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Dr. Thomas Moch was conferred fellowship (FARSI) during inaugural Session

A section of attentive audience

Vote of thanks - Prof. V. K. Mehta, organizing secretary

Presidential address - Dr. R. D. Prabhu

From Editor Desk

Dear Members:

Here's wishing each one of you a very happy, healthy, productive and a meaningful new year. I also take this opportunity to say a big "Thank you"- for your contributions, comments, compliments, criticism and above all for reiterating your faith in me as the editor of our esteemed bulletin "Rural Surgery" for another term.

In the last two years, while I tried to steer this job whole-heartedly, I also remained aware of the fact that a man who does many things makes many mistakes but he obviously doesn't make the biggest mistake of them all - DOING NOTHING. I take this dictum as an alibi to my follies, if there were any.

"Rural Surgery" bulletin has now gone through some further "face-lifting": I hope you like the new design! Comments (positive or otherwise) are always welcome.

This issue begins with an interesting article titled "ARSI, its origin, present status and future", by Dr. N. H. Antia, our past president and founder member of ARSI, expressing his concern about the future of this association. Dr. J. Gnanaraj's paper, based on the survey analysis - "What do rural surgical patients say", gives us the patient's perspective on rural surgeons and rural surgery.

Innovation, tenacity and courage are the trait of a rural surgeon. The next two articles titled "Removal of Foreign body Bronchus with a Right angled Nephroscope" by Dr. P. V. Alexander & Dr. G. Verghese and "Angiography and vascular surgery in a remote coal mine hospital" by Dr. Sanjeev Golash reaffirm these distinguishing traits.

Dr. R. D. Prabhu's series 'Fron the pages of a Rural Surgeon's diary' describe the partisan view and innate distrust that many a professor from medical collages hold against the rural surgeons. I do hope you will enjoy reading them ... and be encouraged to submit a paper yourself.

The year 2005 marked the thirteenth anniversary of our "Rural Surgery" bulletin. This also coincided with the formation of International Federation of Rural Surgeons. And with our own 340 plus committed and exemplary members it won't be too much to aim for a full fledged journal of Rural Surgery in near future or at least a move to a slightly enlarged quarterly publication.

Complimentary circulation of this bulletin has already been extended to the members of ASRI. Dr. Siva Subramaniyam and Dr. K. Dakshinamoorthy were kind enough to promise to bear the postal expenditure on behalf of ASRI.

The "Rural Medicare Society award" conferred to the author of the best written paper, would be given out this year as well.

Therefore please send your articles to me and as always I shall be pleased to consider any paper or write-up related to rural surgery for publication.

In case you have missed any of our previous bulletins you may still have a look at them by simply logging into our ARSI web site-**www.arsi-india.org**

Once again with best wishes

Dr. S. K. Baasu
Editor

ARSI, Its origin, Present status and Future

Dr. N. H. Antia FRCS, FACS (Honorary)

Several members of Association of Surgeons of India (ASI) had approached their association for creating a sub-section of ASI on rural surgery. This was because they were a group of surgeons who were working in rural areas and seriously concerned as to how ASI could help in the outreach of surgery to the vast majority of our people, often at or below the poverty line. They desired that such a sub-section of ASI would permit them to exchange their experiences to evolve a better understanding of the problem of extending basic general surgery to the unreached in an accessible and affordable manner. Unfortunately for almost three years there was no response to their request from ASI.

I would like to point out that in the 60's and 70's the annual meetings of ASI were invariably held in medical colleges in various parts of the country during the X'mas-new year period so that the majority of the members could be lodged at low cost in the college hostels. A few doyens would be accommodated as house guest of their senior colleagues. This arrangement not only enabled the young surgeons across the country to exchange ideas among their peers but it also gave them an opportunity to interact with their doyens.

There were very few specialists in those days and they were also a part of the annual meetings. Even the few specialists who attended these meetings also practiced general surgery. The cost of these meetings was very modest, and hence even the students undergoing surgical training could attend.

Another advantage of conducting these meetings in medical colleges was that it stimulated the medical students of the college and exposed them to basic medical and surgical requirements of our country.

Unfortunately the craze for specialization started in the 80's and several sub-section of ASI were formed for them to attend these meetings e.g. Orthopaedics, Urology, Neurology and plastic surgery. Following the examples of the west, especially of the US, many of these specialists broke away from the parent ASI to the detriment of basic general surgery which was and still remains the need of the majority of our people, especially those who live in rural areas.

There were a small group of general surgeons who not only lived and practiced in rural and semi rural areas but also had a genuine desire to extend basic and appropriate surgical services to this large population. They requested the ASI to allow them to form a sub-section on rural surgery. Their aim was to provide basic and affordable health care through the hospitals that they had set up in the rural areas contrary to the expensive high tech hospitals that mushroomed across large towns and cities, where the practice was mostly governed by new market considerations that have crept even in our profession.

Unfortunately, even after three years there was no response to this simple request. In sheer despair and frustration they decided to form a separate surgical forum for this purpose. I was part of this team and seven of us met in Shimoga in the year 1992 to register a new Association of Rural Surgeons of India (ARSI) even though we continued to be members of ASI.

The first meeting of ARSI was held at the Wardha Medical College with the Gandhian Dr. Sushila Nair as the chair person. This was a highly stimulating experience where a considerable number of surgeons with similar interest came together. Dr. Zaffarullah Chowdhury from Bangladesh was one such key personality.

Starting from such humble beginning with seven founder members, ARSI now has membership of more them 340 surgeons as full members, overseas members, and associate members form allied and supporting disciplines. There have been 13 conferences in various parts of the country where remarkable new methods have been demonstrated like a respirator which can be operated by electricity, battery or by hand (by an Anaesthesist) and a simple polypropylene mesh for hernia repair obtained from a mosquito net which cost about 30 paisa as compared to Rs.2000/- imported from out side. An annual award has now been established for such original ideas. Most important is the exchange of ideas between a large numbers of our members who work in remote part of our country under difficult conditions. What differentiates the members of ARSI from other surgeons is the desire to make cost-effective surgical care accessible to the poor in remote areas of our country and not a mere transfer of the "latest" technology regardless of the appropriateness of such technology for those who live at and below the poverty line. This is not second rate surgery but highly appropriate effective surgery at remarkably low cost. Simplicity and effectiveness at affordable cost is the key concept of ARSI which requires not only the desire, but also a lot of originality in keeping with the basic philosophy of ARSI.

