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I N T H I S I S S U E

(Contd. on next page)

Price Rs. 3/-

Dr. Fred Finseth

(Contd. from Front Cover)

I N T H I S I S S U E

Dr. Fred Finseth: A Friend in Need

When we honestly ask ourselves about people who mean the most to us, we often find that it is those who, instead of giving us advice, solutions or mere support, have chosen rather to share our pain and touch our wounds with a warm and tender hand. Dr. Fred Finseth, an internationally acclaimed plastic surgeon with special skill in hand surgery, was one such friend of India.

He not only shared the pain and healed the wounds of thousands of unfortunate handicapped and crippled leprosy patients across the country; he also cured and corrected their deformities with his unparalleled surgical skill.

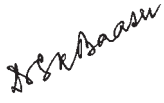
A post graduate from Harvard Medical School, Fred did his training in plastic surgery at the Massachusetts General Hospital. It was during this period that he met Dr. N. H. Antia, who invited Fred to come to India and work with him. This chance meeting resulted in a long and fruitful friendship and collegial relationship between the two and they went on to work together on various projects.

Fred also joined Association of Rural surgeons of India, a forum of surgeons working selflessly for the rural population. The prize money of Antia- Finseth award, conferred by ARSI for original innovation useful in rural surgery, was till now being met from the generous donations made jointly by Dr. Antia and Dr. Fred Finseth.

Fred was in love with India. More than 30 visit in 35 years (*from early 1970s until 2005 when he got cancer and had to undergo chemotherapy*) for conducting surgery on leprosy patients voluntarily is a testimony to that. During his many trips, he would even visit remote places of India such as Muniguda etc with fellow colleagues like Dr. Santosh Rath for performing surgery on rural patients. He was always full of praises for his colleagues in India. He admired them for their selfless dedication to serving the poor and for all the time and skill they put in for the betterment of their patients.

A brilliant personality, his energy and *joie de vivre* was infectious. He dedicated his entire life in trying to make life better for thousands of people. Being an enormously skilled surgeon, he missed no opportunity to pass on his knowledge and technical skills to other surgeons and he did this as a volunteer in various Latin American countries. Popularly called 'Papa' by his students, his engaging and deeply humane nature earned him love and appreciation from every quarter.

Dr. Fred Finseth died of cancer on 4th of December 2007. Both ARSI and India have lost one of its true friends who tried to wipe off the sorrow of thousands of people to alleviate their sufferings. To all those he touched, Fred's name itself will perhaps restore his loss in their lives and help them in ending their sorrows.



Dr. S. K. Baasu

This issue has been sponsored by Emmanuel Hospital Association

Ordinary Sugar for Infected Wound Dressings; A very Effective and Cheap Dressing Agent in Rural Practice

R. D. Prabhu, F.R.C.S.

(Based on the paper presented at the Second conference of IFRS, 26–29 Sept. 2007, Ifakara, Tanzania)

Introduction

It all started in early eighties, when an elderly diabetic lady who had a non-healing sinus on the amputation stump. I had tried all ointments and antibiotics but it would not heal. I was totally exasperated. My wife's brother, a non-medical person, told me about the sugar and how it has been proved to be effective. So I tried it on this sinus of the lady and 'lo and behold' the sinus healed dry in a matter of days! I looked up in the literature and found sound basis for sugar use and have been using sugar for wounds ever since.

Sugar and honey have been used from ancient times. Ancient Indian surgeon Sushrut (whose time probably was about 600 BC) used honey with ghee and a few other herbal ingredients to dress wounds. Similarly, ancient Egypt also used honey with lard to pack wounds. Though I do not know of any ancient recording of sugar use, it has been used in the villages as a primary dressing of fresh wounds for many years. Now a scientific basis for its use has been established. In 1976 Leon Herszage started using it in Buenos Aires, in Argentina, and at the same time Richard Knutson was using it in Greenville, Mississippi, USA. Both of them had good results. In 1980 Herszage and Montenegro reported 99.2% cure rate of wound healing after using sugar in 120 patients.

Herszage was a general surgeon and dental surgeon, head of pathology and abdominal wall at Alvear Hospital Medical College, in Buenos Aires. His study revealed that:

- Sugar in wounds does not get absorbed in blood stream;
- Sugar is hygroscopic and so it draws out the water from the plasma of bacteria, which therefore die. Sugar kills *Streptococci, Staphylococci, E. coli, Pseudomonas, Kl. perfringens, M. tuberculosis*. But *Staph dorodons* are seen in the wounds;
- Hygroscopic effect also draws plasma from the blood vessels, in to the wound thus bringing with it the macrophages, enzymes, antibiotics etc.

Studies by others have shown that:

- Even if sugar is diluted to 50% by serum, it continues to be bactericidal;
- Foul smell from the wound disappears in about a day or two.

Method of use

- Clean the wound as best as possible;
- Pour sugar or sugar paste (in water) on the wound or in to the cavity of the wound to fill it up;
- Cover it with absorbed gauze and cotton and;
- Hold the dressing in place with bandage or tapes.

It is not necessary to sterilize the sugar. Dissolved sugar may form syrup and sometime get escape under the dressings when it may be necessary to change the dressing. Otherwise daily change of dressing is adequate.

The following is case history of a patient who had large wounds that needed dressings and who derived very good benefits from sugar dressings. I have selected this case simply because this was the largest of wounds that I have treated with sugar.

Case Report

Smt. S was admitted in our nursing home on 2nd Aug. 1984. She was diabetic and had multiple pyaemic abscesses on her body; a

large one over the left scapular region extending to the renal region, one over the abdominal wall, one in the axilla and one small one over the lower back (Pic. 1).

Her Hb was 60% and WBC of 15400 pccm. Under GA all the abscesses were incised drained and curetted. One unit each of blood and Haemaccel were transfused. The pus revealed *staph coagulase +ve*. But unfortunately the records do not show sensitivity report. Gentamycin 80 mg. B. D. was used for 5 days. Then Cephalexin 250 QDS was used for 9 days. Then as the wound became 'cleaner' antibiotics were stopped from 18-8-1984.

Sugar was used for dressings with the consent of the patient and her relatives (Pic. 2). Large quantity of sugar was required in view of large size of wounds. Severe stinging pain was felt when the sugar was instilled in the wounds. However, the improvement in the wounds was quite impressive indeed. A week later she had what looked bacillary dysentery which responded to treatment.

On 5-9-1984 split skin graft under local anesthesia was applied to the largest of the wounds on the back (Pic. 3). She had fever following this and the graft sloughed off. The infection was again Coagulase *+ve Staph!* A few days of Ampicillin + Cloxacillin (as was my practice at the time) and only sugar dressings were continued. The wound became 'clean' again (Pic. 4).

Her daughter had learnt how to dress the wound with sugar by now and she went home on 19-9-1984 though the wound was yet to heal. In a few weeks she came back to show that the wounds were all healed.

Discussion

Many ointments, creams and solutions are available in the market for wound dressing. Some contain antibiotics too. BMJ advocates the following for wound dressings:

- Iodine releasing agents, like povidone iodine;
- Potassium permanganate;
- Silver releasing agents like silver sulphadiazine;
- Topical metronidazole;
- I would like to add to this list — "Sugar".

