TEAM VISIT

General Surgical Visit to RSKM, Halilulik, West Timor

July 31st to August 10th 2013

Team Leader's Report

Dr. Bob Sillar – General Surgeon and Team leader

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

Team Members

Dr. Bob Sillar – General Surgeon and Team leader
Dr. Peter Armstrong -- Anaesthetist
Dr. Shanta Velaiutham -- General Surgeon and Interpreter
Dr Vijay Velaiutham – General Practitioner and Minor Surgeon
Ns Janelle Skillen – Nurse and Sterilisation Instructor

Indonesian Medical Group

Dr Intan Pufnamasari
Dr Risky Ilona Saputia
Dr Rudyanto Wiharjo Seger

Dr Silvester Taopan
Dr Juanita Widado
Dr Petrus Doko Rohi
Dr Candra Sari K
Dr Kathryn Suyoto
Dr Agustin Agnes
Dr Yolinda Deonaya

The first three were the resident doctors at Halilulik and the others came from public hospitals and health clinics in West Timor often bringing along problem patients that they wanted us to look at.
A few came because they knew we were there and had been with us before. There were fewer this time than before because of the end of Ramadan. Young Indonesian doctors are compelled to spend at least 12/12 working in rural areas which is very tough as there is virtually no support for them and the arrival of an OSSAA team is very exciting.

OSSAA team with sisters at the convent

Introduction

The trip was at the request of the SpSS sisters from RSKM Halilulik and endorsed by the Health Departments of the Belu District, NTT and Jakarta.

The aim of the visit was to provide a service role to the people of the Belu District of West Timor as well as continue the education and development of staff in the region. We also aimed to enhance the achievements of the last OSSAA General Surgical visit to Halilulik led by Dr Brian Miller in Feb. 2013.

It was unfortunate that Sr. Kerrie Nicholls whom has been so instrumental in the success of previous visits had to pull out at the last moment because of a family accident.

Meeting with the local regent at Atambua

Travel

The team again travelled via Darwin to Dili in Timor Leste, and then overland to Halilulik in West Timor. Shanta and Vijay travelled direct to Kupang after visiting family in Penang, arriving one day early, and were able to triage a lot of patients before our arrival.

The team stayed at the airport hotel in Darwin which is necessary in view of the very early departure of the flight next morning to Dili. We were met at the Dili airport by the transport company, Rentlo-E-Silva, and after dropping off some anaesthetic equipment requested by the hospital in Dili we travelled overland to the border. Timor Leste in-transit visas can be obtained easily on arrival at the airport terminal. No issues were encountered at the border where we were met by the staff from the hospital in Halilulik. Time differences meant we arrived in the early afternoon and received the usual extraordinary welcome.

The return journey was again by road in a Timor Travel mini van organised by the hospital. The 1 hour time difference between East and West Timor needs to be taken into consideration as the border closes for lunch.

Once again the only difficulty encountered travelling this way was the obtaining of the return Timor Leste intransit visas which can't be purchased at the border and need to be done on-line. This process can take many months! I would suggest that that all documents be sent via the Consulate in Sydney in order to expedite things.

The return overnight stop in Dili was a good way to wind down and allowed the team to meet the staff from the hospital in Dili who have very similar problems to those we encounter in Halilulik.

Local schoolboys.

Medical Workload

The team operated for 6 days utilising mostly the single theatre that was functioning. Some procedures under Local Anaesthetic were performed in the second theatre and many were performed by Vijay in the Outpatients Dept.

As Sunday is an important religious and family day for the people of West Timor we reserve this day for emergencies only.

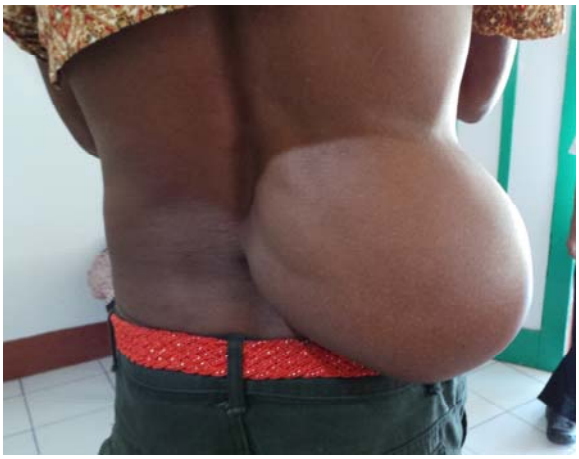
Total Consultations	125
• Operations in OT	40
• Head and neck	16
• Inguino scrotal	12
• Other tumours	12
• Other Procedures	22

Although many patients were seen on arrival, there was a steady stream of patients seen in the OT other days, as well as some emergencies from casualty.

