ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

AUSTRALIA TIMOR LESTE PROGRAMME OF ASSISTANCE

SPECIALIST SERVICE (ATLASS)

TEAM VISIT - DILI, TIMOR LESTE

March 9-16, 2013

TEAM LEADERS REPORT

MARK MOORE AM, FRACS
Plastic and Craniofacial Surgeon

Implementation of Dr John Hargrave's Mission in Timor Leste and Eastern Indonesia: Providing a specialist service to the disadvantaged where the service is not available or affordable.

AIMS AND GOALS:

This volunteer specialist plastic and reconstructive surgical team aimed to:

1. Continue the teaching and training of our counterpart Timor Leste plastic surgical colleague Dr Joao Ximenes in the assessment, management and surgery of cleft lip and palate and burn deformity.

2. Maintain an ongoing role in the teaching and education of anaesthetic trainees, anaesthetic nurses and operating theatre nurses at HNGV.

3. Deliver ongoing management of patients with cleft lip and palate deformity as the initial phase in developing a local multidisciplinary cleft team in Timor Leste.

INTRODUCTION:

The Hospital National Guido Valadares (HNGV) in Dili is the central hub for delivery of specialist tertiary medical services in Timor Leste. Recognising this our teams have provided ongoing reconstructive surgical services and teaching since early 2000 with the last clinical visit to Dili being May 2012.

Having achieved a marked reduction in the backlog of older untreated cleft cases by our regular visits, with appropriate screening and pre-visit communication to the local community by the local RACS staff, we are now seeing more age appropriate cleft patients for assessment and management. This is an ideal scenario in which to maintain and expand the teaching of Dr Joao Ximenes – mentoring and supporting him as he further develops his cleft treatment skills. With increasing numbers of anaesthetic and surgical trainees in T.L. as well as newly commenced medical and nursing students the opportunity to more widely cast the teaching / training net was embraced.

In this the visiting team was also supported in its teaching and clinical endeavours by the now expanded resident RACS team at HNGV.

TEAM PERSONNEL:

The visiting team was comprised as follows:

Dr Mark Moore	Plastic & Craniofacial Surgeon (Women's & Children's Hospital and Royal Adelaide Hospital, Adelaide)
Dr Brian Spain	Anaesthetist (Royal Darwin Hospital, Darwin)
Sr Vanessa Dittmar	Theatre Nurse (Women's & Children's Hospital, Adelaide)

PARTICIPATING LOCAL STAFF AND COUNTERPARTS:

Local staff actively involved in team teaching and clinical activities included:

Dr Joao Ximenes	Surgical Registrar, Plastic Surgical trainee, HNGV.
Dr Joao Pedro	General Surgeon , HNGV
Dr Eddy	Anaesthetist, HNGV
Dr Jose	Anaesthetic trainee HNGV
Dr Colom	Anaesthetic trainee HNGV
Dr Mingata	Anaesthetic trainee HNGV
Mr Rogerio da Conceicao	Nurse / Director, Aileu Health District
Dr Maria Adelzisa	Medical Officer, Aileu Heath District

The members of the anaesthetic and operating theatre nursing staff, the sterilisation staff, the male and female surgical ward and paediatric ward nursing staff of HNGV all assisted in providing a level of pre and post operative care to all our patients.

Mr Sarmento Correia, RACS resident coordinator provided excellent pre-visit planning and day to day oversight of operating theatre lists.

Dr Domingos Soares, Director General of HNGV met with and welcomed the team during the visit.

The resident RACS staff, in particular Dr Eric Vreede, Dr David Schoemaker and Dr David Brewster assisted and supported the teams teaching, mentoring and clinical endeavours during the week long visit.

OVERVIEW:

This visit to HNGV, Dili identifies and highlights some of the ongoing benefits and challenges in the delivery of surgical teaching mission to this region.

- Careful pre-visit planning by local counterparts, utilising advertising via the media ensures a large clinical caseload available for teaching.

- This well trodden pathway ensures appropriately triaged new and follow-up cases both in Dili and Aileu – the later courtesy of a long-term counterpart Mr Rogerio da Conceicao who has worked alongside our visiting teams for 13-14 years. His commitment to his community and knowledge gained through working with our teams is now being translated to his younger local medical colleague Dr Maria Adelzisa. From Aileu and now back practicing in Aileu, after training in Cuba she has now accompanied our team at assessment clinics in Aileu in the past 2 years.

