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लोकाः समस्ताः सुखिनो भवन्तु

Nagarjuna: *World's first Chemotherapist?*

Born in AD 78 during the reign of Chandragupta, he founded *'shunyavad'*, the cult of nothing ness. A Siddha, a sorcerer, a powerful alchemist, he experimented on metals especially on mercury, distinguished between metals and sub metals, solvents and solubles. He also invented the process of 'distillation' and 'calcination', discovered *kajjavali* the black sulphide of antimony and was first to use mercury and antimony *(kharpar)* as medicine, making them insoluble. His Laboratory was on Shree Parvat, i.e. Shrisailam where the famous Shiva temple (Jyotirling) Malikarjuna in Andhra Pradesh is located. The Buddha in one of his discourses said one who serves a patient serves him. Nagarjuna, a Buddhist scholar, followed his tenets, inscribing his prescriptions on the stone slabs in Patna so that they were available to all. As the founder of *Rasayan* or *Raschikitsa* he was given the appellation **Rasraj**.

In This Issue

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President speaks…

Dear Member,

Let me start by welcoming all the new members that Governing Council has gladly admitted to ARSI at its last meeting in Sivakasi. I request all of them to take active part in all the activities of the association and share their experiences with all of us.

I have just returned from the CORSIV-2004 in Sivakasi, Tamilnad. Those who did not participate in it missed a nicely organised conference. This as you all know, was the first combined conference of the both ARSI and the ASRI, the rural surgery section of ASI. Thus it was a meeting of rural surgeons from many more areas of India. Members of both associations mingled as one body and participated in the deliberations. I thank Dr. Asokan, the chairman of organising committee and his team for such a grand meeting.

I am happy that both ASRI and ARSI have decided to continue such combined meeting next year too. **Next years conference will be in Ujjain, M.P.** organised by ARSI. Prof. V.K.Mehta, Professor of Surgery, R.G.Gardi Medical College, Surasa, Ujjain-456 006 has invited all to his place for the conference. So, be on a look out for the announcement.

CORSIV-2004 was special for another reason too. We had a true international flavour at the meeting. We had delegates from USA, Germany, Holland, Uganda and Tanzania besides those from India. All the delegates favoured starting the International Society of Rural Surgery **(ISRS)**. The primary aim of this society is exchange of information and participation of members in each other's meetings. As such there is no significant financial burden on any of the members of the society. Details of the memorandum and rules and regulations are being formulated. In the mean time it has been decided that our next year's conference will be called **International Conference of Rural Surgeons**.

One more step has taken to reduce the cost of surgery by ARSI members. We now may buy gloves and suture material at discounted rates directly from the manufacturers. The members have to place orders with these manufacturers with a letter from our secretary; this is only to authenticate the validity of the membership.

Our enthusiastic editor, Dr. Baasu has started World Wide Web of our association. It is **www.arsi-india.org**. He has told me that you will find detailed information on ARSI and nice pictures too. Do log on and give your suggestions to improve it, if at all.

Lastly, I would like to remind you all right now that **next year is the election year**. We have to elect new Governing Council during the next conference. I would like to see youngsters taking over the reigns of the body. During the conference at Delhi last year, Dr. J.K.Banerjee was marked for the office of the President from next year. This is a very small gesture that we all can make to a man who has done so much for ARSI.

Dr. R.D. Prabhu

Editorial

Availability, accessibility and affordability of health care services for all times, round the year are the major determinants of its success. With these fundamentals in place, delivering health care services by adhering to the socio - cultural compatibility of the community would indeed guarantee deeper reach, increased contribution and make them more appropriate in the rural context. Dr. Viju john, in his article 'Surgical care as if people mattered' - The Asha Kiran Experience, beautifully sums up these basic precepts of rural healthcare services. Initiatives like Asha Kiran Hospital are the only hope for millions in Rural India, who, amidst the vast advances in medical technology, are still deprived of basic health care services.

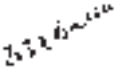
We all know that minimal access surgery (MAS) is less traumatic for the patients, allows faster healing and lowers the probability of post operative infection. However setting up a MAS unit in rural areas is not an effortless job for a rural surgeon due to its many constraints in every step including learning skills, prohibitive cost of instruments and cost of surgery. Dr. Ramakrishna and Dr. Mahabala in their article "Experience at a MAS unit in a rural area" vividly describe the step wise approach for setting up of such unit in rural areas and how to overcome the difficulties faced by a rural surgeon. As said by the author, this experience may be helpful and put into use by other rural surgeons who intend to set up similar unit in their areas to provide access to MAS to the remote population. However, for a rural surgeon the driving force for such planning should be the need of patients rather than the technology. In response to this article, Dr. J.K.Banerjee, member of the editorial board expresses his view point on MAS in a write up titled "The wonderful world of rural surgery".

Two interesting case reports by Dr. Sitanath De and Dr. Sukumar Maiti take us through the complex situations of "Presnancy with Gall Stones" and "Congenital Large Solitory Fibromatosis". While these conditions in themselves are not very uncommon, they always create a disconnect about the management strategy and clinco-histo-pathological diagnosis in the mind of the surgeon.

The tragic aspect of high maternal mortality in our country is that though we have identified the causes long ago, not much progress has been made to combat them. Lack of access to emergency obstetrics care and shortage of skilled health care personnel remains a perpetual problem in the developing world. However, focused attention to this crisis by exploring opportunities, motivation and good management strategies can make the difference. Dr. Sanjib Mukhopadhyaya's article on "Revised management protocol for Eclampsia" reflects the triumph of such effort of a rural surgeon to bring a positive difference in bringing down maternal mortality.

Modernity and rapid changes in health care delivery system quite often shakes the very foundation of doctor-patient relationship. Its essence of involvement with humane touch, sharing and caring is then overpowered by technology and thrill. Patient's care become mechanical based on bookish doctrine. At times our obsession for this modernity fails to recognize that the cultural milieu which is so essential for effective health care is often eroded by these rapid changes. Dr. Kaveri Nambisan's story "Dr.Sad and the power of lunch" told in an eloquent style reflects these dismal realities and makes for fascinating reading.

This also raises a pertinent question; does high-tech always provide better health care for the simple, ignorant and poor rural population who give value to their traditional culture and belief?



