The Surgeon's Towel — Lost and Found!

by Prof M Kabiruddin Ahmed

The story goes like this: Mr X or Mrs. Y was operated by the famous surgeon A or B. But the patient continued to have pain and other problems. After some time the patient was admitted again in famous C clinic or D hospital and a second operation was done and to the surprise and anger of the patient's relatives "lost" surgical towels were "found" in the abdomen of the patient!

THE Turkish Towel over the decades have replaced the Bengali towel or 'Gamchha' from our bathrooms. There are other towels also. The air-hostess and the waiters of the Chinese restaurants provide small hand towels soaked in warm scented water for mopping hands and face. But less known is Surgeon's Towel.

What is a Surgeon's Towel? They are usually the size of small hand-kerchief, made of several layers of soft cotton cloth with a cotton tape attached to one of the corners. They are used by all surgeons and gynaecologists during surgical operations, particularly in operations in the abdomen. Abdominal operations are very common — such as, removing a diseased gall-bladder (cholecystectomy) or an appendix (appendicectomy), repairing a leaking stomach or intestine, delivering a baby by Caesarian section, removing the uterus (hysterectomy) or removing a huge ovarian cyst etc.

The surgeon's towel is used to mop out blood, pus or other liquids from inside the abdomen or other cavities or to hold and pull out soft organs to get better and clear view of the operation field. It is of benefit to both surgeon and the patient.

The surgeon and the nurse count the number of Surgeon's Towel (also called 'Mop') to be used in the operation before the operation begins and the OT nurse writes it down on a board kept in the OT. At the end of the operation recount is done to account for all the mops before abdomen is closed. To be more careful the surgeon usually clamps an artery forcep to the mop so that it can be easily traced.

The towel is lost

In spite of all these precautions if one or more of the towels get lost it gives rise to a sad story, frequently mixed with some comic undertones. The towel gets lost mostly in the abdomen and the unsuspecting surgeon closes the abdomen leaving them inside. After about 7 to 10 days the skin stitches are removed, the surgeon pats the back of the patient, reassures that everything is alright, that he has taken all possible care to make the patient free from the illness and asks the patient to come and report after a month or so. Nobody told the surgeon that one or more of the surgical towels have got lost during the operation. No body advertises for the lost towel in the "lost and found" section of the newspapers as is usually done for lost certificates, passport etc. Luckily, some time the missing towel is found in the waste-bucket or some other odd places in the operation theatre.

The towel is found

Usually it is another surgeon who gets the credit of finding the lost towel. Now is the time when it makes big head lines in the newspapers, not in the "lost and found" section but in the front page.

The story goes like this: Mr X or Mrs. Y was operated by the famous surgeon A or B. But the patient continued to have pain and other problems. After some time the patient was admitted again in famous C clinic or D hospital and a second operation was done and to the surprise and anger of the patient's relatives "lost" surgical towels were "found" in the abdomen of the patient! The patient then recovered quickly. The rest of the story is easy to imagine. The second surgeon continues to enjoy great publicity till one or more of his own towels are "lost" and found by one of his colleagues — may be by the first surgeon!

The Mop Count

To avoid the agony of the patient and loss of face of the surgeon, it is the duty of the OT Nurse to count the mops before the operation and write the number clearly on a board placed in the OT, and count them again at the end of the operation. If any of the mop is unaccounted for, she must inform the surgeon immediately about the discrepancy.

Radio-opaque Thread

All abdominal mops in most countries, except in Bangladesh, contain a Radio-opaque Thread in it. If a mop is found missing the surgeon immediately asks for urgent X-ray of the patient's abdomen. The Radio-opaque thread of the mop will be visible in the X-ray film and the surgeon will reopen the abdomen and bring out the Surgeon's lost towel before any harm is done.

The Trolley Nurse

It is an international custom that a trained staff-nurse is in charge of the trolley where the instruments and towels are kept and are given to the surgeon when necessary. She takes special precaution about correct count and recount of the mops. In Bangladesh, the number of nurses are much less than the doctors, so in most hospitals and clinics a trainee doctor replaces the staff nurse in the trolley. Moreover, here it is the student nurses who work in the OT on shifting duty and they often leave the OT in the middle of the operation to attend lecture classes. This also greatly contributes to the miscount and loss of the towels.

Although the surgeon shares the responsibility he may be too busy looking after bleeding or other difficult aspects of the operation and may forget to supervise a proper and correct mop-count.

Sometimes these lost Surgeon's towels in the patient's abdomen not only gives rise to prolonged illness but may result in the death of the patient by various complications. To prevent these tragedies the conscious public along with the surgeons should ask for at least two things from the clinic managers and hospital directors.

