Military & Hospitaller of St Lazarus of Jerusalem
Grand Priory of England & Wales
Commandery of Wales

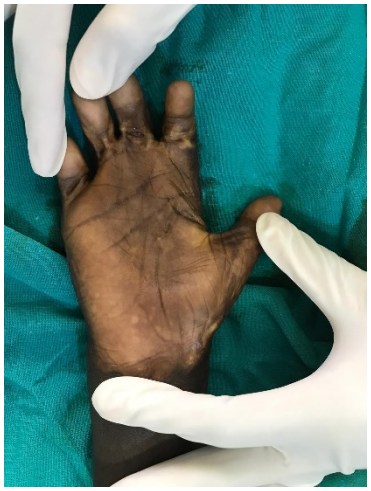
Bursary Student Elective Report 2019

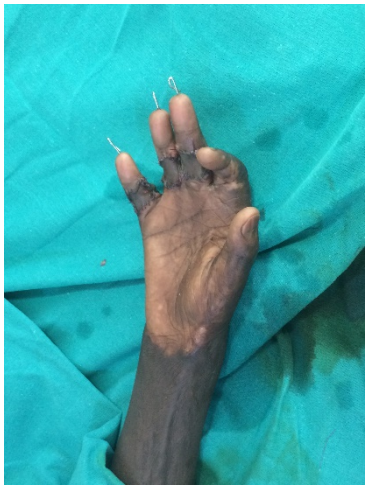
Plastic surgery elective in Comprehensive Rehabilitation Services in Uganda (CoRSU) – Week One

DAY 1

Today was my first day of placement. We started early, leaving at 6.45 am to beat the traffic. Kampala was so beautiful early in the morning! We started the day with a ward round, and then went to theatre. First there were two cleft lip repairs in babies. Next was an 11-year-old girl with a swelling over her left leg, which had been there for about 2 years, but was now causing so much pain that she didn't want to go to school. She was a bit distressed before the anaesthesia but calmed down after some reassurance. She told me that she loved school and that her dream was to be a dentist! A preliminary ultrasound suggested that the lesion might be venous. However, it turned out to be a much less risky lipoma, which was removed and sent for biopsy. The final case was a 5-year-old male with a burn contracture of his 3 right ulnar fingers. This was repaired with a skin graft and the fingers were fixed using k-wires.

11-year old girl with lipoma, before the surgery





Before and after the burn contracture surgery

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DAY 2

Today we started with a ward round to check on the patients that were operated on yesterday. They were all doing really well! The girl who had the leg lipoma was much happier than yesterday and looking forward to going back to school. First on the list was a bone transportation. The patient was a 27-year-old female who had been involved in a road traffic accident in 2014. She had broken both of her legs in the accident. As she had not been able to afford to go to the doctors, she had gone to see the traditional bone setters.

Talking to one of the doctors at CoRSU, this is a common occurrence, as they are more affordable for most people, however, they can lead to horrible complications such as gangrene, or a septic bone, such as what this lady subsequently developed. When she came to CoRSU, she had infected, and very damaged bone. The best way to repair the defect was to use a distractor, which is a specially built metal cage that goes around the leg, and an osteotomy. Following surgery, the distractor is then turned so that the proximal femur moves down to cover the defect. This is done very slowly, at a rate of 1mm per day, which gives the new bone time to form in the gap left near the site of the osteotomy. The defect must not be greater than 5cm, as the tendons will not be able to stretch much further than this. Seeing the surgery was amazing. It is such a clever idea!

After the bone transport surgery was done, I was able to have a go with the microsurgery kits used to train the plastic surgery trainees. I had a go at doing micro-sutures and threading some needles using a tiny 9/0 suture. It required a lot of concentration. A plastic surgery registrar from England kindly gave me some helpful tips and advice, and I improved my skills a lot!

