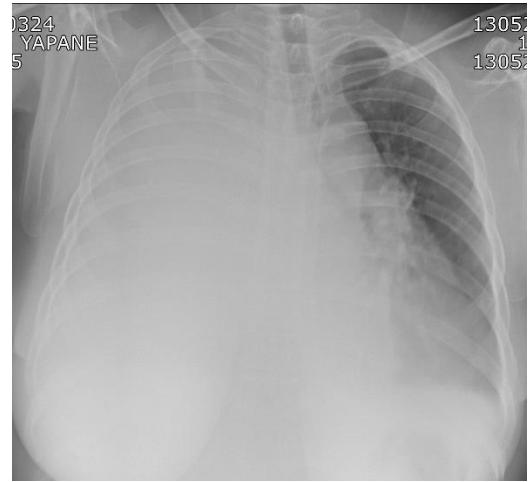


I've settled into the flow of life in Kompia. Days are passing quicker and it is starting to feel a lot more normal. The things that I initially found surprising, are now more standard. Don't think for a second that I am getting bored of the place, but I have just found routine. I wake up, eat my porridge and drink my coffee. Work starts with song, often pidgin gospel songs. As my pidgin improves, I am picking up more of the lyrics, and I will look to conclude my updates with them from now on. After some time of song, we either round on the entire hospital or prepare for elective theatre, depending on which day of the week.

We have recently been looking after some really complex patients, where our limited diagnostic capacity has taught me to be patient. Adding to the hospitals burden, we have continued to have a flux of patients from other areas, as their local facilities have remained closed. Although the hospital management has attempted stamping down on these desperate people, it is very difficult to turn away people who are critically unwell.

The patients who come in from the deep bush continue to present late and often with very severe symptoms. One elderly lady presenting with severe shortness of breath and swelling including facial, chest and both arms. Her main complaint was shortness of breath and abdominal pain, which had been progressively getting worse over the last month. Her oxygen saturations were poor, even whilst on oxygen. Her swelling was of an unusual pattern, affecting only the top half of her body. Superficial veins protruded obviously from her skin on both her neck and chest, but her legs and abdomen were not swollen. Putting her hands on her head, she became even more short of breath. She was found to have fluid in her right lung on examination and her liver was thought to be enlarged. A chest x-ray showed that the large amount of fluid in her right lung was pushing everything else out of place. Her heart was pushed further over to the left and her liver was thought to be normal, just pushed further into her abdomen by the pleural fluid (lung fluid). I removed some of the fluid for symptomatic relief. In Australia, we have a special kit for this and often put it in with ultrasound. In PNG I used the largest venous canula (needle) I could find, connected it up to an IV giving set and a urine bag. I drained about 4 litres of blood-stained fluid from her chest, which improved her shortness of breath and seemed to put her liver in the right spot. However, almost the same amount of fluid had accumulated again the next day. Blood stained fluid is not a good prognostic sign, increasing the possibility of cancer. As there is no chemotherapy available and with TB still a potential diagnosis, we counsel patients informing them of what we think and that we should try TB treatment. After a week of TB treatment, she died.



Sandy was the name of a lady who presented with epigastric pain, nausea and vomiting occurring with eating for the last 3 months. She had progressively lost weight and had become more unwell. She had a reasonable normal examination, however abdominal ultrasound revealed a strange fluid filled mass in the superior part of her abdomen. None of us are sonographers, we all just try our best, but it looked abnormal. Abnormal swelling, weight loss and slow deterioration makes us suspicious of two things, TB and cancer. After a failed trial of anti-acid therapy, we discussed starting TB meds. However, the patient's family hesitated and opted to return home for prayer and then to come back to hospital. When she returned, I did not recognise Sandy initially. In the two weeks away from the ward she had barely eaten and had become a skeleton. She was non-rousable and breathing shallowly. In my mind the diagnosis of cancer had basically been confirmed by the rapid deterioration, so I told the family that she is likely to die shortly, they could let her die here in Hospital with medicine or take her home. Fortunately they opted for her to stay, and after a review with Doctor Mills, it was decided to have a crack with some TB medication via a nasogastric tube. Remarkably, at the time of writing, two weeks from de-palliation, she is showing slow progress. She is more conscious and responsive. Not out of the woods by any means, but certainly on the improve.

