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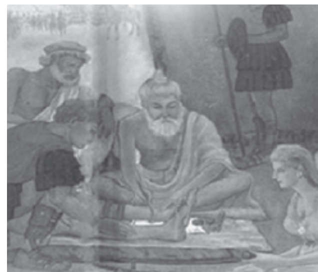

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Price Rs. 3/-

Glimpse of ASRICON 2006

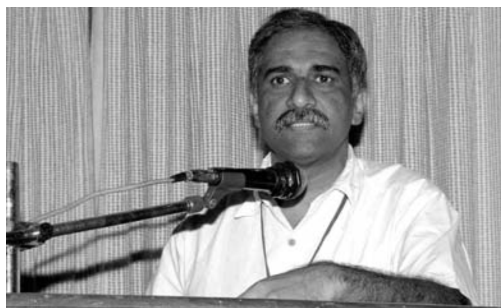
Cross section of the attentive audience during workshop

Inauguration function - Dr. Shyamprasad, (vice president, NBE, New Delhi), Dr. J K. Banerjee (President, ARSI), Dr. V.D. Rawal (President, ASRI) along with other dignitaries on the Dias

Presidential address by Dr. J.K. Banerjee

Dr. K.M. Shyamprasad during his guest lecture on "Training of surgeons for rural India"

Scientific session on progress with apt attention from the audience



Dr. Verghese Philip during his deliberation on "Rural Health Scenario"

Dr. R.D. Prabhu (president, IFRS) and Dr. S.K. Baasu (Editor) chairing the Symposium "Updating concept of Rural Surgery"

Dr. Gabriela Holoch from Germany speaking on "Non operative trauma cares a forgotten option"

President's address

Dear Friends,

It is my proud privilege to be able to stand here as the president of ARSI and address you all. I am now standing on the shoulder of a giant. The wonderful giant made by your efforts and that of my predecessors, namely Dr. Balu Shankaran, Dr. N.H. Antia, Dr. Ravi Tongaonkar, Dr. Sitanath De, and Dr. R.D. Prabhu.

I admit that starting as a founder member and wading through thirteen years of active work in the organization I have learnt many things, which surpasses my combined learning and training of India and the UK in the profession of surgery. I have learnt the importance of value education in our profession to make it an effective tool of service to humanity. I have learnt from you dear rural surgeons, the meaning of the word "self respect". Holding conferences in small towns and interacting with our colleagues, seeing them serving the poor and the downtrodden within limited resources and against many odds, innovating appropriate procedures against the dictates of the greedy industry-You have established new standards of human care. Your respectability lies in serving humanity as your God as against the mammon of self-aggrandizement and a slave of the healthcare industry.

Four hundred million of the total 1.2billion of India's population and five billion of the six billion world population today have no access to modern western type surgical care. You are bending down to cover this shameful gap in the 21st century. Many of you could have become corporate hospital high-tech surgeons or big professors in our universities or NRIs minting money and donating snobbishly in some charitable institutions. But instead you choose to become rural surgeons. This shows your strength of mind and character where you use technology as a slave for human service and not become a slave to technology itself. You have cut across the *ahankar* 'I' inside you and converted it into the holy cross of Christianity. Not 'I' but thou my patient. Prabhuji's logo of the rural surgeon depicts this sentiment beautifully.

And let me tell you, your spirit of service is a great intoxicant. You see our foreign friends forming similar associations in their own countries with the same feelings spending their moneys, traveling, coming to our conferences to network with us and supporting such moves in other developing countries. The only Indian Rotary international President, Nitish Laharry gave the slogan "kindle the light within" during his president ship. You are doing the same through your action, with your lives. The IFRS has been born with its first conference last year.

In the third national conference, we have even been blessed by the WHO. Two regional directors, Dr. Uton Rafei and Dr. Gezairy, himself a surgeon, graced the conference. Dr. Gezairy, as our keynote addressee, mentioned that the rural surgeons experience must be documented and networked with to improve the quality of care in rural areas and developing communities. And this we did and according to his advice, designed and started the CRS course from IGNOU.

All spiritual leaders across the world have preached the practice of *Nishkam Karma* to enable man to realize his divine self. You are doing this *Nishkam Karma* in practice. And I bow down to you my dear friends as your president and humbly take this lesson from you.

Swami Vivekananda said "Civilisation is the manifestation of divinity in man". The world put him on a pedestal as it accepted what he said as truth. If that be so, it becomes our duty, as civilized

human beings, to serve our brethren with whatever tools we have acquired through our education be it surgery, medicine or whatever. And what Vivekananda said was nothing new. Human society is ten thousand years old and ever changing. In this changing society, certain eternal values of human behavior have stood the test of time. And practice of these values in real life forms the basis of civilization. Practice of these values is the path of man's evolution towards his ultimate goal of life that is the realization of the divinity within, God realisation. The rural surgeons of my country and the concept of rural surgery have led me on this path holding me by the hand.

And now as I stand before you as your president, on the shoulder of the giant, I visualize further the path of salvation. I can see that salvation for ARSI and the true rural surgeon will not be there until every man in our country has access to basic limb saving and life saving surgical care. It is not that I am great and need all the attention and limelight because I am a rural surgeon; it is the spirit of service that has awakened in me the sense of responsibility of carrying the benefit of basic healthcare to the last person not only of my country, but of the entire world. Against all odds, be it political or economic or technological. How do we achieve this. Is it at all possible. A million dollar question.

I would not like to ask these questions. We did not ask any questions when we formed this association. We did not ask any questions when went to the IGNOU to start the CRS course or the NBE for the DNB course. We did not ask this question when we formed the IFRS. Then why should we ask this question now. I would rather pledge my life and the life of the present day rural surgeons towards achieving this target. Whether we achieve this, is for the future to say. We should rather plan out a strategy to go ahead with this aim in mind and let the future take care of the results.

In the Katha Upanishad, Nachiketa, a young boy of 8 sees his father donating barren cows in a yagya to the Brahmins. This corruption led him embrace renunciation. He performs penances to reach Yama the Lord of Death. Being pleased with his penances, Yama offers him three boons. The first two boons he asked and Yama gave. In the third boon, he asks Yama for the knowledge of Brahman (God). Yama tries to dissuade him showing him all the other pleasures of life he can ask for. But Nachiketa sticks to his asking and does not budge. Yama becomes pleased and finally gives him the knowledge. In the process, he recites a shloka…

Uttiṣṭhata jāgrata prāpya varān nibodhata;
Kṣurasya dhārā niśitā duratyayā
durgaṁ pathastat kavayo vadanti - (XIII.14)

The meaning is "arise, awake and stop not till the goal is reached. Although the path of realizing this goal is like walking a long distance on a razor's edge in the middle of the night. That is what those sages say".

