President speaks…

Dear member,

As I come to the end of my term of office of President of ARSI, I wish to thank you all once again for the trust you placed in me for this onerous job. I hope I have not failed you.

We are currently trying, as you all know very well, to get UDBT legalised and hope that the Government of India will see the usefulness of it soon. Now, one more difficulty is coming up that will hinder rural surgeons more than others; that is the medical establishment bill.

Most of the states are in the process of bringing in legislation to "control" nursing homes and hospitals. Though this appears to be to give quality health services and hence in the interests of patients in general, there are aspects of it which raise the question "why again".

1. Ayyar committee (1963) and Bajaj committee (1980) had developed norms for equipment standardisation for public hospitals (Anand TR & Aggarval AK 1992, Nandraj 1994). Hospital manuals or hospital standing orders, which are expected to ensure quality of care in Govt. hospitals, were also in existence in certain states (Nandraj and Duggal 1996), though adherence to these norms is doubted.

2. Karnataka State introduced a private nursing homes ordinance in 1976 in a great hurry. It is alleged that it was the result of anger of a minister whose relative's dead body was not released by a nursing home till the bill was cleared. This later became a bill too but it was hardly every practised or enforced.

If that be so, why try to bring in a bill yet once again and be ignored? The answer seems to be not so much in the hype created by the media about the deficiencies of private sector health care but in the pressure from World Bank. **"….it needs to be pointed out that the legislation….are coming up against the background of increasing capitalist investment in the health sector which is being promoted by the World Bank as is reflected in the WDR 1993 (World Bank 1993-George A 1997).** The World Bank in a later document on India also points out that the state Governments should play an active role in creating an environment for greater private participation in the health sector and enact legislation and issue guidelines to ensure minimum standards of care (World Bank 1997)" (Alex George, Director, Centre For Health and Social Sector Studies, 'Need for an Access- Sensitive Approach to Quality Assurance for Rural India, World Rural Health, International Conference, Melbourne 1-3 May 2002).

World Bank looks after the interests of its health care industries making a big show of its 'generosity', and sadly, Indian state governments also favour those industries, ignoring the welfare of its own poor patients. Anyone, who has read the article "Tarnished halos of the G8 leaders" by George Monbiot, in the daily "The Hindu" of 16th June 2005, may understand the compelling reasons why the elected representatives accept such 'aids'. What else can we expect when we elect such self-serving misfits for such responsible positions! ARSI would like

to see if it could do anything in this matter, the subject of standardisation of hospitals and health care in India. Do come and participate in the seminar on this subject, during the next Ujjain conference.

Like this, ARSI tries to look in to the problems of rural surgeons; for this each of you must be sincerely involved in the activities of ARSI. Incidentally, have you sent back duly filled the questionnaire that has been sent with the conference brochure? It will give us important information about the current status of rural hospitals, based on which we may be able to present our case more effectively in the matter of medical establishment bill.

As I had said before the next conference at Ujjain is unique because it is the first international conference on rural surgery. We are likely to launch the International Federation of Rural Surgery. Further you all will have to elect a new President and office bearers at this conference. Make sure that you are there for this historical conference.

Sincerely
Dr. R.D. Prabhu
President

Pre-conference Seminar

On

Standardization of Rural Hospitals and Post graduate CME in Rural Surgery

Date: 22nd September 2005

Time: 10.30 AM to 3 PM

Venue: R.D.Gardi medical College, Ujjain

Participation Fee: Rs. 200/- Including Breakfast, Lunch, Tea, Dinner

Apropos the medical establishment bill/ clinical establishment act that our Govt. is trying to impose, Standardization of Rural Hospital *is an important issue for all surgeons serving the rural community.* You are invited to be a part of this forum and share your views with the fellow surgeons.

Women's Right and Medical technologies

Sanjib Kumar Mukhopadhyay

The great scientific and technological advances that have taken place in last 30 years have brought in big changes not only in human survival rate but also in quality of life. Health sector, through advances in medical technologies, is also no exception.

Medical technology:

Medical technological advances (MTA) have taken place mostly by way of expansion of our knowledge in the field of human physiology, by invention of newer chemical / molecules to interact certain functions or malfunctions in body and application of enhanced knowledge in the field of biophysics. Bringing out a huge gamut of mechanical or electronic gadgets has greatly helped in diagnosing certain physical conditions much earlier and more accurately. It is also obvious that with the advent of our knowledge and scientific discoveries in different fields, medical technology will continue to grow more and more.

The Problem:

There is no doubt that such medical technological advances (MTA) have made illnesses better understood and physical wellbeing more achievable. However the enormous cost involved in procuring such MTAs has made them almost inaccessible for the economically weaker section of the society and thus making them 'class specific'. Although women - irrespective of their class status have a right to certain MTA, which can be of great help for their survival - there will always be a lobby (often closer to state machinery) to establish that these costly interventions are not essential and instead, what they deserve is simply cheaper (and may be substandard also!) alternatives which are equally good if not better.

