
A project of Kind Cuts for Kids,

supported by

University Clinical Center of Kosovo

And

Oceania University of Medicine

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ADD PHORO

## Introduction

Since 2011, Kind Cuts for kids has undertaken 27 country visits to the Balkans, of which 12 have now been to Kosovo. The involvement in the region was stimulated by a recognition that patients being transferred to Australia could be cared for in the Balkans, and that surgery in the country of origin will help empower Balkan Paediatric Surgeons, while giving world's best practice care for the children. Why so many years? Unfortunately, the challenges are great and the duration of the visits brief, and the much-needed resource and system changes have not occurred. A particular feature of this visit was the need to remediate poor outcomes that have arisen from patients having substandard care after seeking treatment outside Kosovo.

## Clinical care

Xxxxxxxxxxxxxxxxxx During the two week visit, which included a student from the Oceania University of Medicine as part of the Kind Cuts for Kids team, a further 36 patients were added to the individual cases seen in Kosovo, taking the total to 300 for the 12 years.

In 2022, 67 patients have been reviewed, 31 of whom have had an operation, during a total of 35 anaesthetics. The recorded contact episodes were 167, although not all ward encounters were noted. Never-the-less, the outpatient and ward encounters totaled 96. And, the number of operative procedures was 71, as detailed in the table, noting that the majority of operations related to anorectal and genital anomalies.

| | |
|---|---|
| Cystoscopy | – 7 |
| Examination under anaesthetic | – 7 |
| Laparotomy | – 2 |
| Pena related | – 12 |
| Hypospadias related | – 18 |
| Ureteric reimplant | – 4 |
| Removal Malone Monte Stoma | – 2 |
| Mitrofanoff stoma | – 1 |
| Ureterocele incision | – 1 |
| Pyeloureterostomy | – 1 |
| Inguinal herniotomy | – 2 |
| Gonadal Biopsy | – 2 |
| Laparoscopy | – 1 |
| Repair of vesicovaginal fistula | – 1 |
| Other | – 5 |

These three boys had surgery after adverse events from previous anorectal operations. All with good results on this occasion.

## *Clinical care … Patient Diagnoses*

| | |
|---|---|
| Anorectal anomalies | – 13 |
| Hirschsprung | – 5 |
| Megarectum | – 4 |
| | |
| Hypospadias | – 21 |
| Disorder of sexual differentiation | – 4 |
| Aphallia | – 1 |
| Renal | – 13 |
| | |
| Spina Bifida | – 3 |
| Other | - 3 |

Two cases that particularly highlight an improved variation in practice were the two girls with vesicoureteric reflux, both of whom were managed without the insertion of a urinary catheter, enabling the first to go home on the day of surgery, and the other to return home within 24 hours of her operation. Recent research from the Oceania University of Medicine indicates that 58% of surgeons leave a catheter in for more than 48 hours, which is unnecessary.

To highlight the need for robust clinical review let us list the events that indicate less than ideal outcome. Firstly, the adverse events that occurred during the visit - one was the blockage of a catheter, that required a separate anaesthetic, the other was the incision of the urethra during an anorectoplasty that was remediated without complication. Both problems were solved easily.

Events that had occurred for patients before their surgery included:

1. Previous dilatation through an anorectal anastomosis, then a probably unnecessary colostomy in another country more recently.
2. A boy had the position of his two colostomy stomas in the incorrect position, and had a posterior approach to find his rectum without completion of the procedure.
3. A boy with hypospadias had a significant failure of an attempt at first stage of a staged procedure.
4. Another hypospadias patient had been left with the need for a minor procedure after a previous KCFK visit, but the further surgery resulted in virtually complete, and prolonged, obstruction.
5. A second patient who had had surgery out of Kosovo, with an outcome that may have resulted in his death, was left with the need for high risk surgery (which was successful).
6. A third such patient had an operation to divert his urine via his umbilicus in another country … which was NOT necessary. Investigation and intervention have remediated the situation.
7. Late presentation of pyloric stenosis resulted in misdiagnosis and higher risk intervention than might have otherwise occurred.

## Equipment Issues

A great leap forward for the care of children with surgical disease has been made with the opening of the New Building (images below), with the notable feature of the excellent infrastructure in the wards and theatre. However, there continues to be a number of system issues and problems of the supply of disposable medical equipment.


Two particularly positive features of the new hospital are the lights in theatre and the ultrasound machine in the ward clinic; as well, there has been an improvement in the endoscopic equipment available. However, the following are of concern, and would require little investment to ensure better outcomes for the patients:

1. Surgical gloves should be without powder.
2. Disposable gloves, for more common, use are cheaper than sterile gloves as now used when non-sterile gloves are required in theatre.
3. Lure-lock syringes are safer for the user but are not readily found in theatre.
4. Finer sutures are more expensive, but not when complications that occur because of their lack of availability is considered.
5. Fine needle point diathermy tips are essential for good Paediatric surgery.
6. Small size and SILICONE-ONLY urethral catheters should be available.
7. Water should be used for all urethral catheter balloons but is not available.
8. Fine feeding tubes for hypospadias repair are not supplied.
9. Hand hygiene in the ward is not common practice – and is essential.
10. The currently available urinary catheter bags are not fit for Paediatric Surgery, and are not adequately managed - often sitting in a relatively obstructed position.
11. An IV bung was a solution to a leaking cystoscope!
12. The notes and Xrays are often not readily available at the induction of anaesthesia, and there is no time-out process to review the intended intervention.
13. Monitoring of funding for overseas care appears to have been lacking.
14. Adverse events do not appear to generate review and change.

## Donations of Equipment

As usual, a range of equipment was provided, including sutures (supplied by BBraun), urethral catheters, feeding tubes and diathermy tips, to name just some of the almost $15,000 of donated equipment, as see in the case (left).

## Media Coverage

Once again the media were very supportive of the project, as was the hospital media department. The cooperation will help promote improved care for children.

## Recommendations

1. An audit of cases, and outcomes, ***of Paediatric patients who have gone to another country*** for urology and general surgery should be undertaken.

2. A audit system for Paediatric Surgery and Urology should be put in place for care in Prishtina, with reporting to a monthly morbidity and mortality surgery department meeting, and reporting of sentinal events to the Department of Health.

3. The supply of disposable surgical and ward equipment should be reviewed with consideration of items that would appropriately be added.

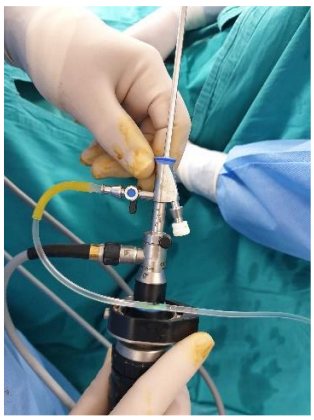
4. Multidisciplinary meetings, including clinicoradiology meetings, should be held to assist with patient care.

5. To assist with the development of the clinical management and organisational aspects of the department, an external review would be appropriate, which should include staffing arrangements.

6. Steps be taken to ensure there are sustainable levels of nursing and technical staff in theatre and the wards.

# *The Pictures Tell the Story – The Work*








# *The Pictures Tell the Story – The Patients*