Sri Lanka

The trip to Sri Lanka was to link with an organization with a related focus, to evaluate the program and learn lessons to help the Kind Cuts for Kids Foundation develop.

In 1995 Sri Lanka (formerly Ceylon) was a country of 16 million people with a Buddhist, Singhalese speaking majority and significant minority groups of Tamils, Christians and Moslems, with the Tamils being the largest of those groups. The country has a long and colourful history, having been settled initially by the Veddhas and later invaded by the Buddhists from northern India, around the fifth century BC, and two hundred years later by Tamils from Southern India. The country came under the rule of the Portuguese in the 16th century, the Dutch in 1638 and the British in 1795, finally achieving independence in 1948. Racial unrest peaked in 1956 when Singhala was made the sole official language. The Singhalese government continues to largely control the eastern region, but the north, until recently, has been mainly under the Tamil Tigers, who aim to establish an independent Tamil state. Medecins Sans Frontieres (MSF) commenced providing surgical, medical and nursing facilities to the northern and eastern regions of Sri Lanka in 1986, an area which has been in a state of civil war since 1983, when 40,000 Tamils fled to Southern India. The then recent hopes of a peaceful settlement with the election of the new Prime Minister were shattered when a suicide bomb attempt successfully damaged a significant portion of the Sri Lankan Government's Navy and a Government plane was shot down by the Tamil Tigers.

The escalation of violence necessitated the continuation of the MSF involvement in the town of Batticaloa, on the east coast. The town has a population of 42,000 in a district of 500,000 people who are served by a hospital with Obstetric, Paediatric, medical facilities and five surgical wards of 25 beds each, four acute admission wards and one for those needing long-term hospitalisation.

During the mission clinics were conducted twice per week. The patients were seen in order of attendance, according to a numbered card which was handed out on arrival. On Tuesdays, 40 new patients and 70 reviews were seen and on Saturday a further 70 reviews were attended to. The consultations all occurred in the one room around a common table with two curtained areas adjacent. History taking was often a community affair particularly as the waiting queue of patients was inside as well as outside the room. Some patients were sent from the general clinic directly to the ward, such that the first surgical review of a number of cases occurred on the ward.

The total number of surgical admissions for June was 814, of which 34 were transferred to Colombo. The transfers included patients for Ear Nose and Throat surgery, those with major injuries (particularly of those in the armed forces), a boy with 40% burns and two children with malignancies. A number of the 34 cases were returned for on-going management of conditions previously treated in Colombo. Unfortunately there were often lengthy delays in arranging such transfers.

There were several admissions of minimally injured people who claimed to have been harmed by either the army or the police and there was a small number of non-operative, significantly injured patients with similar stories, as well as those needing surgery for injuries sustained in the conflict.

Armed guards were always present in the hospital, but the number and the apparent level of tension increased when there were wounded soldiers in the hospital wards.

During twenty-five days in Batticaloa General Hospital, the MSF surgeon was involved in 263 operating room visits, involving 272 operations on 248 patients, with multiple procedures under one anaesthetic and returns to theatre included.

Operations were performed every day of the mission. Twenty-five patients (10%), with 33 theatre episodes (13%) were patients injured as part of the conflict. The over-representation of the theatre episodes related to the need for repeat debridement of gunshot injuries in these patients. Eighteen (72%) of the conflict injuries were to civilians.

Ninety-three of the operative sessions were elective surgery and 170 (65%) were emergencies. An over-representation of younger patients (30% were less than 11 years old) was because of the surgeons subspecialty interest, the high proportion of children in the Sri Lankan community and the high incidence of abscess management.

One hundred and sixty-three (66%) operative patients were male and the greater number of males related to the number of inguinal hernias performed and more males being injured in conflict and civil violence.

There were three deaths: two were related to uncontrolled sepsis and the third to old age and probable electrolyte imbalance. Complications were otherwise minimal - one patient had a wound breakdown after a faecal fistula closure, a milk fistula developed after drainage of a breast abscess and femoral fractures often had poor alignment after management in traction. Overall, the complications were acceptable, given the limited resources.

It should be noted that these data do not include either those cases managed in the ward under local anaesthetic, or the roughly 100 additional operative cases treated by the senior house officer in theatre.