OVERSEAS SPECIALIST SURGICAL
ASSOCIATION OF AUSTRALIA

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

AUSTRALIA TIMOR LESTE PROGRAMME OF ASSISTANCE SPECIALIST SERVICE (ATLASS)

TEAM VISIT – TIMOR LESTE

February 25th – March 3rd 2012

TEAM LEADER'S REPORT

DR MARK MOORE AM, FRACS
PLASTIC AND CRANIOFACIAL SURGEON

Implementation of Dr John Hargrave's mission in East Timor and Eastern Indonesia: providing a specialist service to the disadvantaged where the service is not available or affordable

AIMS AND GOALS:

The objectives of this volunteer specialist plastic and reconstructive surgical team are as follows :

1. The expansion of the ongoing plastic and reconstructive surgical services to Timor Leste, to the district of Oecussi.

2. Maintaining the teaching and training of our counterpart Timor Leste plastic surgical trainee Dr Joao Ximenes, in the surgery and management of cleft lip and palate and burn deformity.

INTRODUCTION:

The enclave of Oecussi, first settled by the Portuguese nearly 500 years ago, remained the last major region of Timor Leste to receive a plastic and reconstructive surgical team visit.

The 64,000 inhabitants of Oecussi are geographically isolated from the rest of Timor Leste, with only limited options for transport of a surgical team into, or patients out of the territory. Twice weekly overnight ferry boat trips for some months of the year, or a relatively costly light plane flight, with significant weight restrictions for passengers and luggage are the only options for entry.

Within Oecussi, the mountainous terrain, poor roads, remote isolated communities and low literacy rates have combined to restrict access to medical services.

Little was known as to the magnitude of the reconstructive surgical needs there, but based on observations elsewhere in Timor (both Timor Leste and West Timor), it was assumed that there would be a significant backlog of untreated clefts – the exact spectrum of these (the extreme age of the patients), did however surprise. This, the first RACS plastic surgical mission to Oecussi was therefore much anticipated by both the visiting surgical team and by local residents.

TEAM PERSONNEL :

The visiting surgical team was comprised as follows:

Dr Mark Moore Plastic Surgeon (Women's and Children's Hospital and Royal Adelaide Hospital, Adelaide)

Dr David Barker Anaesthetist (Women's and Children's Hospital, Adelaide)

Sr Vanessa Dittmar Theatre nurse (Women's and Children's Hospital Adelaide)

PARTICIPATING LOCAL STAFF & COUNTERPARTS :

The local staff working with our team included;

Dr Joao Ximenes Surgeon / Plastic Surgical trainee, HNGV, Dili

Mr Maximiano Neno Director, Oecussi Referral Hospital

Mr Fransisco (Ciko) Xavier Head of Theatre, Oecussi Referral Hospital

Mr Jose Antonio Nurse anaesthetist, Oecussi Referral Hospital

Mr Davel Cabeza Anaesthetic technician (Cuban) Oecussi Ref. Hospital

Ms Viviana (Ana) Scrub nurse Oecussi Referral Hospital

Ms Domingas Circulating nurse Oecussi Referral Hospital

All members of the Oecussi Referral Hospital operating theatre staff and a smaller number ward nursing staff were involved in assisting and supporting our visiting team on this the first plastic surgical mission to Oecussi.

Mr Elvis Guteres, who had previously supported our teams in an administrative and translator role in Dili, and who had provided assistance for patients from Oecussi, was able to fulfil those duties for us again on this mission.

OVERVIEW :

The Oecussi enclave was the last of the main districts to receive a visiting plastic surgical team. In light of the various logistical issues associated with accessing the Oecussi region, careful planning was required by the resident RACS staff and the administration of the Oecussi Referral Hospital.

In the month leading up to our team's visit, Dr Joao Ximenes and Mr Sarmento Correia (RACS coordinator) visited the Oecussi district, meeting local staff, visiting the various sub-districts to advertise the upcoming visit and locate appropriate patients for assessment and treatment. This preliminary scoping of the area identified some 20-30 suitable patients, this being an adequate workload for an initial visit, where the local staff have no real past experience of plastic surgical interventions in their regional hospital. During this preliminary visit Mr Sarmento was able to locate appropriate accommodation for the team - this is at a premium in Oecussi given the relative lack of many basic services. Similarly meal options were identified for the team and the local staff during the working week were sourced.