Generally use of antibiotics is not advocated for dressing of wounds. It may cause:

- Development of antibiotic resistance;
- Hypersensitivity to antibiotic;
- Inadequate penetration of the drug;
- Systemic absorption if the wound is large;
- Local irritation that delays wound healing.

Sugar works like an antibiotic but without any of the above reactions. However, it does cause some stinging discomfort to the patient. But since it is so harmless, available so easily, for such low price and since it is so effective that I like to use it in preference to any proprietary preparations especially in very large wounds.

In the case presented above, the antibiotics sensitivity has not been studied. However, if it is tested, we may learn more on the effectiveness or otherwise of sugar as a bactericidal material. One observation may be worth mentioning here, and that is, when sugar dressings are continued for many weeks, the wounds show fungus like covering on the wound surface! This too needs to be studied. That was the only time I resorted to some other material for dressing.

More recent studies have revealed that Sugar is even more effective if mixed with:

- Honey — it contains some enzymes;
- Hydrogen peroxide, especially for Staphylococcal infections;
- Povidone iodine, which gives additive effect;
- Polyethylene Glycol.

(For Pictures see page no. 12)

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Familial Tuberous Sclerosis with Renal Tumours

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Dr. Sawrup Chakraborty*, Dr. Arun Acharya**, Dr. T. S. Pathak**,
Dr. Sukumar Maiti***, Prof. S. R. Ghosal, Dr. S. Das***

Abstract

[Tuberous sclerosis is a rare genetic disease which causes tumour formation in many different organs like skin, brain, kidney, eyes, and heart. Only some organs are involved (earthy thickening of skin; ash leaf patches, hamartomatous nodule in Cerebral Cortex, angiolipoma even adenocarcinoma of kidney). Hamartomatous swelling resemble potatoes so these are called tubers.

Three cases are presented here, all in a family: father, son and granddaughter. Father and son showed involvement of skin (nose) and kidney. Son and daughter showed involvement of skin, brain (seizure) and kidney.]

Key words

Familial tuberous sclerosis, kidney tumours

Materials and methods

A male patient aged 58 years was admitted with pain and discomfort in left lower abdomen. He was also suffering from fever for about 1 month. There was no other urinary complain. Patient complained of thick blackened skin over the nasal area. As per his statement his son and granddaughter also suffered from the same skin changes. (*See fig. 1 on page no.*12)

The patient was referred to skin OPD. The lesion was diagnosed as rare genetic familial tuberous sclerosis. Subsequently ultrasonography of the abdomen showed a SOL in left kidney (*See fig. 2 on page no.12*). It was suspected to be hypernephroma. All three had no urinary complaints. Father (60 years) and the son (30 years) complained of only skin involvement and loin pain. Son and the granddaughter (6 years) suffered from seizure.

CT scan of abdomen of father revealed a SOL in the left kidney. FNAC showed it to be adenocarcinoma involving upper pole. USG of kidneys of both son and granddaughter showed angiomyolipomatous swelling in both kidneys. CT scan of brain did not show any abnormalities. The patient had episodes of seizure.

Following modalities were taken up for diagnosis:

- Scraping from skin lesion;
- USG of abdomen;
- CT scan of abdomen.

Findings

The investigations revealed the following findings in the family:

- Tuberous sclerosis or tuberous adenoma in all cases as per skin scraping;
- USG of abdomen
  Father — adenocarcinoma
  Son — angiolipoma
  Granddaughter — angiolipoma
- CT guided FNAC — done in father showed fair no of atypical, hyper chromatic, slightly pleomorphic polygonal, spindle shaped cells in cluster suggestive of renal cell carcinoma. SOL situated in mid lower pole of kidney mildly enhancing (4.56cm × 4.26cm)
- USG of kidney of son showed both kidneys enlarged. One SOL 6.5cm × 7.2cm is present in right kidney, one SOL about 5.8 cm × 6.2cm is also present in left kidney. These are suggestive of angiomyolipoma;
- Scraping of skin — features of tuberous sclerosis;

- Molecular analysis for gene TSC1 and TSC2 in chromosome 9q 34 — not done;
- CT scan of brain — normal study.

Discussion

We have searched various journals and websites and gathered the following information.

Tuberous sclerosis is a rare genetic disease that causes benign tumours to grow in various organs like brain, kidney, skin, eye, heart, lungs. In addition to benign tumours other common symptoms include seizures, mental retardation, behaviour problems and skin abnormalities. Hence it is called tuberous sclerosis complex. This was first described by D. M. Bourneville in 1880. The condition is also called Bourneville disease. It is also called EPILOIA (Epi = epilepsy, Loi = low intelligence, A=Adenoma sebaceum. But the classic triad is only seen in minority of patients (15% to 20%). This is a common autosomal inherited autosomal dominant disease. Prevalence rate is about 1 in 5800. Nearly 1 million people worldwide are known to have tuberous sclerosis. There are many undiagnosed cases due to obscurity of the disease.

Several distinct genetic loci have been identified. One locus is present on chromosome 9q34 (TSC1) and another on chromosome 16p13 (TSC2).

Tuberous sclerosis is transmitted either through genetic inheritance or as a spontaneous genetic mutation. Children have a 50% chance of inheriting TSC if one of the parents is involved.[3]

Hamartomatous proliferations of tissue involving vascular, fibrous, glandular or glial tissue form a small potato like swelling, so it called tuber.[1]

Adenoma sebaceum or angiofibroma are 1–3 mm, yellowish translucent discrete waxy papules over nose, cheek and forehead skin. These have also been reported in MEN.[1] They are found in about 85% cases with hypo pigmented patch and tuft of white hair.

Renal hamartomas are usually in the form of angiolipoma (25%), cystic disease (18%) and even rarely adenocarcinoma. In the familial variety, about 80% patients have angiomyolipoma which are bilateral and may lead to renal failure.[3]

Three types of tubers may form in brain; cortical tubers on surface of cortex, subependymal nodules on walls of ventricles and giant celled astrocytoma.[2]

All features are not present in every patient. Skin, brain and kidney are commonly affected with chance of involvement is about 80%; mental deficiency (40%–60%), epilepsy or seizures (90%), angiomyolipoma (45%) or cystic disease (18%) and skin involvement (papular lesion 80%) are found in familial cases.[4]

So for diagnosis of TSC dermatological manifestations, renal and cerebral hamartomas are considered major features. Liver, lung, retina may also be involved. Modern TSC genetic testing may be more helpful.[5]

Although treatment is available for a number of symptoms there is no cure of TSC. Antiepileptic drugs for seizures, laser treatment or scraping for skin condition or removal of kidney tumour may be carried on however the disease process cannot be checked. Longevity will depend upon severity or multiplicity of organ involved.[6]

Conclusion

TSC is still an obscure disease. Mechanism of genetic mutation of TSC is still not known. Epilepsy and autism are two important features that may occur in children. Bilateral renal involvement in the form of

angiomyolipoma or even malignancy rarely attracts attention towards the genetic basis of these tumours. We hope this presentation will enlighten the future scientists to solve the molecular basis of these tumours in brain and kidney and develop method of prevention or cure.

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Congratulations!
Rural Medicare Society Award 2007

For the best paper published in Rural Surgery Bulletin goes to Dr. Sanjay S. Shivade for his paper "Use of Human Placenta in Generation of Biogas"

Incidentally this paper was also presented in 2nd IFRS conference at Ifakara, Tanzania. This subject is very topical for it deals with

1) Disposal of hospital waste;
2) Constructive use of the waste for energy production;
3) Saving of other energy sources and consequently cost savings and;
4) A novel idea.