Dr. S.K.Baasu

Appropriate Surgical Care

'Surgical care as if people mattered' - The Asha Kiran Experience

Dr. Viju John

Introduction

The health care system in our country has become commercialized, technology-oriented and competitive. This has lead to inequitable distribution and availability of health care services between the haves and the have-nots, detachment and indifference of medical profession to the common man and his pathos and last and not the least a phenomenal rise in unethical practice. Surgical care is the main source of income of many hospitals and thus it stands the maximum chance of becoming influenced by market forces and money oriented manipulations. Thus appropriate surgical care has become unattainable for the common man because of various reasons like rising cost, distance of the facility, poor communication and transportation. The surgical patient like any other patient is a person first, who is intrinsically connected to his culture, community and who has his own personal beliefs and fears. Any medical or surgical care can only be appropriate when the whole personality of the patient is taken into account especially his cultural, economical and social milieu.

Asha Kiran experience

Asha Kiran Hospital is established in a remote tribal area of southern Orissa. For the past 12 years it is involved in giving surgical care to the people around this area, with due consideration to the cultural, economical and social structure of this area.

In order that the surgical care becomes appropriate we focus on ensuring availability, improving accessibility and increasing affordability of the surgical care. A conscious effort is made to understand, identify and alter where ever necessary the attitudes of people and finally there is an attempt to see the bigger picture on a national scale.

Availability ensured

Availability is ensured by the location of the surgical facility in a remote area. Scattered around it are about 220 villages and hamlets and the people living here have no surgical care for a distance of 50-100 kms. The health scenario is very dismal. IMR is more than 100, malaria and tuberculosis is very rampant. Now in Asha Kiran hospital the people have a 35-bedded secondary level hospital with provision for care in surgery, medicine, obstetric ad gynaecology and ophthalmology. There is also an X-ray, laboratory, ultra sound scanning and blood bank. Currently there are about 8 doctors and 16 paramedics who are resident staff and their services are available round the clock. The people here are very poor, 80% living in subsistence economy. The transportation and communication facility is very inadequate.

Accessibility improved

The tribals are basically very shy and are wary and cautious of anything new or foreign to them. The facility has been designed in a tribal friendly architecture. Tribal friendly schedule and practices are followed in the facility. The hospital is community based. A network of about 200 female community heath workers from each village is in place.

They provide treatment for common ailments of the villagers, identify serious cases and motivate and refer them to the base hospital.

Affordability increased

It is common for patients here not to avail medical treatment and dying in the villages due to lack of money. In these circumstances

there is hardly any point in setting up a surgical facility unless the affordability of the patient is increased. An attempt is made to keep the personnel cost to about 40% of the revenue budget in our facility. Using generic drugs has helped in bringing down the cost of the treatment and we follow a simple rule of keeping the treatment cost effective and believing that the adherence to latest is not necessarily the best. The facility has started a rural health care scheme for the past 2 years. The villagers are encouraged to pay a nominal amount for a year and they are allowed to avail any treatment from the hospital for one-fourth of the total cost. This to avoid their reluctance to come for treatment during lean seasons, when the money is scarce. The institution also tries to increase cash available in the villages through self-help groups and other income generating programmes.

Attitudes changing

The people have a rich and a proud culture here. However many beliefs and attitudes are wrong and misplaced. Pain and diseases are not rated highly if there is harvest or when there is a festival or a holiday. There is cultural objection to colostomy, mastectomy and caesareans. Conducting regular village health worker training and IEC campaigns on various health related topics challenges these wrong attitudes. The facility is also involved in training NGOs in various aspects of health and related topics. Along with this effort there is an ongoing mother tongue literacy drive targeting mainly women, which has helped in creating health awareness among the villagers.

Attempts to see the Big picture

Surgical care becomes appropriate when it addresses the health and health care needs of people on a national perspective and organizes itself accordingly. It involves seeing the surgeon as part of a Health care team, seeing surgical care as part of holistic care and of total rural development, seeing hospital essentially as a part of social and medical system that provide complete health care for the population and as a community-health-oriented institution with responsibility in the field of preventive medicine and health promotion.

Thus the surgeon and the surgical facility becomes a catalyst or an agent of change in making primary health care - essential health care which is accessible, acceptable, and affordable and which has community participation - for all, a reality in the beloved country of ours.

Adequately helped?

Surgical care becomes appropriate when the people of this region are adequately helped

When can we in Asha Kiran say that? …

When the man across the lake with acute surgical emergency at night need not wait for a boat till morning, or

when the woman with central placenta previa does not refuse caesarean section because of ignorance, or

when the parents do not refuse colostomy on their baby with ARM due to the fear of social ostracism, and

when the people of our area have been ***empowered to access affordable quality (surgical) care in time***.

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Experiences at a M.A.S. unit in a rural area

Dr. Ramakrishna HK

Dr. Mahabala K

This article is aimed to serve as a useful guide for those who want to start minimal access surgery (M.A.S.) in a rural area. For those who are already doing MAS especially in urban area this article may not be interesting.

Bhadravathi is a Taluka place in Shimoga district of Karnataka. It has a population of about 2,00, 000. Most of the patients from this area belong to poor or middle class.

Growing interest

Though I knew about MAS, I got interest in it when I attended KASICON 2001 at Hubli. I decided to start MAS unit at Bhadravathi. To begin with I started collecting information about MAS training centers; about surgery itself, cost of establishing a unit, its problems etc.

Attending conferences is very useful in this regard. There we can meet lot of surgeons who are already doing MAS. With them one could discuss feasibility and problems he is expected to face. We get more confidence if they are also from similar background. There will be lot of stalls of dealers of laparoscopic instruments. This gives an opportunity to look into the instruments and have fairly good idea about their quality, usefulness, costs etc. in one go. We can also see lot of video presentations on laparoscopic procedures. In these conferences I had exposure to lot of discussions on pros and cons of laparoscopic operations.

Preparations

The next step is to get trained in the MAS. I applied for observer ship at Sir.Gangaram hospital, New Delhi, under Dr. Pradeep Chowbey. He and his team taught me lot of useful tips on MAS. There I saw many laparoscopic procedures. Later I attended a workshop at Coimbatore organized by Dr. Palanivelu. I read a few books on MAS to acquaint myself with theoretical aspects.