Second problem with MTAs is tendency to look at common clinical problems more mechanically, so that they are made to appear more medical requiring unnecessary interventions, affecting Women's health.

Third problem that MTAs have managed to create is a media hype which has percolated down in the society. In such a glittering world of technology, basic health care problems in women's life - requiring simple public health measures or application of available knowledge in a scientific manner appears to be neglected.

Finally, some of the medical technological procedures used on women's body make them vulnerable for certain diseased conditions which at times can be of life threatening in nature. Moreover they may also raise a host of ethical issues to which women submit unwillingly, leading to great social or psychological problems.

Real Life Examples:

1. Mammography can detect cancer of female breasts in its early stage. Likewise HPV - DNA testing or transvaginal sonography can be used for mass screening for detecting cancer of cervix or ovaries respectively in their early stage, when they are quite treatable. Colour Doppler study during pregnancy can be of help for successful pregnancy outcome in certain types of pregnancy complications. But the state run public sector hospitals will hardly have them on the pretext of those being costly equipments. However all those having minimum recurrent expenditure and enormous benefits to offer, quite justify their use without any prejudice to class - if necessary by minimising the amount

fixed as bribe and commission for procuring these equipment.

2. Pregnancy is essentially a physiological condition. Use of irrational and unnecessary medications - at times steroid hormone preparations during pregnancy are not without risk. They may prove to be harmful for the unborn child. Similarly, although caesarian section is necessary at times, WHO estimates the rate to be in the range of 5% to 15% for any institutional caesarian delivery. However the following statistics at premier private and public hospitals in Kolkata will give the real picture of present Scenario -

   A) Ramakrishna Mission Seva Pratisthan Hospital - 48% (2003 2004)

   B) S. S. K. M. Hospital - 64% (2003-2004)

   This high incidence of a major operative delivery is partially due to increased technical safety of the procedure and due to the changing attitude of health care providers armed with superior technology at their disposal. That there exists a natural process of pregnancy and child birth resulting in normal delivery, is increasingly being ignored and at least in some cases pregnant women and their children thereby are being targeted for a major physical risk.

3. Some of the technological advances in the field of health care facilities has opened up alternative management strategy for many clinical conditions, increasing comfort level of the acceptor - though at a very high cost. Endoscopic surgery is just an alternative to conventional surgery. But it has managed to draw greater attention from media and uninformed public. As a result of this, not only private sector but also the state cannot resist itself from providing budgetary provisions for such equipment which are to be imported at a very high price and at times ignoring the priorities in health care.

Death and disability rate of ailing helpless women at a relatively younger age is a matter of great concern for all the people working for women's right. In this respect following five broad areas can be identified which require urgent attention for improving health of women of this country in particular and the developing world in general -

i) Prevention and treatment of anemia
ii) Safe abortion
iii) Safe delivery
iv) Early detection and treatment of cancer of breast and cervix
v) Problem of HIV - AIDS

These five areas need urgent attention if we want to improve upon women's health status and prevent their untimely death. All these can be taken care at a reasonably low - cost set up, requiring only moderate investment and can be achieved by developing skills of health care providers (even non-medical). The appalling figure of maternal mortality rate in this country which has remained almost stagnant over past 15 years need most urgent attention mostly through essential and emergency obstetric care, social measures and by improving infrastructure facilities.

The glaring example in this regard is in the state of West Bengal at S.H.S.D.P. (State Health System Development Project) wherein the state has received Rs. 760 crores of World Bank loan for improvement of infra structural facilities of state hospitals up to Sub-district level. However when it comes to providing infrastructure facilities, approx. Rs. 120 crores were spent on purchasing

equipment for Endoscopic surgery and training of doctors to perform this. This may not be out of place to mention here that every year in this state more than 1,000 women die of bleeding during childbirth, unsafe abortion and eclampsia. Some monetary provision could have been made available out of this fund to build up suitable infrastructure to tackle those problems round the clock and save lives of these unfortunate women.

4. Modern medical technology is being used to force women to use harmful contraceptives, hormone replacement therapy or assisted reproductive technology - all of which, far from being beneficial are fast becoming subjects of debate after harmful effects of all these are surfacing over years later.

   Even over stress on food staff produced through genetic engineering, selecting western food habit and implanting mechanical breast massagers are some of the items - being flashed in media for attaining 'ideal body' for women. Initial hype with hormone replacement therapy is now appearing to be dangerous for women. Extremely beneficial equipment like ultrasound is being increasingly used for prenatal sex detection of female fetus for their eventual murder. Assisted reproductive technology is another area which, apart from posing health hazard for women is fast becoming a controversial issue on moral and ethical ground. The problems of genetic, gestational and adoptive motherhood and that of surrogate need special mention in this regard.

What can be done?