The mechanism for getting to and from Oecussi was also well negotiated by the local RACS staff in Dili. Mission Aviation Fellowship (MAF) provide a subsidised air service for NGOs needing to fly in and out of Oecussi, as well as other more remote locations. Flying on a small, single engine , maximum 8 seater aircraft (Gippsland Aeronautics, GA 8 Air van), with significant restrictions on maximum weight, the 3 person visiting team and Dr Joao Ximenes were able to be transported into Oecussi. Safe return, with the addition of Mr Elvis Guteres to our group was possible with the diminution of our surgical and anaesthetic supplies at weeks end, as well as the removal of several seats from the plane!!

The team, all of whom originate from Adelaide, travelled to Darwin on Friday 24 February, with onward flight to Dili on the early morning Air North flight on Saturday 25 February.

Arriving in Dili, Dr Joao Ximenes joined the three Australian team members for our onward MAF flight to Oecussi. This approximately 50-60 minute journey occurred in clear blue skies, allowing easy identification of Batugade at the border , the port of Atapupu and town of Atambua in West Timor, before the gentle landing on the grass airstrip in Oecussi. The airstrip , occupied and surrounded by cattle was littered with cow 'pats'. Unsurprisingly on disembarking from the plane you are met by the sight of the undercarriage splattered with cow dung !!

Being met by Elvis Guteres , who arrived in Oecussi the preceding day, we were transported by hospital car to our accommodation for the week, the Royal Rao Hotel !! This establishment whose entrance driveway is full of nesting pigeons, did however provide new, clean rooms with ensuite facilities, a standard breakfast (bread, eggs and tea/coffee) and a variety of basic local dinner meal options. Water did not always run, drains not always drain and power was nominally available from 7pm to 7am, except the day of the week when it was our districts turn to have a

power outage. Despite these inconveniences we were comfortable and enjoyed, and were well looked after there.

After briefly settling in to the hotel we travelled the short distance to the hospital. There we were met by the sight of a large crowd of patients – most not with plastic surgical problems !! A visiting Korean traditional medicine team visiting for 3 days were attracting far larger numbers of patients than were present to see us. The sight of local people leaving the hospital with small pieces of Micropore tape stuck to their temples and faces confirmed the continuing belief in, and role of faith healing / traditional therapies to these people in this remote community.

The consulting clinic for our team was set up in the emergency department. 15 patients were examined and the appropriate data collected on Saturday. The majority of the cases were cleft patients, most having been identified by Dr Joao on his earlier visit. All cases seen the first day were appropriate and listed for surgery, confirming the good quality of the triaging. Over the following days further cases continued to arrive, so that by weeks end 34 patients were assessed and treatment devised. Of these 19 cases were cleft patients. Four had undergone cleft lip repairs in Dili, three of these by our team . Two of these cases proceeded to palate repair on this occasion, whilst the third was offered a minor cleft lip revision – this was declined by the family. The last of the four previously repaired cases, a young girl with a unilateral cleft lip and palate, had her palate repaired this visit and will need revision of a poorly performed primary lip repair on a future visit.

The 15 remaining new cleft patients were remarkable for their diversity of age at this their primary presentation – ranging from 7 months to 64 years !!! Whilst four cases were aged under 3 years when seen, eight were of adult age, including seven cases aged over 35 years !! None of these cases had been able to access any prior surgical treatment in Portuguese and Indonesian times. The extraordinary isolation of this region till the present day, as well as the lack of availability of appropriate surgical services make this group a sadly unique series in the modern day. Almost all the cases had not been to school. Most had married and gone on to have children themselves. Six of the seven cases were isolated cleft lips, and demonstrated clearly the clinical history of the disease process untreated. The one case with a cleft lip and palate showed similar midfacial flattening, extreme velopharyngeal incompetence with unintelligible speech, and had never married.

In total 14 cleft lips and 3 palate repairs were successfully performed in Oecussi without significant concerns with the operating theatre or postoperative ward care. Careful advance planning with the ward staff ensured all patients went to a common ward area, with well-defined instructions regarding fluid and food intake postoperatively.

The only potential issue with ward care came with the difficulty in ensuring adherence to appropriate preoperative fasting rules. A 5-year-old boy was fed by a

well-meaning family member just prior to going to theatre, this being unnoticed by nursing staff. He subsequently regurgitated food at induction of anaesthesia, fortunately without aspiration, due to the quick actions of our anaesthetist. The surgery was deferred and after confirmation of no serious ill – effects from this episode, he proceeded with uneventful surgery a day later – fully fasted!!

A small number of burn contracture patients also underwent surgical release. Most were treated with multiple Z-plasties to the limb contractures, thus minimising the postoperative nursing requirements after our team's departure. Only a 5-year-old girl , with a significant contracture involving the ankle and foot, required skin grafting – it was possible to perform the first dressing change on this graft in the ward prior to our leaving on Friday.