With this background I started planning for the set-up. I had only a clinic with facility for UGI Endoscopy and minor operations. So, to set up a MAS unit on my own I required infrastructure for major OT and beds. Also, the investment for the instruments was beyond my capacity. So I approached Dr.Mahabala K, who already had a hospital. He came forward for investing in the project. We got quotation from laparoscopic instruments dealers and finalized the deal. We worked on the endo-trainer for a couple of days. I feel it helps only in moving the instruments and in getting "depth" perception. We also tried endo suturing and knotting in endo-trainer.

We didn't try practicing on any animal lab. Ultimately we have to operate on human beings. Until we do human surgeries we never get confidence with any length of training in endo-trainer and animal lab. It is like trying to learn open surgery in post mortem room. However, they help in getting hand-eye co-ordination and getting used to two-dimensional image.

I firmly believe that a good open surgeon can always shift to laparoscopic surgery. It is not necessary to have any Laparoscopy phobias. The criteria for doing laparoscopic surgery found in the textbooks are not possible to meet in our rural surgical set-up. Finally in September 2002 we started doing the surgeries.

Our Statistics (Between Sept 2002 & May 2004)

Appendicectomy	54
Cholecystectomy	09
Sterilization (tubectomy)	70
Ovarian cyst	19
Ovarian drilling	23
LAVH	17
Ectopic rupture	08
Diagnostic	05
Hydatid cyst ovary	01
Cyst of abdominal wall	01
CDU Perforation closure	01
Total	**208**

Conversion

LAVH	05
Diagnostic	01
Appendicectomy	01
Total	**07**

Problems faced:

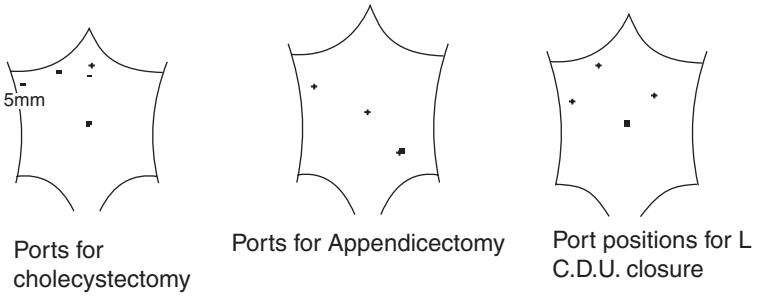
We had difficulty in introducing the first cannula. This is because passing first cannula is blind. We were too scared about causing intra-abdominal injury. But then, it is better that way than being rash and causing injuries. If we get complications in the initial cases, our confidence gets eroded. In one instance it was not possible to introduce the cannula by closed method. So we decided to introduce it by open method. Some time or the other this need arises for every body. So, it is better to have a Hassan's cannula in the armamentarium. Once the first cannula is introduced, rest of the cannulae doesn't pose any difficulty as they are introduced under vision.

Initially, setting up the instruments was time consuming. Now, we have a trolley on which monitor, CO2 insufflators, cautery, light source, camera processor are set. This saves a lot of time in setting them every time.

Initially we used to take longer time to do a case. But, once we got the "hang" of the instruments we became more and more confident. At the beginning we were very cautious about tissue handling, cauterizing, dissecting etc. Fortunately, we never had any major complications like visceral or vascular injury till now. Operative time rapidly decreased with increasing experience, e.g. first Appendicectomy took about two and a half hours whereas now it takes hardly 30 to 40 minutes.

Actually we had more phobias initially about the procedure after reading many textbooks and by the advice of some senior surgeons. In practice we found it is much easier. We believe any good open surgeon can do MAS with some learning. Change over to MAS is possible at any age.

We must be ready for conversion to open surgery at any point of time, if the situation demands. Patient's safety is most important. There should not be any ego or hesitation. In MAS, conversion is considered as a sound judgment and not a failure or complication. In our experience we had to convert in 5 gynecological cases. All were planned for LAVH (Laparoscopic assisted vaginal hysterectomy). In one case there was broad ligament fibroid. This we couldn't enucleate laparoscopically. Hence, we opened and did enucleation. In the other 4 cases, there was troublesome bleeding which we were unable to control laparoscopically. Conversion was done to control bleeding. For general surgical cases, two of them were opened. One case was done as a diagnostic procedure for pain abdomen. During laparoscopy a loop of ileum was found to be gangrenous. Hence, laparotomy and resection-end to end anastomosis was done. In the other case, appendix was too inflamed and covered with omentum and intestinal



Figures of the port positions

loops. Though we could separate adhesions to some extent, it was not possible completely. So, keeping patient's safety in the mind, the case was converted to open surgery and Appendicectomy was done.

Documentation was a problem. Switching on and off the recording button at appropriate time disturbs the concentration of the surgeon. It is not always possible to have medical man who can record only the important steps. Once recording is off, we forget to put it on at the time when recording is required (hence, loosing the important video clipping) and vice versa. We now record the whole procedure in a new VHS video cassette and edit it at our leisure time. But this has the disadvantage of loosing the quality of image to some extent at the time of editing.

In the beginning we had difficulty in getting the specimen out especially for ovarian cysts, hydrosalpinx, which are bigger than 10 mm port. Now, we cut the specimen into small pieces before freeing the specimen completely. Partial attachment helps in giving traction and cut. It is difficult to cut a completely free specimen.

In Appendicectomy, we used to face difficulty in manipulating the instruments intra-abdominally when third port is placed on the Mc. Burney's point. There used to be "sword fighting" inside the abdomen. This can be avoided by placing the third port at a higher level in the right hypochondrium. In pediatric cases, more working space can be obtained by placing the second port (suprapubic) about 2-3 inches laterally rather than midline.

Like wise, epigastric port placement is vital in laparoscopic Cholecystectomy for Calot's triangle dissection. A wrongly placed port gives so much trouble that it is prudent to place another port in correct position as soon as we recognize this problem than to struggle with the wrongly placed port. Some times this "wrong port" helps in retraction of liver with a fan retractor.

