SAJS News

OPERATION HERNIA, GHANA

The Takoradi Team
Marianne, Sandie, Ester, Simon, Frances, Sammy, Linda, Rebecca, Roy, Monica, Michael

In the last *SAJS* we reported that Professor Sandie Thomson had recently taken a small team, including representatives from the ASSA and PAAS, to Ghana, to undertake hernia operations in rural areas. The following are extracts from Professor Thomson's report on the venture.

The initial request to participate in Operation Hernia, Ghana was through the British Hernia Society from its president, Professor Andrew Kingsnorth. He approached me because of a previous contact we had had when I hosted him as our visitor at the SAGES Annual Gastroenterology Congress several years ago. He also did part of his postgraduate studies in Cape Town.

We settled on a team of four individuals. The members were myself, from the Department of Surgery at the University of KwaZulu-Natal, Simon Maseme, the chief surgeon at Prince Mshyeni Hospital, Linda McKenzie, the theatre matron from Addington Hospital, and the most senior member, Roy Wise, from private practice. Sponsorship from industry came from Life Care Hospitals, Johnson & Johnson from their Ethicon Division, Perryhill International, who contributed R25 000 to the project, as well as a variety of different mesh products and sutures for use in Ghana worth a similar amount of money. AstraZeneca kindly donated a significant quantity of local anaesthetic.

We worked at two hospitals. One, Takoradi Hospital, was a district hospital with a rather dilapidated exterior. It is the home of the hernia project and on the second floor there is a converted ward which serves as a reception assessment area, operating theatre and recovery room. The other hospital was the Ghana Port Health Authority (GPHA) Hospital, which is a small semi-private institution run by two doctors, one of whom is the main local instigator of the project and chief medical officer, Dr Bernard Boateng-Duah.

Our first adult clients at GPHA Hospital

We serviced both hospitals simultaneously, which meant we had to split into two pairs. At the GPHA we had three trainees who participated and performed part of the hernia repairs that we did there. During the six working days we did a total of 61 procedures – three incisional hernia repairs, one bilateral hydrocele and 57 inguinal hernias, four of which were in young children, and all but two were indirect hernias. The ages ranged from 2 up to 90. There was one return to theatre, of a large incisional hernia repair, for evacuation of a haematoma. This was 48 hours after the repair, which fortunately we had done on the first day of our visit. It highlighted the need for suction drains, which we had not brought but would have been an asset. My *pièce de résistance* was a 90-year-old who had half his intestine in his right inguinal scrotum, and I decided that discretion was the better part of valour and to sacrifice his right testicle. Fortunately, he made an uneventful immediate recovery, and when I saw him the next day he had a very broad smile on his face. It might have been because he had a very pretty nurse on his arm but I liked to think it was because his appendage had been returned to its rightful location!

We also operated on a complication of a giant inguinal scrotal hernia, which the Spanish team who had finished their stint two weeks previously had repaired. It reflected some of the problems with handing over these far-from-straightforward and long-standing hernias to the local resources at the institutions. This aspect needs a more formalised commitment from the local surgeons, who need to be involved in seeing and, if necessary, treating the complications. It is unrealistic with these types of hernias to suggest that they will all have an uncomplicated course.

ASSA NEWS

Peer review process

ASSA is offering a peer review process, and has set out guidelines to be followed.

ASSA's involvement is aimed primarily at creating a corrective and enabling environment to avoid possible further actions. If the surgeon is receptive to the peer review, corrective actions will be instituted and the matter will be regarded as successfully concluded. If the surgeon is antagonistic, reactive and recalcitrant to the peer review, a report will be formulated without his/her input and submitted to the complainant and the ASSA chairperson.

No further action will usually be initiated by ASSA and it will be left to the complainant to determine if the matter will be pursued further.

To initiate a peer review a letter of request should be submitted to the ASSA secretariat.

New ASSA secretary

The new secretary of ASSA is Marge Greyling. She may be contacted at: ASSA Suite (c/o SAMA Office), Donald Gordon Medical Centre (East Entrance), 18 Eton Road, Parktown, 2193, tel: (011) 484-9571, 0860 SURGEON, cell: 082-507-1159, fax: (011) 482-2336.