One: An experienced staff-nurse should be in charge of the instrument trolley who should be responsible for the proper count and recount of the surgeon's towels and other articles used in the operation.

Two: The mops or the surgeon's towels with a radio-opaque thread should be provided for all abdominal operations. Recently, they are being made available in Bangladesh by importing from abroad. The increased cost will be negligible if we consider the agony and loss of money and time of the unfortunate patients, the victims of surgeons' 'lost' towels.

"To err is human, to forgive is divine." Let us all try to prevent this problem by taking all possible precautions and spare ourselves the agony and bitterness that usually follows this tragedy.

Hollows' Vision Helps Restore Sight Around the World

by Pat Fiske

IMMEDIATELY after the ceremonial opening of Eritrea's first cataract lens factory, Dr Desbele Ghebregiorghis took the first lens off the production line, walked it to the operating table and within 20 minutes had restored someone's sight.

It was the beginning of a programme that will soon see similar factories in Nepal and Vietnam and has the aim of eradicating cataract blindness in developing countries.

The only sadness of the occasion was that the man whose vision started off the whole process was not there to see it: Australian eye-surgeon Professor Fred Hollows had died of cancer a year before, in February 1993.

But his work lives on in the skilled hands of Dr Desbele — whose advanced training he organised — and of Nepalese eye surgeon Dr Sanduk Ruit, a close friend and pupil, and in the plans for cataract eradication.

The story began in the 1980s when Fessehaie Abraham — now Eritrean Ambassador to Australia — went to Hollows' Australian clinic with an eye problem.

Fessehaie, resigned to Western ignorance about his homeland, was surprised to find that Hollows knew where Eritrea was and that it had been fighting for secession from Ethiopia for 39 years.

They discused Eritrea's situation then and on many later occasions: the struggle, the politics, the state of public health. Hollows learned that the country had only one eye doctor — Desbele Ghebregiorghis.

Interested in the principles and politics of the Eritrean People's Liberation Front, which advocated sexual equality, land reform, universal education, basic healthcare and religious freedom, Hollows decided to help them.

He arranged for Desbele to go to Australia, which took three years because of the critical military situation in Eritrea.

Fred Hollows was well-known in Australia for his public championing of the health needs of Aborigines in the face of bureaucratic neglect. Now, with the opening of cataract-lens factories in Eritrea, Nepal and Vietnam, he will also be remembered for his efforts to eradicate cataract blindness in developing countries.

By coincidence, at the time of Desbele's arrival, Hollows got the opportunity to visit Eritrea. Travelling at night to avoid raids by Ethiopian MiG aircraft, he was impressed by the battered country's underground hospital and pharmaceutical factory. He performed operations in the hospital and on the battlefront watched hygiene classes in the trenches.

Inspired by this determination under duress, he returned to Eritrea three times. It was during his work there that he became committed to action against cataract blindness.

Cataracts cause the lens of the eye to become opaque. An estimated 40 million people suffer from this totally reversible condition. In many areas treatment is not available; in others, the cataracts are removed and thick "Coke-bottle" spectacles provided. Such glasses give only poor-quality vision and Hollows felt that everyone, should have access to modern techniques.

Prof Fred Hollows: A vision about vision.

Modern treatment involves putting a small, delicately-crafted plastic lens in a capsule and implanting it. The return of sight is rapid and complete.

In the West the lenses cost $150, so Hollows wanted to find a way of bringing down the price. One way was to make the lenses in developing countries.

Being told he had cancer caused him to re-double his efforts. He set up the Fred Hollows Foundation to raise money and ensure the continuation of his work.

A Kathmandu factory is due to open by June, and there are plans for two more in Vietnam.

Quality control is built into the high-precision production process. Training for the operatives of the Nepali and Vietnamese factories will take place in Eritrea.

The four factories will be able to produce up to 100,000 lenses a year, for between $5 and $15 each. Eritrea will be able to use only 5,000 a year at first, so will sell some of its output abroad.

A facility is being built next to the plant in Kathmandu which will offer training to doctors from India, Myanmar, Thailand, Bhutan and Bangladesh as well as from Eritrea, Vietnam and Nepal itself. They will be trained to carry out operations in "eye camps" in rural areas.

Nepalese surgeon Dr Sanduk Ruit has visited Vietnam along with Australian specialists to train Vietnamese doctors. This is just a start. Other developing countries have approached the Foundation for assistance. The organisation feels the dream of eradicating cataract blindness is not only feasible, but has begun.

—Gemini News

Even when they enjoy good health, old people often need help in their daily activities.

