World Orthopaedic Concern

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This Newsletter is circulated through the internet, and through all WOC Regional Secretaries in the hope that they will be able to download and distribute it to those not connected through the "net." It is addressed to all those interested in orthopaedic surgery in Areas of the World with Limited Resources but with maximum need.

The scope and variety of WOC's projects are illustrated by some of this month's reports. Circumstances could hardly be more different than some of those which obtain in the several communities of sub-Saharan Africa. It is difficult to draw to comparisons between the centres of excellence and the grossly deprived, both of which can often be seen within the same country. In two lands, new to the pages of this newsletter, Dr Ton Schlosser reminds us that in all our disparate endeavours, the aims are to improve the lot of the world's deprived and poorly served.

Success is to be measured in the numbers of people patently lifted from abject stagnation into gainful employment, even at the level of village communities. That is why, side by side, we can laud the achievements of an orphanage, and of the Olympic podium. But numerically there is as much to celebrate in a thousand minor procedures than a single cure through high tech. surgery. We set ourselves to improve the lot of the many, rather than that of the unique.

With these principles in mind, we identify two particular cohorts of volunteer:-
1, the newly retired from formal orthopaedic practice, with abundant experience gleaned over many decades, including that which preceded major joint replacement,
2, the newly trained and certificated, awaiting a consultant appointment, whose experience has not yet included the ancient pathology of orthopaedic neglect.

These groups have priceless experience to both give and to receive.

NEW ACTIVITIES, WOC-NL (WOO-DFOO): reported by Dr Anton Schlösser, 2012

CONGO-BRAZZAVILLE. Former French Congo; a small country with a tiny Atlantic coastline, Size: 342.000 sq Km. Population, varying constantly; about 4 million. GDP per capita: US$ 2240 (Worldbank 2007-2011). Ranking: 150 (of 215) Climate: Rainforest; hot & wet.

French Congo has had only one Orthopaedic surgeon; - Dr **Emmanuel Koutaba**. He is based at the "Centre Hospitalier Universitaire" in Brazzaville and works under abysmal circumstances (no running water), as of 2010.

For more than 30 years a Dutch based foundation (**Stichting** Op Gelijke Voet-OGV), founded by the owner of a major Dutch manufacturer of children's shoes (with his wife, who is handicapped from polio), provides orthopedic appliances, splints, wheelchairs etc.to Congo-Brazzaville. They sponsor the training of two Congolese orthopaedic shoemakers in Togo. With the assistance of their local "Antenna, Fondation sur un Pied d'Égalité (SUPE)". They have built up an excellent relationship with the local "MInistre des Affaires Sociales, de l'Action Humanitaire et de la Solidarité". It is clear from films (still and movie) that the deformities are of the most primitive, utterly untreated, long-established type, mostly in children under the age of 10 and looked after by a convent community of teaching nuns. – which is appropriate on the basis that physical handicap is no bar to education.

In 2008, OGV developed a plan to provide minor surgery for children with "polio-sequelae and congenital deformities". In 2010 a mission of two Dutch orthopaedic surgeons, with extensive tropical experience, visited the two hospitals in Brazzaville (the University, and the Military hospitals) and concluded that the hygiene situation

was too poor for even minor orthopedic surgery. In 2011 a mission with delegates from the ministry and SUPE, visited Hopital Géneral in Dolisie (the third town in Congo - 300km from Brazzaville) and reported a better situation. In 2012 we (WOO-DFOO) were approached to fill in the medical part of the project, with organisation and funding from OGV.

“April 2012, I visited together with Dr **Hans Megens**, and a delegation of OGV, SUPE, the ministry and **Dr Koutaba** and **Dr Obenda,** his anesthetist. The premises at Dolisie were clean and air-conditioned, but almost deserted - an empty hospital with no doctors or surgical instruments, but much severe orthopaedic pathology, preselected by Dr Koutaba. The challenge is how to start what is appropriate and to maintain a relative excellence at Dolisie”. Our plan is to send the first surgical team to Dolisie (two orthopedic surgeons and a scrub nurse) who will perform the first 30 surgical procedures with Dr Koutaba in September 2012. Aftercare and follow-up will be covered by a young doctor **Fleur Kaya**, who completed part of her training in orthopaedic surgery, prior to the civil war in Cote D’Ivoire, when she had to leave that country.