- The large initial assessment clinic at HNGV held soon after the team's arrival provides most of the clinical material for teaching during the following week. With almost 60 cases assessed on Saturday the surgical lists soon filled fast. Adding the cases from Aileu on Sunday, and others that presented during the week, more than 90 patients were examined, surgical lists created, a waitlist for the following visit established and others on-referred to other specialists, or returned for review in future years.

- Dr Joao Ximenes, as our reconstructive surgical team's counterpart trainee has now performed more than 60 unilateral cleft lip repairs as primary surgeon. Most of these procedures heave occurred when accompanying our visiting teams in both Timor Leste and Eastern Indonesia – only one or two of his cleft repairs have been performed in our absence. He well understands the need for a correctly skilled multidisciplinary team to safely and consistently perform such surgery. On this visit we can identify both those elements of the team which are now present, as well as those areas in which the commitment or skills remain deficient.

- From an anaesthetic viewpoint with the appointment of Dr Eddy as an anaesthetic specialist and the commencement of three anaesthetic trainees, this aspect of the team is well catered for.

- Ward nursing support both pre and post operatively is of an adequate standard. The basic principles of pre-operative preparation and fasting for surgery are generally understood and adhered to. The aftercare and feeding regime for cleft lip and palate patients has been taught to Dr Joao and this information transferred to, and implemented by the surgical ward nursing staff.

- The one aspect of teamwork which lags far behind at HNGV is the attitude and work practices of the operating theatre (O.T) nursing staff. Whilst we were forewarned as to recent shortages of consumables in the O.T., and their inability to perform elective surgery – our team came prepared with these items in sufficient quantity to last through the week, as well as leaving the excess for use in elective surgery by the resident surgeons after our departure. What we were not prepared for was the seeming inability of local operating theatre nurses (scrub and scout) to show any interest in, or support of the work by our team or of Dr Joao. This failure of the nurses to behave professionally was highlighted later in the week where a junior nurse (only 3 days in an operating theatre) being left to scrub alone with Dr Joao and the team for a significant surgical procedure. He had no idea about how to handle a scalpel, or other instruments such as scissors and was left alone without a mentor or any other local colleague in theatre with him – this puts him and the patient's well being at significant risk!! This example along with numerous others during the week resulted in our team leader and Dr Joao visiting the HNGV Director General, Dr Domingos Soares at weeks end to forcefully voice our concerns. Potential solutions were discussed and these will be detailed below.

- Despite the above limitations, the completion of this our 36th visit has seen more than 850 cleft patients entered onto a data base – this being effectively the national record of cleft lip and palate deformity. Most cases now presenting for treatment are infants – those born over the last 1-2 years, with relatively fewer of the older untreated patients. More than 750 cleft repairs have now been performed across the country since 2000- Dr Joao having now undertaken more that 60 cleft lip repairs.

- Several older repaired cleft cases were reviewed and may be suitable for orthodontic treatment of their cleft related malocclusions as would occur in the developed world. The orthodontists who accompanied our team in May 2012 have indicated their interest in commencing the provision of this aspect of cleft dental care in the next few months.

- The other area for expansion of teaching in cleft management is that of speech pathology – assisting with infant feeding and speech therapy. With the next visit the team hopes to have included a cleft speech pathologist from Darwin, whose family origins are in Timor Leste. She has an interest in exploring the teaching opportunities for infant feeding and speech acquisition in the cleft patients. Certainly the pattern of cleft presentation here, with an apparent preponderance of incomplete cleft lips and relatively fewer complete cleft lip and palate- the latter having significantly more infant feeding issues, suggests a number of cleft children die from feeding related issues.

- Only a small number of burn contracture cases were referred. Several larger, long-term burn inpatients being managed by Dr Joao were assessed. Many problems in acute burn care remain unanswered – some discussions were had with Dr Joao and Dr Schoemaker, the resident RACS General Surgeon about options for training and improving primary burn care. The names of Mr John Harvey, and Mr Ian Leitch were mentioned as options to run a modified burn management course. Any such programme would require support from the hospital administration in terms of allocating a specific area of the surgical ward and nursing staff to manage these burn patients. Whilst there is a short term cost in setting up of such a subunit, the long term gain for patients and cost reduction would be dramatic.