The poor state of the present day healthcare system in our country created by our intellectual leaders, wading through ten five year plans, the misdistribution of services, the corruption in the systems and the selfishness of approach of those who are in power, have led us rural surgeons into becoming Nachiketas of the present day. While 80% of our hospital beds are in large cities, 80% of our populations live in rural areas and in peri-urban slums. Increasing privatization, "structural adjustments", cultural slavery and multinational dominated policies leading to increasing marginalisation of the poor, has polluted the healthcare scene.

Our Association will continue to work against all these evils in silence. The National Rural Health Mission has come as a beam in our eyes. The DNB in rural surgery is the first step. Our grateful thanks to Prof. Shyamprasad in this regard. We have to support this with all our might. And take it further down the line in creating more rural surgeons for the nation - those who can create and manage small rural hospitals on their own or work devotedly in an already rural setup with devotion. The making of the rural surgeon of tomorrow is now within our reach. Let us now do it with love and care. And towards this end let us frame a set of guidelines for our association members to follow. We have to assure that we are the right examples for them to follow. I venture to say therefore, that the aim of our association in future should be to choose members not only with the right qualifications but also with the right attitudes as well. Let me assure you that a large number of members will not add any extra glory to our association. It is their activity and interaction with the society, which will add glory. It is their contribution to the well being of the impoverished population of our country which will add glory to our association.

For all this we will have to struggle; both externally and internally. Externally, issues like the blood bank (UDBT), nursing care, anaesthesia and nursing home registering legislations etc…and most important of all, training up the future rural surgeon from the younger generation of our colleagues. And internally, getting over our pride, our "*ahankar*". This is what creates friction and breakdown of any organized movement in society. Many good reforming movements have broken down in the past across the world because of individual ego. Let that not happen to us. Let us be focused on achieving the objective of making basic and essential healthcare facilities available to every individual of our country. Let us stimulate that sense of judgment within each one of us, which will erase our individual egos and make us work united in achieving the objective already mentioned. And thus, reach the salvation of our association.

I again repeat, *Uttiṣṭhata, Jāgrata, Prāpyavarān Nibodhata,* arise awake and stop not till the goal is reached.

Dr. J.K. Banerjee,
President, ARSI

This address was delivered on the occasion of ARSICON2006, organized jointly by ASRI (9th midterm conference), and ARSI (14th National conference) in association with North Gujarat Surgeon's Association

The ego itself is the veil of Maya, both hiding and, ultimately, revealing Divine Reality.

Biliary Enteric Anastomosis in a Rural Setup

Dr. D.P.S. Toor, Dr. Medha Vaze, Dr. J.K. Banerjee

Introduction

Gall bladder disease is one of the commonest problems encountered by a surgeon in Northern India. A rural surgeon in his/her day to day practice may witness a spectrum of presentations of cholelithiasis. It is therefore natural that he/she is likely to face a situation necessitating advanced procedures like biliary enteric anastomosis.

An endoscopic procedure of common bile duct surgery might have become routine in tertiary care centers but it continues to be a significant event in resource constrained rural hospital. Endoscopic procedures for CBD pathologies are out of question in a rural setup, primarily due to non availability of facilities and unaffordable cost for the poor patients of rural and periurban areas.

However major surgery like biliary enteric anastomosis can be properly performed in a rural setup and the patients can also be managed well post operatively, provided they have been carefully selected for elective procedures.

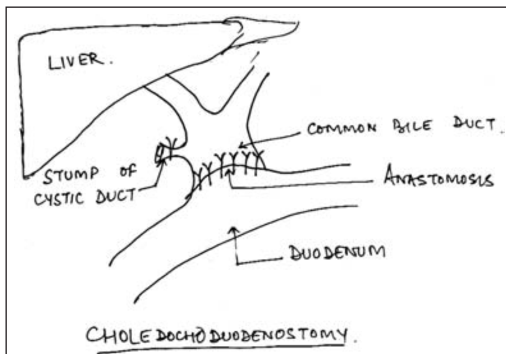
At Rural Medicare Centre we have done biliary enteric anastomosis for many patients. Most of these were choledochoduodenostomies for bile duct calculi though we have done hepatico enteric anastomosis also.

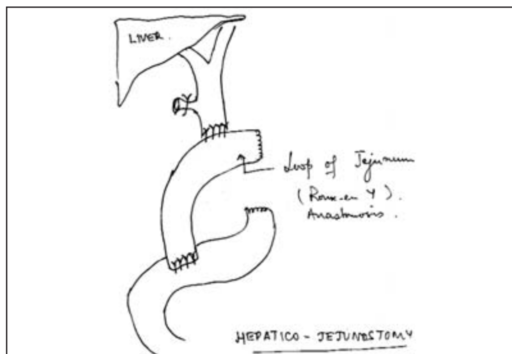
Procedure

Choledochoduodenostomy was done in selected cases of CBD calculi. Hepaticojejunostomy was done in one patient who had undergone cholecystectomy earlier and presented with CBD obstruction due a nodular growth and a stone proximal to it. The segment of CBD bearing the growth was resected and a Roux en Y Hepaticojejunostomy was performed. The patient recovered well and is doing fine 2 years after the surgery.

Second case was a patient with severely contracted gall bladder and a large stone (2 inches in diameter) lying partially in the tiny gall bladder and mostly in the CBD, probably as a result of cholecystocholedochal fistula. The gall bladder was opened and after removal of the stone there was a 1.5x 1 cm gap in the side of the common hepatic duct. It could not be closed by suture without stricture formation; hence a Roux en Y loop of jejunum was anatomized to the opening. This patient had a problematic recovery from anesthesia, necessitating shifting to another centre with ICU facility where she recovered within 24 hours. She was brought back to our hospital after 48 hours and her recovery after that was uneventful.

