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Introduction

Arrived at Cotonou airport almost on schedule in spite of spending over two hours on the runway at Heathrow due to delays in Paris caused by deicing of planes prior to take off. We experienced a dramatic contrast in weather between snow-storms in France and the humid heat of West Africa.

On the ship we found there were problems with the issue of shore passes for crew and permission for the ship's Land Rovers and other vehicles being cleared for use on land. This was probably due to the refusal to pay 'bribes' to local customs officials, who, two days before, had arrived on board optimistically carrying empty bags but had taken them away still empty! I had an interesting discussion with Dr Gary about the issue of when is a bribe a gift and vice versa. That evening we watched the thought-provoking documentary '*Sicko*' by Michael Moore about the health care available in the USA compared unfavourably to UK, Canada, France and Cuba.

The next morning we joined a group of about 20 crew wandering around the city trying to find a suitable church with everyone assuming someone else knew the way. Eventually we arrived by chance at the Catholic Cathedral (fig 1) which had an electric organ, choir-boys in green vestments and a priest in a green chasuble.

Fig 1.Catholic Cathedral

The service was in a French dialect, which was difficult to understand but there was a very pleasant atmosphere and temperature inside in contrast to that in the street.

We met Dr Ed and his wife Ruth from Bristol. He is the pathologist who back in the UK makes histological diagnoses on specimens sent electronically from the ship via a 'Coolscope,' he was there for the screening (fig 2).

Fig 2. Pathologist Dr Ed

That evening while enjoying a coffee at the onboard *Starbucks*, Ed recognized in a mural picture, from a previous screening in Benin a patient who had lost his job and wife because of a large and disfiguring parotid tumour (fig 3) .

Fig 3. Mural in on board 'Starbucks'

After successful surgery by Dr Gary, he was given back his job as a car salesman and his wife and children returned. Quote of the day: '*You can't change the whole world but you can help change one person's world*'.

Bethesda Hospital

During a visit with eye surgeon Dr Glen, I was shown round the general theatre by anaesthetic nurses Richard and Gregoire. The hospital suffered from the usual African lack of drugs and equipment – no functioning anaesthesia machines or monitors and only a few anaesthetic drugs in a cupboard although these at least included fentanyl and pethidine. Only *Quinke* point spinal needles and a 20ml reusable bottle of bupivacaine 0.5% plain were available.

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Fig 4. Suction catheter in cleaning fluid

A 'multiuse' disposable suction catheter in a jar of pink cleaning fluid (fig 4) had been placed on the top of the anesthesia machine and a similar one on top of the neonatal resuscitation trolley. I also visited the ophthalmic theatre where a local eye surgeon was expertly extracting cataracts after peribulbar blocks had been performed by a nurse. Apparently he performed 8-10 operations every Tuesday; sadly the theatre was not used for the rest of the week.

Tracheosophageal fistula (TOF)

I was then taken to see a 12-day-old 1300 gm neonate with a diagnosis of TOF needing surgery (fig 5).


Fig 5. Neonate with TOF

After returning to the *Africa Mercy* I gave the contact number of the doctor in charge to Dr Hosea, a very experienced professor of paed-iatric surgery from Las Palmas who has worked in many challenging places including Mauritania and Afghanistan. The following morning he transferred the baby to HOMEL hospital where, assisted by local surgeon Dr Seraphim, he did the first corrective surgery for 3 Watson TOF ever performed in Benin. The anaesthetic team from the ship (fig 6) visited the hospital a few hours later to discover the baby breathing


Fig 6. Anaesthetic team

spontaneously, still intubated (fig 7)

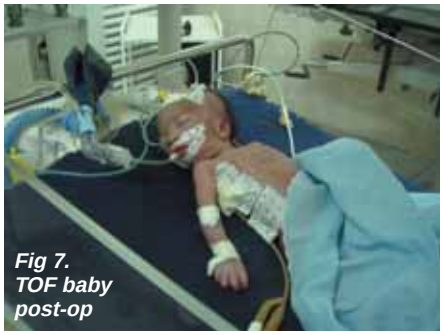
Fig 7. TOF baby post-op

but with significant chest recession, the prognosis did not look good but the child was extubated during the night and was still alive the next morning so was started on 5ml/hr of breast milk via a nasogastric tube. Remarkably a week later he seemed to be thriving (fig 8).


Fig 8. TOF baby 8 days post-op

Screening

On Day 1 of the selection of patients for surgery we arrived at 7.30am at Hall des Arts stadium to find hundreds perhaps even a thousand or more poor and desperate people in a queue disappearing down the road (fig 9).


Fig 9. Queue outside stadium

There were various medical and administration stations set up inside at which selected patients had to queue prior to getting the coveted card with a date to come to the ship for their operation. The job of the four strong anaesthesia team, the crew physician and a nurse practitioner from Guernsey was to do pre-op checks or 'physicals.' The screening process for patients is always one of hope followed by elation or despair depending on whether one is accepted or not for surgery (fig 10).


