There was a lot the press about conjoined twins in June and July. In the past such twins and others needing complex surgery have been sent outside the country. Karanda mission in Mt Darwin is one source of such transfers because the medical team there is well connected to North America. At least one set of conjoined twins was sent to the Sick Childrens hospital in Toronto from there.

There is a strong feeling that cultural beliefs around children with abnormalities and twins in particular are harmful to children. This particular set were kept in Harare Hospital because of fear that discharge would place them in harms way. An earlier set sent home never returned. In earlier times twins were either both left to die or just one was.

Many forms of conjoinedness are not compatible with life for both twins while some involve the sacrifice of one twin. Many families find it hard to make the decision or choice to sacrifice one twin. There are many twins who live joined together and seem to regard that as completely normal. It is the ununtied community that appear to experience some unseemly pleasure in treating them as exhibits.

The press in Zimbabwe enjoyed ‘shock and awe’ headlines about it for a while. The facts were a little thin and it is debatable whether the public were really informed about this condition. After the successful separation there was a fest.

On wikipedia Zimbabwe is the latest country to separate conjoined twins, and the Red Cross Hospital in Cape Town recently published a case series representing their experience over 40 years or so. S Afr Med J 2006; 96: 931-940.

Our own formidable Tiger Mum [Noti by another name] put everyone in their place and orchestrated the entire anaesthetic machine. After being made to check everything from equipment to anaesthetic plan, the machine was set in motion. In the end, everyone was happy to be associated with the project [and the dinners !].

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Bothwell Mbuwayesango is up there as the surgeon who did it.

Another surgeon who ‘did it’ is Ben Carson. For some reason every medical student in Southern Africa knows about Ben Carson and is ‘inspired’ by him. He is an African American who separated craniopagus twins in 1973. Prior to this craniopagus twins were not separated because outcome was very poor [severe disability or death to both].

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The Association Social Responsibility Day was held the day before the Annual Congress. For ‘bambazonke’ folks [ie. Harareans] it was an eye opener. Much of the material used was brought from Harare. There was no Sevoflurane vaporizer at Mpilo. The Association brought that from Harare in order to manage quick recovery of children. There were many other ‘absences’ which people outside ‘skies’ just don’t see. However, the event went so well and such ‘good feel’ generated that the plan is to do a SRD every year somewhere in the country [obviously not in Harare].

Dr Kandawasvike was talking about how he is involved in similar ‘camps’ around the country. Is there really a reason why people can come from across continents to do surgical camps here and we cannot do for ourselves.

Reflecting on the SR day in Byo in 2014, what things would you like to highlight? The waiting lists are long. It probably takes about six months for a patient to reach theatre through the surgical clinic. So for the patient it was a real help, for those operated on the day and the others whose operations were done sooner as a result. Mostly, patients were selected because there were factors that picked them out of the rest, such as very young age. The Bulawayo hospitals are really under resourced at all level, from specialist staff such as doctors and theatre nurses to equipment, consumables, drugs and general maintenance. The training and supervision the junior stuff get is of concern, at the very least compared to Harare. We found morale really low, and that was sad for us. We were feeling all excited about coming to Bulawayo. We had misread the level of organization required and expected to find things at least approximate to Harare. The result was that we spent a lot of time after we arrived in Bulawayo putting things together so we could have flawless operating sessions.

In the Central Hospitals there are many long waiting lists for uncomplicated procedures. Do you think SR days can be applied here?

Camps in the Central hospitals would be competing with major surgery. That is one big problem. The second problem is doctors keep taking time out to private practice. However, with proper planning, organisation and commitment I can see that maybe day cases could be done in larger number without interfering with major cases. That could also shift more uncomplicated cases, like hernias, towards day lists.

Lifebox workshop at Parirenyatwa in April 2014

The first lifebox workshop went off very well. It was held at Pari in April. Most of the leg work was done by the Department of Anaesthesia supporting the two Anaesthesia Associations.

Lifebox is here again

It was a half day workshop which started with pretest, then presentations from LIFEBOX standard tutorials. A set of clinical case scenarios were discussed in small groups before reconvening to discuss in the larger group. A post test followed. Eighteen LIFEBOX oxymeters were given out.

There were still seven left to be handed out at another workshop. This was planned to coincide with the CAA annual conference.

The CAA conference took place at Mendel House in Harare on 30th and 31st October. A morning session was devoted to the LIFEBOX materials again with pre and post tests and needs assessment forms.