We use pre-tied loop (with Roeder's knot) for the appendix stump ligation. Initially we used thread to save money. But the knot doesn't slip easily and sometimes thread breaks while tightening the loop. Like wise, after giving a thorough trial we gave up silk, chromic catgut also. Now we routinely use a new No. 1 vicryl for every case. (Old partially used vicryl stored in spirit looses strength and it breaks while tightening the knot). With this, the stump ligation is no more a problem for us now.

In one case of laparoscopic Cholecystectomy, while dissecting the gall bladder from the liver bed, the wall of the gall bladder got perforated. This should not lead to panic. I placed a grasper on the perforation site so as

to close the perforation (to prevent the bile leak) and continued the dissection. In the end thorough saline wash was given. (Alternatively a pre-tied loop may be placed over the perforation site to close it).

After gaining initial experience we did a duodenal perforation closure by suturing with chromic catgut and intracorporeal knotting. We took a little longer time (about 2 hours) but the end result was satisfactory. Patient was a manual laborer. He could return to his normal duty after about 2 weeks.

In the urban set-up charges for laparoscopic procedures are quite high e.g., laparoscopic Cholecystectomy is about Rs. 25000 to 40000. If we charge this much we will not get a single patient who can afford this. The cost has to be such that majority of the patients could afford. Then only we get sufficient number of patients. If we don't get enough number of patients we will not be able to learn the new procedure. Our policy is, we charge about Rs. 2000 more than open surgery charges. (Sometimes at par). At this rate, if we get 100 cases in a year, it takes 2 years to get back the investment of Rs. 500000. Of course, we also have to consider the repair cost, if any, in this period, other expenditures like cost of CO2, gluteraldehyde used for sterilization etc. We have to compromise in the beginning with the profit margin. When we get more number of cases we get some profit and the money for further investment.

Conclusions

Minimal access surgery is very useful in rural surgical practice. If we can remove its major disadvantage, that is cost, it suits very well in our practice. It is our responsibility to make it more affordable and extend its benefits to the rural population. It can be learnt and practiced at any age, by any surgeon, anywhere provided the surgeon is willing to learn and puts his/her heart. There no need for phobia.

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View point...

The Wonderful World of Rural Surgery

Dr. J.K. Banerjee

"And I Say To myself ...Oh! What a wonderful world....."
(Late Louis Armstrong.....famous US Jazz musician and singer)

As a founder member of the A.R.S.I., I have traveled across the length and breadth of our country attending rural surgery conferences... away from large cities ....into small towns and in remote rural areas. In the process, I have come across many colleagues of ours doing wonderful work for the community. All of them provided warm hospitality. Today my heart is full with their love (which I could hardly reciprocate) and my mind is very rich with the knowledge of their dedicated and innovative works. Taking newer technologies to rural patients - It has so many dimensions. Dr.Tongaonkar`s setting up a rural hospital in Dondaicha and ensuring continuity of service through his sons and daughters in law, Dr.Sitanath De`s practice in Jhargram, Dr.K.C.Sharma`s setup in Udhampur are all examples of taking newer technologies to rural patients. In recent times, the Asha Kiran Hospital in Orissa and the Sittilingi project of the Regi couple are wonderful examples of taking newer technology to rural patients. In the next issue we will publish a communication from our member Dr. Abrol of Jammu regarding taking the technology of "No scalpel vasectomy" to doctors working in dangerous areas of Kashmir. And it is also remarkable how one rural surgeon has taken great pains to carry laparoscopy (M.A.S.) into his area of practice as a new technology to rural patients.

Few years back, I had the opportunity of attending a world conference on "prioritization in healthcare" in Stockholm. It gave me an exposure in the concepts of prioritization being done in the area of healthcare in developed societies. It is unfortunate that many of us have no knowledge of it. We are also reluctant to study the needs of our patients and more often we tend to decide "what is best for the natives" from our points of view.

Today in India, the glamour of M.A.S. has occupied the centre stage of general surgical practice. While Prof.Wilfried Lorenz of Marburg, Germany reviewed about sixty papers published in standard western medical journals relating to the comparative study of lapchole vs. open chole performed in the same unit. His finding was that there was no difference in either meeting the expectations of the patients or in their quality of life between the two procedures. He concluded that it was the surgeon's bias that gave different results between the different procedures. (Personal communication)

Today, one has to be very careful working alone in a rural setting because of its constraints. With blind propagation of laparoscopic surgery in rural settings, by the country's industry-professor nexus, there has been a TEN times increase in patients coming into Delhi teaching hospitals with iatrogenic bile duct injuries from the periphery. Our rural community is quietly bearing the brunt of "newer technologies" imported into rural areas. In our conference at Vapi in Gujarat, I pointed this out to Prof. Udwadia and am still waiting to get a suitable reply.

In this background, it is very heartening to see many rural surgeons not loosing their heads in the glamour of M.A.S., and "prioritizing" their inputs after studying the needs of the communities they are serving. M.A.S. will always

remain a low priority area in the inputs of newer technology they carry to their rural patients.

Albeit this criticism is not being done to undermine the good works of surgeons like Dr. Ramakrishna, or others like Dr. Sivasubramanaiyan or Dr. Dakshinamurthy or Dr. Singhal of Muzaffarnagar. The only important issue is to "prioritize" our inputs in our "wonderful world" of rural surgery.

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Important News

On the 25th July 2004, Rural Medicare Society organized a symposium on "Current Status of Rural Surgery". This was held at the Delhi Medical Association auditorium at daryaganj Delhi. It was held at the request of the CME foundation of the Delhi state chapter of the Association of Surgeons of India. Prof. S.K. Nair and Dr. S.K. Khatri was in the chair. The speakers were Dr. J.K. Banerjee, Dr. Varghese Philip, Dr. R.R. Tongaonkar and Prof. Arvind Kumar from the AIIMS. Organisation was done by Dr. D.P.S. Toor and Dr. V.K. Gopal on behalf of Rural Medicare Society.

The symposium was highly appreciated by the audience which comprised mostly of professors and sophisticated city practitioners. How Dr. Tongaonker evolved his hospital and imparted health education to the population in the village of Dondaicha in Maharashtra, how Dr. Varghese Philip set up a hospital against all odds, amongst tribals in Orissa were admitted as eye openers by Senior surgeons attending the symposium.

Rural Medicare Society remain grateful to them for giving this session a patient hearing.

