

Elective report

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We arrived on Sunday 6th April, and were given a warm welcome at Entebbe airport before being transferred to central Kampala. The area around the airport was strikingly lush and green, in stark contrast to the city centre which was one giant dusty traffic jam. We were met at our accommodation by a student nurse who gave us a brief tour of the hospital and surrounding area, before starting promptly the next morning at 8am.

There were a few other groups of visiting students and doctors already at the hospital, which was clearly used to playing host as they had a very well organised international student's office. The staff here organised several formal teaching sessions (ward, classroom and laboratory based), Lugandan (the local dialect) lessons, as well as various cultural activities. They also gave us plenty of choice with regards to choosing which specialties we wished to be placed in, allowing us to see a wide variety of things over the course of the five weeks.

I started in the medical emergencies department (A&E is split into both medical and surgical/trauma wards), and was immediately struck by how busy and cramped the ward was. There were three bays, each holding approximately 16 to 18 beds (with no separating curtains), in a space which would hold four or perhaps six beds in a UK hospital. The ward was swarming with relatives, as they undertake many of the basic nursing duties, as well as providing food and bedding for the patients. The first few days were particularly chaotic, as all junior doctors were on strike as a result of not being paid for several weeks.

There was a huge variety of presentations, encompassing the familiar (strokes, asthma etc.) and the unfamiliar (a wide range of tropical diseases). Despite a reduction in recent years, the prevalence of HIV in Uganda is still very high, resulting a heavy burden of AIDS related diseases. For example, cryptococcal meningitis accounts for approximately 65% of infective cases of meningitis seen at Mulago, followed by TB meningitis (approximately 30%), with the bacterial (and viral) meningitides more familiar to us in the UK making up the remainder. HAART is widely available and supposedly free, but many patients I encountered were receiving no treatment at all. There is also unfortunately a lot of stigma attached to a diagnosis of HIV/AIDS, meaning it was referred to on the wards as ISS (immune suppression syndrome).

All of the medical staff and students I met clearly had an excellent knowledge base, although they lacked the equipment and medication to make use of it in many cases. For example, there were no nebulisers available to treat patients admitted with an asthma attack, and also often no salbutamol inhalers either. Oxygen was very tightly rationed. One young patient I met with severe pneumonia

and O₂ saturations of 42% (according to a sats probe of questionable reliability) received no oxygen for around 45 minutes following admission, before sharing a tank with three other patients at a rate of 10L/min. He unfortunately died, and I was told by one of the doctors that just before we had started our elective, the entire hospital ran out of oxygen for three days. The hospital has around 1000 beds, and between them just one ECG machine (excluding theatres and ICU), meaning patients with chest pain went without an ECG the majority of the time. There was a high prevalence of both hypertension and diabetes amongst the local population, although according to one consultant, less than 5% of these patients receive adequate treatment. This meant that we encountered many patients with severe complications, often at a young age. Patients needing insulin therapy often had no access to a refrigerator to store their medication, meaning it degraded rapidly. One gentleman we met was storing his vial inside a bottle of gin, in a vain attempt to preserve it.

My second placement was in the ICU. Mulago has the only public ICU in Uganda, a country with a population of over 36 million, and during my stay only seven of its thirteen beds were open. There were four ventilators. It took in both adult and paediatric patients, although beds became free so infrequently that a large part of the registrar's day was spent politely refusing requests for transfer to the unit. It had some features which made it instantly recognisable as an ICU however, with large observation charts at the end of every bed, and monitors attached above. Pressure points were supported with inflated rubber gloves to prevent sores.

My final placement was theatres, and included both anaesthesia and surgery. There were seven theatres in the main block, plus an emergency trauma theatre next to the surgical emergencies ward. Scrubs had been donated from hospitals all over the world, were generally in very poor condition, and seemingly only in sizes XXS or XXL. Surgical gowns, caps and facemasks were also cotton and sterilised throughout the day next to the department.

In comparison to the rest of the hospital, the theatres appeared in pretty good condition. The anaesthetic machines were relatively modern, although the electrodes on the three-lead ECG were used for multiple patients, being taped down each time. The anaesthetists were clearly highly trained, although the quality of the anaesthetic agents appeared to be worryingly variable, with patients often requiring multiple doses at induction, and moving about far more than normal intraoperatively. The anaesthetists also complained that patients rarely received adequate postoperative analgesia once they were transferred to the wards.

The surgery itself was highly interesting. They surprisingly had one ageing laparoscope which I saw used once, but apart from that there was an open approach to everything. There was a huge variety of cases every day, with neurosurgery and orthopaedics accounting for a large proportion, mainly due to trauma sustained in road traffic accidents. One case involved the revision of an above knee amputation, as the wound had become infected and necrotic. On exploration, it turned out that a swab had been left deep within the wound, and had resulted in a highly suppurative fasciitis tracking all the way up to the lower back. The patient had been on the ward for a week in between the two operations, apparently with no pain relief, highlighting the point previously made to me by the anaesthetists.

Overall, my time at Mulago was a thoroughly enjoyable experience, and one that I would not hesitate to recommend to anyone planning an elective in the developing world. I hope to return one day.