There were more referrals from more distant district hospitals such Soe and Kefamananu than on previous visits, and this may be due to the reduction in specialist surgical visits to these areas as well as the minimal local surgical expertise. The team was once again most ably supported by the local junior medical staff as well as those visiting from area Health Clinics [Puskessmas].

The team was asked to make a visit to the Wakil [vice] Bupati in Atambua who made us aware of how important he sees the visits from OSSAA in enhancing the medical services of the area.

We did not have any major complications and there were no returns to theatre. Samples were taken for histology and cytology and these results will forwarded onto the hospital.



Large lipoma over the right flank

Parotid tumor present for 25 yrs.
Superficial parotidectomy performed

Staffing

The local theatre staff performed extremely well considering they didn't have the usual overseas support.

The 3 key persons were the senior scrub nurse Yoram Talan [Addiss], Grace Manek as the senior person in charge of sterilising and Richardus Asamai the anaesthetic assistant. They were critical to the success of the trip but I believe this represented an inadequacy of experienced staff considering the volume and magnitude of the cases performed. They worked hard and were keen to teach the more junior staff. The resident doctors, Intan, Ilona and Rudyanto were of great assistance as were the visiting junior doctors from elsewhere, Juanita, Kathryn, Petrus, Silvester, Candra, Agnes and Yolinda.

Janelle Skillen's support was invaluable and her assistance to Sr Grace in the sterilisation area was much appreciated.

The ward staff are quite experienced now and the regular observations previously introduced have been maintained.

Certificates of merit were presented to all the theatre staff as recognition of their efforts.

Operating theatre

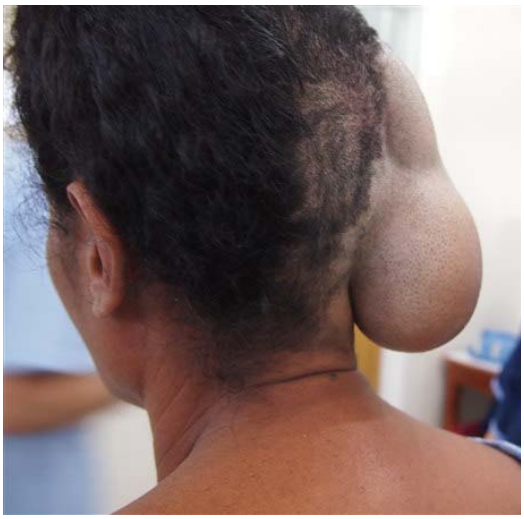
Hospital Facilities

Basic xrays are only available in Atambua [30 minutes] but there was a further extension of the simple blood tests available in the hospital. The ultrasound facilities previously introduced were extensively used. The theatres have an adequate supply of instruments and only ‘special needs’ instruments need to be brought in future. The supply of disposables needs to be supplemented each visit.

There is a new theatre light but is in the OT that is not in use?? Lighting is subject to surges and needs to be supplemented with headlights. The diathermy was dysfunctional and the plate needed running repairs. We had to rely on the Erbe on a few occasions. Diathermy plates are needed.

The wards are unchanged, very basic, crowded, but surprisingly functional.

Daily ward rounds



20 year history of large epidermoid cyst of scalp

Dr. Rudy and Dr. Juanita (Joan) in action.

Accomodation

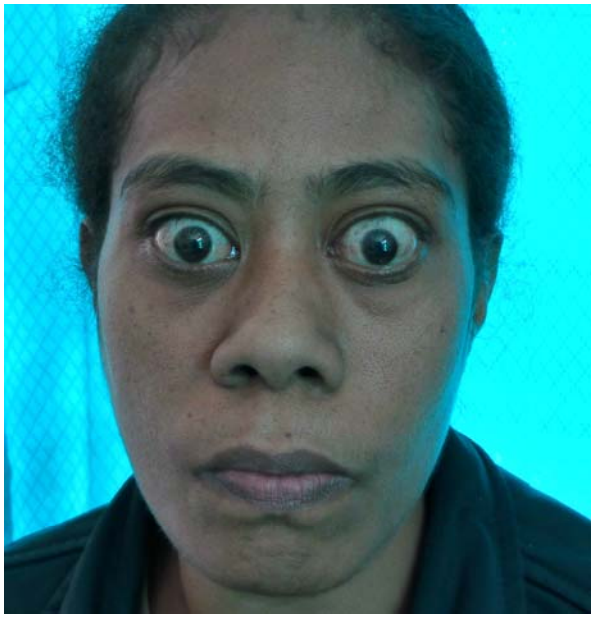
The team was again accommodated in the resident quarters near the hospital. Rooms were shared and ‘mandi’ style bathroom facilities were outside and were adequate. Some resident staff had been moved elsewhere in order to accommodate us. The noise from the nightly dog fights did disturb the peace but the proximity of the quarters to the hospital was a big plus.