Home-care in Denmark

by Slim Allagui

The home nurse is the key personality in Denmark's policy for the elderly.

THE alarm clock goes off at half-past five in the apartment of Stine Nielsen, a 25-year-old home nurse, in Frederiksberg, outside Copenhagen. She prepares breakfast for her six-year-old son Peter, and a sandwich for him to take to the kindergarten. One hour later she gets on her bicycle, leaving her husband Jan, a biologist, to feed and dress the child.

Stine starts work at seven o'clock in the communal centre for home care in Frederiksberg. The centre has 90 nurses, 41 auxiliary nurses and 552 house cleaners to look after some 5000 old-age pensioners, who are for the most part in good health but have to be watched in case they need help in their daily activities. In her office, Stine organizes her working day between 7 and 8 am. "I make between 10-15 home visits each day so they have to be planned almost by stopwatch — efficiently but without forgetting the vital human aspect, so that the pensioners don't get the impression they are being visited by some pre-programmed robot."

She goes on: "There are two categories of pensioners, those who are basically well but need help every day — to take their medicines, to remind them that it is important to eat and drink, and so on; and the others who are sick, but have either family care or are not so disabled that they need to be in hospital or have to end their days in a rest home."

The home nurse, a century-old institution (in fact 101 years old) in Frederiksberg which was originally administered by a group of nuns, is the key person in Denmark's policy for the elderly. That policy rests on a simple philosophy: "To let the elderly live as long as possible in their own environment, because they feel better there and the cost is much lower for the community which is financially responsible for them."

Stine and her colleagues are the ones who decide whether the pensioners can continue living in this "more human" manner, or if they should consider going to a rest home where residents are mostly aged over 80 and have greater need of care. Frederiksberg has 6503 such old folk; 163 of them are over 100 — mostly women.

On her bicycle, with her nurse's bag on the luggage-rack, Stine sets off on her first visit — to the Tenberg couple, childless and in their eighties, living in an attractive three-room flat beside the royal park of Frederiksberg.

The husband, Arne, opens the door with a welcoming smile for Stine – the only contact he has with the outside world. "How is Ada?" she asks. "Not too bad," he replies. "But she is complaining and I can't find out why, perhaps because she has to go to the dentist tomorrow and she hates that." His wife Ada, totally paralysed for the past four years, sits in an electric wheelchair and contemplates the flowering trees in the park. Stine tenderly takes her hand. "Don't be afraid, Stine is here," says Arne to reassure her. Ada has difficulty pronouncing words intelligibly.

For four years, Arne has been a reluctant prisoner in this apartment. "When Ada first got ill, I thought I would be able to manage on my own, but then her condition worsened. They suggested putting her in an old pensioners' home but I refused; you can't put away someone with whom you have spent 55 years of your life," he confides, stroking Ada's newly washed grey hair.

"The Tenberg family gets three visits a day from the nurse and auxiliary nurses", says Stine; "one in the morning, one in the afternoon and one in the evening, to help Ada to take a bath, watch over her health, dress her and put her to bed."

A house-cleaner paid for by the commune comes twice a week for two hours to clean up. "That's the only time off that I get," says Arne, who is getting ready to run some errands, pay bills at the post office and do some business at the bank. Three times a week the couple receive some frozen foods. "The rest of the time I prefer to do the cooking myself, because Ada loves the tasty little dishes that she used to make." With every sign of appreciation, he adds, "The home nursing system is the only thing that helps us to stay together."

In the house, the commune has provided the couple with three wheelchairs, an electrically-operated bed, a bathroom specially equipped for the handicapped, and a little electric lift near the staircase for their rare trips into the town — for blood tests at the hospital or to the dentist.

In the evening, the nurses exchange their bicycles for the seven red service cars, each with a telephone linked to the ambulance services. "There are people with cancer, people with AIDS, people seriously ill, who would rather die at home and who have to be watched 24 hours out of 24," explains Mie Mogensen, one of the two people in charge of the Frederiksberg home-care centre. With 27% people aged over 67 in a district of 86.000 inhabitants, the home nurses are kept busy working in three shifts right round the clock.

"As people are living longer, there is going to be more and more need for home care," she forecasts, adding, "the present system functions well, even if certain patients sometimes grumble that they see too many different faces of the staff and would prefer to get to know just one who would become part of the family and of their everyday life. We may have to re-model our system to respond better to the needs of the next generation of the elderly. But the system we have now, for all its drawbacks, is the best we have found so far."

—WHO

Nurse Stine sets out on her round of home visits.

For the old couple confronted with disease, the visiting nurse is part of the family.