An 8 year old girl presented to us with recurrent jaundice and cholangitis due a fusiform





choledochal cyst. The cyst was anatomized to a Roux en Y loop of jejunum making a wide anastomosis (the ideal treatment would have been excision of cyst). The patient is doing well till date 2 years after surgery.

In a case of difficult cholecystectomy there was an injury to CBD which was recognized on the operation table and a Roux en Y Hepaticojejunostomy was done.

In other 2 cases the duodenum was anastomized to lower common hepatic duct where the anastomosis could be done without tension and without kinking of the duodenum.

Procedures	No. of cases
Cholecystectomy	500
Choledochoduodenostomy	13
Hepaticojejunostomy	3
Hepaticoduodenostomy	2
Choledochocystojejunostomy	1

Table showing the procedures performed and the No. of cases

Discussion

For biliary enteric anastomosis when lower CBD is available Choledochoduodenostomy is a safe and less time consuming procedure.

When anastomosis is required at a higher level, as with common hepatic duct or at porta hepatis, Hepaticojejunostomy, using a Roux en Y loop of jejunum is the standard procedure. Advantage of this procedure is the fewer incidences of cholangitis and regurgitation of enteric contents into the biliary passage. The disadvantage is increase in operative time due to more number of anastomosis which is to be done.

Robert J. Merace et al of Virginia Medical Centre (Archives of Surgery) have studied the effects of Hepaticoduodenostomy and Hepaticojejunostomy after reconstruction for bile duct injuries. They found that the biliary function remain normal even more than 4 years after surgery in both the groups. Hence they prefer Hepaticoduodenostomy to Hepaticojejunostomy whenever the case is surgically feasible.

Hepaticoduodenostomy wherever possible may be an easier option but it needs to be studied for a larger follow up for long term problems and complications.

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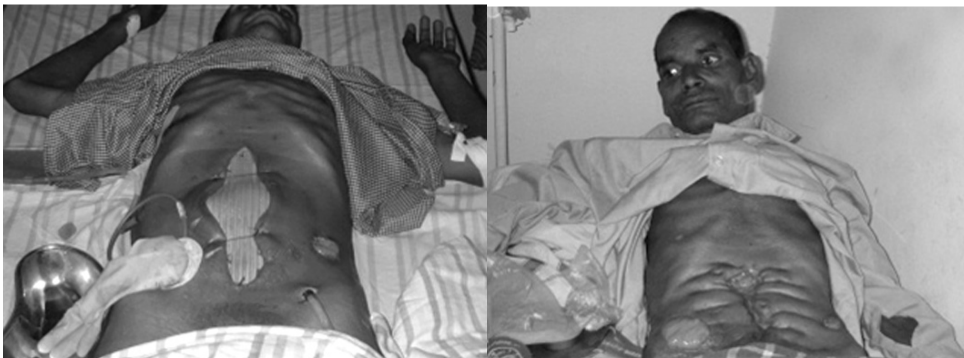
Laparostomy: A technique for the Management of Severe Intra Abdominal Sepsis

Dr. Uttam Mahapatra

Key words
Abdominal compartmental syndrome, temporary abdominal coverage, Laparostomy

Introduction
The fundamental principles of management of severe peritonitis include general supportive management, antibiotic therapy, and prompt surgical intervention. Surgical intervention includes source control, peritoneal toileting, and prevention of recurrent infection. The definitive closure of the abdominal wall, i.e., a closure of the fascial layer and skin may not be favorable in the treatment of numerous surgical conditions, e. g., peritonitis, trauma, or mesenteric ischemia. In these cases, the abdominal wall is temporarily closed. And a Laparostomy is created to facilitate re-exploration or to prevent abdominal compartment syndrome. Abdominal compartment syndrome is a lethal complication of severe intra-abdominal sepsis. It is defined as the sudden increase in the intra-abdominal pressure to more than 25cm of water resulting in alteration in the respiratory mechanism, haemodynamic parameters, and renal as well as cerebral perfusion. Severe intra-abdominal sepsis requires Laparostomy and at least ventilatory and cardiovascular support. Regarding the technique and material used for the temporary closure, no prospective studies are available to show which is the best method or material.

Case Report
A 50 yrs old male presented to the hospital on 30/10/2204, with complains of abdominal pain and constipation for two days. Clinical examination revealed acute intestinal obstruction. Blood examination showed Hb 11.1gm%, TLC 8800/cmm, Creatinine 1.7mg/dl. Exploratory laparotomy on 31/10/2004, showed gangrenous sigmoid volvulas. Hartmann operation was done. Resection of the gangrenous sigmoid colon and closure of the rectum was carried out. The descending colon was brought out as an end colostomy. On 9th post op days, he had abdomen dehiscence and drainage of pus from peritoneal cavity. Re-exploration of the abdomen done under Ketamine revealed torsion of the small intestine, which was de-rotated and decompressed. Peritoneal Lavage done and two tube drains placed in the pelvis and right paracolic gutter. The abdomen was left open with an abdomen sponge sutured loosely to the skin margins, to prevent evisceration of the intestines. Next day, he was in septic shock, needing ionotropic support, to haemodynamically stabilize and maintain renal perfusion. On 11th post op. day his general condition slightly improved. He was taken to OT



under Ketamine, the sponge was removed, peritoneal Lavage done and corrugated rubber drain sheet was stitched to the skin margin with silk. He continued to drain pus from the peritoneal cavity and on the 15th post op. day he drained 950 ml of feculent fluid through the R tube drain. On 16th post op day, under Ketamine the corrugated rubber drain sheet was removed, there were multiple ischemic areas with perforations in the ascending colon and in the hepatic flexure. Loop ileostomy was placed in right iliac fossa, peritoneal Lavage done and abdomen closed with a smaller corrugated rubber drain sheet stitched to the skin margin. The end colostomy was left as mucus fistula. On 17th POD, his vitals stabilized, ionotropic drip was stopped and ileostomy functioned well. On 19th POD, the rubber drain sheet was removed and abdomen closed in single layer with thick nylon. The sutures were removed after 18 days. There was wound dehiscence and blood, during the course of stay in the hospital. He was discharged after 44 days of hospitalization. Saline dressing continued at home, and the wound gradually healed with a mucus fistula in the upper end of the healed scar.

