Surprise Bananas 88.9 (-1.10)

Book: One Hundred Years of Solitude

Thanks for those who showed concern regarding the fridge, it turns out there used to be a small bar fridge in this house until it broke down. There was an intention to replace the fridge, however this was forgotten. The right people just needed to be reminded. The issue with the power going out for anywhere between 8-12 hours overnight can easily be overcome with large containers of water which act as a cool sink, although they take up half the fridge space. They keep the fridge cool overnight just as ice blocks do in an esky. I have an essentially vegetarian diet, therefore I am not too concerned if the fridge temperature does fluctuate.

The temperature and weather of Kompiam is more stable than my fridge. I am comfortable in a shirt and shorts at nearly all times. The sun is hot and harsh in the morning but it's opportunity to bring an uncomfortable heat is hampered by the consistent midday storm clouds. The afternoon rain is patchy but heavy and runs freely from the heavy clay soil.

I have recently prepared a garden for the vegetable seeds that the PNG customs allowed to enter. The garden faces the north west and will get the morning and midday sun. It is only a few buried old tires, some fencing wire to hold some climbing tomatoes and a compost shoot (the polypipe). The soil was easy to work and seems very productive, therefore I am hoping the seeds take well. I only regret not trying to bring more seeds in.

There is but one mystery remaining in my house, which is an unknown animal living in my roof. It is most likely a rat, however it has heavy footsteps and leaves the house around about 8:30 every night. I can hear the plodding along the corrugated iron of the veranda roof, then drop onto the veranda floor. It sounds like a possum to me, however there are no possums here. I reason that it must be going out to hunt, which is unlike a rat as well. However, there have been issues with rats in this house in the past with them causing problems with the electrical wiring. If it is indeed a rodent, it must be one of massive proportions.

I am starting to settle into the hospital work. I can get by with a little of pidgin, however I cannot converse. I can ask a series of yes/no questions but am not able to get into the detail. Having to get a member of the nursing team or another doctor to translate makes me feel like I am wasting their time. And regardless, a large number of patients don't know pidgin, only speaking Engan, which I have no intention to try and learn, as even the Mills struggle with it. Recently we have had multiple admissions of children with severe malnourishment, failure to thrive and developmental delay. Each of the children's growth charts shows a simple repeating story. The children grow well until they are weaned off breast milk, solids are introduced and they take up Kowkow. Kowkow is the Engan Yam and is the staple food. Engans attribute a lot of their strength, their development and their life to Kowkow. This energy dense packet of complex carbs can be roasted, fried and steamed and mostly eaten hot, but ward patients often keep it in its cooked/softened state for hours to days prior to eating it cold. Kowkow are easy to propagate and plant (I was taught in two minutes), grow rapidly, are resistant to local bugs/grubs and can be harvested with ease. Some children, like their parents, would only eat Kowkow and rice, salted with Maggi two-minute noodle chicken stock cubes and occasionally accompanied by a splashing of some loose greens. Hence, the common issue with malnourishment. Whilst in Hospital we provide them with "Plumpy Nut", an oily nut-based paste which looks like cookie mixture and is packaged like a muesli bar. Unexpectantly the children frequently require plenty of encouragement to eat the "Plumpy Nut" (something so full of fat surely should be delicious). One child was so determined against it, having only eaten Kowkow for the last

18 months. The path of least resistance was to splint both his hands and arms and put a tube down his nose into his stomach. The advice to patients approaching discharge is to introduce beans into the diet, as they are high in protein. Bean seeds are accessible locally but require greater effort in every aspect from seed to plate when compared to Kowkow.