“We plan a contract with hospital and ministry for the next five years, providing 3 to 5 missions a year. Our group is now organizing the necessary surgical supplies and gathering a small group of doctors and paramedics to fill in the planned missions in close collaboration with our Belgian friends. The plan is to complete Dr Kaya’s training and enlist others to join her. In taking on this responsibility we understand the importance of our commitment.”

BURKINA FASO

Size: 274.000 km^2 Inhabitants: +/- 16.000.000 GDP per capita: US$ 550 (Worldbank 2007-2011) Ranking: 192 (of 215) Climate: hot & dry (Sahel)

MORIJA is an international co-operation organization, based in Switzerland and France, working in Burkina Faso, Togo, Chad and Cameroon with projects directing towards nuitrition, education, rural development, water, sanitation & hygiene and health. In 1993 they founded in Burkina Faso the **Centre for Handicapped people of Kaya (CHK)** offering physiotherapy and orthopaedic appliances.

“Prior to 2010, there was no structured orthopaedic service in Burkina Faso. People suffering from a physical deformity or disability, and who needed surgery had to choose between general surgery or going abroad, usually either to Benin or Ghana, which were prohibitively expensive. mean

“In January 2010 CHK extended the unit set aside for surgery, with a building for radiology, eight air-conditioned operating rooms and a 30 bed recovery ward. Since its inauguration one of the key-players in this orthopaedic project has been **Dr Dominique Hügli**, based in a clinic in Geneva. He has visited Kaya six times with his team and has carried out 170 operations. He writes- “On site we work in collaboration with a Burkinase surgeon, nurses, anesthetists and operating room assistants, as well as physiotherapists and others, coordinating the training.

“We heard about this work, and the fact that the Centre has underused capacity, between the visits of the Swiss missions, through local contacts, active in other (non-orthopaedic) projects. Clearly here is an opportunity for other surgeons to fill the gap, to help to satisfy the need for often simple surgery, and to maintain the training and instruction. We (WOC-NL) contacted our Swiss colleges, offered our help and this was accepted with enthusiasm .

"In June this year, (2012) I will accompany Dominique Hügli on his next mission to Kaya. Thereafter, Dutch and Swiss teams will alternate carrying out one mission every two months, using the modern communication media to exchange patient-records, X-rays etc., with the generous support of the Swiss philanthropic body, MORIJA, who take that corner of West Africa as their interest." ajj.schlosser@skynet.be (*We shall follow-up of these projects, keenly. From such small seeds, great trees grow*)

WOC (uk)

The **Annual Policy Week-end** meeting, was held on May 19th and 20th, near Birmingham. **Steve Mannion** took the chair; 19 persons attended. Regional reports were delivered covering WOCuk's projects in Cambodia, Ghana, Ethiopia, Burma, Malawi and the West Africa States of Burkino Faso and Congo-Brazzaville – the latter a guest presentation from WOC branches of Belgium, Holland and Switzerland. Support and encouragement was expressed for all these projects.

Discussion touched on the funding of these works. The hon. Treasurer, **Mr K Rajaratnam**, presented his report on the current income and expenditure. An encouraging feature of the meeting was the attendance of several UK surgeons "in training", who expressed interest in the prospect of taking part in the Orthopaedics of areas of the world with low income. Mr **Ashtin Doorgankat** described his two years in Malawi, organised by Health Volunteers Overseas (HVO). He described the help that organisation gave and his own experience of hospital administration and conservative management of factures.

Mr Steve Mannion presented two subjects in which he is involved;- the International organisation in the face of major disaster emergencies, - **International Emergency Trauma Register** set up as an initiative by DFID (UK Department for Internat. Development), with emphasis on logistics and continuity of care. This subject has received much attention, not least because of the coverage by the world's press, of

earthquakes, terrorist attacks, floods and wars in recent years. Harsh lessons have been learned from Haiti and from Pakistan about the magnitude of the damage, extent of injuries, the unpreparedness of our profession, and the need for military involvement.

Members were well aware of the sensitive nature of cross national intervention and the fear of imperialism; but it is the hardware, the lifting gear, the helicopters, that can make the difference, when access is obstructed by destroyed roads, or political opposition. The participation of WOC cannot be more than supportive to individuals. It was hoped that the world's health services, in general and in particular, would be able to release trauma surgeons from clinical commitments in order to contribute to these humanitarian emergencies, as soon as dust settles. Such arrangements will be made by individual members, through major organisations involved in global catastrophe.