Fig 10. Queuing inside

I saw several cleft lips (fig 11), many


Fig 11. Cleft lip

women with large goitres (fig 12), including one with classic pre-tibial myxoedema and a number of men with inguinal hernias, the bagginess of their trousers related to the size. I also saw some unusual clinical signs including bilateral duplicated hallux in a 4-year-old, a 24-year-old man with an ankylosed jaw with a gap resulting from a missing upper tooth through which he fed himself

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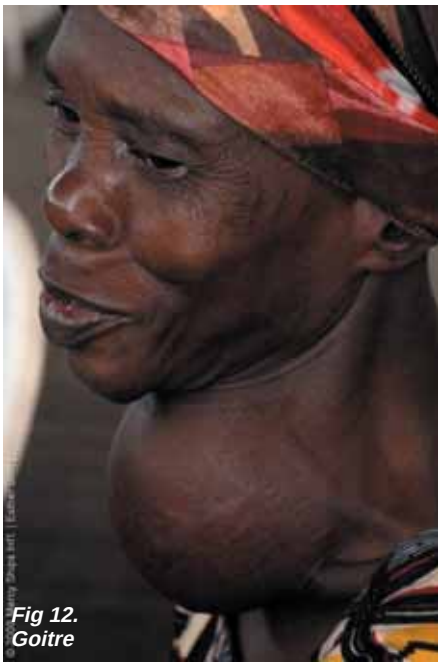

Fig 12. Goitre

(fig 13 – he would require fibreoptic intubation), an aberrant right radial

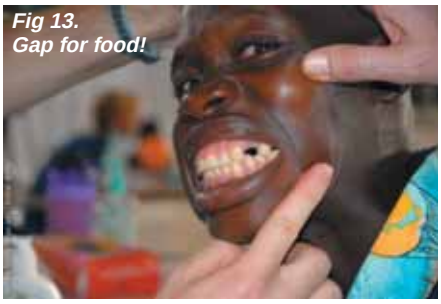

Fig 13. Gap for food!

artery on the dorsum of the wrist, a naso-frontal encephalocoele, club feet, bow legs (fig 14), an orthopaedic plate protruding from a thigh (fig 15) and a five-year-old child

Fig 14. Bowlegs

Fig 15. Protuding plate.

whose right leg had no tibia but a bizarre foot on the end of the femur.

During the second day of screening my friend Willam Akpa arrived from Togo with some colleagues, one of whom had been shot by a robber six weeks before and carried an X-ray which showed his left elbow full of shotgun pellets. Dr Hosea scheduled him for surgery in three months time. Apparently the operation using an image intensifier to remove about 40 large calibre pellets would take about four hours but should decrease the risk of lead poisoning. During these two days 2638 people queued for screening of which 765 were seen by a surgeon. Of these 240 were given a date for their operation and 215 were scheduled for either more tests (e.g. CAT scan) or further specialized screening (e.g. with a plastic surgeon). The day ended for me with an emotional reunion with Ruth Esther and her mother Bernadette (fig 16) who had travelled for 36 hours on a bus from Abidjan to see us.

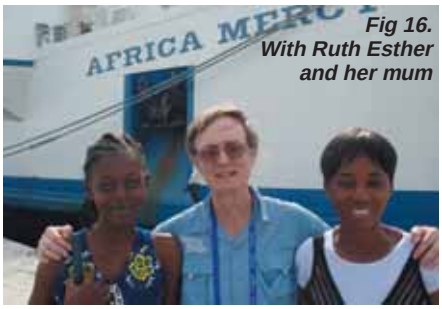

Fig 16. With Ruth Esther and her mum

I had anaesthetised her for a bilateral cleft lip repair performed by Dr Gary in the Ivory Coast seventeen years before on board the *Anastasis*. Subsequently she was diagnosed with a double outlet right ventricle and had had a successful Blaylock Tursig shunt performed in Abidjan. Sadly this remarkable reunion ended in tragedy three days later when Ruth Esther collapsed in a local market and died in the ICU on the ship a few hours later in spite of the combined effort of the intensivists on board. For the full story go to the website **www.africansmiles.co.uk** under BENIN – Ruth Esther.

The morning after the death of Ruth Esther the first patient I anaesthetised for Dr Gary was a three-month-old girl for repair of a bilateral cleft lip.

Last few days

The remainder of my time in Cotonou was spent both working in the six on-board operating theatres (all functioning for the first time) and making contact with members of the local anaesthetic community to try and arrange a conference in the autumn. There are 10 medically trained and 115 nurse anaesthetists in the country as well as a group of 42 trainee doctor anaesthetists from 8 different countries. I lectured at HOMEL hospital to the anaesthetic nurses on 'Maternal Mortality and Morbidity in Africa' mainly featuring experiences from my trip to Uganda four months before and then 'Anaesthesia for Caesarean Section'. Commenting on my photo of 20+ laboring women lying in a corridor at Mulago hospital in Kampala, anaesthetist Dr Eugene said 'it seems that some African countries are more developed than others'.

On my final day in Cotonou I invited Prof. Martin Chobli, the head of anaesthesia in Benin, to lunch on board the ship. He asked me whether I could give a presentation to his students (fig 17).

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Fig 17. Lecture

I agreed and he sent an ambulance to transport myself and colleague Paul to CNHU hospital. I had just shown the first few slides of my 'Airway Adventures in Africa' presentation when the door opened, everyone stood up and a rather irate associate professor demanded to know what I was doing in his lecture theatre. I managed to convince him in my best French that Prof. Chobli, his boss, had invited me and I would be no more than 30 minutes. After my presentation finished I was guided to his office where I shook hands and apologized – we parted the best of friends – I think! Interestingly there was a reasonable ICU in the hospital with a head injury patient being ventilated, an unusual event in that area of Africa (fig 18).

Fig18. Head injury patient

The return journey to the ship by ambulance was interesting as the security in the Port area was very tight due to the impending visit of the President but our driver just put on the sirens and drove past the soldiers manning machine guns mounted on 4X4 vehicles guarding the dock gates. We then waited in a queue for nearly two hours to shake the hand of the President (fig 19) followed by speeches and then my wife and I departed to the airport at the end of another remarkable West African adventure (fig 20) –

Fig 19. President visits the ship

I think at least number twenty five since March 1991 but perhaps I have lost count.

Fig 20. Another great trip