1. State has to take the responsibility of bringing modern medical technology for upliftment of health of women belonging to economically weaker section. It can not be denied to a group of women on the basis of class alone.
2. Continuous propaganda against irrational treatment and illness management by the doctors is to be organized.
3. Basic health problems facing women are to be identified. Even differentiating between basic health problems of women depending upon their age, place of living, economic condition etc. is to be categorized. People who are working in the field primary health care through simpler innovative ways are to be encouraged, highlighted and brought to the limelight.
4. Any new pharmaceutical product or newer technology should not be allowed to be marketed or tested on women unless it passes through international ethical and pharmaceutical guidelines. In India although D.C.I. (Drug Controller of India) is authority for pharmaceutical products, time and again it has failed in its duty to safeguard the interests of millions of uninformed women of this country. For other technology to be used there is no authority which can issue guidelines or monitor their rational use.

With the growth of knowledge and technologies in other branches of science, it is inevitable that growth of medical science will present before us newer technologies. Continuous exploration of human body has made yesterday's fiction a reality to day. We must be able to protect the vulnerable and marginalized groups in our society from the dazzle of lightning in medical technological thunderstorm, in such a way that it helps them in their struggle for existence, in finding the right way for their survival and not make them, in an otherwise dark arena of public health care system - a victim of technological advances.

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Editor's note: Author has rightly pointed out the concerns (both harmful and beneficial effects) associated with medical technological advances. However it can not be denied that no country can any longer afford to pay for all possible health care interventions. Unfortunately the alacrity with which a technology is adopted and used is related to its advantages more for the practitioner and manufacturer, less for the patients. It has been proved beyond doubt that not all the technological advances are beneficial to promote woman's health. Experts may say that the use of new technology and drugs have improved the chances of high-risk pregnancies. But the reality is that even with all technological advances women are 70 percent more likely to die in childbirth in America than in Europe. And in spite of all the sophisticated gadgetries in their nursery their infant mortality rate are much worse than their impoverished neighboring nation Cuba.

Therefore developing countries like India should use the available financial resources optimally and judicially with emphasis on cost effectiveness and on the basis of priority need. And the best criterion in choosing which interventions to support should be evidence based practice.

It should also be recognized that all technological advances even with proven benefit like mammography; DNA testing for HPV can not be used for mass screening in a low-resource setting. No doubt, that such screening procedure may lower the risk of cancer by 50-90%, but they are costly and require a reliable laboratory for analysis. It has been found out that only about 5 cancers will be present in every 1000 screening mammograms. Of those 5 cancers, 4 will actually be found in the mammogram and the other will be missed. A DNA testing for HPV costs $20 to $40 -- out of the reach for poor countries.

Hence alternative strategies like information and instruction of breast self-exam techniques, visual examination of cervix after acetic acid application should have a place and need to be promoted. Unaided visual inspection of the cervix by naked eye can detect 60% of early cervical cancer. They are indeed simple and inexpensive methods and effective as well for mass screening.

- Dr. S.K. Baasu

Localized Sarcoid of a Single Cervical Node

Dr. Sitanath De

Introduction:

Sarcoid can affect almost any tissue. The characteristic histological features represent a cell- mediated immune response to an unidentified antigen.

Localized Sarcoid reaction of a lymph node can occur and is not associated with systemic sarcoidosis. It follows an unpredictable course. Some cases may undergo spontaneous remission.

Key word: Localized Sarcoid.

Case report

On 29.08.03 a young man of 25, presented with a swelling behind and below the left angle of the mandible of 3 weeks' duration. There were no other symptoms.

On examination, his general condition was satisfactory. Local examination showed an enlarged solitary node, which measured 6cm / 3.5cm. It was firm in consistency and not attached to the skin. The mobility was restricted. No other lymphadenopathy could be detected.

He was advised treatment with hot boric compress 3 times a day and to have an F.N.A.C. of swelling.

F.N.A.C was done on 02.09.03. The smear showed blood and a large number of clustered epitheloid cells, occasional Langhan's Giant cells, lymphocytes, plasma cells and macrophages, suggestive of non-caseating granulomatous lymphadenitis. Besides tuberculosis, the possibility of sarcoidosis should always be considered in such a case.

Treatment:

Although there are other causes of non-caseating granuloma, including micro bacterial and fungal infections, the tests to prove or disprove these causes are not available in the rural area. To get these tests done from a more centralized, sophisticated laboratory is expensive and, sometimes, non-conclusive.

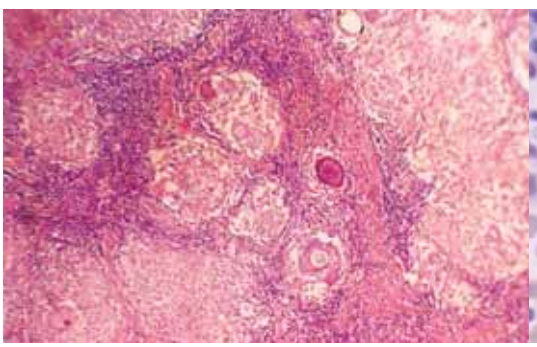
A "wait and watch", policy with the hope of spontaneous regression was undertaken with the help of hot boric compress three times a day.