The award will be presented in ARSICON 2008 conference to be held in Wardha.

Flexion — Abduction Method for Reduction of Anterior Dislocation of Shoulder

Dr. Sunil Sahi M.S. (ortho)

This method of reduction of shoulder dislocation has been described many years back (Cooper Sir A 1832, and Janecki C. J. 1982), but failed to get wide spread popularity. The method is based on anatomical knowledge of shoulder girdle and hence force required for reduction is less. The process is not only physiological, it is relatively less painful. Most of the cases are done under the effect of analgesics (injection Voveran) and apprehensive patients may require additional injection of intravenous Diazepam.

Material and methods

I have been using this method since 1988–89 and reduced more than sixty cases of anterior dislocation shoulder by this method. Patient is administered intramuscular Voveran (3ml) at the time of first examination and is explained about the procedure that this joint will be relocated by very gentle and gradual manipulation. Only two patients in our series required general anesthesia. The oldest patient in this series was more than 80 years. Even patients coming from far flung places with three days old dislocation were reduced without G. A.

Patient was placed on a couch. The procedure was explained to the patient. Sedation was given only if the patient showed resistance during reduction. The surgeon stood on the affected side and held the upper limb at the level of wrist with elbow in 90 degree flexion (Pic. 1). The limb which lies in slight abduction is gently flexed to 90 degree (Pic. 2). Traction is given in the long axis of the arm and the limb is brought to overhead abducted position (Pic. 3–4). A constant traction is maintained in this position; usually the head of humerus is reduced in the glenoid cavity at the end of this stage (Pic. 5). If not, a direct pressure is applied over the head to push it inside the cavity. The limb is then kept across the chest and strapped for three weeks. Post reduction X-rays were taken routinely.

Observations

Dislocation was reduced successfully in all the patients. There were no neurovascular complications. It was observed that young male patient with good muscular built required sustained traction in the long axis of arm which brought the head back into the cavity. The whole procedure may take just 3 to 4 minutes.

Discussion

The forward elevation method is a gentle way of reducing anterior dislocation of shoulder making it a very safe procedure. No complications were observed in our series. Since it does not require anesthesia it is very useful for high risk patients for general anesthesia. In rural areas where facilities for general anesthesia are not available this method is of immense importance.

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(For illustrations see page no. 13)

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Rating of Rural Surgical Centres by the Association of Rural Surgeons of India: A Proposal and its Advantages

Dr. J. Gnanaraj, MS, MCH

Background

Most of the population of India live in rural area while most of the surgeons in India live in urban areas. The Association of Rural Surgeons of India has many surgeons who have chosen to work in rural areas to meet the surgical needs of the poor patients there. With limited resources and few trained personnel they have been providing excellent care. They have trained local persons to perform duties that are carried out in urban areas only by people with relevant qualifications. The Government, the patients and others could question this. It might be difficult to get the necessary licences. For instance without a qualified radiologist the Government would not give licence for taking X-rays while excellent quality X-rays could be taken by locally trained personnel. There has been plenty of discussion about life saving blood transfusions. The Government is forced to take decisions the way they do because of the misuse of loopholes that are available. For instance without strict laws many unauthorised commercial blood banks have sprung up. However for their sake the poor patients should not suffer because of non availability of lifesaving treatment.

The proposal

The Association of Rural Surgeons of India could provide strict rating of the rural surgical centers based on their performance rather than go strictly by paper qualifications. If the Government, patients and others could be convinced about the fairness of evaluation and competence of the evaluating authority it provides the rural surgeons the moral go ahead to continue providing high quality care.

The assessment should be a detailed one based on performance and capabilities and skills and the evaluation should be periodic. The rating could be developed based on the varieties of surgical procedures carried out, the facilities that are available, the complication rates, the measures available for tackling complications, the facilities available for regular upgrading of skills and so on.

The advantages

The rural surgical centres have opportunity for having an assessment by outside qualified personnel and this would give the place an accurate assessment of their capabilities.

There would be an incentive to move up on the scale and quality of the care would improve. There is opportunity to find out what is missing and what needs correction.

It is good for the patients and authorities to know that impartial assessment has been carried out by authorised and trained personnel.

A sample rating system

The rural surgical center could be awarded 1 to 5 stars as follows:

Eligibility for 5 star rating

Capabilities

- Major open surgical procedures like Abdominoperineal resection, Whipple's operation, Radical cancer surgeries (Wertheim's hysterectomies, Composite resection, Radical nephrectomies, etc);
- Speciality procedures like ORIF, cleft lip and palate repairs, pyeloplasties, vascular flaps, etc;
- Laparoscopic surgeries like CBD exploration, laparoscopic nephrectomies, laparoscopic suturing, laparoscopy assisted colectomies, laparoscopic fundoplication, etc;

- Endoscopic surgeries like TURP, ureterorenoscopic retrieval of calculus, Endoscopic internal urethrotomies.

Performance

- Complication rates similar or not more than one and a half times that in Urban centres;
- Interviews and assessment of the local surgeons by the experts in the field;
- Presentation of the work at conferences and Journals.

Turnover

- At least one or two of the above major procedures in a month;
- At least one major surgical procedure a day.

Facilities

- A good laboratory with semiautomatic auto analysers;
- An X-ray machine >300 mA;
- An ultrasound machine;
- Intensive care unit;
- Facilities for blood transfusion;
- Continuing medical education programmes;
- Referral facilities.

Others

- More than one publication a year;
- Doctors attending at least one conference a year;
- Facilities for patients relatives to stay and cook.

Eligibility for 4 star rating

Capabilities

- Major open surgical procedures like Gastrectomies, total abdominal hysterectomies, Cholecystectomies and CBD explorations, simple mastectomies, etc;
- Speciality procedures like open and closed reduction of fractures, vaginal hysterectomies, cleft lip repairs, tonsillectomies, etc;
- Facilities for either laparoscopic or endoscopic surgeries like laparoscopic cholecystectomies, laparoscopic appendicectomies, LAVH, TURP, ureterorenoscopy, etc.

Performance

- Complication rates similar or not more than one and a half times that in Urban centres;
- Interviews and assessment of the local surgeons by the experts in the field;
- Presentation of the work at conferences and Journals.

Turnover

- At least one or two of the above major procedures in a month;
- At least three major surgical procedures in a week.

Facilities

- A good laboratory with semiautomatic auto analysers;
- An X-ray machine >300 mA;
- An ultrasound machine;
- Intensive care unit;
- Facilities for blood transfusion;
- Referral facilities.

Others

- More than one publication from the institute;
- Doctors attending at least one conference a year;
- Facilities for patients relatives to stay and cook.

Eligibility for 3 star rating

Capabilities

- Major open surgical procedures like Gastrectomies, total abdominal hysterectomies, Cholecystectomies and CBD explorations, simple mastectomies, etc;
- Speciality procedures like open and closed reduction of fractures, cleft lip repairs, tonsillectomies, etc;

Performance
- Complication rates similar or not more than one and a half times that in Urban centres;
- Interviews and assessment of the local surgeons by the experts in the field.

Turnover
- About 30 surgical procedures a month with at least 10 major surgeries.