At the end of the session, Dr. K.C. Mahajan, patron of the foundation, and Emeritus surgeon and chairman department of Academics, Sir Ganga Ram Hospital, New Delhi, promised to start the DNB course in "Rural Surgery" in his institution. We understand he has to overcome many hurdles in doing so. We however extend our whole hearted support to him in this regard. A course has been designed and he has sent this to the chairman of the National Board of Examinations. And we now eagerly wait for the results. Dr. Vinode Shah of CMC Vellore has also agreed to team up with us in our efforts.

Once this comes through, the rural surgeons could send their children who become doctors to do this course and take charge of their work in future.

Part of the practical training will have to be in our hospitals. For that purpose our hospitals will have to be "standardised". The Association will now have to work in this direction. For any postgraduate course in Rural Surgery, our Association will have to be able to provide practical training in our hospitals.

Pregnancy and Gall Stone

Dr. Sitanath De F.R.C.S.

[Abstract: The author presents a case of 27 years old, female patient with Gall stone (sludge) developed during pregnancy and detected a month after Caesarian Section, when she presented for investigation following an attack of cholecystits (U.S.G. proved) A repeat U.S.G. after 2 months showed complete clearance of stones from the gall bladder. A decision to perform a Cholecystectomy earlier was deferred. The findings have raised questions regarding follow-up and management in relation to subsequent pregnancies.]

Key notes: Gall stones during pregnancy, Disappearance of stones in puerperium

Introduction:

Pregnancy is one of the predisposing factors producing billiary sludge and stones in the Gall bladder. The fate of this sludge during the puerperium and the remaining part of fertile life is not fully known. But it is well known that gall stones are frequently found in fertile females.

Case History:

A 27 Year-old female developed Billiary colic with Acute Cholecystits, 4wks. after caesarian delivery of first baby

Date of L.S.C.S. - 9:12:02
Date of onset - 9:0 1:03

U.S.G. done on 9: 1:03 revealed stone in the gall bladder. She was treated conservatively, with success, and advised operation within six weeks.

The patient's date for operation was further deferred due to persistent lochial discharge and urinary infection for a few days.

On 9:3:03, a check U.S.G. was done, on her husband's request, and it was seen that there was no stone in the gall bladder. The decision to operate was temporarily withdrawn and the patient is under follow-up for any further symptoms, with or without pregnancy.

On recent enquiry, (28:4:04), the patient remains well but complains of intermittent flatulence and dyspepsia.

Fig 1: Multiple echo reflective calculi seen, which layers posterior walls and casts strong shadows.
No mass seen.
G.B. size normal.
Walls are normal. CBD 5mm.

Fig 2: Gall bladder normal in shape, size wall thickness normal.
No calculi / intraluminal pathology seen.
CBD normal size 5mm.

Discussion:

The presented case poses several questions regarding its management.

Is the patient likely to develop Billiary sludge in subsequent pregnancies?

- If thought "Yes" should she have undergone a Cholecystectomy?
- Should she be followed up by repeat U.S.G.?

The explanation of the disappearance of the gallstones remains thought provoking. It is possible that during puerperium the gall bladder has regained its contractility and has been able to expel the sludge during the episode of billiary colic on 9:1: 03.

Possibly an improved appetite and a change of diet after delivery have led to the reversal of cholesterol crystals into soluble cholesterol! As a rural surgeon, it is very difficult to obtain relevant references to similar cases. The author has been compelled to rely on his own clinical judgments in dealing with this case, the first he has seen in a long surgical carrier

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Editor's note: *Pregnancy is associated with an increased incidence of gallstones. However, most gallstones disappear spontaneously after pregnancy without having given any symptoms. These conditions support a conservative attitude towards treatment of gallstone by the author. The fluctuating course of biliary sludge and gallstones (present during pregnancy and absent after delivery) may be attributed to the impressive modifications of flow dynamics and lithogenicity of the bile and motility of gallbladder that occur during pregnancy and resolve completely after labour. This may explain the disappearance of most of the gallstones. The changes in hepatic bile that occur in the last trimester of pregnancy are due to high estrogen levels [1]. The lithogenicity of bile [1] and the gallbladder stasis that is present during pregnancy [2] may favor the retention of bile, nucleation, and crystal formation that finally generate sludge and stones [3,4,5]. After delivery, billiary composition and gallbladder motility return to normal; thus, sludge and small stones may be eliminated or dissolved [7,4,6].*

Alberto M, in his study, reported new formation of billiary sludge and gall stone in otherwise normal pregnant women as 31% and 2% respectively. With a mean follow up of 5 months after delivery he found sludge disappeared in 61% of these women and stone disappeared in 28% of them.[8]

Van Bodegraven et al after a similar kind of study concluded that increased fasting gallbladder volume seemed to be a permissive factor of pregnancy-associated gallstone formation.[9]

Contd. on p. 15

Abstract from the Journal

Treatment of Amebic Liver Abscess

Christopher Wells and Miguel Arguedas
(From southern Medical journal via med scape)

The main stay of therapy for Amebic Liver Abscess is metronidazole, which is effective in eliminating the intestinal and extra intestinal infection. The standard dose is 750mg orally three times daily or 500mg intravenously every 6 hours for 7 to 10 days, with oral administration being the preferred route. A shorter duration of therapy has been shown to be efficacious with metronidazole and other nitromidazoles such as tinidazole or ornidazole are effective. After treatment with metronidazole patients should be given a course of another agent to the luminal carrier state that occurs to 40 to 60% of patients. This can be accomplished by treatment with other iodoquinol, paromomycin, or diloxanide furoate. Some authors have suggested that critically ill patients or patients not responding to metronidazole receive emetine or chlroquine in addition to metronidazole, but these drugs have a high incidence of side effects and their use should be limited to special circumstances. Pharmacologic therapy is adequate in more than 85% of cases. No documented resistance to metronidazole by E histolytica has been observed clinically, but there have been experiments demonstrating resistance related to inducing increased super oxide dismutase activity in vitro.