The size of the swelling gradually reduced as follows:

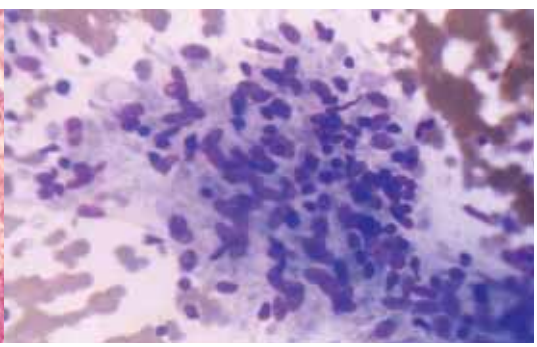
On 4.9.03	4cm/3.5cm
12.9.03	2.5cm/1.5cm
29.9.93	The swelling has disappeared

Discussion:

For a single node enlargement, as in the above case, F.N.A.C. is essential at least to



Multiple non caseating granulomas with calcified bodies



Epitheloid cells

exclude malignancy (primary or secondary). The histopathological findings of multiple non caseating granulomas with epitheloid cells and calcified bodies and asteroid bodies are very suggestive of Sarcoid.

The necessary tests to confirm or discount tuberculosis are not available in this area. Again, there is a tendency with a tentative histopathological report of tuberculosis, to put the patient on anti tubercular drugs. However, a close follow up for a month might cure the disease and save the cost of long anti-tubercular treatment, always a matter of concern in attempting to bring lower-cost, but effective, surgical care to the rural- based patient.

Acknowledgement:
I am grateful to Dr. C.L.Bhunia M.D. (Cal), histopatholoigst), for the microphotographs of the slides relating to the above case.

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Editor's note: *It is often said that* ***"More is unknown about sarcoidosis than is known"****. First identified about 100 years ago, the disease was originally known as Hutchinson's disease or Boeck's disease named after two dermatologists who described the disease. It was Dr. Boeck of Norway who fashioned today's name for the disease from the Greek words "sark" and "oid," meaning flesh-like.*

In general, sarcoidosis appears briefly and heals naturally in 60 to 70 percent of the cases, often without the patient knowing or doing anything about it. In 10 to 15 percent of the patients, sarcoidosis can become chronic. Fortunately, many patients with sarcoidosis require no treatment, as the disease often causes no symptoms or is self-limiting. Because sarcoidosis can disappear even without therapy, doctors sometimes disagree on when to start the treatment, what dose to prescribe, and how long to continue the medicine. The doctor's decision depends on the organ system involved and how far the inflammation has progressed.

In incidents as described in the case above, where the Sarcoid does not affect a vital organ system and where facilities for conclusive tests are inadequate (because of the rural set up), a wait and watch policy for a defined period, as adopted by the author was a rational approach. However as sarcoidosis tend to recur in some cases, it will be interesting to follow-up the patient for at least 2 years.

- Dr. S.K. Baasu

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Experience with duodenal ulcer perforations in a district level rural hospital

(A Study over a Period of Four Years)

Dr. R. K. Garyali

Duodenal ulcer, though not as common as before, continues to be amongst the major diseases in India, especially in our part of the country.

Complications of Duodenal ulcer have drastically decreased because of the use of drugs like H2 blockers, proton pump inhibitors etc.

Complications like perforation of duodenal ulcer still continue to happen with a relatively high mortality rate, especially if not treated in time. The relative increase in DU perforations has been attributed to unscrupulous use of NSAID, consumption of alcohol, smoking, use of pan masala and chewing tobacco.

Material and Methods

Our hospital is a district level hospital catering to needs of two districts in J&K State and the only hospital where emergency and such type of surgery is undertaken.

Patients admitted from May 2000 to May 2004 in surgery unit were included in this study. Patients were mostly admitted through causality department and were subjected to a detailed clinical examination.

On admission the patients were given I V infusions .A nasogastric tube and an indwelling bladder catheter was put. A bolus dose of 1.5 Gms. of 3rd generation cephalosporin, IV penta perazol and Tiniba (Tinidazol) infusion was given.

Investigations like hemoglobin, BT CT, CBC. Blood urea, sugar and grouping were routinely done. Pre operative X-Ray abdomen in standing posture, chest X-Ray, E.C. G and U/S (For free fluid) was done routinely. In a good number of cases paracentesis Perotonii was also done.

Laparotomy was done under a General Anesthesia through a right Paramedian or Upper Midline incision. Duodenal Perforation was closed by 00 interrupted vicryl sutures with an omental patch used very regularly.

A through peritoneal wash was given by normal saline and betadine solution. An intra-peritoneal drain was kept in Hepatico-Morison's pouch, right and left gutter and pelvis. Abdomen closed with 1-0 vicryl and skin sutured by silk. Invariably, peritoneum was not closed.

