

INTERPLAST OF AUSTRALIA PROGRAM REPORT

June 2005 was the second consecutive tour of the Interplast team comprising of John Crock, Simon Donahoe, Renald Portelli and Jim Beaumont to Labasa, Fiji. To outsiders the area is known as the 'friendly north' but to the locals it is called the 'forgotten north'.



Cane Fields, Labasa Fiji.

The draining population is in the vicinity of 50,000. 25,000 live in the township capital, 5,000 come from the international yachting mecca, Savu Savu, and the rest live in the remote interior or the surrounding islands. Labasa itself is predominantly Indian and is the nerve centre of sugar production in Fiji. Presently the country is basking in a trade agreement with the EC, who pay 30% inflated prices for the countries sugar in a longstanding preferential market deal. Accordingly, extravagant inefficiency (including hand harvesting) is tolerated. In 2007 this agreement finishes and Fiji is in danger of sinking in the sea of competition for its main cash crop. In order to come up to the standard of its main competitor, Brazil, mechanised harvesting will have to be introduced, as well as the infrastructure to collect ethanol (for fuel additives and alcohols such as Rum) as a by product from the sugar cane. There is some hope that some investment from India and Malaysia may allow this to realise, but at this stage the hope is only speculative.

Without its sugar Fiji relies on tourism. Currently plans for an international airport on the North Island have been shelved by authorities in Suva, in spite of the fact that funding is available for this venture. Accordingly the livelihood of those in the north is currently hanging in the balance. In the meantime, the people of that area

continue to be very poor but in many cases blissfully happy and fairly unaware of the precarious situation that they are in.



The Southern port of Savu Savu

As a whole the Fijians (both Indo-Fijian and Indigenous) are very grateful for help offered to them and neither see this as a sign of weakness nor inferiority. This appreciation was evident on our arrival: when our team arrived at the hotel the head receptionist greeted us extremely warmly and told us that she had kept a piece of forgotten luggage from our last trip one whole year ago. She joyfully produced the parcel with the greeting “We have prayed that God would bring you back and we kept this in hope”. The community also demonstrated this sentiment, and many of the locals remembered us well from the year before. Not only did some of the Rotarians remember us, but also links with local expat missionaries and indigenous church leaders who had helped us in 2004 were re-established and strengthened. Separate dinners were held with the local Rotarians, the Hospital Board of Trustees, and with local Pastors. At all of these meetings the resounding sentiment was extreme gratitude that a team from Australia was committed to return to the district and offer help to a community of people who feel rather neglected by the world outside them.

The local Indian surgeons are excellent and were extremely helpful in co-ordinating our venture and yet the reality is that they have little or no training in Plastic and Reconstructive Surgery, and patients requiring this form of specialist care often go wanting. Not only had these surgeons triaged patients for our assessment, but they had also made the community aware that we were coming by placing an announcement on the local radio station, and even though an American Interplast

Team had been through only 3 months before, on our first day 99 souls crowded into the tiny antiquated outpatient facility for assessment. A further 16 people knocked on the operating room reception door over the next week seeking our help. Although patients came from even the far reaches of Fiji, the majority were from the North Island. In addition a recent Interplast trip to Lautoka (attended by surgeons Kirsty McGill and Murray Beagley) had performed surgery on a young boy with severe burns scar contractures, and this child required second stage procedures to be performed. Kirsty communicated with me (JC) prior to the trip alerting me to the needs of this, and other, patients, and our team was able to finish off the good work which had been started by these others.



Scenes from the outpatient clinic and visitors to the surgical ward!

The surgical cases ranged from fungating tumours, debilitating infections, horrendous burns scar contractures, complex hand pathology, head and neck tumours to minor lumps and bumps, keloid scars, split earlobes and cosmetic surgery cases. It was a fascinating study in a community's perception of what Plastic Surgeons do. The aim of this visit was to offer plastic and reconstructive surgery to the locals. It was made clear that we would not be doing cleft lip and palate surgery nor hypospadias repairs and we indicated that we had a particular interest in hand surgery. The vast majority of cases were bona fide reconstructive problems, many of them either life threatening or debilitating. However even in this poor remote corner of the world people are exposed to the television (sometimes only in the public arena, watching Extreme Makeover on a shopfront TV set), and this has impacted peoples' perceptions of normality. In spite of the fact that they go home to a bare shack for a house, and have jobs netting 90c FJ an hour, some local folk presented for correction of prominent ears and abdominoplasty- driven by a desire to look 'normal'.



