First Liberian Anaesthetic conference

Monrovia 15-17 November 2007

Author:

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Introduction

The challenges involved in a trip to Liberia to run a three day conference for anaesthesia providers were significant. Until the first day we had no idea how many would turn up although we were told at least 15. Support consisted of some money from the WFSA and books and CDs funded by the Overseas Anaesthesia Fund of the AAGBI.

The whole venture was only made possible by the support of *Mercy Ships* who allowed us to stay as guests on board the *Africa Mercy* (fig 1) and provided us with a driver and free transport every day to and from the conference venue at the JFK Hospital in Monrovia. I designed a T-shirt for each delegate and *Doctor's Updates* provided name badge holders.

Fig. 1 The Africa Mercy

My main contact in Monrovia was Dr James Tomarken who worked as a hospital administrator funded by the Clinton Foundation. Dr James organised and I funded tea and cakes every day at 11am and then lunch at the Flag Pole cafeteria in the hospital grounds.

The local facilities

The team consisted of Dr Alex Bojarska (Consultant Anaesthetist, Manchester), Dr Ela Kloda (Physician, Gdansk, Poland) and myself.

We arrived in Monrovia two days before the meeting allowing us time to visit JFK and ELWA hospitals to meet some local anaesthetic providers and see for ourselves the availability of drugs and anaesthetic equipment.

Predictably the mainstay of anaesthesia in the country is ketamine and spinals. The only intra and post-op analgesic agents available seemed to be pentazocine and tramadol. There was a supply of both morphine and fentanyl in the JFK hospital pharmacy in the '*disposal of poison cupboard*' but these were rarely used.

Suxamethonium was available and limited supplies of vecuronium and pancuronium also 0.75% heavy bupivacaine. There was an intermittent supply of ephedrine but at the JFK they also had some phenylephrine.

One of the anaesthetists told me that he used to get '*bad bad*' headaches in patients given phenylephrine but now he just puts a small amount in a 5ml syringe, empties it and fills the syringe with 5mls of saline and gives 1ml boluses; seems a sensible idea. Tracheal tubes were either red rubber or used many times plastic ones.

JFK had a Chinese-made monitor which included oxygen saturation and end tidal CO_2 donated by a visiting Chinese medical team. We watched a splenectomy performed under ketamine and suxamethonium +/- minimal amounts of halothane. At ELWA a Caesarean section was done under spinal (1ml 0.75% bupivacaine) with the patient flat on her back (no tilt) and O_2 via by an anaesthetic mask tightly held in place by a Clausen harness.

Recovery facilities were non-existent and patients were returned once '*awake*' back to the ward where there was minimal nursing care. The unsupervised anaesthetic nurses (there are no medically trained anaesthetists in Liberia) were allowed to give analgesics IV in the operating room, but were not permitted to write up post-op analgesia, this was done by the surgeon.

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We visited a Maternity Unit where magnesium sulphate and misoprostil were available. There were about 2500 deliveries a year, with an average of two maternal deaths per month giving a mortality of about 1000 deaths per 100,000 pregnancies, compared to 10 in the UK. This figure is consistent with those published for Sub-Saharan Africa.

Conference: Day 1

We arrived to find 24 delegates from nine different hospitals sitting round one long table (fig 2) .

Fig 2.
During a lecture

We gave out the T-shirts and badges which acted as an ice breaker.

The initial talks were "*The aim of the meeting*" and "*What is Anaesthesia*?" by myself, followed by "*Pre-op assessment*" (not something often done in Liberia), and then Alex's presentation on "*The Airway*". Talks entitled "*Ketamine – the King*," and "*Post-operative care including analgesia*" completed the morning.

After lunch we asked everyone to complete the WFSA questionnaires, which gave us an idea of their needs and what drugs and equipment were available in each hospital. I then gave a presentation on '*difficult airways*' discussing some of the most challenging intubations I have had over the past 16 years on board the Mercy Ship *Anastasis*.

Day 2

This began with "*Anaesthesia for Caesarean Section*" emphasising the benefits of spinal as opposed to GA. There are no antacids locally but our colleagues were familiar with rapid sequence induction and the need for lateral tilt. Alex spoke on '*pre-eclampsia and eclampsia*' and then myself on '*major obstetric haemorrhage*'. A discussion also took place about the use of an African cell saver technique: blood from the abdomen is poured through 4 layers of gauze in a funnel connected to a 20ml syringe (minus plunger) the end of which is inserted into a blood bag containing citrate.

The afternoon topics included "*Neonatal Resuscitation*", "*Paediatric Fluids*" stressing resuscitation bolus doses of 20ml/kg and the 4- 2 -1 ml/kg/hr regime for maintenance fluids. We handed out to representatives of each hospital various textbooks including *Safe Anaesthesia* by Lucille Bartholomeusz. Alex then did a presentation on monitoring which she started by saying "*What is the most important monitor*?" After a multitude of suggestions including pulse oximetry she said of course the answer is '*the continuous presence of the anaesthetist*!'

Dinner that night was held at a restaurant in Mambo Point to the obvious pleasure of the participants. It seemed a way of honouring the much maligned, under equipped and lowly status of these practitioners.

One man shook my hand at the end of the meal and just said '*thank you doctor for putting us on the map*'.

After dinner Alex, Ela and I had another late night, not only organising the presentations for the next day, but marking the essays that almost all the delegates had written.