Facilities
- A good laboratory with semiautomatic auto analysers;
- An X-ray machine >300 mA;
- An ultrasound machine;
- Intensive care unit;
- Facilities for blood transfusion;
- Referral facilities.

Others
- Doctors attending at least one conference a year;
- Facilities for patients relatives to stay and cook.

Eligibility for 2 star rating

Capabilities
- Major open surgical procedures like Gastrectomies, total abdominal hysterectomies, Cholecystectomies and CBD explorations, simple mastectomies, etc;
- Speciality procedures like open and closed reduction of fractures, cleft lip repairs, tonsillectomies, etc.

Performance
- Complication rates similar or not more than one and a half times that in Urban centres;
- Interviews and assessment of the local surgeons by the experts in the field.

Facilities
- A good laboratory;
- An ultrasound machine;
- An X-ray machine;
- Facilities for blood transfusion;
- Referral facilities.

Eligibility for 1 star rating

Capabilities
- Open surgical procedures like appendicectomies, laparotomies, closure of Duodenal ulcer perforations, etc;
- Speciality procedures like open and closed reduction of fractures, LSCS, etc.

Performance
- Complication rates similar or not more than one and a half times that in Urban centres;
- Interviews and assessment of the local surgeons by the experts in the field.

Facilities
- A good laboratory;
- Facilities for blood transfusion;
- Referral facilities.

Others

Doctors attending a conference once in two years to update the knowledge.

Logistics

The Association of Rural Surgeons of India can form a team of senior doctors who could go and inspect and rate the rural surgical centers. The rural surgical centres could apply and also pay for the expenses involved in inspection and accreditation.

Discussion

The Burrows Memorial Christian Hospital is a 70 bed mission hospital in a small village called Alipur serving the poor in this area since 1935. About 3500 surgical procedures are performed every year including major laparoscopic surgeries and endoscopic surgeries. However the hospital does not have a doctor anaesthetist and the major surgeries are performed using the EMO machine ether anaesthesia given by a nurse anaesthetist. Although many Urological procedures are carried out, the X-rays are carried out by

locally trained personnel. The laboratory has very accurate Johnson and Johnson dry chemistry semiautomatic analyser but only locally trained technicians operate it. Only recently one of them has completed Christian Medical Association of India's recognised training.

Senior staffs from CMC Vellore come frequently to help and teach. Impressed by the quality of care that they received, some senior army officials wanted the hospital to be empanelled for treatment of the army veterans. However the team of inspectors were interested only in the paper qualifications and the hospital could not be authorised to do any laboratory tests, ultrasound, X-rays or surgeries. Poor patients could get an ultrasound examination for Rs. 200 and a laparoscopic cholecystectomy for Rs. 1500.

If an organisation like Association of Rural Surgeons of India could give accreditation and rating for hospitals like Burrows Memorial Christian Hospital it would go a long way to help these hospitals have dignity.

Address for correspondence: Burrows memorial Christian hospital, Alipur, PO. Banskandi, Dist. Cachar, E mail ID: jgnanaraj@gmail.com

*(For the past few years ARSI is discussing in various meetings about the method of standardisation of rural hospitals. Author has given a proposal for rating such setups. Comments are invited from the readers about the feasibility of accrediting rural hospitals based on the criteria discussed by the author. - **Ed**)*

Ordinary Sugar for Infected Wound Dressings; A very Effective and Cheap Dressing Agent in Rural Practice.

(from page no. 3)

(Pic. 1)

(Pic. 3)

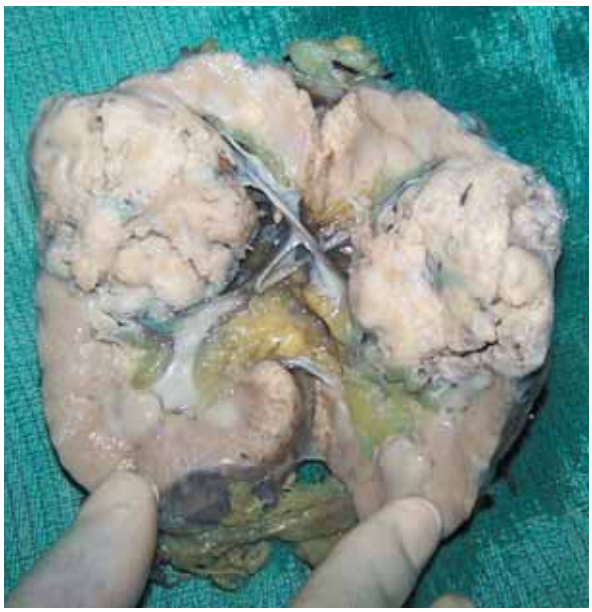
(Pic. 2)

(Pic. 4)

Familial Tuberous Sclerosis with Renal Tumours

(from page no. 4)

Tuberous sclerosis with lesions on the faces of father and son (fig. 1)



The renal tumour (left side) after excision (fig. 2)

Buruli Ulcer

(from page no. 17)

No comment

Nodules

Oedematous

Undermined ulcer

Plaque

Flexion — Abduction Method for Reduction of Anterior Dislocation of Shoulder

(from page no. 7)

(Pic. 1)

(Pic. 2)

(Pic. 3)

(Pic. 4)

(Pic. 5)

CME article for DNB (Rural Surgery) Students

(Starting with this bulletin, The Gov. Council of ARSI has decided to introduce a section on CME for our DNB (rural surgery) students. The possible topics that can be covered under this section and the format for presenting the same have been discussed on page no. 23, in the information column.

While many of our dear members did promise to contribute to this initiative, the articles are yet to reach the editor's office. To make a beginning — an article on obstructed labour has been presented in this issue as this condition is commonly encountered in rural practice and one of the most challenging emergencies in obstetrics).

Obstructed Labour

Dr. S. K. Baasu

Obstructed labor is one where in spite of good uterine contractions, the progressive descent of the presenting part is arrested due to mechanical obstruction. Because of the advances in obstetric care, while death due to obstructed labour is more or less consigned to history in developed countries they account for substantial proportion of maternal death in Asia and African countries, accounting for about 8% of all maternal deaths in developing countries likes India.

Etio-pathology

Following are the causes of obstructed labour

i) Cephalo pelvic Disproportion (most important cause, two-thirds of cases) — contracted pelvis or a large baby;
ii) Foetal abnormality (Hydrocephaly, occasionally foetal ascitis);
iii) Malpresentation of foetus (Brow, face or a shoulder presentation, or a prolapsed arm in transverse lie);
iv) Rare causes such as stenosis of vagina, locked twins, pelvic tumours, particularly fibroids or an ovarian cyst.

In a labour that is going to obstruct, the first stage is often prolonged, but it can be normal or even short. A mother's membranes rupture, and her liquor escapes. Her uterus contracts and retracts and thickens at the expense of the lower segment forcing her baby into its lower segment, which gradually becomes overstretched. Obstruction prevents baby's escape, so her lower segment moulds closely round the baby and thins. Should the obstruction persist the retraction ring of Bandl form and marks the junction of lower edge of retracted upper segment with the thinned lower segment. The contractions of her uterus become hypertonic, and relaxation between them becomes poor. The placenta is poorly perfused, there is fetal distress, and ultimately the baby dies.