A severe burns scar contracture, characteristic of the neglected state of some of these people.

After a gruelling day of preoperative assessments the team met at night for a debriefing and we triaged the cases. All non-urgent cases were identified. Life threatening and/or major cases were prioritised. The next day we arranged for the patients to be contacted and counselled and the skeleton of the weeks' list was booked, leaving room for additions.

We worked our way through the list utilising two theatres; Dr Portelli anaesthetizing in one theatre and the local anaesthetists working in the adjacent operating room. We also had access to an area called the 'MOT' – an alcove used for anaesthetizing minor cases. The facilities were rudimentary. We were treated to some Betadine and one bar of soap for the week, which we all shared for surgical scrubs. The water was nice and cool in the sink before lunch, after which time it generally ran out (for periods of time). The concrete operating room floor was possibly a bit bumpier than last year, but they had improved the air-conditioning unit stuck in the window (which was boarded up to keep one's mind off the outside world). This was good as it appeared that the surgical gowns had been donated from post war Europe (the winter models, at least). They were also styled with flowing open sleeves, which begs the question, were these designed to give the surgeon an added French cavalier feel?

The new wing of the hospital has not progressed much since last year and this is to be set aside for general medical and psychiatric use. There are no plans afoot to improve the operating complex. (Next door to the hospital a first class law court complex is nearing completion, having been started a few months ago).

We tried to coordinate the timing of our cases with the local surgeons, who occasionally required one theatre for their emergency workload. Notwithstanding, they had cancelled their own elective lists for the duration of our visit. We utilized the two operating rooms as much as we could, and worked together on major cases when only one room was free. Any gaps in our original list were well and truly filled with emergency cases: During the week we were invited on ward rounds with the

local surgeons and asked to assist them manage their difficult in-patient cases. In addition emergency reconstructive cases presented during our time.

In particular we reconstructed the hand of a young lad who had been dragged along behind a ute and ground off the dorsum of his wrist some 5 weeks prior to our arrival. He had been languishing on the ward as the local surgeons were at a loss as to how to proceed with his management. In this particular case we were able to radically debride the wound, reconstruct the extensor compartment with multiple tendon grafts and then cover the defect with a large groin flap.



Complex hand reconstruction for a young man post motor vehicle accident

We also assisted in the management of a boy who had had his ankle dragged along under a car, another young fisherman who had been attacked by a Moray eel, as well as many other serious but less spectacular problems. All the cases were photographed for documentation, although on the first day some of the cases could not be photographed as the camera battery went flat! At the end of our time in Labasa we had consulted 116 patients and performed 64 surgical procedures. Follow up has been co-ordinated with the local surgeons and phone contact and email contact has been maintained with Dr Bushan Ogle.

In 2004 we had helped the local surgeons treat a young girl who had nearly been killed by a tiger shark on the reef of her local village in the far north. We had reconstructed her lower leg by cable grafting all the major nerves at the level of the knee, as the shark had latched onto the popliteal fossa. On the fifth day of our time in Labasa this year she walked into the operating room to show us how her life had been salvaged. She had both dorsiflexion and plantar flexion of the foot with some protected sensation in the heel and an advancing Tinel's sign in the distribution of the posterior tibial nerve. It was a great privilege to witness this knowing that in her outback community an amputation is effectively a prison sentence as crutches are not available, much less a decent prosthesis.



This man was only able to drag himself along the ground because of an amputation.



Thanks to the INTERPLAST venture, this lady was able to walk back to visit the team following complex reconstruction of her leg. She nearly died after a shark attack which all but amputated her leg in 2004, and using reconstructive techniques the team was able to more than salvage her limb.

We were also delighted to be greeted by a postal worker at the Post Office several days before our departure who remembered us warmly. He had once been one of the senior workers but over one year ago his livelihood was dashed by an injury which led to a gross flexion contracture of his dominant index finger. His digit was permanently flexed at over 90 degrees at the PIP joint and this precluded him from effectively picking up parcels, which in turn made it virtually impossible for him to perform his normal duties. His career was in tatters. We were able to correct his deformity using standard plastic surgery reconstructive techniques, and when we saw him this year he told us that he was now able to perform all of his normal duties at work and was a useful (and senior) member of the postal team again.