SUMMARY OF CLINICAL ACTIVITIES

1. SCREENING:

A consistent turnout of new and follow-up patients both at HNGV Dili and Aileu indicates that the pre-visit notification process is working well. Mr Sarmento ensured the appropriate dissemination of the team visit details to local health authorities and radio / T.V. media. Confirmation of this came in part from asking a cleft patients mother from Maubisse as to how she knew to bring her child to the clinic in Aileu – she indicated that family members had heard of the clinic on the radio and that her 4 year old son with a cleft could be treated.

2. SURGERY

As discussed above the treatment of patients with cleft lip and palate remains the principal focus. With most of these cases now presenting within the first year or two of life there exists the opportunity to provide age – appropriate surgery, thus increasing the likelihood these children will have schooling and a life only minimally affected by their cleft deformity.

A number of older previously treated cleft cases are also returning for revisionary, or staged surgery, e.g. an 18 year old with a bilateral cleft deformity treated initially in Indonesian times. She has gross flattening of her mid-face and poor dentition. By using an Abbe flap, taking the soft tissue from her lower lip and transposing it into her upper lip it is possible to improve her appearance. Dr Joao will divide the flap in 2 weeks time, completing the second stage of the surgery.

3. POST OPERATIVE CARE

As has been standard practice all our cleft cases are pre- and post –operatively nursed in separate 4-6 bed bays with appropriately allocated nursing staff to monitor their post-surgical recovery.

Such an approach may have inadvertently contributed to an adverse outcome in one of our cases. At this time of the year in the wet-season upper respiratory illnesses are more prevalent – a number of our cases were deferred as they presented with a fever and upper airway symptoms. One 7 month old with a unilateral cleft lip presented well and asymptomatic for surgical repair – in retrospect he pre-operatively shared the ward with a number of other cases who were subsequently cancelled because of airway issues. Surgery and anaesthesia was uneventful. On day 1 post-op he was slightly unwell such that Dr Joao kept the child in. On day 2 he was febrile and had respiratory symptoms resulting in referral to the paediatric service. Dr Brewster (Paediatrician) diagnosed respiratory syncytial virus (RSV) bronchiolitis and commenced oxygen and supportive care. Despite initially seeming to improve slightly by day 3 post-op, he deteriorated and died on day 4. With the incubation period for this virus being 2-3days it seems possible that this child may have been exposed to the virus in on the children who became symptomatic prior to surgery and were cancelled. He was asymptomatic at surgery and only developed clinical symptoms and signs 1-2 days after surgery. There seems no aspect of his management which we could alter which would change the sequence of events pre-operatively and all aspects of airway support and care that are available for infants at HNGV were utilised.

SUMMARY OF TRAINING ACTIVITIES

1. INFORMAL TRAINING

a) Outpatient clinic

Dr Joao actively participated in initial patient assessment clinic and the formulation of the week's surgical workloads.

b) Operating Theatre

-The mentoring of Dr Joao continued during this visit, with him performing a further 6 unilateral cleft lip repairs. As indicated in the overview above the formulation and functioning of the surgical team is the key to him progressing to regular cleft lip repairs when our team is not present. With an anaesthetic complement now in place all he needs is an appropriate level of nursing support.

- considerable time was spent by Dr Spain in teaching a range of anaesthetic techniques to the newly commenced anaesthetic trainees.

2. FORMAL TRAINING

To date this remains underutilised – it was planned for Dr Spain to lecture in a more formal capacity but on this occasion it was not possible.
Groups of medical and nursing students attended the operating theatre during the week and were involved in the teaching process.

3. TRAINING PRIORITIES / RECOMMENDATIONS

A return visit is planned for June 2013 and the following teaching opportunities exist.