Clinical feature

In rural practice most of the cases with obstructed labour are brought to the hospital after the patient may be in labour for days and tried many home remedies. Most of such patients are primiparous. When she arrives she is tired, exhausted, anxious, and febrile, with a fast pulse. Her contractions may be strong and painful, with little relaxation between them. The head of her baby, who shows signs of fetal distress, is high, and overlaps the brim of her pelvis. Her liquor has drained; as a result her uterus is moulded around the foetus. Her vulva and cervix are oedematous, vagina is dry and 'hot', and her cervix not fully dilated. Although baby's head can be felt just inside her cervix, this is not because it has descended, but because baby's head is severely elongated. There is lot

of moulding with caput formation. Abdominal examination will reveal that most of it is still above her pelvic brim.

Management

When you diagnose obstructed labour, the next critical question is: Has her uterus already ruptured?

How to diagnose whether the uterus is already ruptured:

Before rupture the signs that it is imminent are: (1) The failure of labour to progress. Lack of progress should therefore alert you to the possibility that rupture might be imminent. (2) Bandl's ring. (3) A distended bladder which is difficult to catheterize and often blood stained urine. (4) Frequent strong uterine contractions, with little or no pause between them.

After rupture, a mother may have little or no pain. If you ask her, she will tell you that contractions were strong, but then suddenly stopped, and were replaced by a lesser continuous pain, or no pain. She may be in severe hypovolaemic shock, with cold, sweaty skin, and a weak or absent radial pulse. She may be quite obviously collapsed, or alert and even talkative. You can feel no uterine contractions, but you can usually feel her baby through her abdominal wall lying free in her abdomen. While doing internal examination you may experience unexpectedly easy dislodgement of the presenting part followed by a gush of vaginal blood.

If it has not ruptured, proceed as follows:

- Make preliminary assessment of the general condition of the mother, presentation and position of the fetus and pelvic size. Assess the height of the baby's head. Don't assess the height of his head by vaginal examination only. There will be much caput, and this will mislead you. Note down the condition of the fetus;
- Resuscitate the mother rapidly with intravenous fluids to combat hypovolaemic shock (very common). Rehydrate her with 0.9% saline or Ringer's lactate, and continue with dextrose 5%. Resuscitation must be rapid, because delivery is urgent. She may be admitted directly to the theatre, and resuscitate her there. This will allow you to operate as soon as she is in an optimal condition. Blood transfusion when necessary is to be carried out. Insert a bladder catheter for continuous catheterization. Take vaginal swab for culture and sensitivity;
- Patient may go into septic shock (less common) if you don't prevent it. Give her intravenous broad spectrum antibiotic along with metronidazole. Measure urine output.

Method of Delivery: Caesarean section or Destructive operation?

Every patient needs an individualized approach for management of obstructed labor by either LSCS or by a destructive operation according to the situation to have a favorable outcome.

Caesarean section has a limited role, and is likely to be a serious risk, so don't do it lightly. Cesarean section is undertaken in cases 1) with good general condition and living baby, or 2) with severely contracted pelvis and/or impending uterine rupture even with a dead fetus.

Criteria for destructive operations are 1) when the baby is dead (even with a live baby in severe hydrocephalus/multiple congenital malformations), 2) cervix is fully dilated or nearly so (except in hydrocephalus where perforation of fore-coming head can be performed as soon as cervix is 5cm dilated) 3) Baby's head must be impacted. Only 2/5 or less of baby's head must be above the brim (if it is higher than this, Caesarean section is usually safer) 4) Uterus must be unruptured. Be very careful in a multipara who has been in labour for a long time, her lower segment will

be very thin. If it is tender and distended she can only be saved by Caesarean section; any destructive operation, except pushing a needle into a hydrocephalic head, will rupture it. Infection is no contraindication. In case of transverse lie destructive operation can be performed if the baby is dead and is lying transversely, her cervix is 8 cm or more dilated, and her uterus is not ruptured. Vaginal deliveries are often possible, but try to avoid a difficult one. An operative vaginal delivery is absolutely contraindicated if her uterus has already ruptured.

Anaesthesia. The patient's stomach is likely to be full, and she can inhale its contents only too easily. Therefore remember to insert a nasogastric tube if she is to have a Caesarean section. If she is to be delivered vaginally, pudendal block, saddle block, or an epidural block may be used.

Sequels, complications

Obstructed labour has two main dangers: (1) Her vagina, bladder, and rectum are trapped between baby's head and her pelvis, so that they become necrotic, slough, and develop fistulae. Usually between 3 and 10 days postpartum, this necrotic tissue sloughs off and a fistula develops between the bladder and the vagina (vesicovaginal) or the rectum and the vagina (Rectovaginal). Rectovaginal fistulas occur far less frequently. (2) Her uterus ruptures. Primiparous usually develop fistulae, and multipara usually rupture their uterus, but both can do either, and rupture and fistulae can occur in the same patient. (3) She is also at risk from septic shock, peritonitis, peritoneal abscesses, atonic postpartum haemorrhage and foot drop from the pressure of baby's head on her sciatic nerves.

Post-op care

Patient should be kept in hospital for 3–4 days to watch for signs of peripheral nerve injury, renal failure and any sign of sepsis. Her baby has a greater chance of brain damage. Therefore watch carefully for signs of twitching, irritability, or fever.

Remarks and conclusion

(1) Even a patient who has had many normal deliveries may get an obstructed labour from a malpresentation or malposition (2) A partogram can give earlier warning of patient's impending obstruction 3) Don't use an oxytocin drip if there are signs of obstruction 4) Tumours like fibroid or ovarian cyst may cause obstruction in labour process. If a patient has an ovarian cyst or tumour, you can remove it at Caesarean section. If she has a fibroid, leave it and remove it later if necessary.

Comments

Lack of skilled attendance at birth, lack of emergency obstetric care, and lack of transportation to maternity facilities in rural areas contribute to the high rates of prolonged and obstructed labor and resultant fistula in developing countries. Proper screening for risk factors especially short stature, a through pelvic assessment at 36 weeks and routine use of the partogram can prevent obstructed labour to a great extent. If a mother is brought to you with obstructed labour and her baby is dead, convey this information. If you don't, she may blame you for baby's death, and not come to hospital when she is pregnant next time. Before she goes home, make sure that she understands: (1) what operation she had, and (2) why it was done. This will be important when she becomes pregnant again. Lastly in the present situation the curriculum in teaching hospitals should include training in destructive operations which is useful in advanced obstructed labor cases which we still continue to encounter in our country.

(1438 words)

[The article has been made short to fit it in the set format. Author will be too pleased to answer to any query related to the topic.]

IFRS Section

Buruli Ulcer; Training in the Rural Setting — Ghana and Cote D'Ivore Experience

Prof. H. Assé and Dr. Albert Paintsil
(Plastic surgeons from Cote D' Ivoire and Ghana)

(Based on Presentation in 2nd IFRS Conference held in Tanzania)

Buruli Ulcer is a disease caused by a bacterium *Mycobacterium ulcerans* belonging to the group of bacteria that cause Tuberculosis and Leprosy. It ranks as the third most common *Mycobacterium* infection after Tuberculosis and Leprosy. The disease may affect skin or deeper tissues e.g. Bones, Tendons, Joints, Nerves. People who live or work close to rivers and stagnant water bodies or areas with changes in the environment e.g. mining activity etc, are commonly affected. The disease is more common in people who live in rural and remote areas. Up to 70% of those affected are children under 15 years of age. Buruli ulcer is named after a village in Uganda following a record of high prevalence detected in this village as was seen in the early 1960s. (McCollum 1948).