In assessing the Oecussi Referral Hospital, it appears from this our first visit to be a well-organised facility with good leadership beginning at the top. The hospital director Mr Maximiano Neno was present to welcome the team on arrival, oversaw the teams clinical activities, provided a farewell dinner for the team and his local staff on our final night, before meeting us for a final debrief on the final morning. Similarly Mr Fransisco Xavier, who headed the operating theatre suite ensured this was the best structured and cleanest theatre complex we have worked in Timor Leste. Attention to sterile / nonsterile boundaries in and around theatre were rigidly maintained, and the staff although small in numbers were willing and enthusiastic in there involvement with our team. The only area where they could be faulted was in recovery – a common finding across this country. All too often the early postoperative child was left alone in recovery with a parent (sometimes holding the oxygen mask to their child's face), albeit with oximeter on !!

The postoperative surgical ward was probably the least impressive element of the hospital. Whilst clean and seemingly adequately staffed, most post op patient care appeared to be in the hands of relatives. A lack of interest by any ward nursing staff in joining our team for post op ward rounds was commented on early in the week. After discussions with appropriate staff , this improved by weeks end. There were no other issues with in ward care otherwise, and Dr Joao was able to provide details to the patients regarding longer term wound care and scar management.

A final post op ward round on Friday morning saw almost all patients safely discharged. Only the young girl with the foot burn contracture/ grafting remained for a repeat ward dressing the following week.

During the week the hospital also provided a car and driver that allowed us to visit Lifau, the site of the first Portuguese landing on Timor in 1515 (497 years ago !) , to the orphanage run by Father Gaspar (in Oecussi for 30-40+ years), and finally the new border crossing facilities being constructed at Sakato, where Oecussi meets Nusa Tenggara Timur in the east.

The team departed for Dili late Friday morning – the MAF plane touching down in Oecussi after the airfield was cleared of wandering cattle by a UN vehicle !! With careful offloading of seats all team members and luggage were able to return on the one flight despite the weight restrictions.

With 34 patients assessed and 28 surgical procedures performed , this proved to be a very successful first plastic surgical venture into Oecussi. There do however remain a number of subdistricts in this region where very few or no patients were seen, indicating the ongoing need to further explore this region. There may be further 60+-year-old cleft patients out there still untreated.

To finish the teams visit, we had the opportunity to meet with Liz Ollier and other AusAID representatives on Sunday to discuss aspects of the ATLASS programme and options for the future surgical service / teaching commitment to Timor Leste.

The team leader, together with Dr Joao Ximenes and Dr Eric Vreede then on Monday had the opportunity to present to the Timor Leste Health Ministry a summary of our clinical work to date, teaching provided and opportunities to progress the service in the future. There was much positive feedback and questions from the assembled health directors about the prevalence of facial clefting in Timor Leste, ongoing education to improve understanding about clefts – through teaching and up skilling of local staff over the next decade.

SUMMARY OF CLINICAL ACTIVITIES :

1. SCREENING.

The outreach visit and pre-screening by Dr Joao Ximenes and Mr Sarmento Correia a month prior to our visits ensured an excellent patient turnout for this first visit to Oecussi. Whilst a number of the subdistricts (Pante Macassar and Pasabe) had a number of patients referred, there are several others (Oesilo and the districts to the western side) seem largely untouched.

Education of local staff as to our team's spectrum of clinical service was possible during this visit and their need to liase with Dr Joao Ximenes regarding any new patients for future visits was reinforced.

2. SURGERY.

On this the first Oecussi mission, excellent triaging resulted in an appropriate volume of cleft and burn contracture cases. While elsewhere in Timor Leste we have seen a shift toward a younger age of presentation of cleft lip and palate, the unique geographic and social isolation in Oecussi saw an extraordinary number of adult, untreated cleft patients present. Unsurprisingly all had not received

any significant education – reinforcing the value of cleft surgery in promoting access to education and reduction in poverty through that.

The small group of burn contracture patients had significant restriction of range of movement in their affected limbs – the release achieved by surgery will maximise limb function and mobility.

3. POSTOPERATIVE CARE.

On this first visit , the local ward staff were initially slow to involve themselves in aftercare. With little prior experience and with language difficulties – many patients only speak Baikeno and not Tetum, communication with the team was less than ideal. After open discussion with some senior staff, they soon met with Dr Joao and the team on regular morning and afternoon ward rounds, ensuring appropriate patient care occurred. The team has resolved to produce a checklist for patient flow through the pre- , intra- and post-operative period translated into local languages to minimise these difficulties when working in new locations and where visits are infrequent.