The road traffic accident patient's leg in a distractor cage after the surgery

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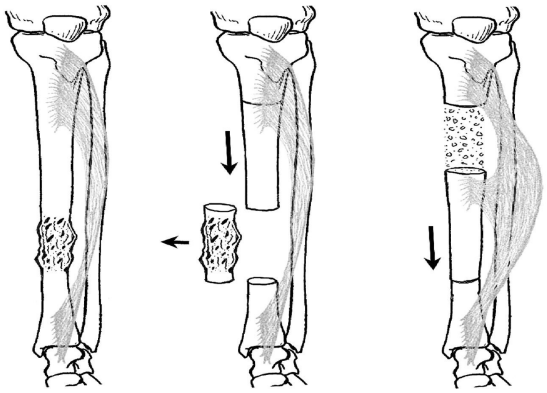


Having a go at microsurgery – concentrating very hard!

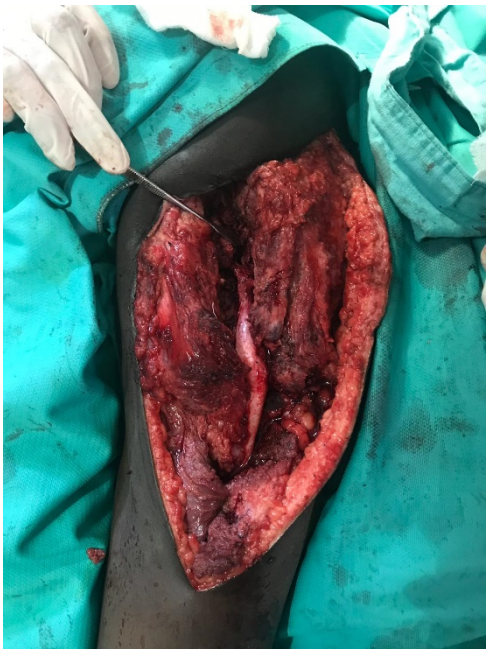
A diagram of bone transportation surgery, although our patient had a damaged femur, rather than tibia as shown here (https://www.jbjs.org)

Today began with a complex case. A 14-year-old girl from Sudan with a recurrence of a desmoid tumour. She had previously presented 2 years ago with a right gluteal mass. The recurrence had was in the right side of the body, in the thigh.

The girl understood the risk of damage to the sciatic nerve and the need for total removal of the tumour to prevent it coming back. The family were not so happy, and a lot of discussions had to be had before they were willing. In Uganda, a child of under 18 is unable to consent to a medical procedure, even if the they are considered competent to understand. Therefore, it was vital to convince them to go ahead with the treatment.

The final case of the day was that of a 26-year-old man who had sustained a nasal defect following a road traffic accident. He had had a Tagliacozzi operation, first described in Italy, in the 16th century! A common method in the UK for this kind of reconstruction is to use a forehead flap, but in darker skin this can leave a very unsightly scar. This operation was to divide the skin joining the donor site (the inside of the arm) and the nose. My suturing skills were put to the test, as I was asked to suture a part of the patient's arm wound.

Miriam Nyeko-Lacek



The desmoid tumour during the surgery. Shown in the middle is the sciatic nerve, which we are trying to preserve.

Suturing during the division of Tagliocozzi operation

DAY 4

Today we had clinic. I met a patient, a 32-year-old Congolese refugee, with a recurrence of an ameloblastoma in his jaw, despite a previous total mandibulectomy. He needed surgery to remove it a second time as it had grown very large (his face appeared very swollen) and a reconstruction of the jaw using a fibula free flap. These operations would cost 8 million Ugandan shillings (about £1600), which he could not afford. The surgeon told him to come back anyway, as he could see the hospital social workers, who are able to reduce the bill for someone in difficult circumstances, and that we could also apply for funding set up for cases like this. I was glad that there was support available for someone like him, as it is not always the case in countries like Uganda where the healthcare system is largely dependent on private income.

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The outpatient department at CoRSU

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