Lately there has been an increasing tendency to dilute the basic concept of ARSI. The craving for "latest" technological innovations regardless of their relevance to the philosophy of rural surgery has come in the scene. Mere practicing of "sophisticated" surgery in hospital located in small towns, like laparoscopic surgery, is being increasingly promoted at our recent ARSI meetings.

With the advent of the National Rural Health mission (NRHM) which aims to provide basic health care to all, regardless of monetary and other considerations, the role of ARSI has increased in relevance and can not be allowed to be distorted by those who subscribe to "the latest is the best".

It was distressing to hear some of these "sophisticated" new members, at the last meeting held in Ujjain, who wanted ARSI to be sponsored by market oriented pharmaceutical and the surgical instrumentation industry: the very nemesis of the concept underline ARSI, and if implemented , would be the death knell of our efforts.

Fortunately, the vast majority of the present young memberships of ARSI are those who are quietly and unobtrusively doing yeomen service to our people devoid of monetary and other conditions. It is high time that this silent majority should take the lead to ensure that there is no dilution of the basic concept of ARSI.

It is a matter of pride that the International Federation of Rural Surgery was inaugurated at our annual meeting held at Ujjain this year. It is time that those who believe in the concept of ASI rather than of ARSI return to their parent body.

This can only be achieved if the vast majority of our younger members take control of this remarkable institution which now enjoys an International recognition, thanks to their efforts.

ARSI cannot be dictated by the market oriented forces and my appeal, as a founder member of this association, to our younger members to accept the challenge.

Dr. Antia is a founder member and past president of our Association. This bit of caution by him should be well taken by us and should be kept in mind while planning our activities in future. Comments on this article are welcome - ***Editor***

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What do rural surgical patients say? Analysis of 1000 Patients Satisfaction Survey Reports

Dr. J. Gnanaraj

Introduction:

India is a country with a large rural population. The social structure of our country is such that most of the medical doctors are in the urban areas rather than the rural areas. This difference is much more as far as the surgeons are concerned. What do the patients think about the few surgeons who choose to serve in the rural areas? What motivates the patients to undergo major surgical procedures in rural areas? The surgeons know that the rural surgeons are very competent. Do the patients agree? This study was under taken to answer such questions.

The place:

The study was carried out at Burrows Memorial Christian Hospital. Burrows Memorial Christian Hospital is a 70-bed mission hospital situated among beautiful tea gardens in Cachar District of Assam in Northeast India. It is well known for its surgical services and has performed over 1000 laparoscopic surgeries and over 5000 minimally invasive surgeries during the last four years. Patients come from many of the nearby states traveling over 400 kilometers sometimes.

The Background: C3MDS

The hospital has locally made computer software that helps in easy collection and analysis of data. C3MDS is the locally produce software that is used at the hospital. It is a user-friendly doctor driven software. For every symptoms it guides by giving the lead questions to ask. For every provisional diagnosis made a pre-defined set of investigations could be ordered by a single click and all necessary medicines with complete instructions could be ordered at once for the diagnosis made. The software generates the questions that the nurses ask and fill for patient satisfaction survey chart. The patient satisfaction survey is an integral part of every indoor patient's care.

Materials and Methods:

1000 consecutive completed patient satisfaction survey reports from October 2004 to April 2005 were analysed. The following questions were added to the regular questions that were asked in the survey.

- Who asked the patient to undergo surgery at BMCH?
- If they have sufficient money where would they prefer to have the surgery?
- Why do they think surgeons settle down in rural areas?
- Drawbacks of having surgeries in a rural area?
- Advantages of having surgeries in a rural area?
- Any other problems that they face having surgery in a rural area?

Some of the limitations of the study were as follows

1. Not all the patients has surgical procedures carried out.
2. The background of the patients was different as they came from four or five different states and ethnic background.
3. The patient satisfaction survey forms were filled up not by the same group of nursing staff and student. Some of them were incomplitely filled up.

Results:

Reasons for choosing BMCH for surgery

Advised by those operated here earlier	92%
Advised by relatives	4%
Cheaper	2%
Doctors from CMC Vellore are available at BMCH	1%
Others (read in news papers, does not know, God talks directly to doctors at BMCH, etc)	1%

If money was not a factor where would they have surgery?

- In cities and towns 72%
- In rural area 28%

Why do surgeons stay at rural areas?

Christian missionary doctors	56%
Can not afford good practice in towns	32%
Have big property in rural areas	12%

The drawback of having surgery in a rural area

Getting blood is difficult	92%
Difficult to get second opinion or expert consultation	16%
Inability to take elsewhere when there is complication	12%

The advantage of rural surgery

Less expensive	92%
Being treated as human being (with respect)	82%
Dedicated & experienced surgeons	72%
Better nursing care	40%
Feeing at home	28%
Better explanations about disease	24%

Complaints

Lack of good drinking water	74%
Insufficient toilets	64%
Rude behavior of some staff	38%
Surgeries going on till very late at night	28%
Lack of signboards	12%

Discussion:

Satisfied patients are the best advertisement for rural surgeons. The other means of advertisement are not very useful in a rural area as they could be in urban areas. Patients felt that they were treated as human being by rural surgeons and not as another surgical patient. Many felt that the surgeons were dedicated and explained better and almost all of them felt that having surgery at rural was much less expensive. Contrary to common feeling that the rural patients would feel more at home in a rural hospital only 28% felt that way.

The greatest drawback that the rural patients felt was the difficulty in getting blood. A few considered lack of second opinion a factor.

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Angiography and vascular surgery in a remote coal mine hospital

Dr. Sanjeev Golash

Introduction: - Vascular surgery has yet to find its place in rural areas of our country. While rural population is ignorant about the existence of peripheral vascular diseases, some amount of skepticism do exist among the surgeons practicing in rural areas to take up this challenge. A bit of concerted effort to create awareness among the patients that peripheral vascular disease is treatable, some amount of skill and very little infrastructure are all that are needed to make vascular surgery possible even at semi urban and rural set up. This paper presents my experience with few cases of angiography and vascular surgery done at Burhar Central Hospital, a remote coalmine hospital, in the last 5 years.