- Outpatient assessment clinic is an ideal forum for a small group of medical students / junior doctors to attend.
- Ongoing informal teaching of medical / nursing students in the operating theatre.
- Allocation of a half day to teach medical students in formal lectures about wound care / surgical trauma / hand and facial injuries etc.
- Pre-visit nomination of 2-3 operating theatre nurses who will be allocated to work with and receive training from our team. This to be done in advance of our visit after discussion with Mr Abilio / Jacinto the theatre managers, so that appropriate rostering occurs. Recognition of this period of training in the form of a certificate of training is possible
- With the above to act as support for encouraging Dr Joao to progress further his cleft surgical expertise.

EQUIPMENT AND SUPPLIES

The team was warned in advance of shortages of sterilizing paper which had curtailed elective operating at HNGV. We were able to be self sufficient in this regard and left a large amount of these materials with local staff at the end of the week, hopefully allowing for a partial resumption of elective surgery the following week.

Other surgical consumables, sutures, dressings etc, suitable for local use were left with Dr Joao for use as needed.

RECOMMENDATIONS

A significant number of cases were wait listed for a next visit, this being planned for June 2013. It is anticipated that this will again be centred in Dili, which should facilitate the best teaching and training opportunities in a central location.

VISIT ORGANISATION

The pre-visit organisation from RACS staff in Melbourne with excess baggage waivers, visa waivers and customs declarations, all ensured the teams arrival and departure proceeded smoothly and uneventfully.

Similarly the in country notification process and day-to-day planning of the visit was expertly managed by Mr Sarmento Correia. His assistance with late arriving patients during the week ensured we were appropriately occupied at all times.

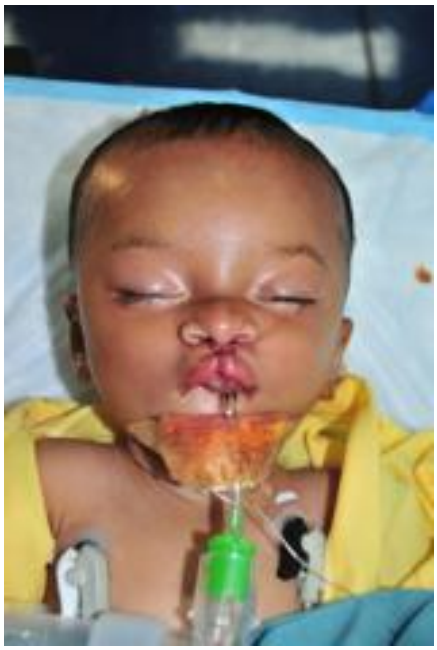
ACKNOWLEDGEMENTS

- The ATLASS Program and RACS International projects staff in Dili and Melbourne.
- The nursing and medical staff at HNGV, Dili and clinic staff in Aileu
- The airlines that assist in our travel to and from Timor Leste, providing extra allowances for luggage.
- The assorted hospitals in Australia and surgical and anaesthetic supply companies who support our teams work, and our families who tolerate our absences and commitment to this work in Timor Leste.

SUMMARY OF CLINICAL ACTIVITIES – PLASTIC SURGERY

MARCH 9TH – 16TH 2013

TOTAL PATIENT CONSULTATIONS		**91**
INITIAL	**67**	
REVIEW	**24**	
TOTAL SURGICAL PROCEDURES		**37**
CLEFT LIP	**15**	
CLEFT PALATE	**6**	
BURNS / CONTRACTURES	**4**	
OTHERS (Excisions, keloids etc)	**12**	