Laparostomy is a valuable technique in the management of severe, intractable intra-abdominal sepsis. Laparostomy allows regular inspection of the bowel and drainage of intra-abdominal collections. For the prevention and therapy of manifested abdominal compartment syndrome (ACS), temporary closure of abdomen is gaining popularity. The diagnosis of ACS is confirmed by measuring the intra abdominal pressure (IAP). This can be done through a 3-way Foley's catheter in the bladder attached to a water column manometer. A good rule of the thumb is that if, when looking at the abdomen horizontally, the guts are seen above the level of the wound, the abdomen should be left open and temporary closure done. Looking in to the reduction in the mortality rate from 80-90% to 30-40 %, different methods and materials are used for temporary closure of abdomen. The materials advocated are mesh, plastic bag, plastic or silicone sheets, zipper, vacuum pack, and Velcro analog.

In my case I have used two materials - abdomen sponge and a corrugated rubber drain sheet. These materials were easily available, and cheap, as compared to the mesh, which is costly. There was absolutely no adhesion below the rubber drain and it allowed the collected materials drain through its corrugations.

Conclusion

Laparostomy is an effective and practical method of managing patients with severe intra-abdominal infection.

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A year or ten years or ten thousand years, what does it matter how long enlightenment takes? It is the only game worth playing.

Asymptomatic Pyocele of TVT

Dr. Sadananda Mishra

Abstract

Out of 220 cases of hydroceles operated in CHC, Banpur, 21 came out to be asymptomatic pyoceles. The cases were diagnosed pre-operatively with the clinical findings of globular, hard, smooth, non-tender, non-fluctuant, non-translucent mass with intact testicular sensation. All cases were treated with total pyocelectomy including orchiectomy. Any other method of treatment was at risk of leaving a scrotal sinus. Sacs of pyoceles were thick and contained yellowish or yellowish brown thick fluid.

Key words:

Hydrocele, Pyocele, Asymptomatic, Scrotal sinus, Pyocelectomy Orchiectomy,
TVT (Tunica vaginalis testis)

Introduction

Hydrocele is a very common surgical disorder operated quite often even by the General Practitioners. However Pyocele, if operated in the same manner as that of normal Hydrocele, may lead to scrotal sinus formation. In my day to day practice I came across with many such cases and treated them with orchiectomy along with excision of sinus tract. Once I myself operated a case of RIH with Rt.Hydrocele with thick sac containing brownish fluid. I did not do orchiectomy. To my bad luck the patient developed scrotal sinus and in next stage I had to do orchiectomy including excision of sinus tract. But since then I maintained a record of all such cases of asymptomatic Pyocele.

Pathology

Hydrocele of TVT occurs due to filariasis or epidedymo-orchitis. With acute pyogenic infections Hydrocele becomes Pyocele. But with intermittent chronic sub clinical infections the Hydrocele sac gets thickened and there occurs minute hemorrhage into the TVT. Therefore in some old cases of hydroceles one may get thick yellowish brown fluid instead of classical pus in TVT. There may be history of orchitis, trauma or tapping. Textbook mentions it as old clotted haematoele. But I prefer to call it asymptomatic Pyocele.

Clinical features

1) Occurs mostly in filarial belts.
2) Found in very old Hydrocele cases.
3) Clinical findings: Globular, hard, small or medium size mass with smooth surface, non-tender, non-fluctuant, non-translucent, intact testicular sensation, dry tap on needle aspiration, enlarged inguinal glands.
4) Sac Contents- Bisected sac after operation exhibits a yellowish or yellowish brown fluid and the sac wall is thick.

Pyocele with typical thick brownish fluid and thick sac wall

Character of Hydrocele fluid

Colour - Amber
Sp. Gr.-1.022to 1.024
Contents -

1. Water
2. Inorganic salts
3. 6%Albumin
4. Fibrinogen

5. Cholesterol
6. Character - Does not clot normally, but clots even with a few drops of blood.

Diagnosis and treatment

Out of 220 hydroceles operated last year 21 were asymptomatic pyoceles. 15 cases were diagnosed pre-operatively and 6 cases per operatively. Needle aspiration was not always confirmatory. Most often it was dry tap. However, per-operative needle aspiration was without any risk and confirmatory. Necessary consent to the effect of orchiectomy was taken. All these 21 cases were treated with total pyocelectomy including orchiectomy.

Incision and drainage as for acute Pyocele, evacuation as for recent haematoele, eversion of sac or excision of sac had the risk of developing scrotal sinus.

Result

Asymptomatic Pyocele of TVT was encountered in 21out of 220 cases in our series. This constitute about 10% of total hydroceles cases in one filarial belt and needed total pyocelectomy including orchiectomy with prior concent for this surgery. This emphasizes proper pre operative diagnosis. The contents of Pyocele were not classical pus, but thick, brownish fluid with a thick sac wall.

Conclusion

Though Hydrocele operation is easy, but in 10% of old cases it may need some special emphasis for pyocelectomy and orchiectomy. Little extra attention during pre operative diagnosis based on the clinical findings makes decision making easy.

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The travails of rural surgery in Nigeria and The Triumph of pragmatism (part III)

Oluyombo A Awojobi

(This concluding part of the article is an abstract of 3rd Surgery Guest Lecture, delivered by Dr.Oluyombo A Awojobi at Department of Surgery, Obafemi Awolowo College of Health Sciences and Olabisi Onabanjo University Teaching Hospital Sagamu, Ogun State, Nigeria. This saga of a rural surgeon's journey tells us about the struggle and hurdle a rural surgeon has to face in his every step to achieve his goal to serve the community. As he passes them successfully with his innovative spirit, commitment, concern for fellow being and fighting against all odds, his biggest challenge still remains i.e. how to animate this spirit to the younger generation.)

TABLE 1
Surgical Operations in Eruwa 1983 - 2005.

