

Bangladesh – A day in the life

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The Kind Cuts for Kids Foundation improves health outcomes for children with diseases needing surgery, particularly those conditions that are general surgical and urological, by teaching in developing countries, while concurrently treating children. A very significant part of the program is teaching the role of appropriate use of investigation. Thus the availability of inexpensive ultrasound equipment, with the appropriate skills to use the radiological hardware, is a common and repeated message to the donors, and those there to learn diagnosis and treatment.

How fitting then to tell the story of a day in the life of a visit to Bangladesh, from where I have just returned, to those interested in art, craft and medical application of ultrasound.

The trip to reach Bangladesh typically takes most of a day. Whether you go via Singapore or Honk Kong, there are delays between flights and, whichever way you travel, Bangladesh is always confronting when you get there. My recent return was after the ninth visit of the Kind Cuts for Kids Foundation, during which we reviewed 36 patients, and performed 30 operations on 12 patients. The work was carried out in one of the major teaching hospitals in Dhaka, a city of 20 million people, with the help of several both junior and senior medical staff.

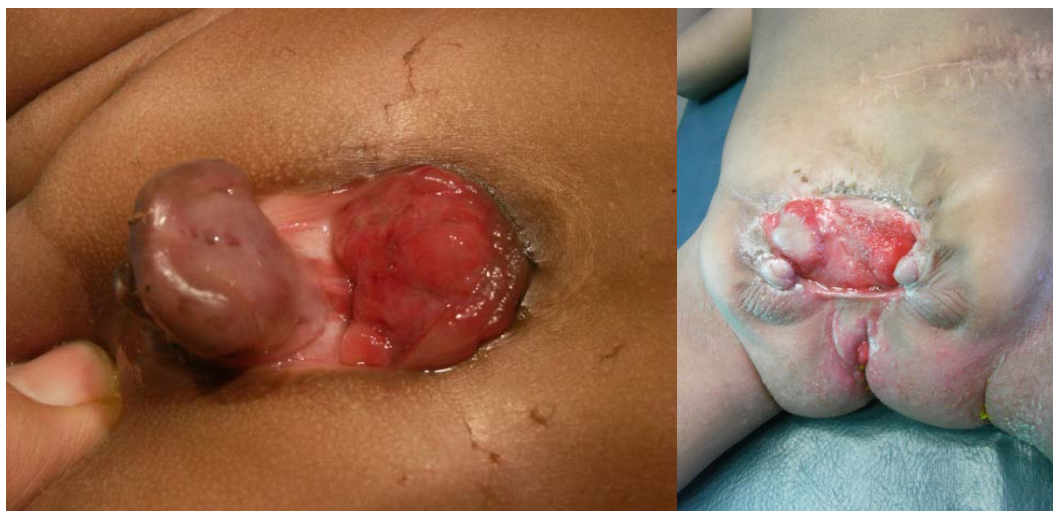
The days usually started, by try to keep pace with life in Australia; emails to answer, reports to write, meetings to arrange, and the next visit to coordinate. A quick breakfast is followed by a greeting from a polite grandfather who comes with his driver and his Toyota van. We drive through heavy traffic, on a journey that can take up to 15 minutes – to cross the road. I take the car; it would be too dangerous to walk. The Hospital, known as BSMMU, is notified in large letters over the entrance; named after one of the countries heroes. His photos are everywhere. Crowds pour into the building before the fasting season starting time of 9 o'clock.

Wednesday was the third day operating in the hospital, working with the Paediatric Surgeons, but also consulting on adult urology cases. Leading up to that eventful day was full of expected surprises. Sunday, I had been met at the airport by a cardboard sign with my name on it that allowed me to walk past the queues in passport control and customs. The name board was accompanied by several men of differing levels of airport security importance, but all were essential for my uneventful passage, which was, by then, midnight Bengali time and three o'clock in Melbourne. It helps to have people at many levels that have children who need special care.

After a brief sleep, it was morning in Dhaka, and time to start seeing an incredibly large collection of patients; incredible for the numbers of patients, given the visit had only been organised 4 weeks before, and incredible for the assembly of major pathology.

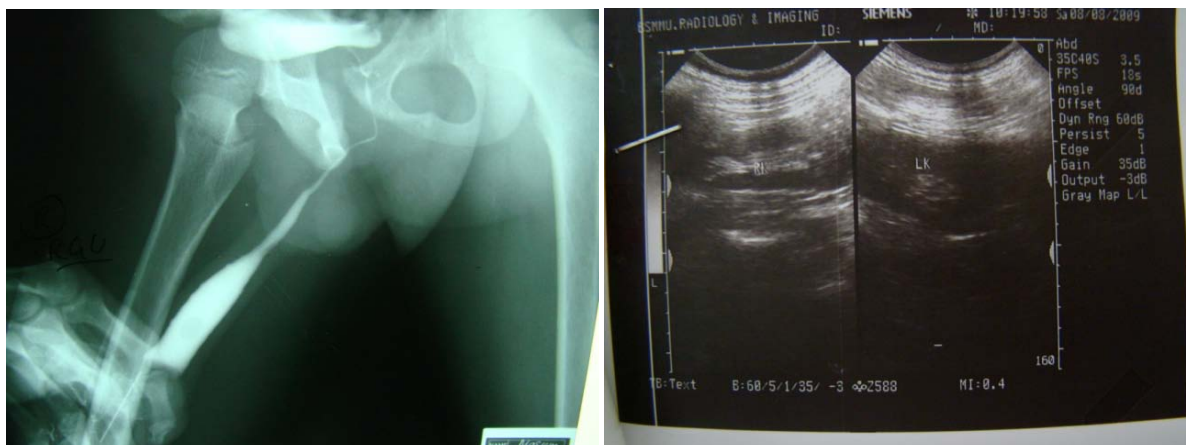
In the office of the chief paediatric surgeon, the children, most with bladder exstrophy, were ushered over to a bed in the far corner, through the crowd of surgeons who were there to listen and learn. Sometimes the discussion with the previous patient hadn't concluded before another major anomaly was being unveiled for review.