Post - operatively patients were put on I.V. fluids, antibiotics (usually 3rd generation cephalosporines with Inj. Amikacin / Inj Gentamycin), Inj Tiniba and I.V. Pentoperazole. Drains in the gutter and the pelvis were removed on 3rd postoperative days while as the one in Hepatico - Morison's pouch was removed on 5th post op day. Naso- gastric suction was kept for 5 days and stitches were removed on 9th postoperative day. In very ill, mal - nourished cases I V proteins were given and in some cases blood transfusion was given.

A total of 108 cases were operated during this period which constitutes about 6.5% of the total surgical operations performed in this hospital.

i. 94 % patients were males, and only 6% were females.

ii. 69 cases were between 21 and 30 years of age, 25 cases in the age group of 31 yrs and 40 yrs. 4 cases were less than 20 yrs old.
iii. 85% of cases gave history of regular alcohol use.
iv. Irrational use of painkillers was a usual feature in most of the cases.
v. 90 % of the patients were smokers.
vi. 54% gave history of D.U. disease.
vii. 6%had upper G.I. bleed in the past.
viii. 85% of cases attended hospital after 24hours of symptoms.

Clinical Examination

a) Tachycardia, dehydration fever was regular feature.
b) Abdomen examination revealed diffuse tenderness, rigidity, rebound tenderness and distension.
c) X-Ray abdomen revealed gas under the right dome in 94% of cases.
d) Paracentesis Perotonii was positive in 90 cases.
e) U.S. of Abdomen showed free fluid in the peritoneal cavity.

Discussion

Duodenal ulcer perforation, if treated in time, carries a very low morbidity and mortality even in district level Hospitals. Early diagnosis and early surgical intervention is the hallmark of treatment.

Although duodenal ulcer disease has shown a steady decline over the decades with the advent of better drugs, perforation of duodenal ulcer still continuous to hover around probably due to irrational use to NSAID, alcohol,

Operative procedures conducted

S. No.	Type of Surgery	No. of cases
1	Closure of DU perforation with peritoneal toileting and drainage	37
2	Closure of perforation with omental patch	66
3	Drainage under local anesthesia	01
4	Closer of perforation with Gastro - jejunostomy	03
5	Partial Gastrectomy	01

Post Operative Complications

S. No.	Type of Complication	No. of cases
1	Wound Infection	8
2	Abdominal wound dehiscence	3
3	Plural effusion	1
4	Residual Abscesses (pelvic)	1
5	Residual abscesses (sub-diaphragmatic)	1
6	External duodenal fistula	2
7	Incisional hernia	2
8	Deaths	3

smoking and chewing tobacco. Most of the cases in the present series belonged to low socio-economic groups and had a high consumption rate of above mentioned items.

Over all prognosis of perforation does not seem gloomy in the rural sector if patients attend hospital in time and a proper surgical method is used including a through peritoneal toileting.

Although Laparoscopic surgery for DU perforations is being widely recommended in higher centers , open surgery followed by 6 weeks of drug therapy still remains the best option in rural sectors where endoscopic surgery is not available and affordable.

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Comments:

Considering the situation of Udhampur hospital (where we had held one of our annual conferences), the incidence of duodenal ulcer perforation brought out by the author is quite high. One of the reasons of such high incidence may be very high degree of mental tension and agony of common man who are constantly under threat by terrorist activities. Although why and how three deaths occurred in the series has not been analyzed and why was partial gastrectomy done in one case has not been explained, the incidence of recovery under local working condition is remarkable. Gastro-jejunostomy must have been done due to associated pyloric obstruction.

It would be interesting to see how many patients in that area develop recurrent ulcers or recurrent perforations on follow up. Instead of single closure, my practice has been that of closure by a single Heinecke-miculicz pyleroplasty - cutting through the perforation as a preventive measure for recurrent ulcer formation in the patient.

- Dr. J.K. Banerjee, member Editorial board

Prevention of Blindness: Experience from rural India

Dr. Alkesh Chaudhary

It is indeed a tragedy that while India was the first country to start National Program for Control of Blindness (NPCB), 23.5% of world blind population is still in India. Further worse is the survey result by WHO/NPCB, which says that there is a backlog of over22 million blind eyes (12 million blind people) awaiting treatment.

All surveys in India have shown that cataract is the most common cause of blindness. 80% of blindness is due to cataract. Other important common causes are Glaucoma, Trachoma, Diabetes, Hypertension, Corneal ulcers, Injuries to the eye etc. The annual incidence of Cataract blindness is about 3.8 million. Unfortunately majority of blind population due to Cataract live in rural India. Therefore it is important that all possible measures should be taken for prevention of blindness and treating curable blindness for rural population of India on priority basis.

Problems with Rural India

My experience:

In spite of the facts that so many NGO's and Govt. organizations are working with the extensive programs for prevention and treatment of blindness, we are still left with backlog. What could be the reason?

