NOTES FROM THE FIELD

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and Scott Camazine, MD

Back to Ibo Land

Surgery in Nigeria

In June 2004, we arrived, after 36 hours of travel, at the Nigerian Christian Hospital (NCH). This was the first time all three Camazine siblings had made the trip together, but Brian was a veteran visiting surgeon at NCH (with 10 previous visits under his belt), and Scott had been here four times before. The rest of our group included Paul Ellebrecht, a high school student and Brian's nephew; Barbara Maufas, an operating room nurse, U.S. Army Major, and two-time visitor to NCH; Greg Ramsey, a premedical student and emergency medical technician; and Herbert Burns, an emergency department nurse.

We had come for what had developed into a yearly "vacation" for Brian and Scott, a four-week blitzkrieg of surgery concentrating on patients with complex and unusual problems. For months, the physicians at NCH had been "saving" these cases until our team arrived. In addition to surgery, our goal was education—both the local physicians' and our own. Through education, our total impact could be magnified exponentially.

THE HOSPITAL

Since its founding in 1964 by Dr. Henry Farrar, a U.S. missionary surgeon, the NCH has served as a protective enclave of health care for the region of southwestern Nigeria in which it's located. In the late 1960s, this region, home to the Ibo people, seceded briefly from Nigeria and attempted to form the Republic of Biafra. After three years—in which Biafra was isolated and more than one million Ibos died of starvation—the coup failed. It is this period in the region's history that yielded those oft seen photographs of children with the extremely distended abdomen of marasmus or kwashiorkor.

Today, the NCH is a 110-bed hospital staffed by five Nigerian physicians and one resident missionary physician.[1] Our surgical team included Dr. Mike Enyinnah and Eric Ojbe, who serve as the hospital's only full-time surgeon and nurse anesthetist, respectively. Brian and Dr. Mike, as he is called, have known one another for seven years: Brian participated in Dr. Mike's residency training and says he is well on his way to becoming one of the best surgeons in Nigeria. Eric attended nurse anesthetist school on a scholarship provided by the International Health Care Foundation and has become an expert at delivering anesthesia. He is never flustered (even when presented with the most difficult cases), is always on call, and never complains about the workload. We owed many of our successes to him.

RIGHT TO WORK

Thirty minutes after arriving—even before we unpacked our quarter ton of donated medical and surgical supplies—we began examining patients. In the 30-bed female unit, we encountered an elderly woman with parched lips, sunken eyes, a distended abdomen, and sepsis. Suspecting a bowel obstruction with perforation, we immediately took her to the "theatre"—the British term for the operating room. We found a Richter hernia with a perforation of the small bowel. There were liters of stool in her abdomen, which we scooped out with a kidney dish since the suction device was not working. We then irrigated the abdomen with gallons of tap water until the overflow pouring down on our rubber boots was clear. Using surgical

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*All patient names have been changed to preserve confidentiality.

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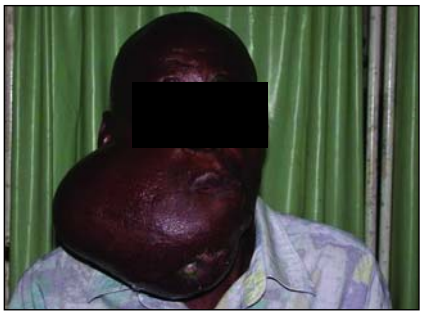

Figure 1. "Louis" with his mandibular tumor, prior to surgical resection.

staplers donated by Ethicon Inc. (Somerville, NJ), we rapidly performed a bowel resection. Miraculously, the patient survived. Perhaps even more amazing was the appearance, within 24 hours, of a second woman with the relatively rare Richter hernia. She also survived.

By the third day, patients were pouring into the hospital with a myriad of surgical problems. Between surgeries we ran a clinic, seeing as many patients as possible and shouting out "*Enyozo*!"—Ibo for "next"—after each one. During this clinic, we saw many conditions that were hard to imagine patients enduring from day to day. Several had massive, grotesque tumors of the face or torso. Sometimes all we could think was, "We don't know what it is, but it's the worst case we've ever seen."

One day, a man entered the examining area with the largest tumor of the mandible we had ever seen (Figure 1). It had a draining sinus that smelled terrible and dripped pus constantly. The tumor had been resected once before, 14 years ago, but it had quickly returned. Although it was inconceivable to us that "Louis"* had lived this way for over a decade, this was not unusual. Sadly, many Nigerians resolutely accept inaccessible medical and surgical care as a fact of life.

Several days later, we operated on Louis. We performed a hemimandibulectomy, partial resection of the floor of the mouth, and pectoralis muscle flap. Louis and his family were ecstatic with the results (Figure 2).

NEONATES

On the fifth day, Dr. Samuel Ojbe, a local doctor serving his internship at NCH, presented a 10-day-old patient to us. The infant had been vomiting after each feeding and weighed only 2.4 kg. We suspected pyloric stenosis, but the clinical picture was not completely consistent with this diagnosis. As a surgeon at a VA medical center, Brian's main experience had been with patients about 65 years older than this little Nigerian, so he was quite nervous about operating.

Fortunately, there was a satellite phone available, so we made a quick intercontinental consultation with Dr. Farrar, Brian's mentor as well as the founder of NCH. The elderly Dr. Farrar has seen every kind of surgery and still visits NCH for one month each year. With his help, we decided that immediate surgery after hydration was the best course of action. When we operated the next morning, we were relieved to find a hypertrophic pylorus. Thankfully, the baby went on to an uneventful recovery.