The indications for percutaneous drainage include large ALA in which rupture is believed to be imminent, abscesses in the left hepatic lobe at risk for rupturing into the pericardium, and treatment failure in which fever and pain persist for 3 to 5 days after the initiation of therapy. It should be noted that even large (>5cm) uncomplicated ALA typically respond to medical therapy. Surgical drainage has been replaced by percutaneous drainage in most cases; it is rarely performed and should be reserved for those lesions that are large, at high risk for rupture and not accessible for percutaneous drainage. Abscess fluid obtained should be sent for Gram stain and culture to rule out bacterial superinfection, which would require more aggressive drainage techniques. Complications arising form aspiration include bleeding, bacterial superinfection, peritoneal leakage and injury to adjacent structures.

Revised management protocol for eclampsia in rural Purulia (West Bengal) and lowering of maternal mortality

Dr. Sanjibkumar Mukhopadhyaya

Out of different social and health indicators, maternal mortality ratio is one factor which concerns not only the doctors but also the social scientists for various reasons. If one observes the maternal mortality rate in India over past 20 years, it will be evident that although other mortality rates (eg.infant mortality rate) have decreased considerably over the years, maternal mortality rate has not changed significantly. Women continue to die out of a physiological process i.e. pregnancy and delivery.

Maternal mortality is perhaps unique among public health problems, in that its reduction depends on the treatment rather than the prevention of illness. In other public health areas the emphasis is often on primary prevention (preventing the disease) rather than secondary prevention (preventing death and disability as a consequence of the disease).

What is most frustrating part in combating maternal mortality is that the causes of maternal mortality have been identified long back and yet not much progress has been made in treating those conditions when they actually occur.

Thus although we know that haemorrhage, eclampsia and sepsis are the principal causes of maternal mortality in the developing world-high percentage of cases remain unattended or attended by unskilled persons at home deliveries. No uniform protocol of management is followed for their management even for institutional deliveries. This is because no uniform guideline exists from the administrative or academic policy making authorities and thus the lack of uniformity in management at the available facilities.

While working at one of the remote districts of West Bengal - Purulia in connection with emergency obstetric care training programme - it was found that at the District Hospital level the principal maternal killer was eclampsia. More than 50% of total maternal deaths were in cases of eclampsia (table I).The district hospital being the only referral hospital (level III) in the whole of the district - all cases of eclampsia are sent there.

Table 1

Initial Survey 2001		
Total no. of deliveries	:	6039
Maternal deaths	:	80
Deaths due to eclampsia	:	47
Total no. of eclampsia cases admitted	:	184
Eclampsia deaths as % of all maternal deaths	:	58.7%
No. of cases of eclampsia treated with standard	:	0
Protocol i.e. MgSO4 Case fatality rate of eclampsia	:	25.5%

While investigating the cases of deaths due to eclampsia, major obstacles in improving mortality were identified as:

1. Lack of initial management
2. Patients -traveling a long distance
3. No uniform protocol of management being followed
4. Mostly lytic cocktail and/or diazepam are used to control convulsion

Table 2
Eclampsia management & death in Purulia district hospital

INDICATOR	2001	2002*	2003 (January-July)
Total no. of delivery	6039	5993	3657
Maternal deaths	80	68	38
Eclampsia deaths as % of All maternal deaths	58.7%	57.3%	44.7%
Total no. of eclampsia Cases admitted	184	204	127
No. & % of eclampsia cases Managed using standard Protocol (MgSO4 regimen)	0(0%)	4(2%)	65 (51.
Case fatality rate of eclampsia	25.5%	19%	13.4%
CFR of eclampsia cases treated With MgSO4	NA	0%	7.7%
CFR of eclampsia cases NOT Treated with MgSO4	25.5%	19.5%	19.3%

*EmOC training started in Purulia in September 2002

$MgSO_4$ was found to be very effective in controlling convulsion without any serious side effects provided one adheres to proper monitoring criteria. Another great advantage with it was patients remained well alert during the course of treatment.

First and foremost task undertaken was to familiarize the doctors and nursing staff with preparing a definite treatment protocol and use of Inj. Magsulph. It was emphasised that eclampsia can be treated at the peripheral centers also with the use of same treatment protocol. Only indication of transfer may be - when patient requires an operative delivery or develop some complications.

Treatment protocol with MgSO4
Loading dose:

- First dose- 4 Gms (20ml.of 20% solution) of Inj.MgSO4 I V slowly over 20 mins.
- 10gms. of MgSO4(undiluted-5gms.in each buttock) given deep I M

Maintenance dose:
Before initiating the maintenance dose one should check:
1. Urine output is at least 100ml.per 4 hrs.
2. Respiratory rate is at least 16/min.
3. Knee jerk is present
(If they are absent -the next dose is postponed)

Treatment with MgSO4 should be contd. for 24hrs. after delay or last convulsion, which ever occurs last. [Antidote: Inj.Calcium Gluconate 1gm.10ml. Of 10% soln. May be given I V slowly]

Later some modifications were tried in the Magsulph. Regime-

1. 4 gms of Magsulph was given IV over 30

minutes after diluting it in 100 ml of 5% dextrose- through IV infusion along with 10gms. of IM injection.

(This was necessitated by the fact that giving IV injection in shot over 15-20 minutes using 20 ml. Syringe was found not to be very practical with Nursing Staff)

2. Maintenance dose was reduced to 2gms.IM 3 hrly. (If there was no convulsion in-between)

3. Prophylactic use of Magsulph. - In cases of severe PET with features of imminent eclampsia in a dose of 2gms. IM - 3hrly depending upon disappearance of symptoms/delivery

4. Use of a single dose of 5gms. of Magsulph. IM while shifting the patient of eclampsia/imminent eclampsia from periphery to higher centers.

The results were compared later after the introduction of altered management protocol at the district hospital of Purulia and shown in Table II.

It is evident from the results obtained so far that present management strategy has helped to a great extent in reducing deaths from eclampsia. However what is more important in peripheral centers is to realise the fact that certain obstetric complications like eclampsia can be effectively treated in desperate situations with minimum equipments but sound knowledge base with some amount of commitment.

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Editor's... contd

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Congenital Large Solitary Fibromatosis (a case report)

Dr. Sukumar Maiti

Abstract:
Congenital solitary fibromatosis is an uncommon lesion. Sometimes it may be mistaken as a sarcoma. Prognosis is commendable after simple excision.

