Report on visits to Thyolo District Hospital, Mulanje District Hospital & Mulanje Mission Hospitals- April 2016.

David Hunter- Consultant General Surgeon

I arrived at Kara O'Mula, in Mulanje on 17April and met up with surgical colleague David Melville and surgical trainee Jessica Kam. David explained the 'ropes' at Mulanje district hospital and the Mission Hospital during an excellent dinner.

18 April, Week One: Thyolo District Hospital

I drove 43km to Thylo district hospital (40mins). This hospital is set in beautiful undulating countryside and tea estates.

I met Steady Vinkhumbo the most senior of the clinical officers and was shown around the hospital by Stephen Dimba. I was introduced to every department even the repair shop! The hospital is a tidy relatively new series of single story buildings painted pink. It was generally clean, patients lying on beds mostly without bed linen, in bays of up to six. Each patient had a 'guardian,' (generally a relative), looking after them. There were also ward nurses and a sister in charge.

I was then taken around the patients by Stephen, who is the third clinical officer.
Here I saw burns in a small child, a head injury, a number of hernias and a paraplegic lady with bed-sores. There were also post-operative patients and orthopaedic cases. Some of the cases had been brought in for my opinion; all seemed well looked after.
I attended a clinic, partly of cases to operate on. This was run by Francis Kapanga, the second most senior clinical officer, Stephen and Knoxy Ndalama. All were very keen.

There were a number of inguinal hernias and umbilical hernias. One of the latter had a large hernia from cirrhosis and ascites (thought 2ndry to alcohol). I advised against operating on this poor cachectic man. (Blood clotting not easy to check, no blood for transfusion and a large hernia unlikely to obstruct). There were also patients with prostatism, the clinical officers performing hernia repair, circumcisions, open retro public prostatectomy, hysterectomy, and Caesarian sections. Also seen in the clinic was a lady with a large mouth cancer we sent to Queens on Blantyre.

In the mornings I attended the handover meeting at 7.30am. Here the wards explain what has been admitted overnight, deaths, ill patients and if any had been discharged or absconded! The on call clinical officer also presented what he had done. Following this there was a question and answer session and general feedback. I was impressed by the matron and by Steady and Stephen who provided calm leadership at these events. If there was anything important from other departments, notices were then given. On one occasion there was a lack of reagents for a biochemical test and so advice re alternative testing was given. Lack of anti-malarial drugs or antibiotics would be notified here. On one occasion, the reason for and the best way to perform a test, was explained by the lab.

Each morning there was a tutorial, which followed the handover; this was often given by student nurse.

Surgery:
Some skin lesions, a likely liposarcoma of the knee (sample sent to Queens) and 2 inguinal hernias. The other list was an epigastric hernia and a large inguinoscrotal hernia. There were some cancellations (not come in, or anaemia, or ran out of time).
I did not operate with Steady as he had been on at night.

Francis was capable and did a good mesh repair of a hernia. He had trained as a Clinical Officer in Malawi and had been fortunate enough to benefit from several hernia training initiatives conducted by consultant surgeon Paul Thomas, during his visits to Thyolo. Francis had also been to Sweden to learn hysterectomy. He was hoping to get on the BSc course at Queens. I spoke to Prof Borgstein who was aware of this.

Stephen was more junior but operated well and was capable; I was impressed by his leadership at the hospital handover too. Knoxy was the youngest recruit was not operating alone.

The 2 theatres were rather dark; electricity supply was intermittent and even when power was available, the lights were of poor quality. Instruments were poor and rather damaged drapes. Anaesthetics variable.

Week Two: Mulanje District and Mulanje Mission Hospitals:

Mulanje Mission Hospital is a clean facility smelling of chlorine floor wash. There was bed linen and every bed had a mosquito net. The buildings themselves were similar in all the hospitals. Dr Jacka and Ruth Shakespeare knew all the patients.

There were side rooms for examination and there were screens to place around the beds for privacy. When it came to consent forms the form explained that the operations complications and alternatives had been explained. In the District hospitals the consent form was much less specific (Mr X can do what is necessary to my body).

Monday and Wednesday were spent at the District Hospital and Tuesday and Thursday at the Mission.