Operation		Number	%
External Hernia repair		5570	46.5%
Excision of Lumps		1625	13.6%
Hydrocelectomy		720	6.1%
Laparotomy	Infection	68	5.7%
	Gynaecologic	390	3.3%
	Intestinal Obstruction	194	1.6%
Caesarean section		712	6.0%
Prostatectomy		516	4.3%
Thyroidectomy		191	1.6%
Sequestrectomy		130	1.2%
Vagotomy and drainage		125	1.1%
Orchidopexy		124	1.1%
Major open fracture		100	0.9%
Chest tube Insertion		90	0.8%
Vaginal hysterectomy		44	0.4%
Splenectomy		28	0.2%
Vesico vaginal fistula repair		38	0.3%
Nepherectomy		24	0.2%
Others		485	4.1%
TOTAL		11971	100%

Table 1 shows the operations performed in the 22-year period August 1983 to August 2005. It reflects closely the pattern of surgical diseases seen excluding minor trauma, snakebite and minor surgical problems like superficial abscesses and lacerations. Until recently, trauma has not constituted a major clinical problem. However, with the advent of democracy and the concomitant increase in purchasing power of the people, coupled with the establishment of a satellite campus of the Ibadan Polytechnic in Eruwa and a College of Education in neighbouring town, Lanlate, there has been an upsurge in trauma cases of varying severity.

Although poisonous snakebite is quite common, its complications - the most common being haemorrhage - are not of surgical importance.

The overall referral rate of patients - mostly to the University College Hospital, UCH, Ibadan and other specialists in Ibadan was 1 in 1500.The rate of referral for surgical patients was 1 in 1000 (0.1%).

Recent reviews of rural surgical practices, that have been in existence for over twenty years in Nigeria, have shown that close to ninety per cent of surgical patients could be taken care of by a general surgeon working in a secondary level institution, using appropriate and scientifically sound technology and assisted by few nurses, several auxiliary nurses and paramedical professionals.

The referred cases included patients with cataracts and pterygia, a patient with complete heart block who had a permanent pace maker successfully inserted in UCH in 1984 but died in Eruwa at the District Hospital of severe enteritis some months later, a few patients with subdural hematoma for burr hole evacuation in the early years, patients with giant goitres that might need Endotracheal intubation and patients with carcinoma of the uterine cervix or post mastectomy for cancer needing radiotherapy.

As the number of patients with eye problems requiring the ophthalmologist's attention increased, my chief, Dr B G K Ajayi started a rural outreach of his practice based in our clinic in October 2001. He comes monthly (usually the last Thursday) without fail and the demand is on the increase. To date, he has seen a total of 564 patients. He has operated four times in our Clinic.

One of the dramatic cases referred was that of a young lady involved in a road traffic accident on the night of Friday, 24th January 2002. She had a plank of wood transfixed into her chest. We stabilized her overnight but due to the menace of the armed robbers we delayed her transfer to Ibadan till Saturday morning. But UCH was on strike. Eventually, Prof O A Adebo, the cardiothoracic surgeon, and myself started the operation on her at a private hospital in Ibadan at 2 00pm. This was 18hours after injury.

Unfortunately, the patient died 12hours after surgery due to severe stress and delay in intervention. Had there been availability of mobile telephone available at that time and the night armed robbers were not a factor, perhaps she would have survived.

Surgical research in the rural setting

The Alma Ata report on primary health care emphasized that research and evaluation should be conducted by those providing the services, those using them and those responsible for managerial and technical control at various levels of the health care system.

While the unavailability of modern technology has limited the scope of research, it is still possible to conduct appropriate, "low-tech," and relevant research that is subject to excellent study design, proper controls, and scientifically valid interpretations. As a matter of fact, over the last 50 years many more major advances have been made in medicine by simple observation than by all the current molecular techniques put together.

It is easy for the rural surgeon to decay while offering routine service if he does not subject himself to regular auditing by way of publishing his experiences.

Regular reviews and auditing of the surgical problems encountered and the results of tested solutions have produced publications that document the incidence and pattern of diseases, the modifications in the management of patients occasioned by their poverty, ignorance, costly and inadequate transportation and the activities of the ubiquitous traditional healers.

Research has been carried out in an environment devoid of the "publish or perish' syndrome that prevails in the ivory towers.

The Rural Surgical team

'*A tree can not make a forest*' so the adage goes and so is the team that has been operating in Eruwa in the last twenty-two years.

I wish to appreciate all the nurses, laboratory technologists, ward orderlies and artisans with whom I worked at the District Hospital, Eruwa from 1983 to 1986. We showed it was possible to make the pyramidal health structure work in a rural setting in the public sector.

The Financial Travails of Rural Surgery

Finance has always been the bone of contention in any practice particularly medical practice in the rural area where the populace is relatively poor. For the practice to be successful, the services provided must not only be accessible and acceptable but also affordable. The adoption of appropriate low cost but effective technology had significantly reduced our capital investment.

In our Clinic, there is no employer or employee. We owe allegiance to our patients who receive the best we can offer and in return sustain us within their resources. Ours is a cooperative of professionals and non-professionals offering service in the health sector of the economy and in so doing earn our means of livelihood.

Everybody is placed on a salary agreed by all. Every month a meeting of all workers is convened during which all financial returns of the month are tendered and decisions taken on payment of salaries and what to do with profit or loss.

In this way, a sense of belonging is generated in all workers and there can be no labour unrest, as the financial standing of the practice is known to all. In a private institution it will form a solid foundation for continuity when the pioneers must eventually take their leave.

Social Travails of the Rural Surgeons.

Residency training in the UCH of the 70's and 80's was a very serious business. Our teachers were often the first to be in the hospital at 7.00am and the last to leave at 7.00pm. Consultants like Prof E O Nkposong would buy moinmoin during clinic and operating sessions so that there was no disruption of activity. There was nothing like going to pick the children at school at 2.00pm. No excuses were allowed for not getting the results of investigations on time for the next ward round; definitely not in the cardiothoracic unit, where before and after inserting a chest tube, a chest radiograph was mandatory no matter the time of day. It was a hectic schedule in the Intensive Care Unit on Tuesdays when the cardiac surgeons operated on elective cases.

It was in the CTSU I started my residency in August 1977. While running to get chest x-rays done quickly, I met a beautiful young radiographer who very soon taught me how to position and calibrate the mobile x-ray machine, expose the film and develop the film. Miss Atinuke Makanjuola naturally became my wife in 1978 and she has stood by me since then. In August 1980, she resigned her level 9 job at the UCH to stay at home and look after little Yombo and myself so that I could face the training squarely. By today's standard, it is equivalent to leaving a N100 000, 00 per month job.

On arrival in Eruwa in 1983, her colleagues persuaded her to take up the job again as the workload might not be heavy and our son could play around in the hospital.

Educating our boys (Ayodele was born in 1985) was going to be another travail in the rural setting.

We resolved to teach them at home until they were five years old to enter the public school.