Technique of Angiography: Under aseptic condition the vessel was carefully palpated. The skin over the vessel followed by Anterior or post. wall of the vessel was penetrated by venocath at right angle. Venocath is then withdrawn until brisk arterial flow is noted. Plastic cannula was advanced distally after withdrawing the needle stylet. Dye (Urograffin) was pushed as fast as possible by 30ml syringe. X-Ray film was taken when only 5ml of dye remained in the syringe.

Case I

Femero-popliteal Vein Bypass Grafting in a case of atherosclerotic femoral artery occlusion

A 60 years old male presented in May 2001 with H/O pain in (Left) calf muscles region on walking a distance of around 200 feet. He was a smoker and hypertensive. There were mild trophic changes in the form of loss of hair and brittle nails. There was no H/O resting pain/ulcer in foot.

Peripheral arterial pulsations in lower limb: On (Lt.) side - only femoral artery was palpable and pulsation of Popliteal, Post.Tibial and Dorsalis pedis arteries beyond that were absent. Arterial pulsations in upper limbs and neck were normal. Left foot was colder with paraesthesia and numbness. Peripheral arterial pulsation in (Rt.) lower limb was normal.

Investigations: Serum triglycerides and cholesterol were raised. There were border lineECG changes with LVH and ST depression. Echo-Cardiographs showed concentric LVH with diastolic dysfunction.

Femoral Angiography- showed atherosclerotic block of (Lt.) superficial femoral artery in adductor canal and patent distal vessel around adductor hiatus. Profunda femoris artery was patent and free from atheromatous changes (Fig.1). Based on history, clinical exam and angiography a diagnosis of atherosclerotic femoral artery occlusion was made.

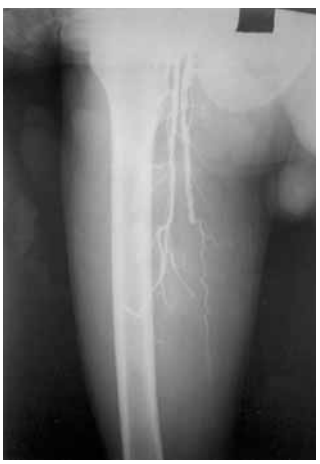


Fig. 1

Atherosclerotic block of supf. Femoral artery In adductor canal and patent Profunda Femoris artery

Address for correspondence: Burhar Central Hospital, PO Dhanpuri Dist., Shadol (MP), PIN 484114

As intermittent claudication was adversely affecting the quality of life of the patient and there was no response to vasodilators and exercise, surgery (Femoro Popliteal vein bypass grafting) was done under GA.

Operative procedure: A long incision was made starting from mid inguinal point to adductor tubercle. Long saphenous vein, femoral artery in the groin, adductor canal and popliteal artery below obstruction were explored. On the table angiogram showed patent distal vessel including ant. and post. Tibial arteries (Fig.2). There was complete block of superficial femoral artery in adductor canal as evidenced by loss of pulsations. A suitable length of saphenous vein was carefully dissected out and each tributary was carefully ligated with silk. Vein was flushed with chilled heparinised ringer lactate and vein ends were reversed. Femoral artery was clamped with bulldog vascular clamps above and below obstruction. Vein was cut obliquely. A 2cm. incision was made on the femoral artery and end to side vascular anastomosis was done with continuous sutures of 5 '0' prolene (Fig.3) Angiogram on the table showed good flow in vein graft. Vein graft was placed in adductor canal.

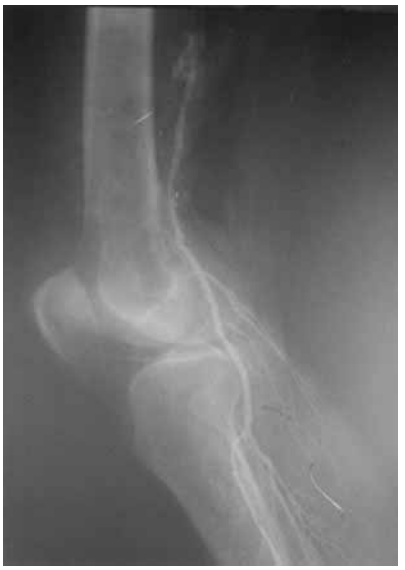
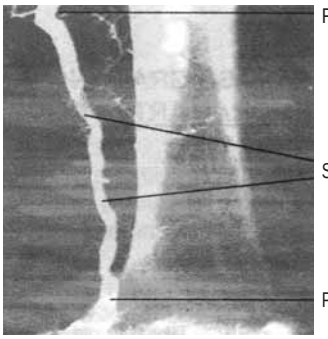


Fig. 2

Patient distal vessels in leg



Post operative course: (Lt.) Dorsalis pedis artery pulsations were weakly palpable and patient was relieved of intermittent claudication. (Fig. 3)

Case II

Chronic pseudo fibrous aneurysm of left Radial artery

Partial arterial tear presenting as pseudo aneurysm is very rare. In partial tear wound gapes but adjacent tissues compress and tear in vessel in sealed with a patch of clot which on organization becomes a pseudo aneurysm. Due to formation of pseudo aneurism there is massive bleeding at the time of injury but as flow persists there is minimal ischemia. Surgery is done to prevent life threatening hemorrhage/recurrent bleeding.

Case Report: An 18yrs. old male was admitted in our hospital in Jan. 1998 with H/o injury in left lower forearm by sharp object 2 months back. There was extensive bleeding at the time of injury. Wound was primarily repaired but subsequently margins gaped, giving rise to a pulsating swelling in lower Lt. forearm. Radial artery pulsations distal to pulsating swelling were absent. Left hand was colder and pale as compared to its counter part. Systolic brunt was present.

Investigations: Routine hematological and biochemical parameters were within normal limits. X-Ray elbow and left forearm - NAD. Left brachial arteriogram revealed an aneurysm at the level of pulsatile swelling and non-visualization of left radial artery beyond 5cms of its origin (fig.4).