On the first morning we gave them a choice of three alternative topics: "*a patient who should have died but lived*", "*a patient who should have survived but died*", or "*your most memorable anaesthetic experience*".

Some of the essays were remarkable and give an insight into challenges faced by our relatively untrained delegates. These will soon be available on my website: **www.africansmiles.co.uk**

Day 3

Topics included: "*paediatric anaesthesia*" and "*the sick patient for abdominal surgery*", followed by a quiz which was a great success and resulted in much hilarity. The questions were projected in '*powerpoint*' on the wall – those who thought the answer to the question was true stood up and those in whose opinion it was false stayed sitting. Subsequent questions resulted in an eventual winner.

Fig 3.
The delegates and faculty

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The final ceremony organised by Chairman Garrison Kerwillain was covered by both local radio and television journalists. This was started by a delegate, who was also a pastor, with a prayer. The Chairman spoke and then myself. I particularly stressed the importance of using anaesthetic charts, keeping logbooks and to consider managing post-operative pain more effectively. I thanked them all for making the three of us feel so welcome, and congratulated them on having resurrected 'LANA' (Liberian Association of Nurse Anaesthetists).

After prize-giving we handed out laminated attendance certificates which we had signed, CDs of all the presentations and $20 per person for travel expenses. After photographs (fig 3) Emmanuel our driver drove us safely back to the ship.

After supper we collapsed exhausted in front of a television and watched a DVD of "*MASH*".

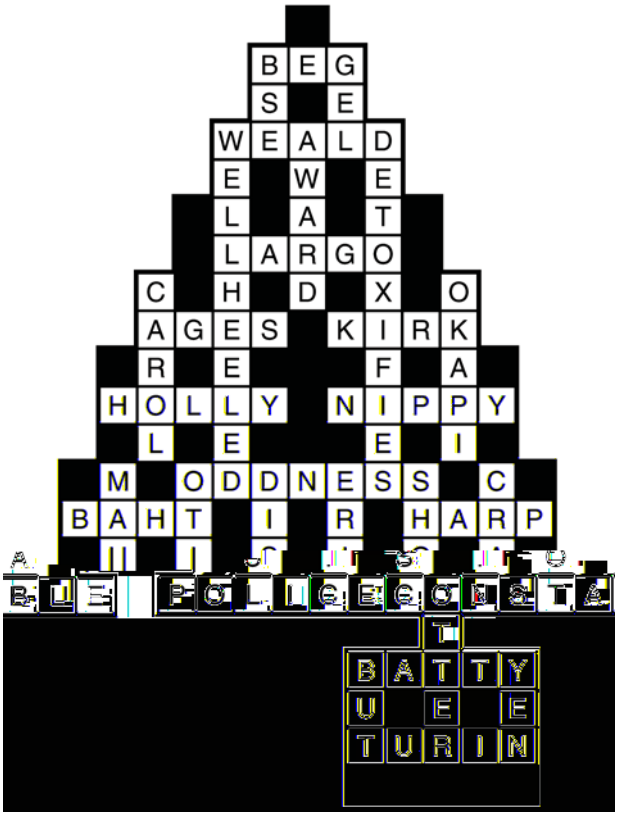
Conclusion

Overall the feeling was that it had been a successful conference with two thirds of the nurse anaesthetists in the whole country of four million people present. (My own hospital in the UKhas 35 doctors in the anaesthetic department for a population served of only 300,000.)

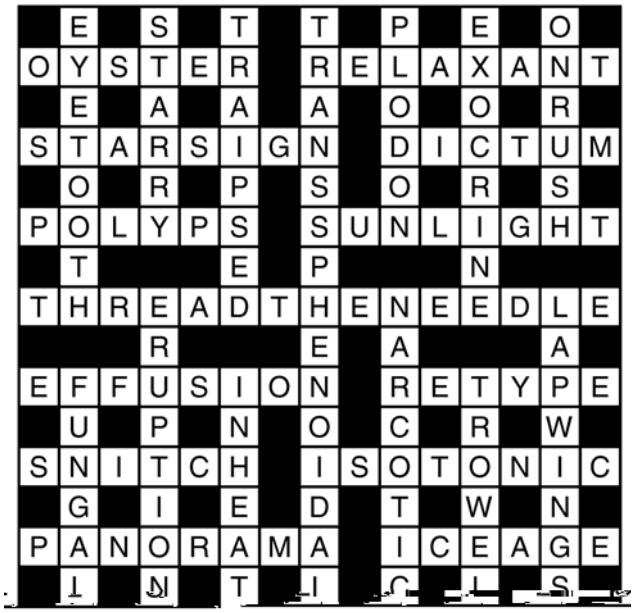
With continuing support from the WFSA, AAGBI and Mercy Ships there may be a unique opportunity to help improve the provision of anaesthesia in this country which under recently elected President Ellen Johnson-Serleaf is emerging from 25 years of civil strife.

They need help to address the issues of training, drug supply, monitors and anaesthetic machines. The '*Glostavent*' might be a suitable machine to be used in all hospitals. I am hoping to arrange a follow- up conference for two days in March 2008 when I am working on board the *Africa Mercy*.

Christmas Tree Solution



Solution to Prize Crossword 26



Another Seasonal Offering will be sent to:

for correctly completing the Autumn Crossword