SUMMARY OF TRAINING ACTIVITIES :

1. INFORMAL TRAINING.

The ongoing training of Dr Joao Ximenes in cleft and plastic surgery continued on this visit. Despite only having done a couple of cleft lip repairs since our last visit, he is now very capable in the repair of incomplete cleft lips. We will plan to move him forward to more complex cleft repairs when back in Dili in May. In the mean time he will attend the Pacific Island registrar's course in basic plastic surgery later this month. On a negative note, sadly Dr Joao was not involved at all in the Operation Smile Singapore mission to Dili in November – I have addressed this with Operation Smile administration, as it rather defeats the purpose of such missions if local surgeons are not involved!!

The remaining areas of training occurred with the local nurse anaesthetists and theatre scrub nurses. The Timorese nurse anaesthetists and Cuban anaesthetic technician were actively involved in the provision of anaesthetics for all our cases. Similarly the local scrub nurse was the scrubbed theatre sister for the majority of our cases. Our theatre sister assisted the local staff with instrument sterilisation, an area in which they are relatively unskilled – this is an issue more across the region, with shortcuts and probable inadequate sterilisation is all too common. Recognition of the importance of this aspect of operating theatre activity and training in it should be a consideration for future RACS programmes.

2. FORMAL TRAINING.

This remains an area which is much under-utilised. An offer was again made at the Timor Leste Health ministry meeting of our interest and willingness to be involved in more widespread teaching of local medical students and junior doctors.

3. TRAINING PRIORITIES.

At weeks end other discussions were had with Dr Joao Ximenes re future training opportunities. These include :

a. Plastic Surgical training week in Fiji – March 2012. Possibly with a burn nurse for the EMSB course.

b. A one-week visit to Adelaide to follow the May – June team visit to Timor Leste. The aim for this visit is to see the day-to-day workings of a plastic surgical unit, as well as spend time with the physiotherapy department to discuss splinting for burns and burn contractures.

c. Possible future visits to Surabaya – Dr Joao to organise as and when he wishes.

d. Future team visits in :

May – June, 2012	Dili
November 2012	Baucau and ? Maliana.

4. EQUIPMENT AND SUPPLIES.

With the limitations on weight on the MAF flight, the team was careful not to overload with equipment or supplies. Despite this we had no shortages and were able to leave a good quantity of anaesthetic drugs and surgical supplies with the local staff in Oecussi.

The only anaesthetic issue that arose was the Halothane vaporiser in Oecussi. From early in the week it was apparent that it was not delivering the amount of gas registering on the dial – despite being turned up to maximal gas delivery it was not possible to perform gaseous inductions, nor maintain appropriate depth of anaesthesia without extra agent supplementation. This vaporiser, whilst seldom used by local staff, should be cleaned and checked before a visiting team returns.

5. RECOMMENDATIONS & PLANNING FOR FUTURE VISITS.

It is our recommendation that a plastic surgical team should return to Oecussi in one year. The local hospital plan to collect patient details for those requiring surgery and forward this information to Dr Joao. Thus planning for a return visit is already in progress for a similar time in 2013.

In the interim, a team will travel to Dili in May – June 2012, and Baucau +/- Maliana in November 2012.

6. VISIT ORGANISATION.

For this the first visit to Oecussi, the pre-visit planning and organization of team travel and accommodation, and patient retrieval was excellent, and a tribute to Mr Sarmento Correia and Dr Joao and their pre-visit work, and to Mr Elvis Guterres during the week in liasing with hospital administration, and ensuring team meals and accommodation needs were met.

SUMMARY OF CLINICAL ACTIVITIES
PLASTIC SURGERY
FEBRUARY 25 – MARCH 3 2012

TOTAL PATIENT CONSULTATIONS		**34**
	INITIAL	**31**
	REVIEW	**3**
TOTAL SURGICAL PROCEDURES		**28**
	CLEFT LIP	**14**
	CLEFT PALATE	**3**
	BURNS/CONTRACTURES	**5**
	OTHERS (EXCISIONS / KELOIDS)	**6**

WAITLIST CASES **6**

ACKNOWLEDGEMENTS.

- The ATLASS Programme and RACS International projects staff in Dili and Melbourne.
- The various airlines that assist in our travel to and from our places of work in Timor Leste – especially on this occasion the Mission Aviation Fellowship organization and its pilot in Timor Leste Mr Jonathan Love.
- The nursing and medical staff at Oecussi Referral Hospital.
- The assorted Australian Public and Private hospitals, and other associated surgical supply companies who continue to support our teams work in so many ways.
- The team members and their families who maintain their support and long-term commitment to this work in Timor Leste.