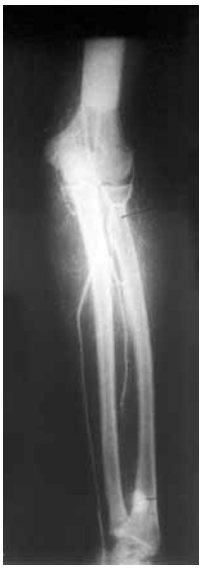
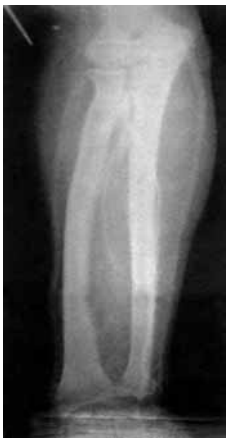


Fig. 4

Pseudo aneurysm and non visualization of Radial art. beyond 5cms. of origin

Operative Procedure: Patient was under taken for surgery under local anesthesia. Exploration revealed partial tear of left radial artery with pseudo aneurysm made of fibrous tissue and connected with the arterial lumen. Pseudo aneurysm was excised. Proximal left radial artery was in spasm, but after passing a No. 5 feeding tube proximally, spasm subsided and free arterial bleeding resulted. Heparin was pushed into distal arterial segment. Bulldog clamps were applied. An end to end arterial anastomosis was done using continuous 5 '0' prolene sutures.



Post operative care: Post operative angiogram showed full visualization of left radial artery even beyond anastomosis (Fig.5). Clinically distal arterial pulsations were palpable.

Fig. 5

Radial art. beyond anastomosis

Case III

A case of Metastasis Carcinoma Penis with Femoral Artery Erosion

A 58yrs. Old male was admitted in our hospital in April 2004 with history of bleeding from a wound in left upper thigh while working in coal mine. On examination he was found to have a fungating mass in left upper thigh with mild oozing but no active bleeding from there. A detail history revealed that he was initially operated for carcinoma penis in a private hospital at Jabalpur in Dec. 2002. After surgery at Jabalpur he never attended our hospital.

Examination: The patient was anaemic with 8gms.Hb level. He was a known diabetic and diabetes was poorly controlled. X-Ray chest and USG abdomen was normal. CT scan abdomen revealed metastasis in iliac lymph nodes. Biopsy from the growth suggested invasive squamous cell carcinoma of penis. Inguinal, femoral and iliac lymph nodes biopsy showed metastatic deposits. Left lower limb was swollen. There was a fungating mass measuring 10X 15cms over left inguino-femoral region with everted margins.

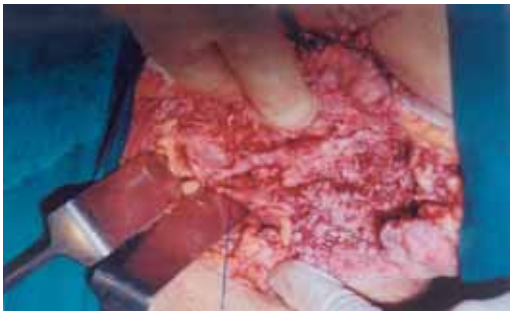
Course in Hospital:

Patient was given 2 units of blood and was referred to Cancer Hospital Nagpur. Next day when the patient was about to be shifted, he started bleeding torrentially from inside the fungating mass. It was bleeding very heavily and in spurts. A pressure pack was applied in position by a nurse and he was immediately shifted to the operation theatre.

Operative Findings:

Under GA left external iliac artery was approached by an incision in left iliac fossa. The artery was dissected (Fig.6) with utmost care and cleared for a sufficient length to apply bulldog clamps. Bleeding stopped after application of bulldog clamps. As there was extensive tumor erosion with friable tumour mass, the inguinal ligament had to be divided witch made the dissection easy. There was a 2cms. long tear in

superficial femoral artery due to metastatic femoral lymph node erosion. Wall of femoral artery was too friable to hold smaller bites with 5 "0" prolene sutures. Hence the tear was repaired with continuous sutures of 3 "0" prolene. After complete repair the clamp on external iliac artery was released and there was no bleeding from repaired artery or elsewhere.



Dissected out femoral art. and dissected Lymph node (Fig. 6)

Repair of fungating lymph node mass was not possible as it was too friable to hold sutures. Patient did well post operatively and was referred to Nagpur for further treatment. He was given both radio and chemotherapy (cisplatin and 5 FU). In Oct. 2004 when patient was about to receive 6th cycle of chemotherapy in our hospital, he again had bleeding from fungating mass. This time tear was 4cms proximal and postero- medical to previous tear. It was repaired with prolene. On both the occasion heavy bleeding could be stopped after repair and that saved the patient's life.

Conclusion:

Peripheral angiography and vascular surgery can be performed in a remote hospital and do not entail much additional expenditure. Nature has already given us best vascular conduit. Long saphenous vein is absolutely free. All that is required (apart from training) is a set of atraumatic vascular clamps, good instruments and sutures. Giving relief to a patient with peripheral vascular disease and preventing life threatening hemorrhage during emergency by simple surgical measure is indeed satisfying.

'Report on NABH Seminar'

*Dr. R. R. Tongaonkar, past president of our association & Dr. Shashank Kulkarni (our treasurer) attended the NABH (**National Accreditation Board of Hospitals**) seminar in Mumbai. Dr. R. D. Prabhu (Immediate past president) and Dr.Regi George and Dr Lalitha attended the same seminar in Bangalore. Following report on NABH seminar has been sent by them (based on their observation).*

- NABH is an autonomous Body, a constituent board of Quality Council of India (QCI) set up by Govt. of India.
- The standards for hospital are already set. These seminars are only for sensitization of the doctors and the stakeholders.
- Accreditation to NABH is not compulsory for every hospital. It is voluntary for those organizations which want to get this Accreditation. This is similar to getting ISO mark.
- NABH is not a regulating body (like FDA) neither is it going to do job of policing.
- At present they are going to concentrate only on tertiary care hospitals and not thinking about small hospitals. This will be taken up later and the matter is being refereed to? Planning board.
- During introductory remarks the real object behind all this business of NABH was explained. The big five Star hospitals were hunting for international customers (patients). Across the world now it is known that in India one gets quality medical services at damn cheap rates as compared to developed countries. But these patients cannot decide which hospitals are good and which adhere to the International standards. The question often asked to the management of these Indian hospitals was whether they are accredited or not? And therefore the need for NABH has come up. It appears that there is big money behind all this standardization under the disguise of improving medical facilities in India.
- At least at present, we have not to worry about NABH.
- The booklet on Standards for hospitals has been given to each participant. There are more than 500 items which have to be fulfilled by the organization wishing to get accreditation from NABH.
- Many participants expressed the view that it is very difficult to get qualified nurses which is one of the foremost- requirement.
- On behalf of Association of Rural Surgeons of India I requested the organizers to give me 3 minutes for my presentation with a CD with many photographs. The permission was granted. (The copy of my write up is attached separately,). The organizers agreed to forward our demands to the planners and asked for written Statement. I had already prepared 5 copies which were handed over to them. They also asked for the CD which was also given to them. Many participants congratulated me and appreciated my presentation.