Mr. Geoffrey Walker, referred to the lengthy report of **Professor Alain Patel's** work in Myanmar, over the past 40 years (which followed WOC's early work in Burma, set up by Edgar Somerville from Oxford). The report was summarised in the last WOC Newsletter. Alain was congratulated on his comprehensive accomplishment, in surgical training and the provision and maintenance of equipment, through his organisation, **AMFA.** This is even more extensive than the work of **Dalton Boot** in nearby Cambodia. The common denominator of those projects has been the financial backing and support of the **French Government**.

UGANDA

Dr **James Leiffer** writes, in HVOUSA's pamphlet, "Volunteer Connection. (*This editor has taken the liberty of precis, to emphasize the nature of the work. Any who would follow, should read the whole report in HVO's journal*. <n.kelly@hvousa.org>)

"I first was in Uganda four years ago, when there were only three residents in each training year at the Hospital. Now there are twice that number. Residents are

considered students, so they have actually to pay to become orthopedically trained for the four years of the program! The increase in manpower means that there was rarely a shortage of hands in the operating room. Most of my ability to assist surgery was in the emergency room theatres, where the residents were basically operating on their own, performing emergency procedures and some elective cases, such as femoral rodding.

“The Uganda Ministry of Health is “cash strapped”. The ER plaster/fracture care room, may go for days or weeks without plaster of Paris. When there's no plaster, all they can do is write a prescription for the patient to go “off-campus” to a pharmacy and buy some. And for those who do procure plaster there is no saw to remove it. (*Knowing this, I had brought one from the US*). The plaster may cost $5 US, but many don't have that money; so they can’t have casts.

“In Uganda, my teaching was limited to anecdotal one-on-one and bedside sessions. There is very little point in teaching orthopaedic personnel new techniques that are dependent on hardware they don’t have, and cannot procure. Basically the visiting volunteer helps them do what they already do. Mostly, their implants are donated. For instance, intramedullary femoral rodding depends upon the excellent SIGN system, ideal for developing countries, and by no means substandard. But it depends upon philanthropy for replacements. They use stainless steel screws which do not match titanium rods for locking. All the drill bits are dull from overuse, and the Ministry of Health says it cannot replace them! (*A good item for a volunteer to bring, is a pocketful of sharp drill bits*). The image intensifier is rarely used. Blind nailing is a risky business. I assisted on a number of cases of malunion and nonunion, of which they have an abundance because of late presentation and bad “bone setters.” Lack of anaesthesia is another problem.

“I enjoyed working in the outpatient clinic on Fridays, as that is an opportunity to interact one-on-one with Ugandans and understand their orthopaedic problems. Most,

mercifully, speak English. RTAs constitute the bulk of the work at Mulago Hospital, with the minority - bone infection and tumour. One child was hospitalized on the wards with an osteosarcoma of the distal femur about the size of a basketball that had been treated by the traditional village doctors, without success !"

Dr Leffer's wife, a nurse educator, took an active part in their Nursing School; and it is clear from James' colourful description of the country, that they were given wonderful hospitality. They saw more than they ever hoped to see in game parks and dramatic scenery of mountains, rivers and lakes. His final paragraph reads:-

"This is a developing country, obviously, and being there as a volunteer is quite an adjustment, and also a privilege to be part of their daily life. To witness how a country deals with too few resources, too little infrastructure, and too little prosperity is a stressful but rewarding (and in a way necessary) education for anyone from the developed world. This country has huge challenges; 50 % of the population is under the age of 14. I am worried for them, and I wonder."
<jlbones@comcast.net>

As we approach the international meeting this year (**S.I.C.O.T in November in Dubai**) and the national meeting of the **B.O.A. in September in Manchester,** the sessions given over to WOC in the course of each meeting, will concentrate on the affordable and effective, rather than the remarkably rare.

Please remember too, the Annual General Meeting of WOC(International) at the **Dubai Meeting of SICOT**, to which all who are interested in the activities of WOC, are cordially invited. The exact date (at the end of November) and venue, are yet to be announced – but will be in future Newsletters. This will be your opportunity to comment, criticise and appreciate.

M. Laurence.