INFECTIOUS DISEASES
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Describe the pattern of illness in Cusco, Peru. How does this differ regionally and compare to the UK.

Peru is home to a range of deep jungles and therefore sees diseases like dengue fever, yellow fever and leishmaniasis. Infectious diseases such as leishmaniasis and tuberculosis are major public health problems and we saw many cases of these in Hospital Regional, Cusco. Cutaneous leishmaniasis is endemic in Cusco and mucosal leishmaniasis is endemic in the tropical rainforests at lower altitudes. Tuberculosis is also highly endemic in Peru.

Tuberculosis is also a major public health problem in the UK with most cases concentrated in and around London. These cases however are usually as a consequence of visits to TB endemic countries. Leishmaniasis is not a disease found naturally in the UK.

Chagas disease is common in the south of the country and HIV/AIDS are prevalent in Peru and has increased much more in the recent times.

Malaria occurs year-round in rural areas below 1,500 meters elevation in eastern, northeastern, and northwestern Peru, especially along the border with Ecuador. There is no risk of malaria in the capital Lima, or the highland tourist areas of Cusco, Machu Picchu, and Lake Titacaca[1]. Malaria does not occur naturally in the UK and cases seen are usually as a result of travel to malaria endemic countries.

When shadowing the general medicine team the wards were made up of patients with pneumonia, cancer, and complications of diabetes and alcohol abuse, which is very similar to what you might see in hospitals in the UK. However there were no such specialties as oncology, respiratory, endocrinology and all patients were put on the same ward and seen by one general medicine team. The signs and symptoms these patients presented with were a lot more severe and advanced than you would see in the UK due to lack of access to healthcare, whether it be due to financial constraints or difficulty in getting there from remote areas.

How well was patient services organised and acted on? Describe what you witnessed and how may this relate to your own level of practice.

Patient services were organised so that patients would queue up in reception (sometimes the queues were so big people they would gooutside the hospital). They would then be referred to a specialty directly (thereby bypassing general practice). Patients would then be seen in outpatients and if their condition is serious then they may be admitted as an inpatient. There would be a teaching ward round every day where a team could spend almost an hour with one patient. In outpatients there would be a single room for a particular specialty and patients would be seen very quickly by the consultant. A consultant could be doing an outpatient endoscopy on a patient while taking a history from a different patient through the open door of the next room!

The wards themselves were basic with patients with problems corresponding to different specialties in the same room. There were no curtains surrounding the beds so that other patients could see and hear the consultations. We actually saw a patient place himself

strategically to steal a glanceat the patient next to him being examined (rather difficult for him since there was about 20 health professionals surrounding his neighbour - this typically made up the team on a ward round!). There were no facilities in the rooms for healthcare professionals to wash their hands and this was seldom done when examining patients.At my request for hand-washing facilities before examining a patient on ward round the team seemed rather baffled! This contrasts our level of practice where washing hands before and after seeing patients is scrupulous. Patient confidentiality and privacy are taken very seriously and is a basic right of anyone seen in the NHS.

Describe the care of a patient with an infectious disease not commonly seen in the UK.

Patients with cutaneous leishmaniasis (spread by the female sandfly) are usually treated as an outpatient while patients with mucosal leishmaniasis are nursed insanatoriums.At the time of visiting the sanatorium there was five men cramped in a very small room at various stages of mucosal disease from nasal sores to collapse of the nasal septum.

Standard treatment isa pentavalant antimonialsuch as sodium stibogluconate.Amphotercin B is typically used in those patients who do not respond to pentavalent antimony. We were told by the consultant to avoid placing people onAmphotercin B (second – line) due to severe and potentially lethal side-effects.

As there are no vaccines or drugs that prevent leishmaniasis preventing sandfly bites is the most immediate form of protection. This can be done by putting netting around the bed, screening windows, wearing insect repellent and wearing protective clothing in regions such as in the jungle where many of the patients appeared to live. However due to a non-existent public health sector educating people is a huge problem.

How has the medical elective affected me and how will I draw upon this experience to make a better health care professional.

The medical elective made me realisehow fortunate we are to have widespread access to healthcare unlike many of the Peruvian people, where healthcares services are concentrated in certain urban region. It was saddening to see many people presenting at end-stage disease due to lack of access to medical care.

It has also taught me the values of patient-centred teaching. Teaching we have received throughout our training, with themes such as consent, confidentiality and privacy.The placement taught me the value of making all services and consultations patient-centred. I will endeavour to put patients first in everycircumstance; this includes making confidentiality and privacy a priority. I will also endeavour to make patients feel comfortable and address all their questions and concerns even when time is a constraint.

References

1. Travel Medicine. Peru [online] 2012. Available at: http://www.travmed.com/guide/country.php?c=Peru [accessed 08/06/2012]