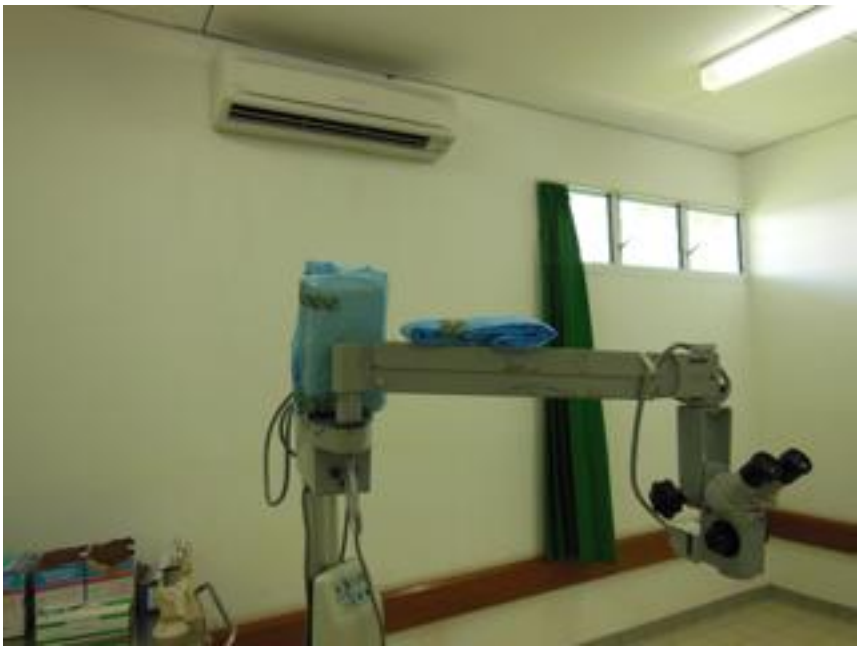
2-3 year follow-up of twins with bilateral cleft.

Unilateral cleft lip repair as infants – 1 year follow-up

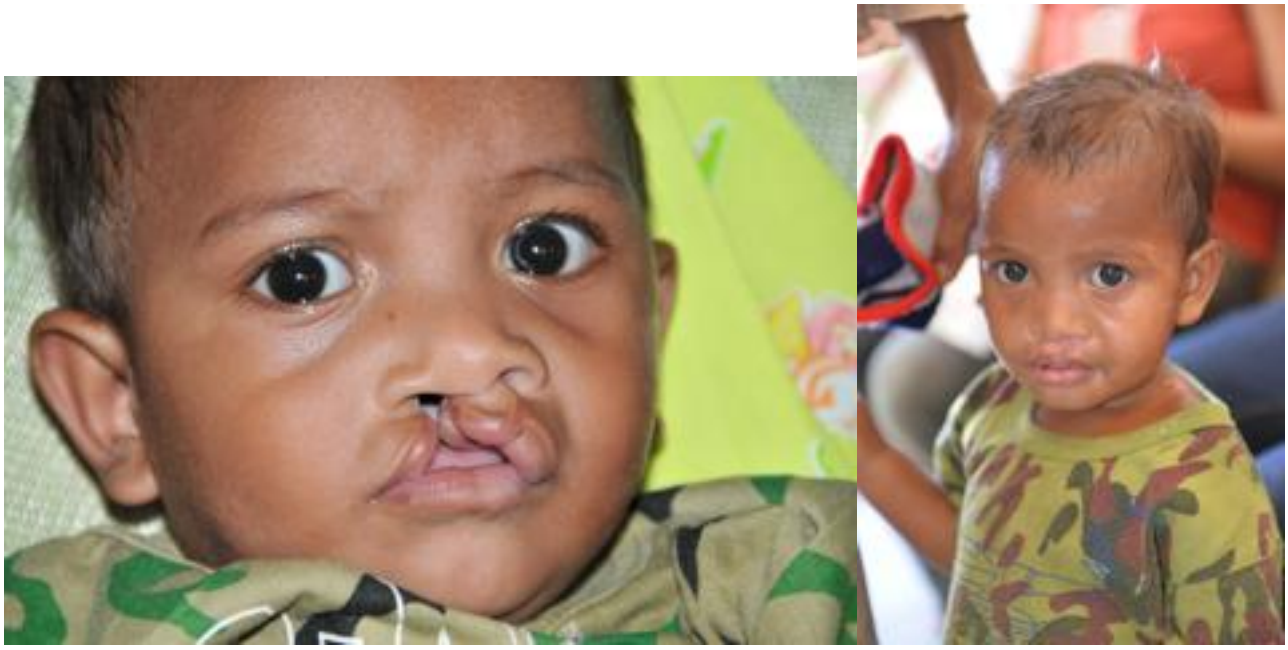
Congenital dermoid cyst

- left untreated for 23 years

Dr Joao operating surrounded by Timorese students and trainees.



Drying instruments after sterilising – putting the eye operating microscope to another use



1 year follow-up of cleft lip repair

Cleft lip – untreated at 1 year and 53 years

Scenes from Aileu