From flexion contracture to surgery: This sequence of events transformed this man's life and got him back into the workforce.



Cross finger flap reconstruction to cover a new pulley system and a released joint. One year follow up at the local Post Office!

Sadly, not all the news we received following our last visit was good. In 2004 a beautiful 8 year old girl presented with a painless mass in the gastrocnemius. We took a biopsy which we flew back to Graham Mason at Melbourne Pathology. He diagnosed synovial cell sarcoma. This dear little girl died in our absence this year.

The team dispersed in several groups. Mr Jim Beaumont co-ordinated the baggage, although Mr Crock had arranged for baggage handling to be performed by a tour company based in Nadi because the surgical cases were flown there from Labasa and had to be stored for 24 hours prior to the baggage being flown home. (Because

of the size of the aircraft some of the baggage was delayed and was flown down separately from Labasa on the day of departure). Mr Crock also arranged for the departing team members to be given a tour of the west coast of Viti Levu on the day of their departure. Mr Crock stayed in Fiji and ran medical clinics at a number of outlying posts including one on the beautiful but remote Yanuca Island, where in 2004 the Geelong Rotarians had built a new nursing post and also equipped the village with new water storage tanks. Last year Mr Crock unofficially opened this facility and this year revisited the island and ran more clinics.

The Labasa tour was very successful. A significant surgical caseload was handled, follow up arrangements were secured and links with the local community were strengthened. The community is certainly deserving of a long term commitment from Interplast, and were more than pleasantly surprised that the same members returned two years running. They have expressed a heartfelt desire that we continue this trend.

Dr Portelli has expressed an interest in ongoing internet based education of the local anaesthetic staff. Together with Mr Crock he collected some 12 boxes of medical supplies to donate to the hospital. Mr Beaumont has also expressed an interest in developing a link with the hospital to mentor the theatre nursing staff. He was very involved in both community work and with nursing staff to strengthen ties with our country.

The local medical staff who co-ordinated this visit were Dr Bushan Ogle and Dr's Abi Choudhary and Robert Gayappa, two consultant surgeons on staff. Dr Ogle is now the medical director of the hospital and is friendly, efficient and helpful.

The theatre staff remains relatively stable, however the theatre manager has recently been replaced and the new manager is Mrs Salma Hussein, who was extremely helpful in co-ordinating with Mr Jim Beaumont.

The anaesthetic staff is currently in a state of flux, and is headed by Dr Ann Garcia who is a senior registrar. The unit has been encouraged to utilise the ongoing assistance of Dr Renald Portelli who has offered to give them internet based support.

Teaching was given in several forms: didactically; semi-formally; and hands on assisting with both the Surgical and Nursing staff. In addition the use of VAC dressings has been introduced to the Hospital, and Dr Crock taught the surgeons

how to use this device. It is hoped a study will be performed to measure the impact of this technology on patient care.



Dr Crock instructing Dr Ogle on the use of the VAC dressing.
Postoperative surgical tracking was arranged between Dr Ogle and Mr Crock and ongoing phone and email contact has been maintained.

In addition, links have been strengthened with local community members. In particular, Mr Crock has developed ties with a prominent local community member, Mr Coco Singh, who has many contacts in both the Indian and Fijian community of the north.

Both the local community at large and the local medical community are crying out for ongoing assistance in managing patients who have plastic and reconstructive surgical problems.

It would also be extremely advantageous to offer support in the IT department to facilitate communication with team members when they cannot be physically present. Currently Dr Bushan Ogle spends quite a lot of his own time and effort to maintain email links but there are no facilities in the theatre complex (and they are fairly scant in the hospital precinct) which makes it near impossible for the other surgeons to make email contact with us readily.

Recommendations for further visits include:

- Continued use of digital photography to document cases
- (Electronic) post operative flow sheets to help with post operative management
- IT support to facilitate ongoing contact with interested parties.
- Encouragement of the hospital administration to improve its surgical facilities.
- Formalize the mentoring program of the theatre team to improve operating room flow/dynamics.
- Donations of operating gowns to the hospital
- Donations of surgical packs to the hospital

Following this report photographic documentation of the trip will be forwarded on CD, along with the surgical log.

Yours sincerely,

Mr John Crock.