During our stay we also operated on a seven-day-old infant with an omphalocele. Herb placed a beautiful intravenous line in the baby's wrist, and Eric had him asleep in seconds. We were able to close the skin over the defect, and the patient recovered without problems.

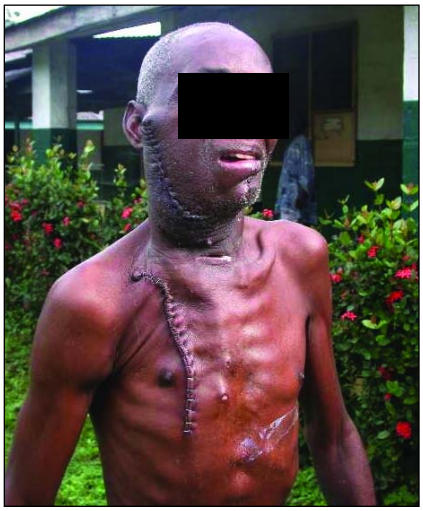

Figure 2. "Louis" after his surgery.

THE BIG CASE

Although we had thought that Louis' mandibular tumor would be the "big case" of the trip, it turned out there was a bigger one to come. Toward the end of our stay, we encountered a woman in a wheelchair whose head was wrapped in a shawl and who exuded a terrible stench. "Joy" appeared elderly, but we were shocked to find that she was only 30 years old and had a two-month-old baby.

> Sometimes all we could think was, "We don't know what it is, but it's the worst case we've ever seen."

When we removed her shawl, we were all astonished. She had an enormous parotid tumor hanging off the left side of her head (Figure 3). The tumor had been growing for more than five years. The lower

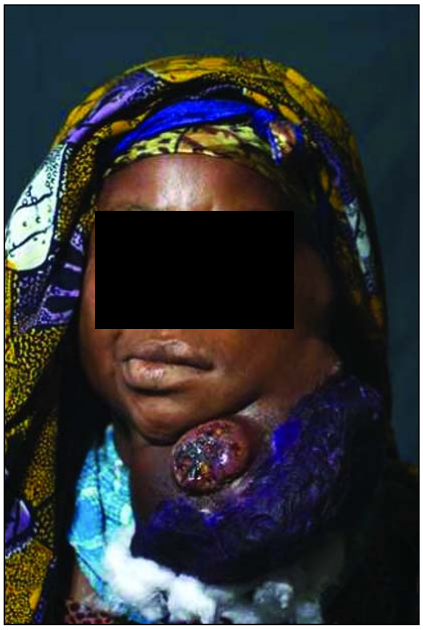

Figure 3. "Joy" with her parotid tumor.

half of the tumor was rotting and dripping pus. She said that she felt weak, and we soon found out why: Her hemoglobin level was only 3.4 g/dL!

After multiple transfusions and treatment for malaria, we carefully (and with some trepidation) began operating on the tumor. The resection was difficult and bloody. At one point we thought we had lost Joy—and we certainly would have without Eric's help. Finally, the tumor was removed, leaving an enormous soft tissue defect. We performed a pectoralis myocutaneous flap and covered the wound completely. We finished the reconstruction after five and a half hours: the longest surgery ever performed at the hospital. Everyone was extremely pleased with the results (Figure 4). Although the patient had some minor problems with the flap, she recovered well.

Of course, not all our surgeries ended in success. We lost an elderly woman after a difficult resection of a giant retroperitoneal tumor; a male patient suddenly had a seizure and died several hours after a relatively simple inguinal hernia repair; a 12-year-old girl had unresectable ovarian cancer. Surgeons and families alike suffered these setbacks with equanimity.

EXHAUSTED BUT PROUD

After 17 days and 69 major cases, we started to feel the effects of running on overdrive. The days blended together and we were all exhausted. Every day we operated from 8:30 AM to 5:00 PM—and we frequently handled emergency cases at night. Each of us gave at least one unit of blood during our stay, sometimes immediately after a bloody surgery, which also wore us down.

By the end of our stay in Nigeria, we had completed all the cases we could. We regretted having to leave the hospital still full of patients hoping to get a chance on the operating table. But we knew we had done our best, and we were happy and satisfied with our work. The rewards of using our talents to help people truly in need were dramatic and fulfilling. ●

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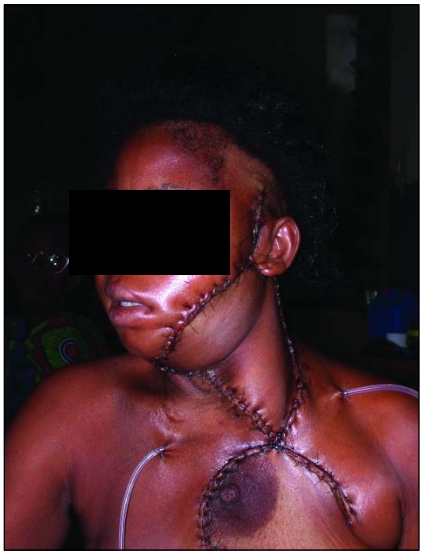

Figure 4. "Joy" following resection and reconstructive surgery.

REFERENCE

1. Nigerian Christian Hospital. International Health Care Foundation web site. Available at: www.ihcf.net/NCH.htm. Accessed January 25, 2005.

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