The Anaemic Blood Bank 86.1 (-3.90)

Book: The Rise and Fall of the Third Reich
12 years a Slave

The animal that lives in my roof has been revealed. I am pleased to announce that it is not a rat but, in fact, a cat. I'm hoping that its presence ensures that I have a ratless/miceless ceiling, so thus I am pleased. I am actually considering how I can make friends with the roof cat, or whether just leaving him alone as a sub-tenant that just lives above is the best way forward. I will attempt contact.

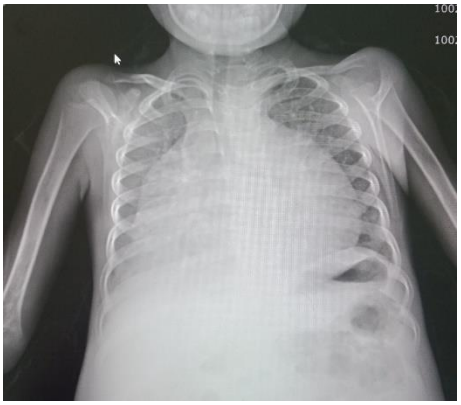
My fridge has ensured the continuation of my vegetarian diet. The supposedly frozen chicken within the icebox/coldest spot of the fridge, has been in a constant cycle of freezing then defrosting for the past month. This has left a telling trail of semi-frozen chick juice. Although, I was tempted to gamble on the chicken's microbes, it is now spiced with Salmonella and will be defrosted permanently in the trash hole.

I was invited to join a running group which, after an exercise hiatus of nearly 5 months, I hesitantly accepted. The group wakes at 5am to run to a nearby village called Iakos. The route is chosen because it is steep, has good views and the road is reasonably good without too much mud. The run starts flat, then goes quickly into a descent followed by a long gruelling ascent. It is about 5km and it took the group about 45mins with breaks. It was tough work, not only due to the gradient, but due to my poor baseline fitness and the attitude, but I got there. I am hoping that running becomes more of a habit, as the mornings are a very comfortable running temperature.

Iakos, marked by arrow, with the road to the R side of the picture. The road continues it descent off picture to the depth of the valley.

Work has been very busy this fortnight, which did start with a feeling of exasperation on my behalf. I was getting frustrated by how ineffective and inefficient I had felt, as I always required a translator at every review and was still getting used to the equipment. I frequently found myself making mistakes using equipment, that was often out of date and near breaking point. Despite the continual frustration I plugged away, somewhat disgruntled with my seeming lack of progress. However, my attitude changed after coming to the realisation that I was mainly getting upset because I thought that people would perceive me as incompetent. I am not in Kompiam to boost my fragile ego, but to serve and learn. Therefore, with a change of mindset to that of being a servant, I have found extra patience and as a result felt more refreshed.

During a weekday on call I had my first patient die. She was only 5 years old and had been in hospital since February, and was assumed to have a significant congenital heart defect (Figure 1). She had a distended abdomen, rapid heart rate and low blood saturations. She was small for her age and had global developmental delays. She had remained in hospital so that we could eventually get her seen by a visiting paediatric cardiothoracic surgeon for surgery. We had been aggressively treated her with diuretics, to attempt to remove fluid from her struggling heart. I was called to see her because she had pain in her arms and legs, I woke quickly despite it being 2am, dressed and arrived at the hospital within 5 minutes to find her father inconsolably weeping, cradling his dead child. I am not entirely sure how she had died, however I suspect that we may have contributed to her death through overzealous diuresis and disrupting her electrolytes. Thus, tipping the extremely sensitive scales of her fragile heart function into a likely arrythmia. The exact cause will never be established.



XR of a paediatric patient with severe heart failure

The after-hours roster is shared between the three of us, Dr Rebecca, Tania and myself. Dr Mills is the second on call the majority of the time. One person covers Monday and Wednesday, one covers Tuesday and Thursday and the other covers the weekend. My first weekend on call went well, being very quiet, no overnight admissions and no critically unwell patients. Although, the concern that at any moment I could be awoken to go assist in a birth or delivery keeps me from solid sleep. I also had my first day as the only doctor in the hospital and we were down a lot of the senior nursing staff. However, it was pretty uneventful really. I rounded basically on patients who wanted to be seen, as I did not have much else to do, and then tried to convince people to donate blood.

