3rd Mission Report SpineCare@CURE Uganda

Monday 1st until Wednesday 3rd February 2016

2nd Mbarara Neurosurgical Camp

Belgian team: Ricky - Hans - Katrien - Dirk
Ugandan team: David – Alex – Tom – Andrew

Sunday 31 January 2016

Arrival in Mbarara and quick stop . Katrien took to lead to deliver all the medical supplies and instruments we were able to carry with us.

In the evening we met again with the nurses Tom and Andrew and dr. David Kitya for dinner and discussions.

We regretted the smaller team as 2 members dropped out only 3-4 days before the start of the camp, not allowing us enough time to find replacements.

At MRRH most of the neurosurgical procedures remain trauma (mostly due to motorcycle accidents). A dedicated neurosurgical theatre everyday would allow more elective cases. The current department of neurosurgery however at this moment only consists of dr. Kitya and the 2 nurses Tom and Andrew, making them continuously on call.
We strongly support the transfer of dr. Alex from Mulago Hospital, Kampala, to MRRH.

Another important discussion are the neurosurgical camps of Duke University, dr. Häglund and the Spinal Surgery camps of the Texas Back Institute, dr. Liebermann.
Would it be possible to join forces of all three teams to increase quality and maintain continuity in care???

Hans, independent sales manager for Nuvasive, mentions that the Duke team also cooperates with Nuvasive. The first contacts with the Nuvasive Spine Foundation have already been made. Mr. Pitchou from Nuvasive headquarters joined the former team.
Bryan Cornwall, director of the Spine Foundation has been updated by Hans a couple of weeks ago in San Diego.
A micro discectomy set, worth 20000 $, has been promised to the Mbarara Neurosurgical department.

A short overview of the surgical program was given. One of the problems we encountered is the lack of anaesthesiological medication. If patients cannot provide for it, the surgery has to be cancelled/postponed.

Monday 1 february 2016

The camp started at the emergency department where we saw and discussed some trauma and postoperative cases. We continue to the private ward and surgical wing to see the surgical cases for the camp.

Once the patients were seen the agenda for the next three days was made. Several outpatients were present for a joined outpatient clinic. Surgical and non-surgical advice was given.

One patient with a herniated disc was decided to be a surgical case, but preferred to go to India or South Africa.

On our way to theatre we met the hospital director with whom we had a short meeting .

We transferred to theatre to start up the first surgeries. Unfortunately there was no anaesthesiologist available so we had to postpone the surgical camp to the next day.

An elderly lady with a large olfactory meningioma or tuberculum sellae meningioma could not be operated due to lack of time.

The Belgian team decided to visit OURS, a community based rehabilitation center for spina bifida and hydrocephalus children to hand over the package provided by IFSBH . At present there were no admitted children, only outpatient evaluations and treatments. We got a guided tour along the facilities.

Pediatric catheters are needed and we promised to try and gather some in the coming year for the next mission.

Next we transferred to the Ruharo mission and the eye clinic, where we met dr. Keith Waddell, British Ophtalmologist, residing in Uganda for 52 years. We visited the clinic and discussed some cases. Everyone was impressed by the tremendous work he has been doing. The clinic treated last year over 80 retinoblastomas, a very rare tumour of the eye in the western world.

He proves that also in Uganda, with limited resources certain malignant tumour can successfully be treated. In early stage and diagnosis eye saving therapy is possible, in later stage removal of the eye, together with bleomycin is necessary.

Everyone agrees on the absolute necessity to provide a prosthetic eye to avoid outcasting the patients from the community.

Currently he has enough funding from an English family to cover the cost to run the clinic.
Additional funding would be beneficial for continuation of the project, as governmental support seems rather unlikely.

Tuesday 2 February 2016

At 7.30 we can start up surgeries in 2 theatres. We decided that dr. Alex would start up a craniotomy for a left frontal lesion. Total removal of the lesion was planned, but as we opened the dura the brain tissue seemed to be rather normal and we decided to do a large biopsy without risking motor deficit.

Parallel to this case we did a 2-level lumbar decompression in a lumbar lateral recess stenosis. Sister Leocardia, the patient, underwent ACDF by the Duke team a couple of months earlier.
CT scan showed a good reconstruction and decompression at the C5C6 level.

Next case in theatre 4 was a bilateral chronic subdural hematoma, surgically treated by a bilateral burr hole. Old blood evacuated under pressure and being a young patient the brain expanded nicely so no cavity was left.

Dr. Ricky held a clinical presentation of the cases to the medical students present in the available time.

He suggested the creation of a subcutaneous pouch for further drainage of the subdural space to avoid external drainage for 48/72 hours.

The next case was a multilevel cervical spinal stenosis in which we performed a classic cervical laminectomy C2C7. Luckily the patient still had a lordotic cervical spine, so no necessity for laminoplasty or lateral mass reconstruction.

The last procedure for the day was a young female patient with a right cerebellar hemangioblastoma. On the CT-scan a second lesion at the craniocervical junction on the left side was shown. The lesion was contrast enhanced and non-cystic on the posterior side, so we all thought it being a meningioma.

After dr. Alex opening the posterior fossa and removing C1 the dura was opened and dr. Ricky took over exploring the posterior area. There was no clear meningioma, only aberrant blood vessels overlying the spinal cord/brainstem.

During the (careful) exploration there was bleeding necessitating the removal of the lesion. Clinically it seemed to be a non-cystic hemangioblastoma. Once finished we concentrated on the cystic lesion. A small corticotomy was made but the lesion was not retrieved. We switched to a puncture with a cushing needle helping in the approach to the cyst a bit more cranial and lateral. Once the cyst was opened, the orange looking lesion could easily be removed. Hemostasis was easy for the cystic lesion but the brainstem lesion caused some more problems of bleeding. Eventually hemostasis was possible with Floseal and lowered blood pressure.
The calm continuation and patience to finally reach hemostasis of dr. Ricky seemed to have impressed dr. Alex and the rest of the people present.

Wednesday 3 February 2016

The final day of the neurosurgical camp started at the emergency department. Several new cases were admitted. One trauma case that was presented should be discussed, as it would be the last case treated during the camp. A young male was presumed dead after trauma and "thrown away". He was still alive but quadriplegic and brought to MRRH. Lateral X-ray of the cervical spine showed a bilateral facet joint dislocation. As the first patients were already in theatre and anaesthesia started we planned him for an attempt to closed reduction under sedation and full muscle relaxation. Unfortunately all attempts for closed reduction failed and we decided to transfer patient to the ward and start traction for some time. Non-instrumented surgery (not available) was decided not to be beneficial for the patient.

The first case was a 2-level ACDF with iliac crest bonegraft and cervical plate. A good decompression and reconstruction was accomplished.

Hans explained how to manipulate the C-arm to David and Andrew.

Parallel in theatre 4 Dr. Alex and Dr. David started a severe case of right-sided exophthalmia. CT shows an intra-orbital lesion protruding the eye with an intracranial extension. They removed the lesion together with the ophtalmologist.

Around 2 pm the neurosurgical camp came to an end. We promised to come back in 2017 and stay a full week. We should bring an anaesthesiologist and a second neurosurgeon or spine surgeon.

Ricky

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