During the visit to Mpilo for the ZAA annual congress Dr Chikumba and team visited the recovery ward in main theatre to find that the lifebox oximeters were the only oximeters available. One in main theatre and the
Zimbabwe anaesthesia has been without ODAs [Operating Dept Assistants]. The Health Professions Authority [HPA] has opened a Register. That has to be good news... but solutions come with problems.

The next hurdle now is who is going to employ them? There is as yet no understanding of the role of ODAs [ODP by another name] by potential employers.

Whose role is it to ‘promote’ this cadre? Anaesthetists need ODAs, particularly in complex cases and in big centres like Pari and Avenues Clinic.

The next hurdle is their numbers. At present only one (!) person is registered. There is no local training so for the foreseeable future they will have to come from abroad.

The story of Zimbabwe’s first ODA is interesting. She trained in the UK and has worked in UK and New Zealand. So what do ODAs do:

Tendai: ODPs work mostly as scrub ‘nurses’, anaesthetic ‘nurses’ an recovery ‘nurses’. In the last 2 years of my career (a year in the UK and a year in New Zealand) I have been working in Education as an Assistant Blood Transfusion Nurse Practitioner (Transfusion Safety Officer) which involved teaching and updating all members of the clinical team on safe transfusion practices. This involved delivering mandatory weekly sessions to staff. The job included a practical audit, my job also included auditing wards and following through any transfusion reaction complaints, working with the haematology department on research etc and the Blood Transfusion Laboratory to follow through on any errors e.g. wrong blood in tube cases. This involved working very closely with the National Transfusion Team and I was also part of the Hospital Transfusion Team & Blood Transfusion Laboratory.

Tendai Rambakuzimbzwa
First ODA / ODP to be registered by Health Professions Authority. Who will employ her. There should be opportunities in Theatres, Recovery, Blood Transfusion and Peri-operative Care......

Developing Critical Care Medicine in Zimbabwe

The Association CME meeting in March focused in whether we had capacity to develop ICU training locally.

Internationally, Critical Care Medicine has become more separated from Anaesthesia. In Zimbabwe Anaesthetists are still the only physicians covering ICU. We need to see that developing anaesthesia includes growing CCM as a specialty.

Alister Smith covered the history and emergence of ICUs. Dr Shumbairerwa spoke about the current MMed content that covers CCM. ‘Noti’ Chifamba spoke on developing local research in ICU.

Emmerson Mutetwa gave a wonderful talk called ‘tennis or soccer player’. This focused on individual or team player. He plays both sports and could speak from personal knowledge.

Farai Madzimbamuto spoke on what resources are available for developing a course in CCM locally.

Finally, Jonah Kasule had everyone on the edge of their seats talking ‘metabolomics’ or metabolic phenotyping.

In the period since we have seen Helen Karonga arrive back in Harare with Critical Care Medicine qualifications. That could tip the balance to get that ball rolling [as we love to say].

There are ICUs springing up everywhere now. In the public sector the provincial hospitals are finding space to have ‘an ICU’ and in the private sector the ‘trauma centre’ has become another focus of ICU.

The high cost of an ICU admission, shortage of anaesthetists means, in our environment, there is much in the way of short cuts going. In addition, with the developing CANECSA Fellowship pro-

Anaesthetic Association CME Calendar 2015
In 2013 I did a year of post CCT (Certificate of Specialist Training) paediatric fellowship training in Great Ormond Street hospital in London. It was challenging and at times a daunting experience. Living 3 hours away from a family was not easy but it was worthwhile. My fellowship consisted of a three months experience in Paediatric Intensive Care and Neonatal Intensive care. This very busy unit admits 2 – 3 patients a night. One registrar/fellow at night looks after over 12 patients most of the times. Most of the patients have complex problems that include metabolic disorders, endocrine, oncology as well as surgical patients. This experience was extremely useful as I currently deal with paediatric patients that need resuscitation, stabilisation and retrieval to the regional paediatric Intensive care in Cardiff.

Nine months of my fellowship followed modular training in various sub-specialties that included neurosurgery, craniofacial, cardiac including heart and lung transplant cases, interventional radiology and nuclear medicine among several specialties. I was fortunate to have been one of the four anaesthetists that anaesthetised the conjoined twins that were referred from one of the DGH. The majority of cases are ASA 3 or higher and tend to come for multiple procedures. Over 90 percent of these cases are admitted on the day of surgery including major surgery such as cardiac, neuro and craniofacial.