The hospital is looking at improving facilities for the visiting staff.
There are exciting plans to build a completely new hospital a few kilometres out of Halilulik towards Atambua and it was indicated that the Sisters may be asking OSSAA for advice re design. This appears to be a short term aim and the building might even start next year.

Dinner at the Convent

Tour of the lab facilities by Sr. Priska

Grave’s disease reviewed by team in Feb 2013, and was started on medical treatment. Clinically euthyroid and thyroidectomy performed during this visit.



Untreated Grave’s disease. Started medical treatment during this visit

Anaesthesia Report – Peter Armstrong

This short trip to Halilulik was one of the most enjoyable and successful overseas surgical trips I have done. In large part this was due to the personnel involved from both the Indonesian and Australian teams.

The wing housing the two operating theatres is well designed but has no dedicated recovery area. There is a light and airy waiting area with a curtained off cubicle for consultations and minor procedures. Outside there are ample verandahs where relatives can wait. Off the main hall are a dining room, change rooms and bathrooms, a reading area/lounge, and a small sterilizing room.

Of the two theatres only one is operational and it contains a Penlon Prima SP Anaesthetic machine, a Mindray PM 7000 monitor with ECG, NIBP and pulse oximetry and G sized oxygen cylinders. Nitrous oxide is supplied in a D sized cylinder. There is one suction apparatus shared between surgery and anaesthesia. The machine should be turned off when not in use to minimize wastage of oxygen. There is no mechanical ventilator.

Halothane is the principle anaesthetic vapour supplied. There were at least six 250 ml bottles of which I used two. There were two bottles of Isoflurane, of which I used one. There is a halothane vaporizer and an enflurane vaporizer mounted on the machine.

On my initial inspection of the machine there was a loud, high pressure leak from the body of the machine behind the vaporizers. With the help of the anaesthetic nurse, Ricardus and the scrub nurse, Adys I took off the front fascia behind the vaporizers and located the leak in the nitrous oxide valve in the anti-hypoxic manifold. The leak stops if the nitrous oxide is disconnected. I would strongly advise that the oxygen cylinder only be connected to this machine until the valve is replaced. John Hunter Hospital biomedical engineer, Stephen Threlfo, provided very useful advice during this process.

I took a Diamedica drawover anaesthetic apparatus from Australia through which I administered isoflurane in air/oxygen. This proved useful on more than one occasion. There is a small back-up Boyles machine in the anaesthetic store room adjacent to theatre.

Performing six to ten surgical procedures each day for a week puts a lot of stress on the whole hospital. All the staff are asked to work very long hours and in the case of the theatre staff, many of them must sleep at the hospital because of travelling times.

We took many of the medications we needed but some are in short supply. Opioids are scarce and difficult to obtain due to government regulations. The hospital has limited supply and so we used a lot of tramadol and ketorolac combined with local anaesthesia. I ran out of antibiotics for surgical prophylaxis, atropine and neostigmine, and used almost all the local anaesthetics I brought. I left a good supply of ketamine and vasopressors. I

would suggest bringing oxytocics for obstetric emergencies and a good supply of adrenaline.

There are plenty of intravenous fluids. The giving sets are basic and access to them is by needle only. Some form of three-way tap might help but this should be removed before the patient returns to the ward.

There are plenty of masks, Guedel airways, LMAs and endotracheal tubes. Most are of the single use type which have had multiple uses. Bring your own bougies and introducers and any specialized ETTs that you might need. Laryngoscope blades are of varying brightness and some do not fit the available handles. I left a dozen spare globes, three handles and some paediatric blades.

Spinal anaesthesia was used whenever possible. There are sufficient spinal needles and spinal bupivacaine, however some are out of date.

I took two spare portable oximeters and one of these was used in the recovery area, which is the hall outside theatre. There is a weak suction apparatus there and an oxygen cylinder. The John Hunter department lent me a portable side-stream carbon dioxide analyser/oximeter. Gauging the output of the halothane vaporizer is problematic and a portable agent monitor would be useful.