Those of us who wish to participate in their future seminars may certainly do so and present our views but if we are not allowed to participate (as happened with our Delhi colleagues and colleagues from Sittilingi) nothing much will be lost. I think I have made things clear. If you need any further details or information please be free to ask

Dr. R. R. Tongaonkar

We both felt that there was a lot of material and ideas that may be useful to every

member of our association. The main idea and principle of their exercise is to provide patient friendly health-care in all types of hospitals.

The actual procedure and guidelines that they have drafted are however, aimed at corporate and commercial hospitals. Even then there were a lot we and you all may implement to improve our services.

Their main target is towards the hospitals providing secondary and tertiary care, and it appears that they are not aware that rural hospitals provide secondary care. I pointed this out and they said that now they are looking in this aspect since even the central govt is interested in quality control in smaller hospitals. They would like some of us to help them in this and I have suggested that our President is nearer to Delhi and may be able to meet them. They have welcomed it.

The talk I heard during the lunch break was that it is mainly for accreditation of hospitals for the medical insurance that QCI protocols will be used. I tend to believe that.

After all these let me point out that State medical establishment bills (smeb) / acts/ laws are in no way connected with this quality control exercise. They will come independently and QCI accreditation protocols will incorporate each requirement of the smeb in the related state. So we are back to "square one".

Dr. R. D. Prabhu

1. The QCI is only trying to bring in accreditation mechanisms for secondary and tertiary care systems and not prescribing any standards. They will keep in mind the cultural and other beliefs of our society and not blindly ape the west.
2. They have not made any partition between where primary care ends and where secondary care begins.
3. They have not mentioned any physical standards like bed space etc-just quality of care. However if there are standards imposed by other govt bodies, their accreditation will come only after these standards have been met , but they are not into imposing any standards on anyone.
4. They have requested the planning commission to have a panel to suggest quality standards for primary care and after Dr. Prabhu's statements they also have agreed to try and recommend someone from ARSI to be in that panel, but there is no guarantee. This committee is to be announced by the planning commission soon.
5. There is a panel for midterm review of the last 5 year plan and they have suggested that we get to look into this or get our suggestions to this committee.
6. They remembered Dr. Tongaonkar's presentation and said that they are looking into what he had said.
7. They only want to bring in a "corporate environment" and not corporate hospitals. By corporate environment they mean a built in systems into hospitals where there are written procedures for all things and the staff and hospitals are to comply with them. The written procedures can be decided by the hospitals based on their location and local cultural preferences. What they want to bring in is a system of accountability for all staff and medical care in the hospitals.
8. Quality of care should be uniform whatever the setting - the level of care can vary.

Dr. Regi & Dr. Lalitha

(Comments are invited from readers and members of our association)

IFRS Section

International Federation of Rural Surgery (I.F.R.S.)

Dr. R.D. Prabhu

It is a happy feeling to notice that more and more people are realising the importance of rural surgeons and of focussing on rural health care. The Government of India has launched the Rural Health Mission. Surgeons in USA have realised that they need more rural surgeons and are concentrating on special training to prepare them to face the difficult conditions of a rural setting. The Association of Rural Surgeons of India (ARSI) has learnt from African surgeons that they too need concentrated efforts to improve rural health care and so need more rural surgeons. In view of such widespread awareness of rural health care and importance of rural surgeons, it was felt that networking by rural surgeons from different countries would go a long way in achieving the goals of each country namely, better rural health care. In view of this the delegates of the rural surgeons' conference, CORSIV 2004 on 23-25 September 2004, at Sivakasi, India unanimously decided on formation of an International Federation of Rural Surgeons. This was formally launched during the First International Conference of Rural Surgeons (IFRS), in Ujjain, M.P.India, on 23-25 of September 2005. The signatories of the decision were members of:

1. ARSI,
2. Association of Surgeons of Rural India, a section of ASI,
3. Emanuel Hospitals Association, India,
4. German Society of Tropical Surgery (DTC),
5. Dutch Group of Surgeons,
6. Surgeons from Tanzania, Uganda, Kenya and of Mithoefer Centre for Rural Surgery, New York, USA.

All have accepted the newly drafted Constitution, Rules and Regulations of the IFRS. During the same meeting the following have been elected for the first Board of Directors of the IFRS:

President: Dr. R.D.Prabhu, India
Vice President: Dr. P.L.Kibatala, Tanzania
Secretary: Dr. Thomas Moch, Germany.
Joint Secretary: Dr. J.K.Banerjee, India
Treasurer: Dr. Peter Reemst, Holland,
Directors:
Dr. K.Dakshinamurthy, Patron ASRI (ASI),
Dr. Randall Zuckerman, Mithoefer Centre for Rural Surgery, USA,
Dr. Vincent Mubangizi, Uganda
Dr. John Wachira, Kenya
Dr. Rupert Poeschl, Germany.

IFRS is a federation of rural surgeons' associations of different countries. If any country does not have an association of rural surgeons and rural surgeons of that country wish to participate in the activities of IFRS, they may do so as associate members of IFRS. The fee pattern is yet to be decided by the newly elected governing body, but it is not going to be a big issue.

The primary aim of the IFRS is to promote good, affordable and safe rural health care in each country, by sharing knowledge and by networking. It aims to encourage exchange of information by networking, and by participation in meetings and conferences in other countries.

We would welcome many more countries to join hands with us by becoming members of the IFRS. We welcome suggestions and ideas from any one to promote the aims of the IFRS more meaningfully.

(An Earnest Appeal)

Dear members,

I take this opportunity to introduce a new section of our Rural Surgery Bulletin to all of you.