Transmission

Aquatic insects *Naucoris and Dyplonychus* are thought to be involved in transmission. However mode of transmission is not conclusive. Therefore one must protect oneself when examining patients with this disease.

M Ulcerans is a slow growing environmental *mycobacterium* belonging to Acid fast bacillus group; it grows best at temperature of 30–32°C with low oxygen tension. The organism gets through a breach in the skin which could be due to minor trauma, patient usually remain unaware of it. Involvement of the infection is more common on extremities (85% of cases).

Pathogenesis

The organism gets into subcutaneous tissues, proliferates and produces polyketide toxin with affinity for fat cells. It is cytotoxic and immunosuppressive in nature. It causes tissue necrosis resulting in necrosis of subcutaneous tissue. This leads to further proliferation of the bacteria, more tissue damage and further spread of disease. Some cell mediated immunity leads to healing by fibrosis.

Diagnosis

Clinically Buruli ulcer may present as non ulcerative and ulcerative form. In non ulcerative form it may present as plaque or oedematous and pain less nodules. While in ulcerative form, the starting point could be and undermined edge. (For illustrations see page no.13)

Laboratory confirmation is by demonstrating AFBs Culture Histopathology, PCR.

Management

While medical management with Rifampicin (10mg/kg BWt) and Streptomycin (15mg/kg BWt) has to be started as soon as diagnosis is made, perhaps surgical method is the main stay of treatment. At the same time disability needs to be prevented by physiotherapy, necessary splinting and watching out for other problems.

Problems with Buruli ulcer

Buruli ulcer is an endemic disease and is widely reported in developing countries without health facilites (surgery). BU affects poor people. The disease is more severe in impoverished inhabitant of remote rural areas. Access to district hospital from these remote places is difficult.

Strategies to reach the patients of rural areas

A suitable program of proximity surgical care was made with the objective of providing

surgical services to BU patients in endemic areas by

1. Developing temporary surgical unit in rural health centres;
2. Use of mobile surgical unit in remote rural areas.

The current control strategy promoted by the Global Buruli Ulcer Initiative by WHO consists of:

1. Raising awareness, health education and staff training in the communities most affected; Raising awareness about Buruli ulcer disease in the context of neglected tropical diseases is required at all levels in order to increase its profile and obtain commitments from governments, policy makers and donors for its research and control;
2. Strengthening the health care capacity in endemic areas by upgrading surgical facilities, ensuring adequate treatment supplies and improving laboratories thereby improving access to early diagnosis, treatment and prevention of disability;
3. Surgical training to enable other health workers (e.g. nurses, medical assistants) to perform effective minor surgery;
4. Community-based surveillance to improve early detection and rapid referral for treatment in collaboration with disease control programmes such as those for leprosy and dracunculiasis; and obtaining a more accurate data at local, national and global levels;
5. Adoption of educational material appropriate to the needs of each country;
6. Developing successful motivational strategies;
7. Rehabilitation of those already deformed by the disease.

With this stretegic indications both international and local training program was organized aiming at Buruli ulcers treatment.

International training program was conducted with active involvement and assistance of WHO and five other countries. Participants were from the English speaking and French speaking countries. The one month training was conducted in district hospitals. Besides providing them with necessary theoretical knowledge about diagnosis, treatment and prevention of disability, they were also given hand on training. Participants also operated 120 cases under supervision. Skin graft knife with blades were offered to all the participants.

Local training was also conducted with the help of a team consisting of consultant plastic surgeons, clinician (Consultant Dermatologist), anaesthetist, laboratory scientists (Microbiologist and Pathologist), physiotherapist, theatre nurse, nursing officer (ward) and public health physician. The participants included were doctors, anaesthetist/nurse anaesthetist, laboratory technologist/technician physiotherapist/-physiotherapy assistant theatre nurse, ward nurse. GIEESC Manual formed part of material.

The team helped in hand on practice, ward rounds with their advice from case to case basis, operating on "other cases" and with their support visits. Training was conducted in participants own district hospital.

With the help of collaborators i.e. WHO BU Initiative and ANESVAD (Acción Sanitaria y Desarrollo Social, (Spanish NGO) effort was made to provide standard theatre equipments like skin grafting knife and blades. They were made available to all participants to take back to be able to practice what they have learnt and alieviate the suffering of their local patients.

Overview of Tribals

Dr. Dhairyasheel. B. Shirole

(Dr. D. B. Shirole, a well known pediatrician from Pune, is also a post graduate degree holder in Sanskrit and Indology and diploma holder in Ecology. He has travelled extensively in various tribal belts of India and working for tribals in different areas of Maharashtra. He has authored many books on Tribals).

The Author with Madia Tribal

The tribals constitute a unique stream of our national life. There are a lot of misconceptions about the tribal people because of their different ways and practices. The tribals are small, homogenous, self contained and relatively isolated communities residing in natural habitats, spread all over the country with same areas of large concentration.

At one time practically whole of India was inhabited by tribals and in ancient and medieval times they were more numerous and occupied a wider area than at present. From the earliest invasion they waged a losing battle against the advancing culture of the Aryans. Most of the tribes are getting gradually civilized. Some tribal communities are knit together by tribal customs into solid self supporting and self sufficient communities and preserve vestiges of ferocious and barbaric traditions. In the Sanskrit literature there are references to the tribals as wild raiders. In Ramayana and Mahabharata epics they are mentioned as Nishad, Shabar Kirat and Pulind.

The year 1993 was declared as "The year of the Aboriginals" by the U.N.O to focus attention of the developed countries on the problems of the tribals. The tribal people are regarded as the oldest ethnic group of the Indian population. They live in isolated areas as a distinct group speaking their own dialect. They follow primitive occupations such as hunting, fishing, gathering of forest produce and are economically and educationally backward. Tribals protect a primitive religion and observe certain taboos in all walks of life. They dress scantily.

The tribes numbering over 250 are spread over 21 states and in Maharashtra there are 47 tribal communities. Tribals constitute about 8% of the Indian population; maximum concentration is in North Eastern area.

The tribal year starts with a function to welcome rain. After this they have Mahuva and Mango celebrations. This is followed by community hunting and fish catching. There are many more functions after the harvesting season. Every tribal participates in all these functions and the chief of the tribe directs all activities. All the disputes are settled by the head of the tribe and everybody obeys the verdict.

The tribals have very simple food. They consume rice, ragi, maize, beans, fruits and tubers, honey, birds and animals. They prepare wine from rice, Mahuva flowers, dates and plums. Drinking of wine is an integral part of any celebration like child birth, marriage or death. Tribals dance very enthusiastically and their movements are very artistic on the beats of the drums.

Tribal women have a place of importance in tribal culture. They have the freedom to choose their life partners. If they are unhappy in married life they can ask for divorce. Women have property right. They are hard working. They can conduct their own delivery in sitting posture under the directions of a senior tribal woman.

Tribals are known for their art. They decorate the entrances to their houses by artistic woodwork. They erect beautiful marriage poles

and also prepare mats from bamboo and grass. There tobacco containers are very decorative and attractive. They prepare lethal weapons for protection and hunting.

The data on tribal health and nature of treatment are rather scanty. Morbidity patterns are yet to be established on the basis of scientific survey and research. Extreme poverty, illiteracy, ignorance, infections, infestations and superstitions are the basic problems of the tribals. Lack of clean water and nutritious food are the two major obstacles. Every now and then one hears of diseases and deaths in tribal pockets due to malnutrition and communicable diseases.