We have had a pair of similar major abdominal surgeries over the last fortnight. One a lady from the deep bush, was retrieved by plane after falling onto a stick and as well as a middle-aged man with abdominal pain. The lady had been walking along at night when she fell down a small ditch and a stick perforated her abdomen. Her family members took out the stick, and took her home that evening, where she tried to sleep it off. The next morning, she presented to the aid post for assistance as her abdominal pain had significantly worsened, he notified us and we arranged her retrieval. On arrival she was able to walk from the ambulance bay, relatively unaided, to the hospitals equivalent to the "resuscitation bay". (The "resuscitation bay" is the ward bed closest to the nursing station which is equipped with oxygen as well as a wall mounted BP cuff, oxygen saturations monitor and 3 lead ECG.) On initial assessment she had not lost significant blood and had stable vitals. She had a tense area of her abdomen but was not obviously peritonitic. She looked remarkably well considering the story, with the stick apparently penetrating about 15cm. Consifering how well she looked I suspected that, as can frequently be the case from the aid outposts, the story of the injury was exaggerated to ensure retrieval. The family produced the stick that she

The stick caught red handed

had fallen on, as if it was a snake to assist with the antivenom to use in treatment. It was about 3-4cm in diameter and 20cm long. We ensured that she was stable, collected some blood and then went to theatre. The stick had gone through her anterior vaginal wall, just anterior to her cervix, lacerated a section of her left uterine artery, perforated a loop of small bowel, sigmoid colon and had entered but not exited the left side of the transverse colon. It was remarkable how little bleeding the uterine artery had caused in the abdomen, however if the stick had travelled a little further, the spleen would have been involved. However, it was not and she was patched up relatively quickly. I was wrong regarding the injury, it was certainly severe. I was again surprised by the remarkable strength of the PNG people in the face of significant health issues.

The other case, emphasising the endurance of the PNG, is of gentleman who had suffered severe abdominal pain, nausea and decreased appetite for the past 2 weeks. He had not eaten or left his home for two weeks. I was not able to really establish anything else on initial history, between the lack of English on the nurse's behalf and the lack of pidgin on mine. On abdominal examination he had all the signs of an "acute abdomen", basically indicating a perforation of something from his stomach to his rectum. The X-ray taken to confirm the suspicion was done and there was objective evidence of perforated bowel. I called the team, as he needed to be operated on ASAP and within the hour we had him in OT with two bags of freshly sourced and crossmatched blood. (Often the patient's family bring them in when they are unwell, and subsequently they are willing to give blood. His blood type was B and majority of his family were discovered to be A, much to my frustration. A couple of in-laws eventually provided some donations). It was initially expected that he would have a perforated stomach ulcer, as these have the potential to not kill someone quickly, while perforations in other areas of the bowel are more likely to do, due to secondary sepsis. However, after initial exploration, he was found to have a perforated appendiceal abscess. It is likely that his 2-week illness had been a brewing appendicitis, which became an abscess, eventually bursting causing the worsening of symptoms and his consequent presentation. It was a difficult surgery, with multiple adhesions. I have seen many an appendix taken out in Australia, which looked slightly inflamed but I have not seen anything like the mess in this gent's belly. This experience again showed that these people rarely complain, and emphasized that I need to take their statements seriously.

Managing these two patients post-operatively was difficult as well. They require a tube into their stomach to prevent vomiting and to give their bowels a rest, as they often take 4-5 days to start working again. Due to not eating and drinking, they require fluid replacement and often had electrolyte abnormalities secondary to this. Even in Australia, these electrolyte abnormalities can be difficult to manage. We do have the ability to test the main electrolytes here, however the machine can be temperamental. We also only have one tri-flow (a gismo which encourages deep breathing, aimed at preventing post-operative respiratory tract infections), which is often given to the person with the most recent operation, with the previous user graduating to a plastic glove to blow up.

Aside from the above two cases, we have had four other patients who have contributed to cleaning out our blood bank. One with Osteomyelitis of the leg, who lost a lot of blood in the operation and with subsequent debridement. One with a massive spleen, which is blamed for eating all her blood cells and causing an anaemia (including her white blood cells). One with tongue cancer, in his palliative phase. One with a blood count of 19, the normal being >110 for a woman, although not formally diagnosed, I wonder if it is secondary to liver failure/cancer. An appeal to the community to contribute blood have mostly fallen on deaf ears. Often people here would prefer to give blood only when they know who it is

going to, rather than potentially donating to a member of a rival tribe. The patient with a massive spleen confessed that her family/tribe are scared to come to Kompiam to donate blood, as there is recent bad blood between them and a local clan. Due to the issue of too little blood, we now have to prioritize who gets blood. It has thus far been challenging triaging, to say the least. Pray that our anaemic blood bank may be replenished as donors come forward.