GENERAL MEDICINE

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Elective Report for Teule Hospital, Muheza, Tanzania

1. What are the most prevalent diseases in Tanzania? How do they compare with the UK's most prevalent diseases?

I had planned to focus on HIV and obstetrics and gynaecology during my elective. However, I spent my first day in the hospital on the female general medical ward named "IMANI", and was so interested and taken in what I observed, that I ended up spending my entire elective on the general medicine ward!!

I was warmly welcomed on Imani Ward by the doctor in charge- Dr Mbaga and all the nurses. Here, I was able to see a wide spectrum of diseases and a range of clinical signs. As resources were limited, a great deal of the medicine focused on the history and clinical signs of the patient.

Consequently, I was able to practise my examination skills on a number of occasions, and I now feel confident in the four main clinical examinations of cardio, respiratory, abdominal and UMN/LMN. I also feel confident in spotting clinical signs such as clubbing, corneal arcus, lymphadenopathy, caput medusa, ascites, jaundice and pansystolic heart mumurs.

The most prevalent diseases on Imani Ward were infectious diseases such as malaria, tuberculosis, ascariasis (a worm infection), schistosomiasis, and Human Immuno-Deficiency Virus (HIV). Other common admissions included diarrhoea, malignant hypertension, epileptic fits, Congestive Cardiac Failure (CCF), diabetic ketone acidosis (DKA) and generalised abdominal pain.

The latter conditions mentioned such as DKA, CCF and hypertension are also prevalent in the UK and the management for these conditions were similar. However, one striking difference was the limited use of fluids in DKA.

Whilst on Imani, I also saw a number of cases of gross ascites in young women, aged between 20-30 and TB infection was the main cause of this ascites. I was taught how to undertake an ascetic tap and was able to do the procedure on two occasions.

This experience was different to that of the UK, as here, I had only ever seen mild ascites in adult males aged between 50 and 60 years old. In the UK, the most common cause of ascites in the patients I had seen was normally alcohol related liver cirrhosis.

Exposure to tropical infectious diseases such as malaria and tuberculosis and their signs and symptoms was good clinical experience for me and a great learning tool. Indeed, in the UK, I had never seen a case of malaria, active tuberculosis, schistosomiasis or ascariasis, and so I feel that my experience and knowledge of these areas has now grown immensely.

Moreover, many of the patients on Imani Ward had advance HIV infection and had developed Acquired Immuno-deficiency syndrome. These patients had very low CD4 counts (some as low as 7), and had a wide spectrum of opportunistic infections such as pneumocystis pneumonia (PCP),

oesophageal candidiasis, kaposi's sarcoma and herpes. I also saw cases of Burkitt's lymphoma and cytomegalovirus.

Involvement in the care of HIV/AIDS patients also allowed me to see the side effects of anti-retrovirals used to treat HIV and how these impacted on the patients' lives. For instance, many patients had peripheral neuropathies, jaundice, fat distribution changes and dermatological rashes.

I also witnessed how HIV affected patients emotionally, socially, and psychologically. Indeed, the stigma attached to having HIV is still great in Tanzania, and many patients were ashamed of their positive status and told few relatives and friends, meaning that they were living with their condition in isolation. This was heartbreaking, especially when many who were close to death were unable to spend time with their relatives due to stigma.

I was also able to observe the palliative work involved in caring for patients with HIV/AIDS and I attended a number of palliative ward rounds and sessions at the Diana Centre- a specialist HIV centre at the hospital.

In summary, the range of medical cases on Imani ward was very educational and I feel that I was very lucky to be involved in caring for patients on this ward. The challenge of using clinical signs and limited investigations in making the diagnosis was good experience, as was the feeling of satisfaction when successfully treating patients. My time on Imani ward was very rewarding and I would like to take this opportunity to thank all the staff of Imani ward.

2. How is the ante-natal care delivered in Tanzania? How does this compare to ante-natal care in the UK?

During my time at Teule, I was also able to observe a few ante-natal clinics. Ante-natal care differed immensely from that in the United Kingdom.

One of the major issues is that many Tanzanian women view pregnancy as a natural, non-medical condition. Many Tanzanian women go through the 9 month gestation period without visiting a nurse, doctor or midwife, especially if they live in rural areas with limited access to healthcare. This attitude, teamed with limited resources and healthcare access, means that ante-natal care has a very different approach to that found in the UK.

For instance, as many women were unfamiliar with their last menstrual period date (LMP), it was difficult to work out the gestational age accurately. Limited use of routine ultrasound also made gestation difficult to assess. Thus, many of the doctors relied on their clinical judgement to ascertain an expected delivery date.

Routine ultra-scan was also not performed regularly, and there was no 20-week anomaly scan. Screening tests for genetic conditions were also not routinely offered. Moreover, as a lot of the pregnant women seen in clinic were HIV positive, there was a great deal of education to these mothers on the prevention of mother to child transmission (PMTCT).

Many women came to their first antenatal consultation at around a six months gestation period. Moreover, pregnant women often presented in clinic or as an emergency admission to hospital with complications to their pregnancy

such as malaria, diarrhoea and vomiting, anaemia, hyper-emesis, high blood pressure or urinary tract infections.