Fund Approved for Fetal Tissue Transplants

THE National Institute of Health of USA has approved the first federal grant to study the effects of implanting fetal tissue into the brains of patients as a possible treatment for Parkinson's disease.

Dr Patricia Grady, director of the National Institute of Neurological Disorders and Stroke, announced January 4 that the $4.5 million grant will fund a fetal neural transplant programme developed by physicians at three private medical institutions.

She sad there may be more grants this year, both for Parkinson's and other brain disorders.

Former presidents Reagan and Bush prohibited the use of federal funds for research involving the use of tissue taken from aborted fetuses. But President Clinton lifted the five-year-old ban during his first week in the White House.

"By making federal funds available, President Clinton has made it possible to determine whether fetal tissue implants are worthwhile for treating patients with severe Parkinson's disease," said Dr Curt Freed of the University of Colorado Health Sciences Center, one of the institutions that will receive grant money as part of the fetal tissue research programme.

Physicians at the university performed the first fetal brain tissue transplant in the United States in 1988, and continued to develop the neural transplant programme using private funds. Most patients paid for the surgery themselves.

Parkinson's, which affects an estimated one million people in the United State, most of them over 60 years old, is a chronic 'nervous disease characterized by slowly spreading tremors, muscular weakness and rigidity. The illness destroys tissue in the brain that makes dopamine, a chemical that affects body movement.

Patients can be treated with drugs that ease the symptoms but do not stop the disease, which eventually cause dementia and virtual paralysis.

Under the new grant, 40 Parkinson's patients now under treatment at the Columbia-Presbyterian Medical Centre in New York will be evaluated to determine the extent of their disease. They will be videotaped and their movements measured by computer-timed tests.

The patients will then be evaluated at the Cornell University Medical College on Long Island using a brain imaging technique called Positron Emission Tomography (PET). The technique measures the function of brain cells that produce dopamine.

Following these initial tests, the patients will be sent to the University of Colorado in Denver, where half of them will receive fetal tissue transplants. The remaining patients will receive placebos — injections not containing the tissue. Neither the patients nor the doctors will know who gets the fetal tissue.

Tissue used in the transplants comes from human fetuses aborted after seven to eight weeks of gestation. Long needles are used to inject the fetal cells into the brains of the Parkinson's patients under local anesthesia.

PET scanning will be used on the patients again after surgery to detect changes in dopamine production. Researchers believe the fetal tissue implants should replace the lost dopamine-producing cells, restoring normal movement and providing a better response to drug treatments.

Researchers said that the fetal tissue has several useful properties, including the fact that the host body does not reject it as "foreign," and its ability to mature and establish new connections with surrounding cells.

The results of three studies published last November found that although fetal tissue transplants do not cure Parkinson's disease, some patients improved enough to walk without falling, feed and clothe themselves, and drive cars. Others, however, showed no measurable benefit.

— USIS

New Frontiers in Treatment of Depression

by A S M Nurunnabi

A new drug named Prozac has opened up new frontiers in the treatment of depression. Millions agree that it is the hottest psychiatric drug in history. Since its introduction five years ago, 5 million Americans and another 10 million people world-wide have used it. It is a medical breakthrough that has brought unprecedented relief to many patients with severe depressions, phobias, obsessions and compulsions, 'it is claimed.

But it is also increasingly used by people with milder problems, and its immense popularity is raising some unsettling questions, such as these. When should Prozac be prescribed? How does a doctor draw the line between illness and normal behaviour? When does drug therapy become drug abuse? Will Prozac become the medically approved feel-good-drug, a cocaine substitute without the dangerous highs and lows?

Some doctors who prescribe Prozac to their patients during private practice, are both impressed by the drug and uneasy about what its widespread use may portend for human society. In case after case, they contend, Prozac does more than treat disease; it has the power to transform a personality, instill self-confidence and enhance a person's performance at work and play. One patient claims that the drug made him "better than well," his depression lifted, and he became more poised and thoughtful, with keener concentration and a more reliable memory than ever before. Another doctor observed that Prozac seemed to "give social confidence to the habitually timid, to make the sensitive brash, to lend the introvert the social skills of a salesman."

It is maintained by some psychiatrists that the power of Prozac challenges basic assumptions about the origins and uniqueness of individual personalities. They may be less the result of experiences and more a matter of brain chemistry. If temperament lies in a tablet, is there an essential immutable Self! Ultimately, they muse, society could enter a new era of "psychopharmacology" in which changing personality traits may be as simple as shampooing in a new hair colour. Already, pharmaceutical houses are churning out new class of similar drugs that mimic the effects of Prozac.