Of late, I've been toying with the idea of including a section on international federation of rural surgeons. Since we already have 340 plus membership strength, I feel now is right time to undertake such an initiative.

To make this section a success, I'll need academic contributions from each one of you. You can all pitch in by sending articles on rural surgery around the world, write-ups on related aims, objectives, practices and goals of IFRS or snippets on different health related issues across the developing countries in the world.

These were just guidelines, but let these by no means limit your academic boundaries.

If we have enough content for our next issue, this will be a section that would definitely be worth starting.

So I urge all of you to put on your thinking caps, bring out the academician in you and sincerely give a shot at making this initiative a success.

Dr. S. K. Baasu
Editor

Should Rural Residents with Colon Cancer Travel to Urban Hospitals for Colectomy?

Melissa Meyers, MD; Samuel R. G. Finlayson, MD, MPH

Dept. of Surgery, Dartmouth Medical School, Hanover, NH
VA Outcomes Group, VAMC, White River Junction, VT

Introduction: Many rural patients requiring surgery travel to urban hospitals expecting better care. Whether rural patients requiring elective colectomy lower their risk of operative mortality by traveling to urban hospitals is unknown.

Methods: We used Medicare claims data to compare mortality rates with colectomy for cancer in rural vs. urban hospitals in the US from 1994 to 1999. Urban and rural designations were based on Rural-Urban Commuting Area codes. Multiple logistic regressions were used to describe the relationship between mortality (combined in-hospital and 30 day) and rural/urban hospital location, controlling for patient and hospital characteristics.

Results: Adjusted operative mortality in small rural hospitals (6.7%, 95% CI 6.4-7.0) was slightly higher than in urban hospitals (6.4%, 95% CI 6.3-6.5), but this difference was not statistically significant. Nearly 90% of rural hospitals were in the lowest two quintiles of hospital procedure volume (<57 colectomies/year), compared to 28% of urban hospitals. Adjusted operative mortality in these low volume rural hospitals (6.6%, 95% CI 6.3-6.9%) was significantly lower than mortality in urban hospitals with similar procedure volume (7.2%, 95% CI 7.0-7.4%).

Conclusions: Rural patients who choose to travel to an urban hospital for colectomy may not experience lower mortality risk. Our finding that low volume urban hospitals have higher mortality rates than low volume rural hospitals suggests that patients who elect to travel to the city for care must choose their providers carefully.

Formation of International Federation of Rural Surgeons (IFRS)
Discussion in progress

Dr.J. K. Banerjee expressing his point of view

Dr. Thomas Moch, secretary-IFRS

Dr. Pascience Kibatala (Tanzania). Dr. John wachira (Kenya) on the extreme right

Dr. Vincent Mubangizi (Zambia). Dr. Samuel R. G. Finlayson (USA) on his right

Dr. Peter Reemst (Holland). Dr. K. Dakshinamurthy and Dr. Shivasubramanium on the extreme left

Dr. Rupert Poeschl (Germany)

Removal of Foreign body Bronchus with a Right Angled Nephroscope

Alexander, P. V., Verghese G.

Introduction:

Foreign body aspiration is a common problem in children necessitating prompt recognition and early treatment to minimize the potentially serious and sometimes even fatal consequences[1]. The most common symptoms are choking followed by a protracted cough. Physical examination findings include fever, stridor, retractions, and decreased breath sounds. Radiographic imaging can be helpful if the object aspirated is radiopaque or if there are signs of hyper expansion on expiration[2]. Negative-imaging studies, however, do not exclude the presence of a foreign body in the airway. The longer a foreign body resides in the airway, the more likely it is to migrate distally. When this occurs, symptoms of chronic cough and wheezing may mimic asthma like condition[3]. Organic materials such as nuts, seeds, and bones are most commonly aspirated. In Northern India the groundnut is commonly aspirated by children particularly in winter months of October to January.[4] The key to diagnosis remains a high index of suspicion, and a good clinical examination. The removals of foreign bodies have been successful with a variety of techniques including rigid endoscopy[5], bronchoscopy[6], flexible fibreoptic bronchoscopy[7], foreign body forceps and Fogarty balloons[8]. We report removal of a peanut from the right bronchus using a right-angled Nephroscope and a Dormia basket.

Case report:

A 2-year-old female child was brought with the history of cough and wheezing for the past twelve hours. The mother was aware of the child eating peanuts but was not clear about aspiration. The child was dyspnoeic, tachypnoeic with a respiratory rate of 32 per minute and tachycardic with a pulse rate of 128 per minute. Air entry was equal on both sides, but there was intercostals recession, flaring of the ala nasi and bilateral wheezes, more on the right than the left. A chest x ray showed some hyperinflation of the left lung. She was taken up for bronchoscopy under general anesthesia. After intubation, the tube was replaced with a right angled working Nephroscope. An Ambou bag was connected to the water inlet of the scope using the hub of a 5 cc syringe and the child was ventilated in this way for the brief period. The Nephroscope was connected to a laparoscopic camera to enable visualization under a video monitor. The peanut was found sitting in the right bronchus and was extracted successfully with a Dormia basket. The patient was monitored with an oxygen saturation monitor and E.C.G. monitor right through the procedure. She withstood the procedure well.

Discussion:

A foreign body aspiration in the tracheobronchial tree is a dangerous and common medical emergency in childhood, with serious and potentially lethal consequences. It must be suspected in children with a suggestive history, even though the clinical symptoms or radiographic findings are not pathognomonic for foreign body aspiration[5]. Bronchoscopy is mandatory in all patients in whom aspiration is suspected. Removal of foreign bodies has been done with a variety of techniques. Bronchoscopic removal is usually done with a ventilation bronchoscope and cold light source5. Bronchoscopy is a standard practice and the results are uniformly satisfactory with a low complication rate[9], though the reported mortality of foreign body aspiration is 0% and 1.8% according to various studies[8]. Correct instrumentation and expertise are essential for success and a good coordination needs to exist between endoscopist and anesthetist. Large series have been reported all of whom have reported successful removal with the rigid

ventilation bronchoscope.[10,11] A number of studies have demonstrated the use of the flexible bronchoscope using local anesthesia, but all of them have underlined the need to have the rigid instrument on standby in cases of failure[2,12]. Series from Indian authors also have underlined this recommendation.[13,14] The lack of equipment can be a serious constraint in developing countries, and a ventilation bronchoscope may not always be available. We report the use of the right angled working Nephroscope for extraction of the foreign body and the Dormia basket for retrieval. The Dormia basket has been used and reported earlier. However, the working right angled Nephroscope has not been reported in the literature as yet. We connected the barrel of an empty syringe to the water inlet port and connected an Ambou bag to the barrel with at piece, through which we were able to administer intermittent positive pressure ventilation. The straight working channel allowed easy passage of instruments for retrieval and the lens could be connected to a laparoscope to allow for video endoscopic visualization. We think this is a practical and simple method in the absence of a ventilation bronchoscope for extraction of foreign bodies, even in pediatric ages.