Preoperative visit means trawling through multiple volumes of notes, looking up various ACRO-NYMS and syndromes. Fortunately, most patients will have previous anaesthetic record and clinic letters which help speed up the pre-op assessment. Team brief is done prior to commencement of every list as part of the WHO checklist and the most senior surgeon and anaesthetist on the list must be present at these meetings. Children are brought directly into the anaesthetic rooms. Both parents are allowed into the anaesthetic room for induction including grand-parents and in some instances even boyfriends and girlfriends (Yes!! occasionally for a fifteen or so year old). A few patients may require premedication. Both oral midazolam and buccal midazolam are commonly used.

Near patient testing kit is readily available particularly for major surgery that results in significant haemorrhage and fluid shifts. There is also a well-established pain service team consisting of Consultants and pain nurses. There are a lot of international private patients, particularly from the Middle East and as far afield as South America. In addition to clinical work, there are regular weekly departmental meetings in which fellows and registrars are expected to present. These meetings happen between 0800 and 0900hrs with lists starting later on these days.

Prof Chinyanga: From Anaesthesia to Physiology and Back

Many will remember Prof Chinyanga as the one who set up the MMed programme in Anaesthetics. The programme has a well deserved reputation of being one of the best structured and organized programmes in the CHS. After a long stint in the department he was called to higher office in the university, helping to set up a new medical school in Bulawayo.

Upon completion of the Appointment and Acting as Pro Vice Chancellor to establish the second National Medical School in Zimbabwe at Bulawayo in 2000-2004, I returned to UZ in the same capacity before reaching the retirement age of 65 years and Emeritus status in 2005.

From 2005 to 2015 (10 years) I remained at UZ-CHS as Professor in the Department of Physiology teaching Respiration and Neurophysiology to 1st and 2nd year medical students.

During these years, with skeleton staff, we resuscitated the BSc (Honours) in Intercalated Degree in Physiology. Each year we enrolled one to five post Part II MBChB/BDS bright students who spent one year on a research project, learnt to analyse research publication reports, and pass a multi faceted examination including a viva with External examiners now making a total of 27 graduants. These students went on to complete their MBChB degrees.

The first of these graduate doctors has since received an MSc degree in Neuroscience with Distinctions from London University and has been appointed lecturer in the Department of Physiology. We expected and hoped that more of the BSc Hons Intercalated Physiology degree holders will follow suit and attain higher degrees in the Basic Sciences and Clinical specialities.

Returning to the Department of Anaesthetics I first entered in 1985, hope to continue the mentorship role in order to firm up what is already a well established Clinical and Research Department which is respected regionally and internationally.

Professor Herbert M Chinyanga
MSc. MD, FRCP,
During 2014 the Blood Transfusion Service of Zimbabwe co-hosted the 7th Congress of the African Society for Blood Transfusion [AfSBT]. Prof James was an invited speaker as he is a well-known authority on fluid resuscitation. Zimbabwe was the convergence of a number of things. David Mvere, CEO of BTS was also the Chair of AfSBT and Jean Emmanuel is back from WHO where he distinguished himself in Blood Transfusion. Mike James, who has also retired from UCT, was able to part of the conference. Prof James visited the department and gave a talk to the trainees and staff. He also spoke at the Association. Prof James, who is now Emeritus Professor, was the Head of our Department before Prof Chinyanga. His medical degree is from here and he trained in Anaesthesia in the UK.

There are other Zimbabweans setting. She presented her work at the annual UZCHS Research Day. Cleopatra Mugero explored sore throat in intubated patients in our Central hospital practice. David Pagwiwa also explored delayed admissions to ICU. It was a big study, needing big numbers. Mufudzi Mushaninga did an audit of fasting times in Harare and Parirenyatwa Hospitals. Average 15 hrs! Intervention are now on-going to address that. Finally Tafadzwa Mutukwa could save the system money by reducing unnecessary oxygen during spinal anaesthesia.

Regional Anaesthesia

We had a very strong team at the World Congress Regional Analgesia Pain Treatment (WCRAPT) in Cape Town in November 2014. From left to right: Tarwirei Kurisa, Edson Chikumba, Laurence Marks, Harunavamwe Chifamba, Fadzai Mugadza [Registrar], Ancicaria Bingura, Simbarashe Mazonde and Gerald Nyoni.