The infant mortality rate according to survey by non-government agencies is much higher than Governments official figures. I.M.R was 132 and child mortality rate (0–5 yrs) was 209 per 1000 live births.

The prevalent diseases are Malnutrition, Bronchopneumonia, Tuberculosis, Malaria, especially Cerebral Malaria, Gastroenteritis. Other diseases are Leprosy, Sexually transmitted diseases and fungal infections along with parasitic infestations. Burns, fall from tree, snake bite and wild animal bites are known causes of mortality and morbidity.

A high incidence of sickle cell anemia and G6PD deficiency exists in the tribals. Study of sickle cell disease in Gadchiroli district by Kate et al showed that Pardhan community has 34% prevalence while Madia Gonds had 17%, Raj Gonds 10% Halbi 14%.

High frequencies of stickle cell anemia and G6PD deficiency observed among the tribals is a very delicate problem and difficult to solve. It is important to understand the scio-cultural dimensions of health and disease. The factors affecting the health of the tribals are environmental factors like improper housing, lack of safe drinking water, poor sanitation and personal hygiene, insanitary disposal of human excreta and other solid and liquid waste. Deforestation and new law regarding forests have affected the tribals to a great extent. Tremendous influence of superstition is a great obstacle in introducing new methods.

To the tribal mind the real enemies of human health are Gods and dead. They feel that the disease is caused by the breach of some taboos or by hostile spirits or the ghosts. They attribute certain diseases to deities like *Sitala Mata*. The tribals depend upon the local bhagats-quacks-for treatment of many of the diseases. The local herbal medicines are used for the cure of certain diseases. There are bone setters, snake bite curers and others to attend to the tribals. The dependence and confidence on the traditional medicine people are often responsible for the non acceptance of modern medicine. It is important to study the socio cultural dimensions of health and family welfare. It is also essential for health workers to have knowledge about the culture of tribal people.

The overall development of rods, schools, farming, and health care systems is essential for overall improvement of tribal communities. Simultaneously, measures to improve socio economic conditions are urgently needed so that tribals can afford a nutritious diet and hygienic surroundings and do not go into extinct.

Province wise population of tribals	
Madhya Pradesh	23%
Maharashtra	09%
Orissa	22%
Gujarat	14%
Rajasthan	12%
Meghalaya	85%
Nagaland	87%
Mizoram	94%
Arunachal	63%
Lakshadweep	93%

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Letters to the Editor

Cystoscopic removal of a coin in the mid-esophagus

I am a new member of ARSI and have been working in this remote rural hospital in Assam bordering Mizoram and Tripura for the past 15 years. I read with interest the article on cystoscopic removal of a coin in the mid-esophagus in the January 2008 issue of Rural Surgery and would like to share some comments.

Coins are usually lodged (as shown in the X-ray) in the upper esophagus at the cricopharynx. If a coin passes below the cricopharynx, it will usually pass out spontaneously unless the patient has some other problem such as a stricture in the esophagus (such as after esophageal surgery). Coins which have passed the cricopharynx (this sometimes happens when removal is attempted) can usually be left alone.

The best technique for removal of a coin in the esophagus is to use the Foley technique under image intensification. Here, a 14 or 16 size Foley catheter is used. The balloon can be inflated and deflated once it is decided how much air needs to be filled in the balloon. The child is restrained in the sitting (ENT) or lying lateral position without anesthesia and the catheter passed through the nose (like a NG tube) into the esophagus below the coin, inflated and pulled back until the coin appears in the mouth. Using image intensification, the coin and the Foley balloon can be visualized; a tug can be given when the balloon appears to be in contact with the coin.

The regular 'fluoroscopy' which comes with 300–500 mA X-ray machines is useless. The yellow 'rare-earth' fluoroscopic screen is a passive device and comes between the surgeon and the patient and obstructs his view. The image is very indistinct and the Foley balloon cannot be visualized. The room also has to be darkened to see this indistinct image.

Image intensifiers or C-arms are very expensive and the same procedure can be done blindly, quite safely and effectively. The best technique for a small hospital will be the blind Foley technique. I have removed several coins using this blind technique.

If the coin is firmly impacted for a prolonged period and the patient has severe dysphagia and is spitting out saliva, it can be removed with a regular adult fiber optic upper GI scope using a pediatric mouthpiece and a rat-toothed forceps. Anyone having a fiber optic gastroscope should consider acquiring these two inexpensive accessories for this purpose. The same technique is the best for the rare coin which has not passed into the stomach even after sufficient time has been given and cannot be removed by the Foley technique.

It may be possible to remove the coin under anesthesia with a regular laryngoscope and Magill forceps, if the upper rim of the coin is visible.

Rigid (especially adult sized) scopes are dangerous when used to remove coins at the cricopharynx. This is because the passage across the cricopharynx is blind and with an anesthetized child, it is easy to rupture the esophagus with a rigid scope passing alongside the coin. Rigid scopes are useful to remove sharp objects (which can be pulled into the lumen of the scope) when they have slipped below the cricopharynx. They should be used only by experienced operators.

Dr. Vijay Anand Ismavel MS, MCH (Ped. Surgery)
Makunda Christian Hospital, PO. Bazaricherra,
District. Karimganj, Assam–788 727

(***Author replies:*** *Most the methods mentioned by Dr. Vijay Anand Ismavel have already been mentioned, briefly though, in the discussion part of my article. I do agree with him that most of the articles mention the blind Foley's catheter method is the best one to try first and although we were not successful many others have successfully done so. I do feel that since we do use camera and we are doing under vision the procedure should be a safe one).*

Heartiest Congratulations to Dr. O. A. Awojobi for starting Nigerian Association of Rural Surgical practitioners

On 6th Feb, 2008 4:21 PM, Dr. Awojobi <oluyombo1@yahoo.com> wrote:

Dear colleagues,

At last, here are the constitution and the minutes of the inaugural meeting of the **Nigerian association of rural surgical practitioners**.

I apologize for the delay. Since arrival from Gboko, I have been to Ambrose Alli University, Ekpoma, Edo State to deliver a guest lecture at the induction ceremony of the second set of medical doctors of the College of Medicine on 24th January 2008. Remember, our member Prof. E. Alufohai is the Provost of the College. We are endeavoring to register the Association with the Corporate Affairs Commission after which opening of a bank accounts will be possible

I have opened an email address for the Association:

ID: narsp2008@yahoo.com PASSWORD: ruralnigeria

We could exchange more information using this medium pending the creation of our website.

I will keep you updated on all issues.

Regards

Dr. O. A. Awojobi

National Secretary

Information

CME Rural Surgery

In the last Gov. Council meeting held in Delhi on 27th of January it was decided to start a CME section in ARSI bulletin for the DNB Rural Surgery students. Following are the probable topics and the set format for contribution to the CME papers. Interested members may send their articles based on the set format.