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Ideas are the source of innovation. The method described by the author to remove foreign body from the bronchus is highly creative and innovative. Creative, because they thought up something new and innovative as they did new things. The end result was saving of a precious life even with serious constraint of equipment like bronchoscope. Author deserves all credits and kudos for his out of the box thinking. - ***Editor***

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Cont. on page no. 20

From the Pages of a Rural Surgeon's diary….

My two Memorable Patients

Dr. R. D. Prabhu

Very often rural surgeon's referrals are viewed with suspicion or are not respected. It is not uncommon to hear from the patient who was referred to a bigger institution, adverse comments about the management by the rural surgeon. "Why did you go that surgeon at all? You should have come here for the surgery!" was the comment by a HOD of Radiotherapy of a teaching institution when the treatment given by the surgeon (mastectomy with axillary clearance) was perfectly correct! In such state of affairs, I remember the following two patients with two different and opposite experiences.

I had newly started surgical practice in Shimoga in 1970. Amoebic colitis was endemic there. We did not have any laboratory that examined stools to identify amoebae. So it was common to treat all patients with blood and mucus in stools on clinical diagnosis of amoebic colitis, unless there was any strong reason to think otherwise. So it was with a lady doctor who came with dysenteric symptoms. But the lady doctor was very anxious and tense. Though the clinical examination did not reveal anything, I suggested sigmoidoscopy just to relieve her anxiety. That was just as well, for she had a polypoid growth in the rectum beyond the reach of examining digit in the rectum. I quietly took a biopsy and sent her home; but explained the situation to her husband. I also told him not to tell her anything till the histo-pathological report is received. Histo-pathological report from K.M.C. Manipal came and our worst fears were confirmed; it was a carcinoma of rectum. I explained the matter to the doctor and also tried to cheer her by saying that it is an early stage and that the prognosis is good. She was to go to her medical college but some how landed in C.M.C.Vellore.

There was no news about her for over a month. Then suddenly one day a friend of the doctor came for a copy of the sigmoidoscopy report. I asked why and he said that the surgeons at C.M.C.Vellore have been unable to locate any growth in the rectum in spite of repeated sigmoidoscopies (nearly 10-12 times) by different surgeons in the department. I gave a second report describing the exact spot where I had seen the growth. They repeated the sigmoidoscopy once again, this time focussing on the spot described in my report. They found only a patch of redness in that area; they took a biopsy of the area. The report was that it was carcinoma and had gone up to submucosa only. They excised the rectum and the doctor was cured of the cancer.

If it were not for the histopathology report and the persistence of the surgeons at C.M.C.Vellore to make sure that they were not missing something important, she might have been sent back with a clean chit as it happened with another patient of mine.

Other side of the coin

This was an elderly man who had passed blood in stools. He came with his doctor to me. On digital examination I found he had a malignancy in the rectum so low that it could be seen through the proctoscope. I showed it to the doctor too and told them that this should be biopsied and operated upon as fast as possible; I felt that such obvious clinical appearance did not warrant a biopsy by me since it may delay his going for definitive treatment by about a week or so (we did not have any facility for histopathological examination in my town at the time), and that the operating surgeon will perform it any way. They went to Bangalore to a reputed consulting surgeon. In two days he was back at home and his doctor conveyed me that the Bangalore surgeon had told them not to worry about; it was only a case of Hemorrhoids ('piles').

First I was embarrassed and then annoyed; had I had really erred!

In another few weeks the old man came to me again; this time with his dhoti spattered with fresh blood. Examination revealed that the carcinoma had spread all around and had become fixed to the sacrum. This time I quickly took a biopsy and there was no doubt about the diagnosis. He was taken to Madras where they said it was inoperable. Then they went to Bangalore and some other cancer specialist performed an unnecessary, unsuccessful laparotomy only to say that it was inoperable. He died soon after.

It is clear to see how the rural surgeon's clinical opinions are wrongly discredited by 'professors'; only the wise few ones believe that rural surgeons also can have good clinical acumen that they could be equally reliable.

Book review

Great contributors in medical science

By ***Dr Sukumar Maiti,** published by MSV Infotech, Kanakpura, Panskura RS, Purba medinapur, W.B.

A collection of brief biographies on the greatest contributors to medical science, tracing them from antiquity to the mid twentieth century, Dr. Sukumar Maiti's latest book makes for an enriching experience/ read.

Narration is kept simple yet eloquent. The author not only tells us about the great contributors and their various discoveries in the field of medicine, he also tries to draw out the life philosophies of each of these exemplary human beings.

Many of these individuals came from the weaker sections of the society. As they revolutionized the field of medical science and thinking, they also championed the cause of humanism and compassion. As they worked harder for their mission with boundless enthusiasm, they also stood for courage, dignity and nobility of the medical profession.

Though a lucky few were appreciated and rewarded, many had to suffer helplessly in the hands of tyrannical rulers; face hostility & jealousy; were imprisoned and even forced to leave the country.

This compilation also brings to fore many other interesting revelations that were hitherto not known to a majority of us. That Leonardo Da Vinci was a great singer and dissected more than 30 human bodies, described curvature of spine, painted brain, spinal cord, maxillary and frontal sinuses along with his immortal paintings of *"Monalisa"* and *"The last supper"*, is a fact that most us are probably unaware of.

Every page of this book is filled with defining moments of colourful multifaceted characters, who besides being great discoverer had unmatched proficiency in art, music, mathematics, astronomy etc. Chapters have been laid out in a sequential manner which follows the era of the contributors. Quotes at the beginning, miniature illustrations and the bold display of author's comment at the end of each article are aesthetic. Bibliography will be useful for those interested in further study of history of medicine. In a way it is simply not the history of an era but the history of intrepid spirit of people whose origin goes back into the mists of time. The intensity with which Dr. Maiti approaches the history of medicine needs to be lauded.