They presented at the Association Monday meeting on the 19th Jan 2015. This regular feature is back on the calendar and all members and trainees are encouraged to

Association Monday Meetings re-start. Every third Monday of the month.

2014 Final Year MMeds

During 2014 Six MMed trainees wrote the final exam. Seen here at the end of a tutorial session.

Dr Saurombe [lt] studied phenylephrine as a vasopressor for Caesarean Section. In Zimbabwe we do not have infusion pumps galore. Should we be giving it by infusion or bolus.

Nomaqhawe Moyo was performing TAP blocks and learnt how to use ultrasound for blocks. She wrote a letter to SAJAA in response to a paper on TAP blocks in low resource setting. She presented her work at the annual UZCHS Research Day.
The Tapia Twins [postage stamp image]

An exhibition opened on Sept 5th to October 26th at the Virginia Commonwealth University in the USA. This was ennobled with the title ‘The Tapia Twins: Bringing Together Art & Medicine’.

The Tapia twins [Maria and Teresa] were born in Dominica Republic. The ‘art’ part consisted of Departments of Sculpture [who made casts and models of the children for the surgical team], Fashion [who made clothes and a modified car seat together with Occupational Therapy Dept], Art History [who mounted the exhibition], http://esterknows.com/archives/tapia-twins-bringing-together-art-medicine-sept-5-oct-26.

The children were 19 months when separated. A year later they were doing well and living in Dominica.

Art and Medicine is part of a growing fusion that includes Narrative Medicine [which includes Literature, Drama, Film etc]. Issues around quality of life, quality of care, communication skills etc have opened up the ‘human’ side of medicine. The question ‘Is medicine art or science?’ may have seemed answered years ago, has gone misty again.

The ZAA was founded in 1958 [see CAJM ] in Harare. In the mid-to late-60s it went into the doldrums, and was resurrected in the 70s through the active agency of the Department of Anaesthesia at the University of Rhodesia. The Association has a constitution and an executive that have govern and manage its affairs. There are several committees under the executive including ‘Education Committee’ which organizes the MPD meetings and the programme of the Annual Congress. The ‘Audit Committee’ inspects the premises where anaesthesia is conducted and reviews practice queries.

Each year in October the ZAA hold an annual Congress and AGM. These started as Refresher courses supported by the WFSA in the 1980s.

The ZAA is the MPD accrediting body for physician anaesthetists in Zimbabwe. Nurse Anaesthetists are accredited through the CAA [Clinical anaesthetists Association]. ZAA is affiliated to the Zimbabwe Medical association [ZiMA] and World Federation of Societies of Anaesthesia [WFSA since 1976].

In 1997 the ZAA hosted the first ever Africa regional meeting of the WFSA – the All Africa Anaesthesia Congress, now in its sixth cycle after Harare, Tripoli, Cape Town, Nairobi, Cairo. Next is Lagos.

ZAA is also founder member Association of the College of Anaesthesia of East Central and Southern Africa [CAAnECSA].

At the CME meeting in July the surgeon Prof Godfrey Muguti spoke about snake bites in Zimbabwe. A very lively discussion followed which continued after the meeting into the email-o-sphere. It spilled over to discussion two works of African literature that have snakes as a centre of the story.

One story was in the collection edited by Chinua Achebe and CL Innes [African Short Stories—African Writers Series]. The story is ‘The will of Allah’ by David Owoyele. Two thieves go out stealing. They steal a calabash, hoping it contains money. It’s a snake. The one puts his hand in to take some money before his partner catches up with him. He is bitten, and realizes it. He knows he is going to die. He cannot let his partner have all the money, so decides not to tell him when he arrives. When his friend gets bitten, a conversation follows about why he wasn’t told.

The second is by Charles Herman Bosman, a South African. In this two Afrikaaners go to bury one of their workers who has been bitten by a snake. A rather unsympathetic conversation is taking place about the bitten worker, when one of the Afrikaaners himself gets bitten. He starts to realize how the ‘kaffir’ must have gone through.

The art of narrating [story telling] has become a resource in mining the technic of history taking. Oral story telling, written story telling and visual story telling have become such highly developed and specialized skills our ancestors would not recognize them. Rock painting has morphed into film and oral telling into ‘performing art’.

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