



MSF Diary (experience from the field) March 2010

My first mission field experience - " Bush knife: the villain of the

land ": Papua New Guinea - The country is beautiful and the people are, in large part, very friendly and well-behaved. But between them there is a very strange form of violence, particularly in Tari, the Southern Highlands Province situated about 2000 meters altitude. The MSF Emergency Surgical Care Unit and the Family Support Centre taking care of the victims of family violence and sexual violence are attached to the Tari General Hospital working in alliance with the Ministry of Health staff.



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After completing my PPD (Pre departure training) course and briefings in head quarters in Europe, I finally landed in Tari on the 12th October 2009 to work in the surgical care unit as anesthesiologist for a mission lasting 6 months. It was exciting with a really nice team of 9 expatriates and the climate is ideal, between 15 to 22^o C: and it rains almost everyday. The so-called town is just an air strip with a few shops around it. The 3 houses for the expatriates are really good, which I heard is rare in MSF settings. Tari Hospital was deserted

doctors for more than a decade before MSF started its endeavor here in 2008.

The MSF surgical unit is teeming with patients and in fact it is not possible to cater the surgical needs of all coming for treatment; therefore mostly the emergency cases were attended to. The ailing ones that baffled me from day one were the victims of violence. There was not even a single day that passed by in the last 4 months since I came without having had a case of violence related injury. The cause of lacerations vary from bush knives, spears, axes, gun shots, stoning, iron bars, sticks, human bites etc. But it is the bush knife chopping that we see the most, almost 3/4th of the total injuries. The type of injuries includes head injury, multiple compound fractures, penetrating injuries in the chest and abdomen, deep lacerations and amputation of limbs. It is for the first time in my life that I have seen many of these injuries. Apart from wounds, the other emergencies that we get include intestinal obstruction, bowel perforation, acute abdomen, ruptured ectopic, C section, bleeding PV, pneumothorax, haemothorax and a lot of abscesses.

When I see a grievously slashed victim I think of documenting it, but when I see another one next day, I set aside my decision to describe the most dreadful one that I see here. Though I have still 2 more months to go, I think I have seen the worst live victim of violence in my career; consequently I am documenting it.

On the morning of 20th January 2010, we were in the minor theatre doing minor procedures as usual. At 9 AM a 38 year old lady was brought to the theatre on a trolley covered from face to foot with a cloth fully soaked with blood. Initially we thought it was a dead body, but when we exposed her face and chest, we could see her chest moving. Her radial pulse was feeble and rapid; heart sounds heard muffled and systolic blood pressure was 70. She was semiconscious and was responding to painful stimuli.

From head to foot she was soaked in blood. Our surgeon who was on morning rounds was also summoned. We managed to put in two IV lines, one on (L) femoral vein and another one on (L) cubital and started running fluids. In about 10 minutes her blood pressure was 90 systolic and she started to bleed from the wounds. She had 5 brutal lacerations, all from a bush knife. Two cut injuries on the back of the scalp one below the other. The upper one (13 cms cut) had gone through her bone exposing the brain matter. Another 10 cms cut below had gone just bone deep. The 3rd slash was on her face on the right side and had severed the lower jaw into two. The 4th one was on the middle of the right fore arm, a near amputation fracturing both radius and ulna. The 5th one was a 10 cms cut on the right mid quadrant of the abdomen through which omentum was sticking out. In addition to these she had multiple small cuts on the fingers of both hands. The most surprising fact was that she was chopped almost 24 hours before. She was living in highlands and was carried all the way through the mountains.

Her wounds were packed for bleeding control by a rural health centre on the way. After stabilizing her she was shifted to the major operation theatre and was prepared for laparotomy and wound repair. The main challenge anticipated was difficult intubation since the lower jaw was severed. Keeping the tracheostomy set ready she was administered general anaesthesia with ketamine induction. Although it was difficult we managed to intubate her and a laparotomy was done. We also managed to get 2 units of blood which was transfused. Inside the abdomen there was no blood and obviously no bowel injury. Laparotomy wound was closed and the abdominal laceration packed after putting back the omentum. Then the



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scalp wounds were sutured after approximating the severed bone, leaving space for blood to drain. The perfusion on the distal part of the cut right arm was fair and the wound was sutured after approximating the fractured bones and the hand was put in a back slab. There was no facility or

expertise in our centre to wire the fractured lower jaw. Hence just bone approximation was done using sutures.

It was 1PM then; the patient was on the operating table for more than 3 hours and her condition was adequately stable. But she definitely required post operative intensive care and repair of the fractured lower jaw. We decided to refer her to the nearest hospital with an intensive care facility. It was Mendi General Hospital which was 5 hours drive by road. She was referred at 2 PM with the endotracheal tube in situ with oxygen, ambu etc. An anaesthetic technical officer accompanied the patient in the ambulance. The vehicle with the patient was expected to reach Mendi Hospital by 7 PM, but there was a road block on the way close to Mendi and the ambulance was stoned. Hence they reached the hospital by 8 PM only and the patient was admitted in the ICU. 24 hours later we heard the good news that the patient is stable and recovering well in the ICU.

Working here gives me immense professional satisfaction and all tributes to MSF, which is widely acclaimed by the people here. If the bush knives could be totally banned in the country the violence may drop significantly. But in a country where 75% of the total land is covered with bush growing more than human height how does it become possible? The country has abundant natural resources and a strong politically motivated Government with firm law and order enforcement in place could change the violent behavior of the people. I wish this would happen at least in the next decade.

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