The left picture is a boy with neonatal bladder exstrophy and the right is a boy who has cloacal exstrophy.



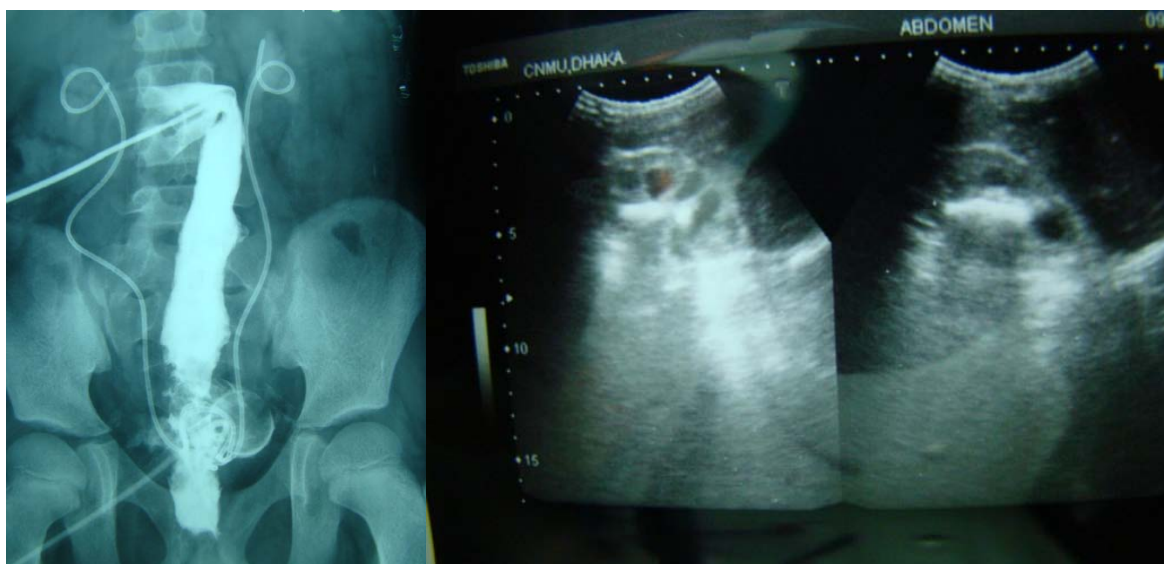
The families came with hope, a bundle of x-rays and the child's old notes. Some were new to me; many I had seen before. As they are virtually all paediatric Urology patients, the radiology is an important part of the evaluation and care of the patients. Since 1993, my first visit, things have improved. We now see images of the ultrasound, but usually only a single view of each kidney and bladder. Previously there was no hard copy. Those with an MCU usually have a radiograph of a hand

thrown in for good measure. Retrograde urethrogram, not a technique we often use in Australia in children, seems a hard habit to break.



The above images show the renal ultrasound hardcopy of a boy with normal kidneys and a duplex urethra, the orthotopic of which is associated with a megalourethra and penis, and the x-ray of which shows a hand during a retrograde study in a young boy.

That day, the visit to the hospital ended with the review of a contrast study through the distal end of an upper abdominal transverse loop colostomy. Contrast came out through the anus, the multiple perianal fistulas, the permanent suprapubic catheter and, for good measure, a little came through the urethra. The DJ stents seen on the left radiograph had been present for months and had become calcified, obstructed, and surrounded by a staghorn calculus on each side. Sadly, that boy's surgery was cancelled because the power supply was going to be shut on the day of his planned surgery. It may not be done until March next year.



Many pictures could be added, just from this trip; the kidney rupture during the MCU, the hospital sterilizing system; the beggars on the road; the crowded buses; the crowded ward; the crows; the heat; the noise; the smells. However, even I don't feel the same looking at the pictures as when amongst the reality, it is so extreme you just have to be there. And if you feel are able to go, you will love it, and if you do like it, you will want to return. It is one of the places you will find where, as Dr Padma Rao would say "their smiles reach their eyes".

The day ends with trying to keep pace with the reality of working in Australia and ensuring that others are encouraged to reach out and assist with the poverty and privation that seems impossible human suffering. I go to sleep wondering how the human form endures the hardship that so many are inflicted by in Bangladesh alone.