MAF plane used by team to fly to and from Oecussi.


View of the North coast of Timor from the plane during flight To Oecussi.



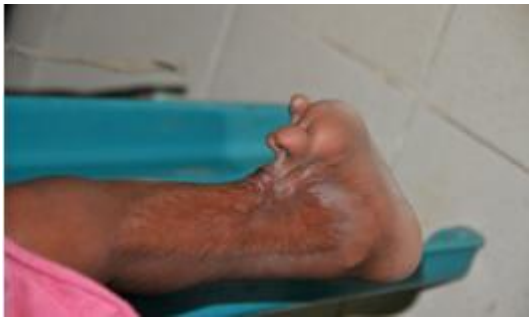
The new Oecussi Referral Hospital , with staff participating in " Poco –poco' dance and exercise programme on Friday morning.

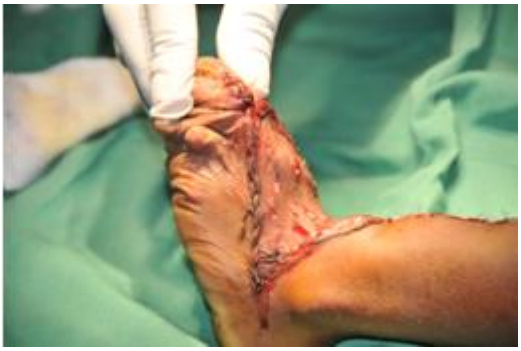

Infant girl with unilateral cleft lip and palate.

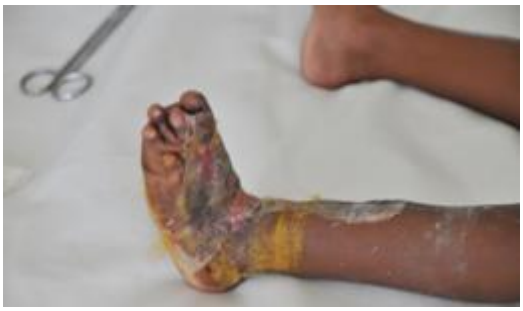
Left – prior to cleft lip repair in Dili , August 2011.
Right – at return for cleft palate repair in Oecussi , February 2012.



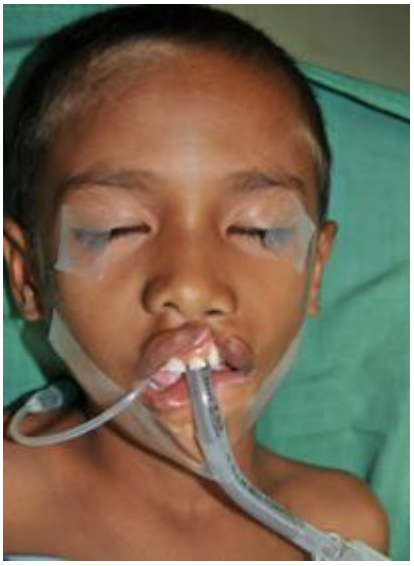

Adult unrepaired cleft lip patients – Oecussi 2012 all had no prior access to surgical care, and had been denied access to appropriate educational opportunities.

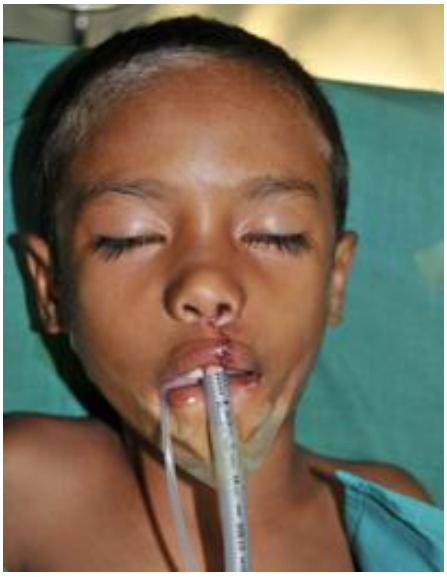






Five year old with severe foot and ankle burn contracture (above)
Surgical release and skin grafting , and at first dressing change prior to team departure.





Incomplete cleft lip repairs in children.

More unrepaired adult cleft lip patients

Scenes from around Oecussi – famous for it's high quality rice (above and below right), and the monument at Lifau to Portuguese settlement , 497 years ago (below left)