It was a status symbol to send your child to the only private nursery/primary school in town but we were determined that our children would grow with those of the rural farmers. At the public secondary school in Eruwa, we got teachers in the science subjects to supplement our efforts. We created a science laboratory at home and used the clinic's laboratory where necessary.

Two decades after, Yombo fixes our x-ray and ultrasound machines as a budding electrical/electronics engineer and Ayodele assists in the operating room and produces the histopathology slides whenever he is on holiday from the medical school at Ile-Ife.

This has been our pragmatic solution to the social travail of rural surgery in Nigeria.

To my teachers and colleagues with Gratitude.

Many of my teachers and colleagues have continued to provide moral, financial, material and psychological support to us since 1983. Following are some of the comments made by few of them during their visit to our centre.

> *"We must work out through research, ways of assessing and thereby improving the quality of care that we give our patients. There are three approaches to the problem of quality of care. The most basic is paying attention to structural aspects such as financial resources, facilities (e.g. water and electricity), equipment and staff. I think most of Awojobi's work in Eruwa is in this direction and he has been able to fashion equipment from locally available materials and device treatment manoeuvres suited to the structural background of his working environment."* Professor E A Elebute (1988)

'This is the setting for teaching Primary Care Surgery in Nigeria.'- The late Professor Emeritus T F Solanke

"Highly privileged to visit this hospital, an example of commitment, concern for fellow beings, innovation and imagination. I like the way he admits relations to the theatre to watch operations on their sick relatives. I like the way he fabricates every thing and saves everything. I have visited an exemplary phenomenon and honoured to be here. Can this be replicated? It must take a particular kind of person!! The late Professor Olikoye Ransome-Kuti, former Federal Minister of Health, visited in August 2000

'What constitute significant contributions to knowledge do not necessarily emanate from the technical sophistications and disproportionately luxurious environments. The challenge the Awojobi's face is how their innovative spirit and sense of community commitment will pass on to younger generations.' the late Prof Emeritus T F Solanke

Every step is part of the journey.

Report of a case of Pena-Shokeir Syndrome

Dr. S.K. Baasu, Dr.V. Basu

Abstract

A rare varity of fetal anomaly called Pena- Shokeir syndrome, first described by Pena and Shokeir in 1974 charecterized by arthrogryposis and dysmorphic features, resulting from fetal akinesia is presented here. This lethal fetal abnormality can't be diagnosed in early pregnancy and is interesting because of rarity of the condition.

Key words

Camptodactyly is a flexion contracture of the proximal interphalangeal joint of the finger(s).
Arthrogryposis (contractures of the joints), IUGR (intra uterine growth retardation)

Case report

Mrs M , primigravida, aged 25 years, was having regular uneventful antenatal check up with no unusual findings till 20 weeks of her pregnancy. During later part of 28 weeks gestation she complained of diminished fetal movement. Clinically she had mild IUGR although there was no apparent cause. Her fetal heart sound was normal in rate and rhythm. She was advised to have a routine U/S.

Ultra sounds scan during pregnancy at 28th weeks of gestation

Placenta was located in the upper segment with homogeneous echo pattern. Umbilical cord was normal. Moderate hydramnios. There was a single live fetus. The fetus showed markedly reduced movement, consisting only occasional trunk and wrist movement. Fetal swallowing was absent. The fetus also showed growth restriction. No facial, cranial, thoracic or abdominal structural anomalies were evident. There was a fixed flexion of both hips, a fixed, extension at both knees, bilateral club feet, club hand and fixed flexion of both elbows. Findings indicated a lethal disorder: Pena- Shokeir Syndrome. The head perimeter/ abdominal perimeter ratio was 1.35. Cranial perimeters and bone lengths corresponded to 28-29 weeks size. Cephalic index was 80% *(only the relevant ultrasound findings are presented here)*.

Management

The patient and her husband were explained about the prognosis of the fetus and termination of pregnancy was offered. With their consent the pregnancy was terminated successfully with Misopristol. Post delivery hospital stay was uneventful. Follow up of the case with necessary chromosomal analysis and karyotyping was not possible as the patient's husband, an army man posted out station, was in a hurry to take his wife to his place of posting. However they were advised for the same.

Discussion

Pena-Shokeir syndrome Type I is a rare disease. The actual incidence of Pena-Shokeir syndrome Type I is not known, but about 80 to 100 cases have been reported in the medical literature. This syndrome causes contractures of the joints (arthrogryposis), growth problems, lungs that are underdeveloped, and abnormalities of facial features.

This syndrome occurs in males and females, and it does not have any specific ethnic group association. Both sporadic and familial (inherited in families) cases have been reported. Autosomal-recessive is the most common pattern of transmission. Several descriptions of unusual presentations suggest a heterogenic etiology.

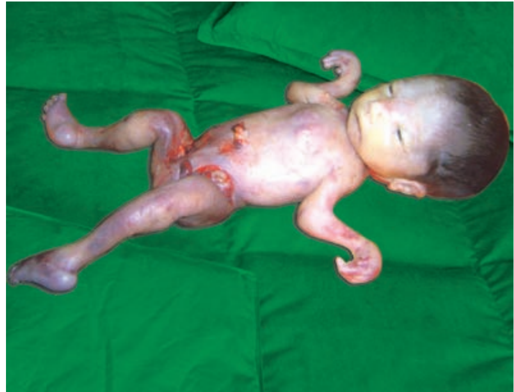
The majority of the signs and symptoms seen in Pena-Shokeir syndrome are caused by restricted movement of the fetus during pregnancy. Some time during the first trimester, the fetus is supposed to start moving its body in the amniotic sac. This fetal movement is really important for the development of the joints, bones, muscles, and other tissues of the body. If there is little or no movement of the fetus, the joints can become stiff and the neuro-muscular system will develop abnormally and not function properly. Causes of restricted fetal movement include genetic defects, tissue defects, and environmental causes.