-Dr. S. K. Baasu

** Dr. Sukumar Maiti MS, DNB, MCh (Paediatric Surgery) is the Associate Prof. of surgery at B.S. Medical College, West Bengal and an active member of ARSI*

Journal scan

Complications of vasectomy

Source: *Annals of The Royal College of Surgeons of England,2005; 87 (Nov,no6), 406 - 410*
Ninaad S Awsarf, Jai Krishnan,
Greg B Boustead, Damin C Hanbury, Thomas A McNicholas

Introduction: Vasectomy is a common method of sterilisation. However, it is less popular than tubal ligation world-wide. It is also a frequent cause of litigation relating to its complications. This article reviews the early and late risks associated with the procedure.

Patients and Methods: Data collection was done using the internet to search Medline for obtaining evidence-based medicine reviews. Cross-references were obtained from key articles. Websites of government bodies and medical associations were searched for guidelines relating to vasectomy.

Discussion: Early complications include haematoma, wound and genito-urinary infections, and traumatic fistulae. Vasectomy failure occurs in 0-2% of patients. Late recanalisation causes failure in 0.2% of vasectomies. Significant chronic orchalgia may occur in up to 15% of men after vasectomy, and may require epididyectomy or vasectomy reversal. Antisperm antibodies develop in a significant proportion of men post-vasectomy, but do not increase the risk of immune-complex or atherosclerotic heart disease. Similarly, vasectomy does not enhance risk of testicular or prostate cancer. Vasectomy has a lower mortality as compared to tubal occlusion, but is still significantly high in non-industrialised countries because of infections.

Conclusions: Vasectomy, though safe and relatively simple, requires a high level of expertise to minimise complications. Adequate pre-operative counselling is essential to increase patient acceptability of this method of permanent contraception.

Acupuncture May Improve Sperm Quality

Source: *Fertil Steril. 2005; 84:141-147* Reviewed by **Gary D. Vogin, MD**

July 25, 2005 - Acupuncture may improve sperm quality in idiopathic male infertility, according to the results of a prospective study reported in the July issue of Fertility and Sterility.

"Reports from uncontrolled trials using acupuncture on infertile men have shown a positive effect on sperm concentration and motility, an increase in testosterone, and some improvement in luteinizing hormone (LH) level," write Jian Pei, PhD, from Shanghai University of Traditional Chinese Medicine in the People's Republic of China, and colleagues. "These studies have also shown an increase of normally shaped sperm and a significant decrease in the percentage of morphologically abnormal sperm."

Of 40 men with idiopathic oligospermia, asthenospermia, or teratozoospermia, 28 (70%) received acupuncture twice weekly for five weeks, and their semen samples were randomized with semen samples from the 12 men in the untreated control group. The primary outcome was quantitative analysis by transmission electron microscopy.

After acupuncture, there was a statistically significant increase in the percentage and number of sperm and improvement in acrosome position and shape, nuclear shape, axonemal pattern and shape, and accessory fibers of sperm organelles, without ultrastructural defects in the total ejaculates. Specific sperm pathologies in the form of apoptosis, immaturity, and necrosis did not change significantly between the control and treatment groups before and after treatment.

"The treatment of idiopathic male infertility could benefit from employing acupuncture," the authors write. "A general improvement of sperm quality, specifically in the ultrastructural integrity of spermatozoa, was seen after acupuncture, although we did not identify specific sperm pathologies that could be particularly sensitive to this therapy."

The National Natural Science Foundation of China and the Key Projects Foundation, State Administration of Traditional Chinese Medicine, People's Republic of China, supported this study.

Dr. V. Brahma Reddy from Kurnool, Andhra Pradesh was the recipient of Dr. Antia-Finseth award (2005) for his innovation of using ordinary mosquito net (a co-polymer of polyethene and polypropylene) for Hernia repair in place of Prolene mesh, thereby reducing the cost of the material from Rs. 1700/- to 0.45 paise only. Multicentric trial found it absolutely safe to be used for Hernioraphy. Incidentaily way back in 1996 the trial was also conducted at Rural Medicare Centre, New Delhi and the preliminary result was presented at ASI conference in Mumbai.

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Glimpse of 1st International Conference of Rural Surgery
13th National Conference of ARSI & 8th Midterm Conference of ASRI

Dr. Randall Zuckerman speaking on "Status of rural surgery in America"

Scientific session in progress (Dr. Thomas Egglseder during his deliberation on Laparoscopy in Perforated Appendicitis)

Dr. R.D. Prabhu handing over the President's medallion to Dr. J. K. Banerjee

Pre conference workshop on standardization of rural hospitals and training in rural surgery

Cultural Program organised on the occasion

(An Ideal Gift for Doctor and Friends)

The Hills of Angheri *by Kavery Nambisan*

The hills stand guarding the village of Angheri where twelve-year-old Nalli has a dream. She dreams that when she grows up she will be a doctor and work among her people. Her old-fashioned family has other plans. But Nalli follows her destiny - and the path blazed by her childhood hero, Jai. She goes to Madras to study medicine and then to England to become a surgeon. On the way, she learns to keep her voice down and sit with her knees together; she forgets to wash her hands after cutting up cadavers at dissection; she watches as the panorama of human woes unrolls daily before her eyes. She encounters people who test her faith in the values her father taught her to live by, and in her own skills as a surgeon. But all the time she is haunted by a dream….

Sensitive and humorous, graceful and invariably engaging, The Hills of Angheri is a captivating story of a young woman coming to terms with the untidiness of life and her profession. *The story deals with the pain, thrills and frustrations of a doctor's life. All medical and surgical scenes in the book are from real life.*

About the author

Kavery Nambisan is a practising surgeon. She has written several award-winning books for children, and four novels:

The Truth (almost) about Bharat, The Scent of Pepper, Mango-Coloured Fish and On Wings of Butterflies.

Praise for Kavery Nambisan

'Nambisan has a gift that cannot come with practice - the art of empathising with her characters… they stay with you long after you've finished the book.' - *Business Standard*

The Hills of Angheri, paperback, pages 400, price Rs 350

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