I had been to the Mission hospital the previous week where a 15 yr old boy had been admitted with a 4-day history of an obstructed inguinal hernia. That night he was operated upon and required a bowel resection. This had been done by the most senior clinical officer who also rejoined the bowel. I had been asked to review him. I met with Ruth Shakespeare, Medical Officer in Charge and with Dr Ben Jacka, a very capable training doctor from Australia who had come to Malawi for 3 years. The boy was unwell with a fever tachycardia and poor urine output. He was oxygenating well and had a pulse oxymeter on continuous monitoring. His abdomen was soft and there was minimal coming up his nasogastric tube. There was a suggestion that he might be better to go back to theatre to have a look but I thought he needed more resuscitation first. I returned some hours later where he was off oxygen but otherwise no different. I understood that there was no ventilated bed available in Queens either so suggested a continuation of resuscitation and treat expectantly.

I returned on the Tuesday following to find the boy recovering, his bowels working. There was nothing up his nasogastric tube, no drainage in the drain. His fever was down but he had some tenderness in his right groin, otherwise he was well. An impressive result.

The handover meeting was at 7.15am and followed with a tutorial. I gave this tutorial on paediatric hernias and in undescended testes. There were 5 English medical students on elective here too. Following the tutorial I went around the wards and reviewed the bowel resection boy. I also saw the preoperative cases. One was a boy with bilateral undescended testes. I was unable to feel any so explained I would explore one side and if I couldn't find one I would stop there.

The operating theatre had air conditioning, LED lights and was spacious. There was a second theatre too. The linen was of good quality and instruments were slightly better than the district hospitals. The scalpels though new in all hospitals were very poor. Anaesthetic quality here was good, both spinal and general, without ventilation.
The clinical officers I operated with were: Majorobela a capable operator, Felix Tembo, capable and progressing, and Phamoli Fungai also competent.
Operations: undescended testes, (could not find, nor could ultrasound). Left inguinal hernia and bilateral inguinal hernia. The meshes we supplied. They worked well but could do 2 hernias, so ideal for bilateral hernias.

I returned on the Thursday. I gave a tutorial on mesh repair of hernias to the clinical officers. Ward round included a baby with ? Cystic hygroma of chin or thyroglossal cyst. This baby was feeding well without difficulties and we sent to Queens. A child with multiple abscesses, weight loss and fever who needed working up (blood tests chest X-ray etc). We operated on 2 adult hydrocoeles, 2 epigastric and umbilical hernias.

Mulanje District hospital. (Very close to Kara O'Mula hotel.):

7.30am handover, attended by Dr Sylvester Chambunya the District Health Officer, (DHO).
I met up with Martin Malunga, Morris Chalusa and Oscar Kuboma the clinical officers. Martin went off to a meeting in Blantyre so I worked with the other two.
Hospital clean, slightly older than others. The hospital is situated at the edge of the town with Mount Mulanje towering above. Wards clean with most beds having mosquito nets. They had run out of ultrasound gel and X-ray not working.

Clinic on Monday am post hand over. 3 small inguinal hernias, large inguinoscrotal hernia, 2 babies with strawberry naevi. A hydrocoeles, lipoma, a lady with stone in right ureter on scan and left VUJ obstruction no fever but right ureteric colic. Suggested urgent Queens referral. Breast swelling with Peau d'orange, shoulder lipoma.

Operating list:
2 inguinal hernias and 1 hydrocoele.
Wednesday preoperative: umbilical hernia on small girl, adult communicating hydrocoele, right inguinal hernia with undescended testis palpable in groin in 42-year old, 2 right inguinal hernia (latter not done as ran out of kit, 2 emergency sections).
2 theatres one very small. Poor lights. Ran out of drapes.
Poor kit generally. Similar to Thyolo.
Ward round with Dr Sylvester to see sick patients. Then I was taken to wards for advice.
Child with rectal prolapse went to Queens. Large fungating breast cancer with 2 mobile lesions in ipsilateral arm. Abdominal trauma post RTA. Child with history of groin swelling, nothing to find.

Visit to Queens Tertiary Hospital, Blantyre:

Professor of Surgery: Eric Borgstein.
Generally busy time. Very keen clinical officers. Most compliant operators in small field.
They can't do hand knot ties but do hysterectomies!
Poor kit. Linen in theatres often full of holes yet plenty of cloth in market outside.
Blades don't cut? Surgeons do very well considering.
I have researched intravenous iron as blood difficult to get and 3 patients in various hospitals with Hb 2. Unfortunately I V iron expensive.
In general surgeons technically competent and keen to do mesh repair of hernias. Need to sort sterilising of mosquito netting out there.

My thanks for the opportunity.

David Hunter