

Elective report

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Obstetrics and Gynaecology

Emergency medicine

1. Describe the pattern of the disease and conditions commonly seen within an acute hospital setting in Tanzania compared to the UK

I have been able to work in the obstetrics and gynaecology (O&G) department and also the emergency department (ED).

Whilst in the O&G department I was impressed by the medical staff's knowledge of obstetric emergencies, I soon grasped that pregnancy along with its complications are considerably more common in Tanzania than the UK. The wards in general were extremely busy with pregnant patients representing all ages including those at the extremes of their fertility (very young and old), presenting further challenges of their associated increased risks. Most of the women are multiparous, sometimes this was because they had unfortunately lost one or more children through illness. On the wards I encountered several pregnancies complicated by malaria, a condition common here and rarely seen in the UK. Although rates of HIV in Tanzania are high (6th highest worldwide), I did not see pregnant seropositive patients as they were attended to on separate wards to seronegative women.

Due to the high pregnancy rates I saw many patients with post partum haemorrhage (PPH), pre-eclampsia, eclampsia, failure to progress needing C-section and spontaneous premature rupture of the membrane. In the UK the main complications include eclampsia and PPH, pregnancy induced hypertension, existing or gestational diabetes, premature labour and twin pregnancies due to increased maternal age and use of IVF. Unfortunately maternal and fetal mortality in Tanzania is still high, far greater than that of the UK, adding to this in Tanzania premature babies younger than 34 weeks cannot be facilitated unlike in the UK. Whilst in gynaecology clinics I saw many women after ectopic pregnancies and women presenting with cervical cancer, the most common female malignancy in Tanzania, a striking comparison to the UK where breast cancer is more common.

In the ED patients commonly presented critical ill, often the terminal stages of a potentially preventable or curable condition. Such critical presentations inevitably further complicated the management. There is often no pre-existing diagnosis or helpful past medical history as patients do not have GP's as we do in the UK. Common presentations included trauma related (RTA or work related), convulsions, rapidly decreasing conscious states, respiratory failure and circulatory failure. Common diagnoses included trauma related injuries and haemorrhage, HIV related sepsis, severe malaria, severe metabolic acidosis from undiagnosed diabetes or renal disease and other causes of sepsis. In the UK there is a substantially higher proportion of patients with cardiovascular or cerebrovascular accidents, and fewer patients with critical infectious illness in the A&E.

2. How does the functioning of this department and the services available differ from that of the UK and how acute medicine is organised in the UK

In Tanzania compared to the UK there is a much stronger emphasis on learning within the ED and knowledge is very much built upon by experience. Every morning begins with a case based discussion, usually of a patient that has recently been admitted and seen by a registrar/resident (SHO/CT1). The interns (f1s) are then encouraged to illicit the history and come to a working diagnosis and differentials. The diagnosis, investigations needed and treatment are discussed and during this time the resident reflects on their own actions. Key improvements and life changing measures are reinforced by senior staff. It was clear that the ED is very much in the making and all

staff are learning huge amounts all the time. Things we have been taught in hospitals were still new concepts for many. Thus these sessions were essential for the interns and all staff development and were excellent ways of spreading awareness and decreasing mortality by discussing mistakes, agreeing on protocols and re-enforcing basic ABCDE primary survey principles.

The department is fairly well equipped with 8 treatment rooms for triage and 4 resuscitation rooms, each resus room with its own oxygen, ventilator, continuous monitoring and crash trolley with defibrillator. However the department usually has to treat around 3-4 patients per room, therefore all these facilities have to be rationed depending on clinical need at that time. Confidentiality is not important like it is in the UK. Investigations such as FBC, clotting, U&Es, LFTs, renal function, ABGs, ultrasound, ECG, and portable x-rays are available in the department, however diagnosis is usually made on clinical grounds as blood work often takes too long to process and receive, and facilities such as x-rays are not utilised to their full potential through hindrances of paperwork, staff availability and the current system in place. Stocks often run low which again hinder use of cheap diagnostic tests potentially available. Unlike the UK there is no prominent ambulance service in Tanzania or other 3rd world countries, patients have either made their own way in or are transferred from other hospitals, also not all medication needed for acute management will be available and will have to be purchased by family members and brought to the hospital.

Generally the ED is an encouraging work in progress and successfully stabilizes critically ill patients. Unfortunately as a consequence of lack of continuity of care this triumph may be short-lived as patients are transferred to wards that lack beds and basic facilities and cannot support the patient's management needs, sadly leading to the patient's untimely demise.

3. To underline some of the differences in treatment and alternative management patterns

There are several conditions that are treated differently in Africa. I found this was often because of the medications available. For example in the treatment of severe asthma oxygen and nebulised salbutamol was used and interns were also being taught to utilise steroids, however adrenaline is also readily used, being given IV at regular 5 minute intervals, something I have definitely not observed in the UK. Ipratropium bromide was more difficult to obtain and had to be brought by patient or relatives and magnesium sulphate was to be used only in children. There was no real use of peak flow monitors and the team was still very much in the process of securing a management plan that worked.

There are also differences in the methods used for delivering babies in smaller hospitals across Tanzania. Interestingly when the patient is in labour the midwife applies great force to the fundus and helps force the baby out, in some areas they also manually stretched the birth passage! Not even common to everyday practice in the UK

4. To better understand the cultural, social and family differences faced and how these influence the patients treatment and patient doctor relationship

Whilst in Tanzania I have been able to observe many social and cultural influences on patient's lives. The most obvious being the influence of the massive divide between the wealthy and the poor. Poor patients often cannot afford to be absent from work and feel pressured to continue working through illness. Many hope to get better naturally or if they can afford will seek diagnosis and medications from local pharmacists. If the patient feels completely unable to cope it is at this point that they may attend a hospital, usually severely ill.

There are wide cultural influences around medicine as many people trust herbal or natural remedies used by their forefathers rather than conventional medicine, preventing them from seeking medical attention.

Different tree barks are boiled and drunk as treatments for hypertension, malaria and various stomach conditions. As abortion is illegal in Tanzania many young women turn to natural methods including drinks made from tree bark and roots, the success rate of which I don't know. Contraception is not widely used, partly culturally, lack of awareness and as a result of high infant mortality leaving parents with the intention to have many children. The lack of barrier contraception use also contributes to the higher rates of cervical cancer.

Cultural influences also play a role in the conduct of wards, for example no men are allowed in the labour wards, and no family members are present at the birth.

Patient education varies considerably depending on family circumstance and wealth as it is not free after primary school. Education influences patients beliefs around their health and treatment, and in the past medical staff have not educated patients about their conditions. However this is changing and doctors are explaining the cause of illness and basis of treatment to patients, empowering the patient to prevent future events and have more control over their recovery and future health.

Having family in Tanzania is very important, especially if you fall ill or are injured. Family members are vital in treatment as they are often needed to buy and bring life saving medications. And family members attend regularly to help the patient. When people do not have family or have been abandoned the patient suffers and is seen to do worse medically.

More emphasis is needed to increase social awareness of disease and preventative medicine. Developing such an area will massively benefit the Tanzanian population. Without GPs social awareness of worrying symptoms and disease consequences is ample and could allow patients to seek medical attention sooner. Preventative measures against malaria continue to lower rates and use should be encouraged especially for young parents as rates in children are high. I hope with time there will also be an increase in uptake and availability of routine vaccines used in the UK.

Overall I have been impressed by the ED and the O&G departments that I have had the pleasure to work at in Muhimbili. The knowledge of the residents and more senior staff is encouraging and I feel with better organisation and reinforcement of protocols, monitoring and implementation of routine many more lives will be saved in years to come.

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