Key words: Fibromatosis, Large and solitary, Injury during birth, Sarcoma-like

Case

A new born female baby was admitted immediately after birth with a swelling on her left deltoid region. There was bleeding from an ulcerated area on the surface of the swelling. The baby was born of a primi mother, after a prolonged labour and obstetric forceps was applied helping the delivery.On examination the baby was otherwise healthy except the lesion near the left shoulder region. It was 12cm X10 cm in size, with bosselated surface, purplish colour and patchy black areas on the surface. Except posteriorly the margins were well defined. There were multiple dilated and tortuous veins radiating away from the surface of the tumour. There was a breach on the surface skin of about 2.5cm X 2cm, through which the tumour was found to bleed. The swelling was firm and not compressible. The tumour was fixed to the overlying skin but apparently not fixed to the underlying bone. The lymph nodes in the neck or axilla were not palpable. The bleeding from the surface of the tumour was stopped with the help of sterile pressure dressing. No other swelling or abnormality was detected anywhere in her body.No neurological deficit detected in the limb.Routine blood examination report was within normal limits. The plain X-Ray showed no abnormality in the underlying bone.

The baby was operated on the 3rd day after admission. Perioperative antibiotics and blood transfusion was given. The tumour was highly vascular. The superficial part of the underlying deltoid muscle was removed as it was found to be infiltrated. The major portion of the wound cover was made possible by mobilising the adjacent skin.Rest of the wound area had to keep uncovered. The postoperative period was uneventful. The uncovered wound area was latter found to be filled with granulation tissue. Epithelial proliferation from the periphery helped needing no further skin grafting.In two year follow up there was no recurrence.

The Specimen- The cut surface of the tumour was fleshy in appearance with small areas of haemorrhages. Two halves of the specimen were sent to two different laboratories. From one laboratory the histopathology report was haemangio-endothelioma, a malignant tumour and from another laboratory the report was infantile fibromatosis without any feature of malignancy. After review, the pathologist of the first laboratory afirmed the diagnosis in favour of fibromatosis changing the previous report of malignant haemangio-endothelioma (fig. 2).

Discussion:

The fibromatosis has been defined as "an infiltrating fibroblastic proliferation showing none of the features of an inflammatory response and no feature of unequivocal neoplasia"[1]. More broadly "a group of non-metastesizing fibroblastic tumours which tend to invade locally and recur after attempted surgical excision". Infantile fibromatosis is more common than other type of fibromatosis viz. desmoid fibromatosis, fibromatosis colli (sternomastoid tumour) and agressive fibromatosis[3]. They are circumscribed but usually non-capsulated and originate

Fig. 1 - Anteroposterior and lateral views of the tumour on the left deltoid region of the newborn

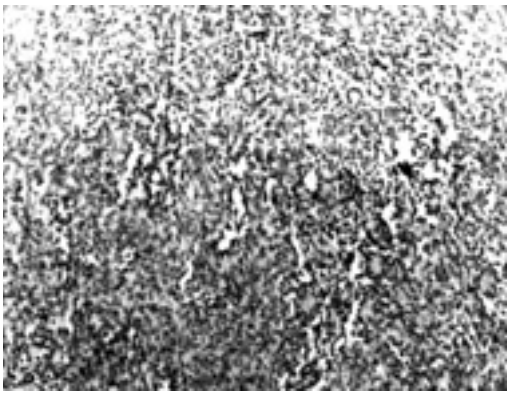

Fig. 2 - Histopathological picture of the tumour (H & E - 100X)

in lower dermis of skin or subcutaneous tissue.

The ultimate clinical evolution of these lesions if untreated is unknown, because they are all locally excised.Although a few has recurred, requiring re-excision, they have no aggressive potential[3]. Their biological behaviour falls between benign fibrous proliferation and malignancy(fibrosarcoma)[4]. They are mostly fibroblastic or myofibroblastic in origin and contain large amount of collagen. Their etiology is debatable but the underlying problem is defect in connective tissue formation[2]. Some of the tumours have little or no tendency to recur[5]. Histological distinction between the infantile fibromatosis in children and a true fibrosarcoma may be impossible in some of the cases. The final truth is being determined only by the patient's clinical course. The infantile fibromatosis commonly occurs in region of head,neck,axilla,shoulder, upper arm or thigh[6].Superficial tumour can be purplish red because of intense vascularity[2]. Visceral involvement has been described and is associated with worse prognosis[7]. Lesions are usually solitary but can be multiple[8]. Multiple fibromatosis involving subcutaneous tissue, muscle and bone has a good prognosis and spontaneous regression can occur. Generalised fibromatosis differ from multiple type in that there is visceral involvement and a very poor prognosis, especially if there are lung lesions with most patients dying within four months[9]. In a series of 55 cases of fibromatosis diagnosed and treated at British Columbia's Children Hospital from 1982 to 1995 in the age ranging from 1 month to 14 years, eighteen (33%) tumours were congenital.Infantile fibromatosis was present in 10 cases. Other types were musculoaponeurotic fibromatosis (n-27), fibromatosis colli (n-7) and digital fibroma (n-4). Clinical follow up showed a survival rate of 98%. Nine cases of infantile fibromatosis spontaneously regressed[10].

Histological appearance consists of increased cellularity, atypical cells and variable mitotic rates within a single tumour. It can be easily confused with infantile fibrosarcoma, haemangiomas and other soft tissue tumours and frequently misdiagnosed6. Although these tumours may initially increase in size, some authors believe that spontaneous regression is the natural history of these tumours[8]. Thus excision of only symptomatic or visceral lesions is recommended. The rate of recurrence after resection is10%. In cases of recurrent or non-resectable tumour, a period of observation is advised. Progressive lessions at dangerous sites can be expected to respond to chemotherapy, but if possible this should be defered until the baby is older and more tolerant to chemotherapy[11]. Chronic low dose therapy appears to be more effective than more intensive treatment[2]. In the present case a large solitary infantile fibromatosis of left deltoid region was probably one of the factor causing difficult labour. The tumour was

injured at birth of the baby during the process of labour. The tumour was resected and it did not recur in 2 year follow up. Dilemna in histopathological diagnosis happened due to close similarity of cells of fibromatoses and malignant connective tissue tumour.