During my periodic visit to many villages of northern India while organizing eye camps, I found 20% of patients are suffering from cataract while 30% are suffering from refractive errors. The rest of the patients are with routine minor eye problems. This last group of patients is the happier lot as they often get free medicines to carry home. On the other hand it is not possible to provide free glasses for every patient with refractive errors. Surprisingly there is always an expectation and demand for it. Unless they are being provided, patients carry on with refractive errors for indefinite time without using appropriate glasses prescribed by the ophthalmologist. Financial constrain is not always the cause. It is also to do with fixed mind set and lack of motivation. During my follow up visit I have observed that even some of those who had been provided with free glasses do not use them due to wrong notion and consider it as stigma.

Some times we get patients with advanced bi-lateral cataracts who do not agree to undergo surgery. This is again out of wrong notion as they believe that so long they could see some light, cataract is not matured and hence should not be operated. This result in lens induced Glaucoma (due to hyper mature cataract) in some patients. Ultimately they either rush to hospitals as emergency patients (due to excruciating pain) which happen less often or they silently progress to incurable blindness due to glaucoma. So, up to the detection level things work. Thereafter problems start. One can not operate on some body without his/her consent. Motivation for treatment still remains a hard task. As such there are not enough of resources. Whatever is available remain mostly unutilized due to lack of awareness, motivation, ignorance, poverty and certainly lack of resources like transportation facilities enough of materials for distribution etc.

Now a day's cataract is being operated as early as it starts interfering with normal day to day activities even at a distance vision of 6/9.This has become possible due to advancement in cataract surgery like phaco-emulsification, SICS(small incision cataract surgery), ECCE with IOL etc. The post operative visual results are very good and rehabilitation of patients is much faster.

What can be done?

To make the NPCB program at least a near success the local physicians of any discipline including the Ayurvedic and Homeopathy physicians, local village leaders, school teachers and preachers - all have an important role to play. As they deal with the masses of rural population they can be trained at different level to educate people by dispelling myths and false belief, to motivate them for treatment where ever needed. They can help in arranging resources for periodic eye check up, transportation etc and thus become an active participant of blindness prevention programs.

Role of Physicians: Physicians can be easily trained for:

- Vision examination for early loss of vision
- Torch examination for early detection of cataract or any other anterior segment problem.
- Intra-ocular pressure testing for Glaucoma (Schiotz Tonometry)
- Fundus examination for Diabetes, Hypertension, Glaucoma etc. to know about early changes in retina so that the patients can be referred in time.

Role of Teachers: Teachers deal with hundred of children of different age group every day and are respected lot in a rural society. They can also be trained easily and their services can be utilized for:

- Routine vision examination of students half yearly or yearly to detect any early refractive errors. This will prevent amblyopia (Loss of vision due to disuse) in children.
- Periodic vision examination of parents and referring them timely for further treatment

Role of preachers: They are the respected lot in the rural society. They can become instrumental to educate and motivate others for proper eye care, for early and appropriate treatment, for removing wrong beliefs etc. (There is a common belief in rural areas that if a person undergoes any surgery after the age of sixty he may not survive.)

Role of local leaders: They are always in a commanding position, respected by the villagers and resourceful too. They can contribute enormously by

- Organizing periodic eye check up camps by mobilizing resources
- Arranging transportation facilities to different centers for treatment
- Motivating and educating people for the need of early treatment for any eye problem.

Blindness presents an enormous problem in India not only in terms of human morbidity but also in terms of economic loss and social burden. A collective effort from every strata of the society can go in a long way to reduce this loss and tragedy which so far India is over burdened with and help NPCB program to achieve its goal.

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Pages from a rural surgeon's diary

Obstetrics in rural practice

One good turn deserves another

Dr. R. D. Prabhu

(The story is true but all names are fictitious)

Gopal was born and brought up in a small town. His father was one of the two medical practitioners in the town. Gopal always dreamed of becoming a doctor like his father and of being able to serve the community. However, he was not aware that a doctor's life was neither easy nor attractive if his community was poor like his own town. Gopal's father managed to look after his family fairly well providing the basic comforts despite the difficulties. He always believed that the best gift a father can give to his children is good education. So he encouraged Gopal to learn whatever, and as much as he wanted to but with sincerity. Despite his personal difficulties he had decided to support Gopal to finish his medical education and hoped to support him further if ever he wanted to study more.

Gopal became a Dr. Gopal after passing MBBS. Now he wanted to become a surgeon. But he knew that if he were to study post-graduation in surgery in India it would strain his family finances further. So he decided to go to abroad where it would be easier to earn and learn all by his own efforts.

During his stay abroad, his father had a heart attack. He knew that his pain was due to ischemia of heart. Later Gopal came to know that the neighbours called in another doctor who had established his practice recently but was not qualified in modern medicine. He did not have a clue about how to proceed in a case of heart attack. Gopal's father himself guided him despite his severe pain. He told and had to convince the new doctor that he needs to be given a strong sedative injection like pethidine. But the new doctor did not have any such injection in his bag; luckily Gopal's father had an ampoule of pethidine in his bag. The new doctor injected it with a lot of hesitation and thus the patient rested for a while. By next day a cardiologist was called in from faraway medical centre. He confirmed the MI and advised strict bed rest and other medications.

