ELECTIVE (SSC5c) REPORT (1200 words)

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

In the UK there is a high prevalence of lifestyle diseases and illness such as ischaemic heart disease, diabetes and COPD. These conditions are usually the result of lifestyale choices resulting in high cholesterol, obesity and smoking related lung conditions. Many of these illnesses will present in the 5th decade onwards - although it is becoming increasingly common to see these illnesses in even younger patients due to the obesity crisis. This is in stark contrast to Zambia, where infectious diseases are common. The majority of patients I saw throughout my placement were in hospital with conditions such as malaria or opportunistic inefctions in HIV patients. There were also several children in the hospital suffering from infectious diseases. There are also several trauma patients - road traffic accidents, alcohol related accidents, assaults. This is comparable to the UK, especially at the Royal London Hospital which sees a large number of trauma patients . I was told that there was quite a big problem with alcohol in the rural areas surrounding the hospital and, as a result, alcoholic liver disease is becoming more common. Again this is similar to the UK, where alcoholic liver disease is already a major problem. I think that these differences are due to the lifestyle of the patients in the 2 countries. In the UK, patients tend to have more disposable income and therefore suffer from obesity related disorders. They also tend to have more office based jobs and lead sedentary lifestyles, whereas in Zambia active, outside jobs are more common. Living conditions in Zambia, along with poor access to vaccination programmes and healthcare leads to an increased number of infectious diseases. This helps to expain the differences seen in the variety of conditions seen across the 2 countires.

HIV infection is far more common in Zambia than it is in the UK. However, there are certain population groups in the UK, for example homosexual men in London, where HIV rates are very high. In the UK there is a big drive to increase HIV testing. This includes a HIV testing week when all patients in hospital are invited for an HIV test. In addition to this, all patients attending Gentito-Urinary Clinics will be offered a HIV test. Genito-Urinary Clinics are confidential, free and very accessible and this results in many people getting tested and finding out their status. In addition to this, point of care testing is offered in some places such as nightclubs and saunas where there is a large number or high risk groups. This ease of reliable, confidential testing means that many HIV infections are detected early in the course of the infection. Again, this is in contrast to Zambia where many patients present to hospital with opportunistic infections due to late presentation and late stage HIV infections. Many of the patients I saw had reactivation of TB due to HIV infections or PCP infections. Many of the patients in the UK with such opportunistic infections are migrants who have not been in the UK for very long. Other patients suffering from opportunistic infections will be patients who are not compliant with medications for social, mental health reasons etc. There is also a much higher incidence of Kaposi sarcoma in HIV patients in Zambia compared to the UK - where it is rare. HIV medicine is something that I am considering as a career and therefore it was exceptionally interesting to see patients who are suffering from the consequences of late diagnosis of the disease as this is not something that I was able to see much of during my time spent in HIV clinics in the UK.

It is often the case in the UK that clinical examination is perceived to be less important than complex imaging and laboratory tests. The vast majoirty of patients will receive such tests. However, in rural Zambiamany of these investigations are not readily available. St Luke's Mission Hospital was able to

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preform x rays but the nearest CT scanner was 100km away in Lusaka. There was also a laboratory at the hospital which was able to perform simple tests such as full blood count, blood chemistry and LFTs with questionable accuracy. There was no blood gas analyser. Because of these limited tests and investigations it highlighted the importance of a thorough, detailed clinical examination. One example of this was a patient who presented with an occipital head injury. In the UK this patient would have quickly received a head CT. However, in rural Zambia where this was not readily available it was necessary to perform a thorough neurological examination of this patient. It was helpful to remind myself the importance of clincal examinations as in the UK, especially in a large teaching hospital such as the Royal Lomdon, it is possible to become reliant on complex investigations. It reminded me that a lot of information can be gathered from simply examining the patient and taking a thorough history. This is something that I aim to take on board when I start working.

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