When Eli Lily, noted pharmaceutical company in the US, unveiled the drug in the US in 1988,,it didn't take long to spread the news that Prozac was something special. Within two years, TV and magazines in the US touted it as a wonder-drug and doctors could hardly write prescriptions fast enough.

Soon after, a backlash set in as reports surfaced that in very rare cases people on Prozac grew violent or intent on suicide. But the Prozac critics haven't been able to prove that the problems are caused by the drug rather than the patients' mental illness. Though the adverse publicity may have scared off some patients and doctors for a time but sales are now as strong as ever.

So what makes Prozac ay different from all the other popular mood-altering potions down through history, from alcohol, opium and marijuana to widely prescribed librium and valium? It is claimed that unlike the typical street-drug which sends people soaring and then crashing, Prozac has an effect that is even and sustained. It is further claimed that it seems safer and has fewer bothersome side-effects than previous medicines prescribed to lift people out of depression. Prozac is said to be what scientists call a "clean drug". Instead of playing havoc with much of the brain's chemistry, the medicine is claimed to have a very specific effect: it regulates the level of serotonin, a crucial compound that carries messages between nerve cells. "Prozac makes people feel different without making them feel drugged," observes one psychiatrist. To other psychiatrists, Prozac enables a person's true personality, often imprisoned by illness and it is correcting an imbalance allowing people to be who they really are and who they are capable of becoming.

Silence Helps Spread AIDS

by Estrella M. Maniquis

IN a rural Ugandan village, a young man who had been strong and active strangely fell sick. Scared, the villagers stayed away.

The wife had to go on by herself, tending their house and farm, caring for the children and for the husband until he died.

Time passed and the sickness began visiting other households. Knowing what it was like to bear misfortune alone, the widow helped out by gathering extra water or firewood and leaving these outside the houses. After a while, she began talking to the women.

As other villagers watched, their fear lessened. Slowly they began to be able to talk about the sickness and to visit afflicted households. At the marketplace they met people from other villages who told them that there is an organisation which could come and help them understand 'these things'.

The AIDS Support Organisation, or TASO, was founded by Noerine Kaleeba in Kampala after the death of her husband Chris, who was found to have AIDS while working in England. She had returned with him to Kampala where they discovered others infected with the Human Immunodficiency Virus (or HIV, which causes AIDS) and with whom they found mutual support.

'TASO provided a haven for those in need of someone to ease their pain, to talk about their fears for themselves and their families, in need of shelter, of companionship,' explains Elizabeth Reid who recalls the story from many others she has heard in various places.

Ms Reid has worked in a number of AIDS programmes and is currently the director of the HIV and Development Programme of the United Nations Development Programme (UNDP).

With TASO's encouragement, people gained confidence to speak out about being infected, and to begin discussing how to protect themselves and how to care for those already infected. 'And so it was that the widow's village invited TASO to come and help them,' Ms Reid says.

The awesome rate of spread of the AIDS virus in Africa can and might already be happening in Asia and the Pacific

understanding that the solutions are going to come from within communities. And they are only going to come about when people within communities start talking about these issues,' she told Depthnews in an interview at the UNDP office in New York.

Ms Reid has seen the ravage of HIV in Africa and believes that the awesome rate of spread of the virus — from 2 per cent to 25 per cent in adult populations in less than four years — can and might already be happening in the Asia-Pacific region.

'In communities and nations where people are more individualistic, concerned only about their own well-being, it will be very difficult to slow the epidemic down,' says Ms Reid. But it can be stopped — 'and stopped quite quickly' — in places where people respect and care for one another.

UNDP's role, she explains, is 'to get the issues raised, to get people to talk about them, and to help draw the lessons out so these can be shared with others.'

For infected communities to begin to talk, protective mechanisms have to be put in place. 'We have to have an ethical and a legal and human rights framework that guarantees, for example, confidentiality, that acknowledges that infected people should remain and be supported within families and communities, that they have the right to continue in employment and to live ordinary, daily lives like everyone else.'

And once communities decide to take the step to protect themselves, they must be provided with the means to do so, 'whether these be good quality condoms or educational services or employment opportunities.'

Ms Reid has more stories of such self-help efforts. In southern Uganda, villages have health meetings and in one meeting it was decided that schoolteachers found to have sexual relations with their students will be booted out.

In Zimbabwe, young girls are beginning to be able to talk about the issues, whether with young men or with their parents, initiating changes in the way young people interact both socially and sexually. In Zambia, schoolchildren have started anti-AIDS clubs where they commit themselves to remaining uninfected with HIV.

One emerging realisation is that the traits encouraged in young girls such as softness, passivity and obedience can make them vulnerable to HIV infection.

— *Depthnews Asia*