Common features of Pena-Shokeir syndrome:

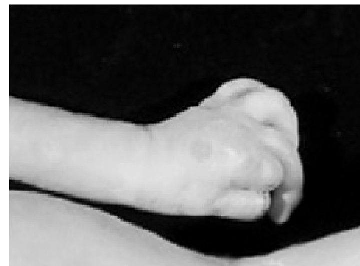
- Multiple Arthrogryposis: This means that the joints are contracted in multiple areas of the body. These contractures can especially occur in areas like the fingers, hands, and feet.
- There may be restricted growth or general growth difficulties
- Pena-Shokeir syndrome can also present with facial features like widely spaced eyes, low set malformed ears, a hole in the roof of the mouth (cleft palate), jaw problems, decreased facial expressions, and a head size that is smaller then usual (microcephaly).
- Pulmonary hypoplasia: This means that the lungs may be underdeveloped. This can cause severe breathing difficulties depending on how underdeveloped the lungs are.

Diagnosis:

The combination of abnormal limb position, restrictive fetal movement with reduced or absent response to acoustic stimulation, growth restriction, polyhydramnios, and pulmonary hypoplasia makes the diagnosis. Low-set malformed ears, hypertelorism, short neck, cleft palate, scalp edema, thoracic deformities, Camptodactyly, and micrognathia may also be found. Anomalies less frequently described in association with Pena-Shokeir syndrome include diaphragmatic hernia, gastroschisis, and microcephaly.



note characteristic faces, short neck, mild contracture of the hip Jt., moderate contracture at elbow and knee, severe ankle contracture, Camptodactyly with ulnar deviation



Note Camptodactyly
(Flexion contracture of the proximal Interphalangeal joint of the finger(s).

Differential diagnosis: Trisomy 18 may present features that overlap with Pena-Shokeir syndrome, in particular craniofacial, limb, and intrathoracic abnormalities. Karyotyping analysis makes the differential diagnosis. Nonlethal forms of arthrogryposis present the same set of findings, except for the pulmonary hypoplasia.

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There is a perverse sort of blessing that comes from calamity: You just might give yourself permission to surrender.

An Appeal

As per the decision of the governing Council, once again an appeal is made to the members of ARSI or to any sympathizer of Rural Surgery to donate generously for the bulletin fund. Even after increasing the budgetary allowance, it has become difficult to meet the expenses because of wider circulation and escalating cost of printing the bulletin. ARSI finds it difficult to increase the allowance any further as the interest rates have fallen steeply and as a policy decision no advertisements from health care industries are entertained. Members may kindly donate any amount. Name of those who donate more than Rs. 500/ will be published in the bulletin. If any one donates Rs.15 000/ or more, he/she will be considered as the sponsor of that issue.

Cheque/ bank draft to be made in the name of:
"Association of Rural Surgeons of India" payable at honorary secretary's address:
Sushruta Hospital, Khetia Road, Shahada-425409, Maharashtr

*Managing a dread iatrogenic complication in a rural set up**

Dr. Balkrishna D. Patel

One day during my routine OPD hours I received a call from one of my Anesthetists colleague, from the Operation Theater of a surgeon, comparatively new in his practice, asking me to come down urgently to his theater for some acute emergency. On my arrival I was told that while operating on a case of ovarian cyst, the surgeon noticed sudden leakage of fecal matter after the cyst was removed. He needed my urgent assistance.

He asked his assistant to remove the gown and give it to me without touching out side. I donned the same gown. (One can guess with how much constraint some time a rural surgeon has to work)

On exploring, I found a tear of almost 5cm size in the sigmoid colon. Peritoneal cavity was cleaned of fecal matter and blood. Foley's catheter was passed which came out in peritoneal cavity. A big tear in the posterior wall of bladder was also found. The rent in bladder was closed in two layers with 1-0 Chr catgut. The sigmoid colon tear closed in single layer with 2-0 silk. Peritoneal Lavage was given. Transverse colon loop was prepared for colostomy and colostomy done. Abdomen was closed in 2 layers with tube drain inside. The patient was shifted to my hospital so that she could remain under my direct supervision all through her post operative period. The colostomy was matured on 3rd day. Postoperative period was uneventful and patient was discharged on 9th post-op day. Patient was called for dressing regularly.

After 6 weeks a retrograde Barium enema was done. It showed good healing of the colonic sutures. The patient was readmitted for colostomy closure. The procedure and post-op period was uneventful.

Patient came back after a week with c/o fecal discharge through the wound. The fecal fistula was managed conservatively in ward and closed after 10 days and patient was discharged. However the patient kept on discharging purulent fluid for 10-15 days through the wound.

The overall management though looks very simple and straightforward, in reality it was not so. The three months period, till the patient completely recovered, was very tough. There were two fold anxieties. First anxiety was about the patient's recovery. A female patient in a rural area is usually mal-nourished. Under this situation would the patient withstand all the procedures? The second anxiety was about relatives' reaction to this iatrogenic complication. Would they go back and trouble the first surgeon. Though it was tough job to manage such case with all the resource constraints in a rural set up, it was indeed satisfying to see the patient recovered fully.

While examining the patient's history sheet and sonographic report, I found the clinical impression was mentioned as 'an immobile lump arising from pelvis', while Sonography report suggested 'cystic mass arising from pelvis'.

Unfortunately the operating surgeon who was a new comer (2nd month in his practice) depended more on the sonography report and took it as a simple ovarian cyst. After opening the abdomen the lump was found to be immobile and a blind dissection with fingers was attempted forcefully which resulted in to colonic and U bladder tear.

Conclusion

This particular incidence is a lesson for younger surgeons that a thorough clinical

examination is mandatory for each case before proceeding for surgery. Due importance should always be given to the clinical findings. Planning for surgery should not be based on investigation reports only. While ultrasonic findings may be complimentary to the clinical finding, during the surgical procedure clinical findings should always be kept in mind. Blind dissection and using undue force can lead to a dreaded complication and may put the surgeon into trouble.

*(Abstract from the paper presented at 1st Inter National Conference of Rural Surgery, Ujjain 2005) Address for Correspondence: Sushrut Nursing Home, Khetiya Road, Shahada, Nandurbur 425409

Everyone who got where they are ... had to begin where they were.

