Bread and Fish 85.00(-5.00)

Book: Great Expectations
The War of the Worlds
A Clockwork Orange

I had considered myself relatively fortunate at missing the social isolation restrictions currently operating in Australia, however, like most episodes of pride, the bubble has popped with the lockdown of Aitape. This has led to the hospital scaling down many of its operations, resulting in a big reduction in the clinical workload. The most patients I have had to see in a day has been 6. I have been intentionally extending my clinical reviews of each patient with lengthy assessments (of course without being invasive). I have been attempting to get involved in the other wards, however we are all in a similar condition.

Over the weekend there was a relative rush of obstetric cases which resulted in my anticipated and greatly feared first attempt at a Caesarean Section. She was a 34 year-old lady presenting in obstructed labour with signs of fetal distress. The case had somewhat been mismanaged overnight, but ongoing attempts at labour were too risky, therefore theatre was arranged. Although, I had hoped to assist Atha with the procedure, he quickly nominated that Josephine and I would do it. Josephine, as a PNG trained doctor is required to do a number of caesarean sections prior to graduation, however she was appointed assistant and with me as the primary surgeon. Although, I had been studying/fearing this moment, I was not well prepared. I scrubbed, gave the spinal anaesthetic, prepared the abdomen, prayed and made the incision. I clumsily went through the abdominal wall, separating the tissues with inefficient, inelegant and often ineffective dissection. I cut things which I had not intended to cut, resulting in more bleeding and likely resulting in more post-operative pain. Eventually, the abdominal cavity was reached, and it was evident that the bladder was much more distended than expected. A feared complication with Caesarean Sections is bladder perforation or including the bladder in sutures on closure, which can result in an opening between the bladder and the uterus (called a fistula). This feared and life altering complication causes severe urinary incontinence until surgical correction. But a urinary catheter was in place, and we were told that it was draining well (therefore the bladder should be empty as normal). Attributing the distended bladder to the prolonged labour, the bladder was retracted as standard and we continued on. The section of uterus for incision was selected and I anxiously mentally prepared for the impending delivery of the child. Adrenaline pumped through my body. Incising into the uterus and then bluntly extending the incision, my hand when in, the baby's head was low and I attempted to retrieve the head to my uterine incision. Fearing that I would hurt or damage the baby, I timidly wrestled the head for a while, but Josephine saw me flailing, took over and delivered the baby's head. Promptly after this I delivered the rest of the baby. It was covered in thick meconium, which is a sign of foetal distress. We got a good suction of its nose and mouth and it then proceeded to cry, filling the room with relief. With the baby in a reasonable state, we handed it to Atha and returned to helping the mother. The placenta was delivered without issue, but after that things went downhill. The uterus was bleeding profusely and the bladder persistently presented itself for perforation. I was becoming really alarmed trying to locate the borders of the uterine tear I had just made, as blood continually obstructed my view. With time, and the continual loss of blood, the uterine hole was marked with surgical clamps and sutured with great difficultly. As well as the bleeding impeding visibility, the bladder persisted past the retractor to interfere with my suture needle, seemingly attempting to provoke this needle into physical blows. I am glad my patient did not understand English, for throughout this time she would have heard my panic and the pleading nature in my voice for intervention from Atha. However, he did not intervene, apart from a few pieces of calm advice. Eventually, through timid and arduous suturing, the uterus was closed and things started to

improve. The bleeding had mostly stopped, the uterus was not overly boggy and the situation was progressing positively. We moved onto a tubal ligation whilst the patient moved onto some ketamine, as the spinal anaesthetic was wearing thin. The rest of the procedure was a cumbersome search and stitch, to find the two sides of tissues I had cut, whether intentionally or not, and suturing them back together as appropriate. The procedure had taken two and a half hours of patience from the theatre staff. Whilst Josephine and I cleaned the patient and prepared her to move back to the ward, the urinary catheter connection was dislodged. This resulted in large amounts of urine leaking from the patient end, and bizarrely not the bag end, as bladder should be at low pressure and freely draining. On investigation of this strange occurrence, the urinary catheter had been kinked throughout the operation and therefore was not draining correctly, thus resulting in the distension of the bladder and the origin of my headache. The rest of the operative staff mostly shrugged their shoulders at this and continued cleaning up the theatre. I was red with the patient's blood and frustration, and left to cool off in the shower. As I washed my shorts and underwear, of the literal blood and other fluids, aside from my frustration at the urinary catheter, I was unsure how to feel. At that moment, I felt relieved that it was over and the patient had stopped bleeding. The actual accounted for, post-operative blood loss was less than I had expected, although my expectations were pessimistic. I was a bit despondent, as there had been significant mistakes and the patient could have secondary problems for the rest of her life. I could not justify my actions by saying that there was no one else to do the procedure, as Atha was present. I can't state I was forced into doing it, as I could have refused to do it. Was it right for me to do this procedure at this time? It certainly was not for the good of this patient.