Continuing medical education topics for Rural Surgery Bulletin

1. Burns — *Dr. Swarn Arora*
2. Thoracic Emergencies (common) — *Dr. Shyamprasad*
3. Urinary Obstruction
4. Benign Prostatic Hypertrophy
5. Airway Emergencies
6. Anal Surgeries
7. Gastrostomy — Jejunostomy — Colostomy
8. Abdominal Emergencies — General and Pediatric (Essential)
9. Abdominal Emergencies — Obstetrical and Gynecological
10. Closed Reduction of Fractures (Essential)
11. Emergency Treatment for Head Injuries
12. Management of Traumatic Wounds Including Suturing of Tendons and Nerves.
13. Management of Shock and Emergency Treatment of Hemorrhages.
14. Treatment of Vascular Emergencies and Infective Emergencies.
15. Emergency Treatment of Hand Injuries with Special Emphasis to Agricultural Injuries — *Dr. Swarn Arora*

Instruction to Authors

The following will be the format for contributions to the CME papers:

1. Title
2. Etiology — 50 words
3. Classification — 30 words
4. Clinical Features — 50 words
5. Investigations — 100 words
6. Treatment 200 words
7. Operative Procedure — (Most suitable in low resource settings) 200 words
8. Post-op care — 100 words
9. Sequelae, Complications and their Management — 100 words
10. Remarks and Conclusions (including possible questions in examinations on this subject)

References to the above content should be given and should be from peer reviewed text books which are widely used.

Example: Surgery and the District Hospital; Available on line: www.who.int/surgery

11. Comments based on authors experience — 100 words

The word count recommendations are approximate and the total word count of the document should not exceed 1500 words.

*Many Doctors, Many Tests, No Rhyme or Reason***

(Reproduction from The Newyork Times)

Sandeep Jauhar, M.D.*

I recently took care of a 50-year-old man who had been admitted to the hospital short of breath. During his month long stay he was seen by a hematologist, an endocrinologist, a kidney specialist, a podiatrist, two cardiologists, a cardiac electro physiologist, an infectious-diseases specialist, a pulmonologist, an ear-nose-throat specialist, a urologist, a gastroenterologist, a neurologist, a nutritionist, a general surgeon, a thoracic surgeon and a pain specialist.

He underwent 12 procedures, including cardiac catheterization, a pacemaker implant and a bone-marrow biopsy (to work-up chronic anemia).

Despite this wearying schedule, he maintained an upbeat manner, walking the corridors daily with assistance to chat with nurses and physician assistants. When he was discharged, follow-up visits were scheduled for him with seven specialists.

This man's case, in which expert consultations sprouted with little rhyme, reason or coordination, reinforced a lesson I have learned many times since entering practice: In our health care system, where doctors are paid piecework for their services, if you have a slew of physicians and a willing patient, almost any sort of terrible excess can occur.

Though accurate data is lacking, the overuse of services in health care probably cost hundreds of billions of dollars last year, out of the more than $2 trillion that Americans spent on health.

Are we getting our money's worth? Not according to the usual measures of public health. The United States ranks 45th in life expectancy, behind Bosnia and Jordan; near last, compared with other developed countries, in infant mortality; and in last place, according to the Commonwealth Fund, a health-care research group, among major industrialized countries in health-care quality, access and efficiency.

And in the United States, regions that spend the most on health care appear to have higher mortality rates than regions that spend the least, perhaps because of increased hospitalization rates that result in more life-threatening errors and infections. It has been estimated that if the entire country spent the same as the lowest spending regions, the Medicare program alone could save about $40 billion a year.

Overutilization is driven by many factors — "defensive" medicine by doctors trying to avoid lawsuits; patients' demands; a pervading belief among doctors and patients that newer, more expensive technology is better.

The most important factor, however, may be the perverse financial incentives of our current system.

Doctors are usually reimbursed for whatever they bill. As reimbursement rates have declined in recent years, most doctors have adapted by increasing the quantity of services. If you cut the amount of air you take in per breath, the only way to maintain ventilation is to breathe faster.

Over consultation and over testing have now become facts of the medical profession. The culture in practice is to grab patients and generate volume. "Medicine has become like everything else," a doctor told me recently. "Everything moves because of money."

Consider medical imaging. According to a federal commission, from 1999 to 2004 the growth in the volume of imaging services per Medicare patient far outstripped the growth of all other physician services. In 2004, the cost of imaging services was close to $100 billion, or an average of roughly $350 per person in the United States.

Not long ago, I visited a friend — a cardiologist in his late 30s — at his office on Long Island to ask him about imaging in private practices.

"When I started in practice, I wanted to do the right thing," he told me matter-of-factly. "A young woman would come in with palpitations. I'd tell her she was fine. But then I realized that she'd just go down the street to another physician and he'd order all the tests anyway: echocardiogram, stress test, Holter monitor — stuff she didn't really need. Then she'd go around and tell her friends what a great doctor — a thorough doctor — the other cardiologist was.

"I tried to practice ethical medicine, but it didn't help. It didn't pay, both from a financial and a reputation standpoint."

His nuclear imaging camera was in an adjoining "procedure" room. He broke down the monthly costs for me: camera lease, $4,500; treadmill lease, $400; office space, $1,000; technician fee, $1,800; nurse fee, $1,000; and miscellaneous expenses of $200.

"Now say I get on average $850 per nuclear stress test," he said. "Then I have to do at least 10 stress tests a month just to cover the costs, no profit going into my pocket."

"So," I said, "there's pressure on you to do more than 10 stress tests a month, whether your patients need it or not."

He shrugged and said, "That is what I have to do to break even."

Last year, Congress approved steep reductions in Medicare payments for certain imaging services. Deeper cuts will almost certainly be forthcoming. This is good; unnecessary imaging is almost certainly taking place, leading to false-positive results, unnecessary invasive procedures, more complications and so on.

But the problem in medicine today is much larger than imaging. Doctors are doing too much testing and too many procedures, often for the sake of business. And patients, unfortunately, are paying the price.

"The hospital is a great place to be when you are sick," a hospital executive told me recently. "But I don't want my mother in here five minutes longer than she needs to be."

**Dr. Sandeep Jauhar is a cardiologist on Long Island and the author of the new memoir "Intern: A Doctor's Initiation."*

***(Published on: 11th March, 2008, The Newyork Times)*

RNI No. DELENG/ 2005 / 16240

Dr. Antia- Finseth
INNOVATION AWARD- 2008

Association of Rural Surgeons of India offers Antia- Finseth Innovation award of Rs. 10,000/- for any innovation that is useful for rural health care. The Innovation may be equipment, procedure or even a concept. However the primary requirement of the innovation has to be its usefulness in rural surgery (Rural health care). Innovator may be medical, paramedical or non-medical person. Applications are invited about the innovation with following details:

1. Brief abstract of the innovation. (About 300 words)
2. Novel features of the innovation.
3. Advantage over the known alternatives.
4. Detailed description accompanied by diagrams, drawings, photographs. neatly labeled.
5. Complete bio-data of the innovator along with photograph.

Terms and conditions

1. Awardee has to present his work at the annual conference of ARSI to be held at Wardha, Maharashtra and receive the award.
2. Award will not be given in absentia.
3. Decision of the selection committee shall be final.
4. Besides award money of Rs. 10000/-, the awardee will be paid for travel allowance and accommodation maximum up to Rs. 10000/-.

One copy of the application has to be sent to each to the following persons:

Dr. K. C. Sharma
President, ARSI
Chairman,
Award committee
1, Trikuta Marg,
Udhampur, J & K
Pin–182101
drkcsharma@rediffmail.com

Dr. R. D. Prabhu
President, IFRS,
Member,
Award committee
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