We had a lad called Imbu from the deep bush come in. When a young guy comes in from the deep bush, you know that something is wrong. These are the kind of guys who walk for a couple of days to go buy a can of coke or some two-minute noodles. Seriously fit guys. If they come into hospital, it is often due to a traumatic injury, either from misadventure or assault. However, when a young guy comes in with a medical complaint, it is often serious. He had been getting progressively weaker, shorter of breath and losing weight for some time (he was unable to quantify how long as has no concept of time). He had lots of clinical signs I could not work out. A puffy/swollen face, pink finger nails, a rash on his forehead and peeling lips. His chest XR was abnormal generally, but otherwise no focal changes. Weight loss and weakness without the weird symptoms would suggest TB here, so we had a crack at treatment, and he has gotten better. He is pretty excited about feeling better, as well as with all the activity that happens around the normal running of the hospital. It's all relative to the surroundings you are familiar with.

A known HIV patient came in with shortness of breath. She had been unwell for a week when she came into hospital. Patients with HIV, as their immune systems are impaired, can get strange infections, but they also get normal infections, just more severely. Her chest sounded terrible and looked terrible on x-ray. She was coughing and a sample of her sputum was positive for tuberculosis. She was suspected to have Milliary TB, where tuberculosis has affected majority of the lung and thus TB meds were started. 4 days later she started to develop nausea and anorexia, we just brushed it off and prescribed some antiemetics. 8 days later she started to get confused and slightly jaundiced. One of the nasty side effects from TB medications is



Hepatitis, from which this patient suffered. It often resolves with cessation of the medications, but will likely restart when she goes back onto the meds. In PNG the medication has been made specifically for TB treatment, with the tablets being the 4 standard drugs in one pill. The standard therapy is with these 4 different drugs for 2 months, then 2 drugs for at least another 4 months, maybe longer for specific cases of TB. It makes it very difficult for us to treat drug reactions because our supply of TB medication is all in the form of the combination, we are therefore still trying to come out with a treatment plan in light of her adverse drug reaction.



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A 11-year-old boy presented to clinic with pain in his femur, worse at night and preventing him from sleeping and walking too far. He had lost weight gradually over a 6-month period. He had no skin changes over the area and nothing palpable but on XR a deformity was obvious. Although we see a lot of osteomyelitis that presents similarly, as this case did not have a draining sinus into the skin, we thought that it could be tuberculosis. The plus of tuberculosis compared to another bacterial infection of the femur, is that it frequently does not require surgery and often is very responsive to medications, unless there is drug resistance. When we discussed the diagnosis of TB, and that the boy would not require surgery, I was surprised that the parents were unhappy. I don't fully understand the local passion for surgery. We frequently are requested to do operations with little gain to be made through the procedures. I am yet to see a patient refuse an operation. As this boy and his older brother could see the problem on the computer screen and were sceptical regarding the medicine, they wanted it taken out with a knife. A compromise was reached, that if there was no improvement in a couple of weeks of TB meds, then surgery can go back into discussion. By the first completed week of treatment the boy was able to walk and sleep through the night without concerns.

Similar to the American medical TV series 'House', where one of the potential diagnosis is always Lupus, TB is at the back of our minds. A baby with chronic diarrhoea is not gaining weight, possibly gastrointestinal TB. Chest infection, not improving of antibiotics, TB???. Bilateral lower limb neurological changes - TB of the spine???. The PNG saying for "having a crack" or "worth a try", is "try em tas al". We are very fortunate to have a TB gene-expert, which allows us to diagnosis TB and drug resistant TB in hours, rather than using the old practice which took weeks. However, we can only run sputum, gastrointestinal aspirates and lymph nodes through the machine, no pleural/lung fluid or ascitic/belly fluid. So we can't get it right every time.

The hospital again is facing funding shortages. The cycle that is getting paid to the staff next week will be the last cycle the Hospital has finds for. The government continues to pledge money, however, we are yet to see anything. This is especially upsetting with further allegations regarding the misuse of the

COVID budget money. The staff are going to meet to plan and discuss what they can do. There are loose plans (as the Hospital supplies housing, water and electricity) that the hospital also looks to provide food for the staff as well. I guess it is all that the Hospital can do, continue to attempt to support the staff and their families the best they are able to. Continue to thank God for what he has provided thus far, but please pray that the Government hears the people rather than the call of corruption.

Swit mor yet¹

Swit mor yet

Swit mor yet

Jisas em he swit mor yet²

Cocola, em no enuf³

Ramu sugar, em no enuf

Ox and palm⁴, em no enuf

Jisas em he swit mor yet.

¹Swit mor yet = sweet more yet

²Jisas em he swit mor yet = Jesus, he is sweet more yet

³Em no enuf = its not enough.

⁴Ox and palm = popular tinned corned beef.