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Op-Ed piece

Dr Sad and the Power Lunch

Dr. Kavery Nambisan

As a young doctor fleeing from the perpetual anxieties of city life, I came to Baitinda to work in a hundred-bed hospital managed by nuns. Baitinda was eighty, pothole-ridden, dacoit infested kilometers from Patna. Given the bare facilities, we did a decent job of treating those who could not afford city prices.

Antiquated medicines like tincture belladonna, ipecechuana, carminative mixture and plaster of turpentine were in common use while penicillin was reserved for nasty infections. We were cheap and reliable. I performed surgery with the naïve poise of a fledgling, using a hallowed textbook of surgery as my surrogate boss, friend and adviser. Over the years, I became isolated from the progressive world of medicine. And when I made mistakes, I found out the hard way.

In my fourth year at Baitinda, a new administrator took over. Sister Perpetual Succour was a foreign-returned doctor. She was determined to modernise the hospital and take it to 'new heights of excellence'. Out went the mixtures, plasters and even penicillin; we prescribed capsules and higher antibiotics. Suddenly realising that the hospital was really very backward, the nuns went on a buying spree. Patients watched bewildered as some equipment or the other was unloaded from a truck every week: a new ECG machine, a cardiac monitor, a pulse oximeter.The nuns worked hard to get donations for purchase. The expenses went up and so also the bills. The villagers believed that machines and expensive medicines would somehow provide good health. And they did not complain. PS was set on making us efficient.

Work started at 700 hours and finished at 1800 hours with a thirty-five minute break for lunch. She set up committees: waste management committee, drug purchase committee, food committee. She encouraged us to read the foreign journals which she subscribed to. Aware of the deficiencies in my knowledge I made amends by staying longer in the library. I walked with brisk steps to the hospital, relied on machines to tell me the diagnosis, did less and felt triumphant. Everyone was given a responsibility: I was in the food committee. Instead of the usual thali meal served at the hospital canteen, we had boiled egg and tomato sandwiches wrapped in plastic; puris and idlis for breakfast were replaced by bread and jam. Easier to serve and less messy. For some of the staff including me, it felt good, almost fashionable to be munching abacterial, aseptic sandwiches while reading a journal in the library.

Soon food came to preoccupy me in another way: An international medical conference was to be held in Mathura which PS kindly recommended that I attend: a two-day jaunt to the land of Sri Krishna, a chance to meet experts, hospitality and entertainment thrown in. I was happy. The main symposium during the conference was on Nutrition. Why, when there was all of medical science? A little thought and I realised that many lives were cut short because of the food people ate or did not eat. The conference was two months away. Being alert to the possibility of impressing people at an international conference, I decided to present a paper: The Importance of Food in Post-operative Care. I read journals and research papers, prepared slides and realised that it was too dull a subject to impress people with. So I wrote another: Rare Surgical Cases. It was a showy

piece with spectacular, lurid details about some of the operations I had done that were in some way connected with eating. I wrote about the chunk of just-eaten meat I had found in the gut of an undefiled brahmin; the gravel, two pounds of it, that I evacuated via the rectum in an eight-year old; the roundworms wriggling inside the belly of a man whose gut was cut to pieces from a gunshot; and about the congealed ball of toffee wrappers blocking the intestines of a young boy. Very clever. I could see myself on the podium; and later, the doctors milling around me, eager to listen to more heroics.

I sent both the papers and waited. Two weeks later came the reply that the papers had been rejected. We have too many submissions; they said., a polite way of telling me that mine were inconsequential.

Humbled, I went to the conference, taking the overnight train to Mathura. I was to stay with Dr Sadashiv, a friend of a friend in Baitinda. The doctor was slightly built and fortyish, with paan-stained teeth and the pinched look of one who thinks too much. He looked so pensive, I labelled him Dr Sad. He wore terelyne bush shirts and scuffed sandals, spoke good English with a Hindi accent and rode a fourth-hand Bajaj that sounded like the rattled breath of an old woman. His wife was a coarse-tongued dehati and they had four children. I shared a cramped little room with one of his school-going daughters. His clinic was an extension of his house. Outside it a once-white board screamed in red letters that he was MBBS, FR - Foreign Returned. Judging from the number of times he was being called to the clinic on a Sunday evening, I reckoned that Dr Sad had a flourishing practice.

We had a simple dinner of daal, chappati and egg bujiya. "I love food but keep things simple," said Dr Sad. "This meal hasn't cost more than ten rupees." Sad could get away with serving dinner to a guest and then announcing how cheap it was. Later, over elaichi tea, we talked.

He had started in the sixties as a compounder, worked his way into Patna Medical College and then gone to England for a while. He came back after eight months because they objected to his chewing paan. It was not an irony that the money he made was inversely proportional to the quality of his work. Sad belonged to that rare breed of doctors who believe that their work should be superior to what they earn. I was nonplussed and slightly annoyed by his simplicity and told him in elaborate detail about the changes in our hospital in Baitinda, about the monitors and scanners that had made work efficient. He was unimpressed. "Sounds like a too-quick transition from a bullock-cart to bulldozer," he remarked. "The patients will be paying more but are they getting better health?"

He said - without arrogance - that he was a good doctor.

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Designing a Rural Hospital-Competition Paper

There are many among the members of ARSI who have had personal experience of planning, building & equipping a Rural Hospital. Unfortunately, their experiences in most instances have not benefited younger colleagues facing a similar challenge.

It is therefore proposed to conduct a competition from among the Members of ARSI on the subject of Designing a 20 to 30-bedded Rural Hospital with facilities for catering to a population of about fifty thousand. The facilities offered should be up to the secondary level care viz., General Surgery, General Medicine, Paediatrics, Maternity & Emergency Care. The paper submitted should contain details of land area, building, type of technology recommended with reasons, equipment & other facilities connected with such a hospital. The aim of the Paper should be to highlight the ways in which a Rural Hospital differs from the Urban and its impact on the design & equipment. Estimates of cost covering all aspects must be given in the paper with due consideration to cost effectiveness. Local factors influencing the Plan may also be included in the Paper for the benefit of Doctors facing similar problems.

The best Paper as adjudged by ARSI will get a prize.

The Paper should be submitted to ARSI on or before 31Mar05.

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