Important Information

Dr.R.R.Tongaonkar, past president of ARSI, is compiling the data on use of mosquito net for hernia repair. Recently he has presented paper on this topic in 10th World congress on Endoscopic surgery held in Germany and 2nd Asia Pacific Hernia Congress in New Delhi. Already 21 centers have participated in multicentric studies and data of more than 2800 cases have been collected. Members of ARSI using this mesh for hernia repair are requested to send their data including complications, recurrences rate etc.to Dr. Tongaonkar to compile much bigger data. Dr. Tongaonkar may be contacted at:

Dr. Tongaonkar Hospital, Dondaicha, Dist Dhule, Maharashtra - 425 408
E mail: rrtong@sancharnet.in

Dr. Antia-Finseth Award (2006)

Dr. B.B. Joshi from Mumbai was the recipient of Dr. Antia-Finseth award (2006) for his innovation **Joshi's External Stabilization System (JESS)**. Development of this mini external fixator system in its present form is the result of his12 years of research work. The concept and philosophy of the system is to present a device that can be used by a surgeon where minimum facilities are available. The system consists of K-wires, clamps with link joints, hinge joints, distraction units, connecting rods and some accessories.

The JESS as it is popularly called can be used for:

1. Management of open fractures
2. Skeletal stabilization
3. Congenital deformities of hand and foot
4 Post burn contracture
5. Management of sequelae to trauma
6. Lengthening procedures,
7. Distraction procedures.

Dr. Joshi has a reputation for developing useful gadgets with commonly available material. In the past he had shown multiple uses of common Ice cream sticks in the management of finger fractures.

Since Dr. Joshi was unable to attend the award ceremony, his daughter received the award on his behalf. Dr. Swaran Arora, renounced plastic and reconstructive surgeon, presented Dr. Joshi's work.

Dr. J.K.Banerjee presenting the award to Dr Joshi's daughter

Attention Please

15th National Conference on "Rural Surgery" will be held at Pune in 2nd week of November, 2007

Organizing committee Chairman: Dr. N. H. Antia

Organizing Secretary: Dr Swaran Arora

Watch out for further details in the next bulletin

Compliment…

Dear Dr. Basu,
I compliment your hard work that you are doing. I fully agree with the cover design, especially when we have gone international. I have known Prof. Antia and because of him I joined ARSI.

Rural surgery does not mean crude and unscientific methods. It means how the surgeons perform well in spite of all limitations. Indian surgeons are very innovative and those in rural areas still more.

Regards,

Your sincerely
D.K.Taneja
Consultant Orthopaedics Surgeon
CHL Apollo Hospital & Arihant Hospital
Anoop Nagar, Indore

"Concomitant Mitrofanoff procedure with bladder neck division"

I read the article of Dr. Sabu Thomas with great interest. I presume that the reason for the particular repair was due to loss of sphincter function. I agree with the editor's method where sphincter mechanism is intact. I have repaired many using bulbo cavernous fat pedicle and also gracilus muscle transposition between muscle and vagina. Some time it was necessary to do temporary stenting of both ureters using infant feeding tubes especially where the loss of tissue involves the whole trigon area. This also keeps the bladder dry for a while enabling healing. Two of the patients needed ureterosigmoidostomy as the damage was extensive. They continue to be well even after 12 years.

Dr. George Varghese
LWH, Manali,
Dated 28.8.06

Editor's reply

Even if the sphincter mechanism is not intact, elevation of the bladder neck / UV- junction / proximal urethra against symphysis either by using the bulbocavernous muscle graft or by fixing the anterior vaginal wall onto the symphysis bring the closing mechanism into a better position. This can be done with the help of a sharp aneurysm needle fixing the graft or anterior vaginal wall into the symphysis periosteum. This should be done as soon as bladder is mobilized completely. Other wise it becomes difficult to position them correctly. In case the loss of urethra is combined with a large VVF, the base and neck of the bladder should be repaired first and then the urethra is reconstructed.

Important information for the ARSI members

(Surgical Camp)

Bharat Heritage Foundation, a registered Entity, with its motto "Striving for a society of self esteem, strength and harmony", is mandated to work in rural areas in educational, social welfare, women empowerment, and poverty alleviation projects. The organization also seeks to strengthen the spiritual impulse of people with a view to promoting harmony in community life.

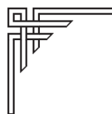
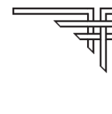
The Foundation, in an exploratory effort, is willing to sponsor a "surgical camp" in a rural area of any part of our country. The following are the criterias:

1) The camp should be based on the felt need, duly verified, of the local people (ENT, Opth, Gynaecological, general surgical camp). The camp should be accessible only to poor and venerable members of rural society and not for any family or person who can afford to pay for the treatment.
2) The organizer should be a staunch member of our Association (ARSI) and should have proper back up services so that patients needing surgical intervention may be managed locally in a cost effective and professionally proper manner and followed up further in each case till his/ her full recovery.
3) The financial help for the sponsorship will not exceed more than Rs. 25000. Financial support will be based on itemized cost and expenditure estimates to be furnished to the undersigned for prior scrutiny. All actual expenses should be supported by certified documentation in the form of bills/ vouchers to be submitted to the Foundation through the undersigned.
4) The camp should be planned, organized and executed in consultation with the undersigned before March 31, 2007
5) The size and the work content of the camp should be appropriate to the quantum of financial assistance available and still should be useful and cost effective
6) The Foundation looks forward to full cooperation in evaluating the success and cost effectiveness of the Camp soon after its conclusion.
7) The Foundation would like this first joint venture to be a precursor to larger cooperative effort with the ARSI as time goes on.
8) ARSI members, interested to hold this camp as a part of community services, may avail this opportunity. Interested member may send the detail of the working plan, location and time as well as the itemized cost and expenditure estimate at his earliest to the following address for further action.

Dr.S.K.Baasu
A-258, Shivalik, Malviya Nagar,
New Delhi- 110017
Phone :(011) 26681495, (011) 26685675
Mobile: 9810078992,
E mail:skbaasu2004@yahoo.co.in

Don't resent the work. It gives you the strength to stand whole and silent before the vast Mystery.

RNI No. DELENG/ 2005 / 16240

2nd International conference on Rural Surgery Organized by International Federation of Rural Surgeons (IFRS) & St.Francis Designated District Hospital IFAKARA, TANZANIA

Theme

"Challenges of practicing surgery in rural areas" September 27 to 29, 2007

Venue:

Tanzania Training Centre for International Health lecture Theatre, Ifakara, Tanzania

Proposed workshops:

Ultrasound, Surgical skills, Anaesthesia, Bone treatment, Care of wound

The deadline for Submission of abstracts: 31st January 2007
Submission of full papers/ posters: 31st July 2007
Space for poster available 60 x100 cm

For further information

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