All the equipment and medication I brought was provided by the Newcastle public and private hospitals free of charge. While the generosity of these hospitals is to be applauded, I do not see this as a viable long-term solution for equipping OSSAA teams to Indonesia. A standard medication and equipment list should be formulated for particular teams and any shortfall purchased by OSSAA.

Peter Armstrong discussing anaesthesia with local doctors

DR SHANTA VELAIUTHAM (Surgeon/Interpreter)

DR VIJAY BALASUNDARAM (General Practitioner/Interpreter)

After a short trip home to Penang, we arrived one day earlier in Kupang on 31st July 2013. We travelled via Jakarta-Denpasar-Kupang. We chose to arrive a day earlier to maximize the time at Halilulik.

The generosity, kindness and hospitality of the West Timor people was overwhelming throughout the trip. Sister Marceline and Ella met us at the airport at about 1 pm and we had lunch at the convent in Kupang. Our trip to Halilulik was due to depart at only 4 pm. The sisters ensured we were well fed and rested before the 6 hour journey to our final destination. They even stocked us with water, lollies and food for the trip. The road to Halilulik was mostly in good condition albeit windy and hilly. We arrived at 10.30 pm and were welcomed by Dr. Intan and Dr. Ilona at RSK Marianum.

Our room was very clean and tidy. Basic amenities were provided – towel, toothbrush, toothpaste, soap and a pail each. The room was also well stocked with bottled water, cans of coke and Bintang beer. The windows and bed were covered with mosquito netting. It was more than what we expected and more than adequate for this trip. We had no issues utilizing the outdoor amenities which were conveniently located outside the rooms. Having our laundry done by the hospital staff was an unexpected bonus.

The rest of the team was due to arrive about 1pm the next day. We commenced the screening/triaging process the next morning at 8 am. Dr.Sillar had briefed us about what the process entailed. Despite this being our first trip, we were able to settle in easily and had screened about 40 patients before the team arrived. The staff at the polyclinic was an enormous help in ensuring a smooth screening process. The benefit of the experience gained from previous OSSAA visits was evident.

Some of the medical team outside the theatre complex

Having two surgeons and a general practitioner enabled us to concurrently run the major theatre and minor theatre cases, as well as provide consultation to outpatients that were coming in daily. One of us would constantly be available to assist the junior doctors (Dr.Rudy, Dr.Intan and Dr.Ilona) with the emergency surgical admissions. The young doctors also approached Dr Vijay to discuss problems involving some medical in-patients. This provided greater teaching opportunities in both the medical and surgical field. Other junior Indonesian doctors who run the government mandated health clinics also joined us during this visit. These doctors assisted us in all the operations and we supervised them performing minor procedures as well assisting with skin closure.

Both of us were able to converse in Bahasa Melayu, a dialect very similar to Bahasa Indonesia. The ability to converse directly with the patients, local staff and doctors was a definite advantage. It provided us insight into the workings of the local healthcare system as well as the challenges faced by the local doctors and hospital staff. We gained a better understanding of the social and cultural issues involved in the overall management of patients.

I would like to thank Dr.Sillar and OSSAA for allowing me to participate in this trip. Having a senior surgeon around to provide insightful advice and experience on managing complex surgical and social issues with limited support and resources was useful. My previous working experience in Malaysia allowed me to easily adapt and work in an almost similar environment. It was a positive experience for both of us and we would readily put our hands up if given the opportunity again.

Overview

This visit to Halilulik went well and was appreciated by the patients. The wide area from which patients come is indicative of the reputation which OSSAA has developed in West Timor. The problem of many patients preferring treatment by traditional methods (a big problem in Timor Leste) presents challenges for follow up and patient review. It is disappointing that most patients identified by Brian Miller on his last trip, as to needing surgery this time, failed to arrive.

There are now at least 4 young doctors we have mentored in West Timor undergoing surgical training in Indonesia and it is hoped that some may return to the Halilulik area so that surgical capacity building can be enhanced by visiting OSSAA teams.

It was invaluable having Shanta Velaiutham on the team as an Indonesian speaking surgeon and her husband Vijay as a general practitioner being able to provide the broader skills that are often needed.

The enthusiasm shown by the Sisters and staff associated with the hospital for the OSSAA program continues to be overwhelming . If the proposed new hospital becomes a reality then it is likely that there will be an ongoing

demand for extended services to the Halilulik area until the local capacity has developed further.

I would like to again thank Dr Stephen Braye and the pathology staff at the John Hunter Hospital for their generosity in processing and reporting on the specimens we have brought back for evaluation.

Dr. Bob Sillar
Team leader

The two team leaders sharing a light moment