One of the cases on the medical ward that has kept me in a constant state of confusion is that of a 44 year-old male. He presented with confusion (after recently being discharged from hospital with anaemia and joint pain) and complaining of pain in his right knee. He had been generally unwell since December, with multiple joint pains, weight loss and anorexia, and had been anaemic, requiring multiple blood transfusions in recent admissions. His condition on previous admissions had been attributed to rheumatoid arthritis, a diagnosis frequently made here to describe a joint pain of unknown origin. The anaemia was previously assumed to be either anaemia of chronic disease or from the supposed rheumatoid arthritis. There was a family history of TB. On admission, he was rousable to pain but responsive. He was tachycardic, with a heart rate between 90-100, his systolic blood pressure was at a similar number and he remained afebrile. These observations stayed consistent throughout his admission. On examination, he had signs of severe anaemia with accompanying oedema. He was found to have large tender lymphadenopathy in his Left axillary region and some smaller lymph nodes in his bilateral inguinal regions. His abdomen was soft and not distended, his chest was clear, and his joints although appearing painful to move, were not obviously deformed or limited in their mobility. On turning the patient, he was found to have bilateral hard masses in each gluteal region, with his R > L. Examination showed no evidence of gastrointestinal bleeding. The laboratory tests were exhausted, limited as they are, and revealed no HIV, Syphilis, normal inflammatory markers, and normal platelets. He was transfused with 5 bags without much change to his symptoms or vitals. I suspect that the gluteal masses are large hematomas, which I attribute to the ongoing anaemia and normal platelets not detracting from the diagnosis of potential coagulation deficit. Bowel cancer/intestinal bleeding has also been considered as a cause of the anaemia. After some reading and discussion, a diagnosis of leukaemia or lymphoma was probable. Strange infections, such as Brucellosis, were less likely as broad spectrum antibiotics did not improve his symptoms. He died a week after readmission, as our oxygen cylinder was emptied. On review to certify the death, 2 person CPR was still continuing, with the wife giving ventilatory support with the bag mask. I called the sweaty nurse off the deceased chest and tried to console the wife, who continued to try and call out to her husband with no avail. The more experienced

nurse discussed with the wife that there was no more that could have been done or any treatment that would have likely worked.

Outside of clinical life I have stuck shrewdly to social isolation and have taken to reading and baking. My guitar is out of order as the bridge is starting to break, which I am pretty annoyed about. The bridge is the part where the strings of the guitar attach to the main base, and is stuck via glue. No trauma or external damage has caused the problem, with the likely culprit the humidity and the constant tug of the strings which has worn the glue loose. It is hard to fix well without the appropriate adhesive. It is really such a shame as it was one of very few vices I had, but I still have my Kindle, of which I have used with more passion then previously. I have kept myself busy by aiming to master handmade bread making. From a memorised/improvised recipe, I have made a small loaf each day, writing on each occasion my method and reflecting on the finished product to tweak the method or improvement to the ingredients. I have therefore predictably been eating a lot of bread, but also have been giving a lot to others. Don't think for a moment that I am some generous baker though, as from experiences with PNG people, whenever something is gifted, they almost always will give something in return. Thus far my bread has been swapped for fresh fruit or vegetables, as most of the locals have a garden. I sincerely hope this deal is a win-win, but they would be too polite to tell me otherwise. So, don't panic (Mum and Dad) I won't get scurvy and my gum health will be maintained.

Aside from bread, my diet is full of fish. I guess it is only appropriate to be dependent on fish and bread in the context of possible impending food shortages - very Biblical. Although, both my stock and range are greater than that of Jesus and his disciples. With tinned tuna, tinned mackerel, tinned sardines and some frozen mackerel fillets, which I learnt to fillet fresh before the lockdown, I am well provisioned. The miscellaneous fish is often accompanied with whatever fresh vegetables that can be scraped up, some legumes, corn and some rice. I have some soy source and some salt and pepper for sweetness and tang. Although, not a glamourous diet, it is sufficient and not requiring miracles to scare off starvation.