The surgical ward has been filled with trauma. One patient had his right upper arm blown apart by a shotgun. The tiny pellets were still being retrieved by the third debridement. He is relatively lucky however, the bullets have only damaged his deltoid muscle with no damage to arteries, nerves or bones and only minor damage to other surrounding muscles of the arm. Although his wound is large, now colonised with Pseudomonas and his only analgesia being paracetamol, he is happy, often walking around all the way to the market. He is likely to have a functional shoulder by time of his discharge. Another patient was not as fortunate after sustaining a shotgun injury to his right hand. Only three pellets (although they were of larger calibre) penetrated through his wrist and shattered his distal radius like glass. There is no repair that we can offer and his wrist is unlikely to ever regain function. Gun injuries are not as common as knife/manchette based injuries, which are often seen as secondary to domestic violence. One unfortunate lady presented after being stabbed in the face with a kitchen knife by her husband's second wife. The wound extended 13-15cm from her lateral L forehead to behind her ear canal. There is a tendency to leave all chop-chop wounds open, as the risk of infection is high, however due to the tendency of facial wounds healing well we closed this on the night it was presented. She did develop a superficial infection in the area around the ear canal, but this settled quickly with antibiotics. The most surprising thing was finding the patient in the maternity ward after giving birth to a healthy baby boy. Through traditional loose clothing, negligence on my behalf and language difficulties, I had no idea she was pregnant. I did not review the medications that may have unknowingly caused problems with the unborn child, however, thankfully, the newborn seemed well and normal at review.

A fascinating case was that of a 50 year-old called Paul. He was admitted to hospital after falling out of the back of vehicle onto his L side. He was assessed and scanned, and was found to have only sustained a 9th rib fracture. He stayed in hospital, was given antibiotics (as everyone gets) and some Panadol. He was discharged the following day as he was well, taking deep breaths and mobilising well. He returned the morning one day post discharge suffering with perfuse diarrhoea, nausea and vomiting. The people who brought him reported that they found him outside on the ground in the early hours of morning, basically unconscious. He was warmed up with blankets, given lots of fluids, broad spectrum antibiotics and cleaned up. When he had become more lucid, further history revealed that he had gone to the market after discharge and eaten some pig. That evening he suffered such intense vomiting and dysentery, and felt so weak that he fell and was unable to get back up from the outhouse/longdrop and collapsed on the ground. There he was exposed to the elements for an uncertain period of time. His main concern was abdominal pain. Blood tests revealed a very low haemoglobin (58), indicating that he was bleeding.

Therefore, the working diagnosis was dysentery with hypothermia, causing the combination of symptoms. The antibiotics were narrowed to local bacteria which cause dysentery (the most likely culprit being Salmonella Typhi) and blood transfusions were arranged (sourced from friends, as he had no relatives in the area). After an unfortunate, prolonged and intimate encounter with the patient's stool, I doubted that it contained blood (as it was orange colour). However, others did not believe me, as the primary diagnosis for the treating team was dysentery. Nevertheless, he had been transfused two units (haemoglobin raised to 85), sufficient intravenous fluids and his observations had mostly normalised.

The next morning, he was in a similar condition, with ongoing abdominal pain as well as ongoing "dysentery". The abdominal pain seemed out of proportion with the diagnosis of dysentery/gastroenteritis. His relatives had arrived from a different area, as they had heard that his condition had worsened. They told a different story regarding the cause of his initial injuries. He had gotten into a fight nearby to Kompiam whilst intoxicated. He had lied regarding these injuries as there is a higher hospital fee for patients involved in violence. This initial injury had been 6 days prior to the 2nd admission. We rechecked his haemoglobin and found it to be 72, indicating that there had been ongoing bleeding overnight. We repeated one of the scans (FAST) from the initial admission and found significant abdominal free fluid throughout the abdomen (likely to be blood).

The diagnosis of splenic rupture secondary to assault was made and the call for significant blood donors went out. The family members were screened and blood taken where appropriate. (Hep B and HIV are rife throughout the community, therefore only about 80% of blood can be used). The patient had few family members present, therefore I had the strange experience of running the group and cross match on my own freshly donated blood. Throughout the afternoon his Hb continued to drop despite continual bags and the decision was made to go to theatre at 1700. 6 different bags of blood were cross matched to the patient. A total of 3 litres of blood was extracted from his abdomen along with an actively bleeding spleen. I doubt I will again have the experience of handling, crossmatching and suctioning some of my own blood from a patient. He recovered well on the ward and surprised the medical staff with the present of a bunch of bananas each.