Making a Difference - Duncan Hospital
(Emmanuel Hospital Association)

JANUARY 21, 2019

A day in Duncan

It was yet another regular Monday morning in Duncan. I, walking about with the young and excellent consultants in Medicine, Anesthesia / Critical care and Paediatrics... me, not doing much but just being around.

As we walked into casualty, there was this 50-year, obese male, in encephalopathy and taking very shallow breaths. A classic and clear patient with Obstructive airways disease and possibly an additional Obesity hypoventilation syndrome in respiratory failure. Some surgeon in a nearby nursing home had taken the risk of doing a surgery on such a high-risk patient and now he had come in with respiratory failure. His complex blood gases started of a series of conversations. **Should we intubate and ventilate, if we ventilate, would he ever come out, or should we wait on NIV alone? If he does not come out of ventilation what would the next step be?** Finally, after much consideration, the Anesthetist turned critical care specialist, decided for NIV (Noninvasive Ventilation) only.

We walked into the ICU and my colleague the anesthetist, showed me another patient. An 80-year- old lady with obstructive airways disease, with type 2 respiratory failure on NIV with blood gases not showing much change despite NIV. **Question of what to do next? With no home oxygen support, no other systems affordable, what would you do to this patient who is from a nearby leprosy colony? Send her off for palliative care or give more time?**

The next bed was a young lady who had presented in severe pulmonary edema and full-term pregnancy 2 weeks prior. Our team had managed to immediately ventilate her and do a LSCS and save the mother and child. An echo had showed a Peripartum Cardiomyopathy. **She had gone home well,** and some where in the local hospital they had pushed in fluids and she **was back in cardiogenic shock and severe pulmonary edema,** recovering on ventilation.

Before I moved out of ICU, I joined the Pediatrician. She was struggling to sort out the complex endocrinological challenge of managing a 12-year-old child who had undergone a cranio-pharyngioma surgery at CMC Ludhiana 40 days prior to this. The Child has been presenting with hypokalemic paralysis, acidosis, a Central Diabetes Insipidus, (CDI) has a TSH of 34 and very low Cortisol. She was struggling with the question - **what were we dealing with?** A single diagnosis of Pan hypopituitarism or multiple diagnoses of Pan hypopituitarism with Primary hypothyroidism, RTA, and CDI?

As I moved to the medical ward, we started talking about another lady, whom we were struggling with. Severe deforming Rheumatoid arthritis, Thyrotoxicosis and an intractable vomiting that was not getting controlled with any anti emetics and preventing her from taking any tablets for the underlying diseases. She was refusing an endoscopy, husband was not willing to accept the diagnosis of Thyrotoxicosis, because **the thyroid swelling was from birth as per him, and not significant, did not have money nor the willingness to take her for further evaluation.**

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We continued to talk about a patient whom we had just referred off, one unusual presentation amid the many hyponatremias we see, due to steroid abuse. This elderly man with severe hyponatremia, thought to be due to steroid abuse, like the many others but having a **carcinoma head of pancreas, and hyponatremia being a para neoplastic syndrome.**

Before I moved out into OPD, there were couple of more patients that caught my attention. A young girl being treated for the last 2 years as TB with multiple courses of ATT, admitted for evaluation. Quick clinical evaluation by the consultant has clinched the diagnosis – a Progressive systemic sclerosis, with Bronchiectasis, Cardiac and Esophageal involvement, **missed in the multiple centers she had visited. At the same time the family unwilling to continue treatment, the moment they knew she had a chronic illness, unwilling to spend any more money on a girl!**

Then there was this 40-year-old man who had presented with seizures, now recovering in the ward, **with no family around – left alone.** Turning out to be Stage IV HIV infection with pulmonary TB and possibly Toxoplasmosis (no CT possible because of lack of support systems) with a CD4 less than 15 with the **Medical team trying to sort the medical, the social and other complexities of managing such a patient with no support systems.**

As I was walking to the OPD my WhatsApp bleeped… an X-ray for opinion. A girl child who had a **chest wall injury one month back** brought in with an effusion on one side and encysted pneumothorax on the other side, question of how many ICDs to put and where. The fluid turned out to be "old blood" one side! **Neglected for more than a month because being a girl child?**

Reaching OPD, a young man was waiting with a recent onset "hyperpigmentation of face and sclera" and a family history of a brother having same problem. Was it just a congenital problem or something like Alkaptonuria? By then a staff was waiting – with history of recurrent parotitis and dry mouth, asking what tests she should do to rule out a Sjogren's…

All these in a single day….

Why am I writing this? I hope some where some Internal Medicine or Paediatrics resident or consultant would read this and decide to take a detour from their planned career directions. To come over and ***experience the thrill of clinical medicine and paediatrics management in a resource limited setting like this.*** *And may be through that exposure, decide to spend some time* ***learning, teaching and caring in a context that needs clinicians to care for a community that cannot go elsewhere, for such complex problems!***

-A senior consultant at Duncan

The *'Making a Difference'* series will be a monthly publication to highlight the lives of patients and staff in our many Mission Hospitals.