Now the recovery of Gopal's father required good care and nursing. The local hospital was not equipped for management of any seriously ill patients. It was common practice then, for all serious patients to be nursed at home. The relatives managed nursing. (This practice has now been taken up by most of the nursing homes for, no nurse can offer the loving, individually personal and morale boosting care like the relatives of the patient.) The only other person in the doctor's house was Gopal's mother. Though she would have been the ideal person for the nursing the doctor, the daily household chores kept her away from the patient frequently. So it was imperative that there was another person to attend to the needs of the bedridden patient all the time. Their neighbour, one Balaji was a local merchant who also doubled as a local chemist. Balaji had great respect and love for Gopal's father. He closed his shop and decided to volunteer to attend to his favourite doctor. Day in and day out he would sit with Gopal's father administering medicines in time, attending to his other needs and also talking and cheering up the spirits of the doctor. In due course doctor recovered and Balaji returned to his trade. Balaji did all this for sheer love of his doctor

without expecting any thing in return. His loving care was greatly contributory to the satisfactory recovery of Gopal's father. Gopal came to know of all this on his return and was sorry that he was not there by the side of his father's bed during this critical illness. He was immensely grateful to Balaji for his magnanimous sacrifice and wondered if he will ever be able to repay this invaluable indebtedness.

Years passed and Gopal qualified in surgery and returned home to his parents and to his town. Things had not changed much in his town and he wondered if he could practice surgery there at all. He suddenly realised that all his foreign training had not prepared him to face the grim realities of small town constraints. All advised him to find a bigger place to settle down. So he chose Shivpur. Shivpur, though a larger place, did not have many of the basic facilities and infrastructure needed for a surgical practice. Yet it was far better than his hometown. Here Gopal had to learn many new aspects of a rural practice and unlearn many things learnt abroad. In due course of time this type of surgery came to be known as rural surgery. Gopal's parents chose to come and live with him in Shivpur.

A few years later, Gopal's father wished to visit his hometown to meet his close and dear friends and Gopal took him there. During these rounds they went to Balaji's house too. But the atmosphere there was very tense. Both Balaji and his wife appeared very worried and in tears. Their daughter was in labour in that house and now the attending nurse had told them that they have to take her to the district hospital many miles away. On Gopal's enquiry, the nurse told him that the lady was in labour for more than a day, the baby's head was being seen in the perineum but the mother was too exhausted to push the baby out. If someone could apply a pair of forceps it might be possible to deliver the baby. There was no obstetrician in town and so they have to shift the mother to the care of the obstetrician in the district hospital. Unfortunately there was no ambulance in town and finding a vehicle to carry the mother was going to take some time. Even then transporting the mother in that late stage of labour may be dangerous to the lives of the baby and the mother. Gopal had reached there just at the time when they all had, in desperation, and with prayers decided to shift the lady away.

Gopal offered to see if he can manage the problem. Though he was a general surgeon he had had some experience with delivering babies with his wife who was practising obstetrics. Now and then he had applied outlet forceps while assisting his wife. When he saw the lady in labour, he realised that what the nurse had said was indeed true. Mother was too exhausted to push the baby out but happily, the baby was not in distress yet. Fortunately there was a pair of sterilised outlet forceps in the nurse's kit bag. He washed his hands. There were no gloves to wear. He injected some local anaesthetic in the perineum and gave a generous episiotomy. He gently applied the forceps and gave a gentle pull. The baby came out easily and gave out a luscious cry cheering everyone around. Gopal completed the delivery of the placenta and sutured the episiotomy wound neatly.

Balaji was overjoyed at the safe delivery. Sudden release of tension made his eyes brim with tears. He hugged Gopal's father for reaching his house at such a crucial moment of his utter helplessness. He had given up all hopes of saving his grandchild and was praying for the life of his daughter. But now Gopal, his own doctor's son had saved them both! He blessed Gopal profusely. Gopal too was very happy that he could be of some help to a person who had cared so much for his father in the times of need. He was happy too that his new obstetric experience of rural surgery could save an innocent life.

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OP-Ed Piece

The Illiterate Surgeon

Nicholas D Kristof
ADDIS ABABA, Ethiopia

Just about the worst thing that can happen to a teenage girl in this world is to develop an obstetric fistula that leaves her trickling bodily wastes, stinking and shunned by everyone around her. That happened four decades ago to Mamitu Gashe.

But the most amazing thing about Ms. Mamitu is not what she endured but what she has become.

Ms. Mamitu's story begins when she was an illiterate 15-year-old in a remote Ethiopian village unreachable by road and with no doctor nearby. She married a local man, became pregnant and after three days of labor, she lapsed into unconsciousness and the baby was stillborn.

"After I woke up, the bed was wet" with urine, she remembers. "I thought I would get better after two or three days, but I didn't."

