, over the course of the six weeks here, a few cases were admitted.

Other conditions that commonly present are more chronic conditions that will be discussed in detail below.

The paediatric services in Fazle Umar are very similar to that found in the UK. There is a paediatric ICU ward, a general paediatric ward as well as a paediatric out patient department. Though there is not a paediatric A&E. The difference lies in the resources available. My first surprise was the number of

consultants working in Fazle Umar. There are only a handful. The rest of the staff, no matter how many years of experience, are known as medical officers (equivalant to senior house officers in the UK). So there is only one paediatric consultant working in the whole hospital. He has the responsibility of managing not only the paediatric medical ward, but also the paediatric ICU and ensuring the outpatient department is staffed. To my even greater surprise, I found out that a number of years ago, this consultant was managing the whole paediatric department single handed. Though there are seven physicians working in his team right now, four are planning to work abroad. A further disadvantage, despite the work load, is that, unlike the UK, where consultants develop an interest in a certain field like cardiovascular disease, all children in the paediatric out patients department are seen by a general paediatrician.

There is a great need of more physicians in the whole hospital. Another difference is due to the lack funding. For example, there are only a few ventilators in the paediatric ICU and those infants requiring ventilation who cannot be venitlated are simply transferred to another hospital. Despite these shortcomings, the paediatric department is working well with what they have.

Chronic diseases are managed in the out patient department. Like mentioned previously, children are seen by a general paediatric physician rather than a consultant who has a special interest. It is sad to say that many chronic conditions that are seen are preventable. These include growth failure and anaemia, both of which are due to lack of a proper diet. The reasons behind these conditions are not simply due to poverty but due to a combination of a lack of education (parents would often not wean their child to solid foods and so lead to anaemia) as well as a degree of neglect. It is common for parents not to bring their children to follow up appointments. They may also not undertake all the tests due to cost issues. I also found that presentations of treatable diseases such as pneumonia, croup or gastroenteritis would present very late. Children would be brought in by their parents in a gasping state, or with such severe dehydration that the child be extremely drousy and unresponsive. It is unsure whether this is because parents are unaware of the ambulance service that is provided by the hospital (at a small fee) or that it is due to neglect that they wait till the hours of the morning to bring their children in.

During my time here, I have been treated like a junior doctor, not as a medical student. Therefore, I was given the task to start examining patients from day one. Initially, while in ICU, I was hesistant to examine neonates and would find it difficult to palpate an enlarged liver due to the child crying. However, over the weeks I have become more confident in examining children from neonates to young children. I have also found ward rounds useful because I would get direct feedback on my treatmant plan and there would be case based discussions during the ward round itself.