

A Day in Uganda

Dr Sarah Hodges
Kampala
Uganda

My husband and I worked in Uganda from 1992 to 1998 in a church of Uganda hospital, near the border with the Democratic Republic of Congo. For the first two years we practiced all types of medicine including paediatrics and obstetrics, but in the final 4 years we were able to concentrate on surgery and anaesthesia. We also taught at Mbarara medical school, and some of our students joined us as interns and medical officers. During this time we came to realise the huge unmet need of patients requiring reconstructive surgery, in particular cleft lip and palate [1].

We returned to the UK in 1998 for 6 years and we both joined SpR training programmes. Andrew, my husband, undertook training in Plastic Surgery; I furthered my studies in anaesthesia. During this time we set up a charity called Interface Uganda [2], with the aim of returning to Uganda and developing a reconstructive surgery service.

We moved to Uganda in January 2005 to set up a plastic surgical service, and hopefully a training programme. In spite of my previous experience, it has taken me longer than I had anticipated getting back into the pattern of medical care in sub-Saharan Africa where there are numerous obstacles to looking after patients, many of which take you totally by surprise.

One day recently, I walked into the main theatres in the Central Teaching Hospital to find a list where I could help out, when I met an orthopaedic surgeon desperately looking for an anaesthetist. Lying, almost moribund, on the emergency ward was a 22 year old boda-boda driver who needed an above knee amputation. Boda-bodas are bicycles or mopeds used as taxis, with the passenger sitting on a makeshift cushion at the back. As these moped drivers weave their way precariously in and out of the busy Kampala traffic, they often find their legs rammed between car bumpers and they constitute a large part of the orthopaedic emergency workload.

This young man had sustained a compound fracture of his tibia and had gone to a local clinic where a bone healer had attempted to repair it. 5 days down the line he turned up at Mulago hospital with a gangrenous leg. Over the weekend the orthopaedic registrar couldn't get into the emergency theatre for a variety of reasons, and by Monday morning the man was severely septic, with crepitus above his knee. He had a



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reasonable blood pressure with a tachycardia but was becoming increasingly confused and was extremely pale.

Main theatres and the emergency theatre refused to let us operate as he had gangrene. The side room in the emergency ward was being fumigated due to a case of tetanus over the weekend, so that was also out of bounds. We eventually found a small, empty treatment room on another floor with no oxygen or anaesthetic machine. I managed to persuade main theatres to lend me some drugs, an Ambu bag, intubating equipment, a pulse oximeter, some needles and syringes, and I even succeeded in organising an ITU bed. While I spent the morning sorting all that out, the orthopaedic surgeon drove out to the blood bank to fetch blood, as there was none in the entire hospital.

We eventually made a start. Needless to say as soon as the surgeon cut through the thigh the young man lost his output, so for the rest of the procedure I gave boluses of epinephrine (the only inotrope available) using my finger on the pulse to monitor the dose. In the meantime, I pressurised the stressed orthopaedic registrar to amputate the leg as quickly as possible! He had to do the entire operation on an ordinary bed with about 3 instruments that the emergency theatres had allowed him to remove from the department, and with no trained assistance. We were surrounded by a handful of curious student nurses whose willingness to help outweighed

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their awareness of the gravity of the situation. I sighed with relief at the end that he was still alive and I could hand him over to ITU.

We pushed the unwieldy bed to the lifts where we had to compete with other patients and relatives for space. I was still titrating the 1:10 000 epinephrine using a palpable pulse as my monitor. At the doors of ITU, we were met by the sister in charge who refused us entry as he had gangrene, so we returned to the ward which also refused to take him, so he had to stay in the corridor next to the ward for his postoperative care.

After a few hours of running around contacting the blood bank, finding catheter bags, IV fluids and leaving a trail of language that I am not proud of, I left him with the blood running, epinephrine in his IV fluids, and strict instructions about monitoring urine output and blood pressure. I did not expect for a second I would find him alive the following day.

The next morning I found him alive and coherent, still in the corridor but with impeccable observations in his notes, and all instructions followed to the letter. I was very impressed with that night nurse and it just showed me that, with the right encouragement and instruction, some of the staff are keen to improve things. The orthopaedic registrar had also shown immense dedication to the task. Fortunately the young man survived and eventually returned home but he will never be a boda boda driver again.

I wrote this a few weeks ago and it probably is a mistake to write when frustration is still fresh in your mind. But since that incident I have had the privilege of attending the AAGBI Annual Congress in Manchester, where I met so many new people, acquired some helpful ideas appropriate for my situation, but above all encountered so much support and encouragement that I have returned refreshed and full of energy to persevere - so watch this space! I was amazed at the interest in the work in Uganda, and I would like to thank Mike Harmer for his very gracious comments in his speech at the Association dinner.

Current problems

On Fridays we try to do a hand list as there are countless hand injuries which are often neglected and I would prefer to do them under brachial plexus block, as we have no recovery facilities. My success rate (blind technique) is barely above 50%, so I would like to obtain a nerve stimulator and needles. This would also enable me to teach regional blocks on a

regular basis to the anaesthetic officers, and then maybe the hospital would start buying bupivacaine, and realise the cost saving compared to a general anaesthetic.

In Mengo hospital we operate mainly on children, and we are starting to do cleft lips and palates as joint procedures in babies as small as 3 months. I am really keen to get hold of a Newton valve for the Penlon 200 I brought from the UK – any offers?!

Editor's note. The AAGBI International Relations Committee supports Sarah through the charitable Overseas Anaesthesia Fund. Contact claireelliott@aagbi.org

Reference

1. Hodges SC, Hodges AM. A protocol for safe anaesthesia for cleft patients in developing countries. *Anaesthesia* 2000;55:436-41
2. Hodges AM, Hodges SC. Interface Uganda – developing a reconstructive surgical service. *Anaesthesia News* 2004; June:19-20

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