That's typically how an obstetric fistula arises: a teenage girl, often malnourished and with an immature pelvis, tries to deliver her first baby. The fetus gets stuck, and after several days of labor it is stillborn - but some of the mother's internal tissues have been damaged in that time, and so to her horror she finds herself constantly trickling urine or sometimes feces from her vagina.

Soon she stinks. Her husband normally abandons her, the constant trickle of urine leaves her with terrible sores on her legs, and if she survives at all she is told to build a hut away from the rest of the village and to stay away from the village well. Some girls die of infections or suicide, but many linger for decades as pariahs and hermits - their lives effectively over at the age of about 15.

Fistulas were common in America in the 19th century. But improved medical care means that they are now almost unknown in the West, while the United Nations has estimated that at least two million girls and women live with fistulas in the developing world, mostly in Africa.

This should be an international scandal, because a $300 operation can normally repair the injury. A major effort to improve maternal health in the developing world should be a no-brainer, for it could prevent most fistulas and reduce deaths in childbirth by half within a decade, saving 300,000 lives a year.

But maternal health is woefully neglected, and those suffering fistulas are completely voiceless - young, female, poor, rural and ostracized. They are the 21st century's lepers.

Ms. Mamitu was exceptionally lucky in that she was brought to a hospital here in Addis Ababa that offered free surgery by a saintly husband and wife pair of gynecologists from Australia, Reginald and Catherine Hamlin. Reg is now dead, while Catherine is the Mother Teresa of our time and is long overdue for a Nobel Peace Prize.

After that operation, 42 years ago, Ms. Mamitu was given a job making beds in the hospital. Then she began helping out during surgeries, and after a couple of years of watching she was asked by Dr. Reg Hamlin to cut some stitches. Eventually, Ms. Mamitu was routinely performing the entire fistula repair herself.

Over the decades, Ms. Mamitu has gradually become one of the world's most experienced fistula surgeons. Gynecologists from around the world go to the Addis Ababa Fistula Hospital to train in fistula repair, and typically their teacher is Ms. Mamitu.

Not bad for an illiterate Ethiopian peasant who as a child never went to a day of school.

A few years ago, Ms. Mamitu tired of being an illiterate master surgeon, and so she began night school. She's now in the third grade.

The Fistula Hospital where Ms. Mamitu works is nicknamed "puddle city" - because patients stroll around dripping urine - but it abounds with joy and hope.

President Bush has increased aid to the developing world generally and to Africa in particular, but a few days ago he rejected Tony Blair's appeal for a further dramatic increase in assistance for Africa. The real stakes in that rejection will be measured in lives like Ms. Mamitu's. I hope that Mr. Bush will reconsider - for the sake of people like those girls with fistula living in huts alone on the edges of hundreds of thousands of villages.

Ms. Mamitu shows us what a tragedy it would be to write them off. A couple of Australians once gave Ms. Mamitu a break, and so today Ms. Mamitu is not a victim at all, but an inspiration.

And, I hope, an inspiration to us to be more generous.

(This article was published in New York Times on June 12, 2005. Nicholas D Kristof was kind enough to allow me to reproduce it in "Rural surgery" - *Editor*).

Abstract:

Beyond reproduction: Women's health in today's developing world

The concept of women's health is tethered strongly to reproductive health. At present, international attention and resources are focused on obstetric events and, recently, HIV/AIDS because of the significance of these problems in the least developed nations. This limited concept of women's health, however, is decreasingly relevant to the global community, and needs to be revisited in the light of decreasing fertility and increasing life expectancy in many countries where it was previously applicable. It should be expanded to embrace the full spectrum of health experienced by women, and preventive and remedial approaches to the major conditions that afflict women. Allocation of health service resources should be aligned with the epidemiological realities of these threats to women's health.

Cause of death data for women aged 15-34 years and 35-44 years were examined for nine less developed countries. Deaths associated with pregnancy and child birth, and HIV was compared with deaths due to three chronic disease categories (cancer, cardiovascular disease, and diabetes). The women's health research literature for developing countries appearing in the American Journal of Public Health and British Medical Journal was also examined.

In seven out of the nine countries, among women aged 15-34 years, chronic diseases caused over 20% of deaths, while reproductive causes and HIV together accounted for 10% of deaths, in all countries except in India. Among women aged 35-44 years, in all but India, chronic diseases accounted for over four times the deaths attributable to reproductive causes and HIV. The causes of death were not related to the level of development in these countries as measured by GNI PPP. Papers pertaining to women's health published in public health and medical research journals focused principally on reproduction.

Extending the definition of women's health to include a concern for chronic diseases is critical if the needs of women in less developed nations are to be met. In less developed countries, chronic disease is the most important cause of female death even during childbearing years and for women with young families. Development agencies and private philanthropy must begin to fund the studies that will further refine our understanding of the role of chronic diseases in women's health in the developing world.

Susan U. Raymond, Henry M. Greenberg, and Stephen R. Leeder

From: International Journal of Epidemiology

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