REPORT ON VISIT

TO

THE SADGURU NETRA CHIKITSALAYA HOSPITAL, CHITRAKOOT, INDIA

DECEMBER 2004

By

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INTRODUCTION

Shri Sadguru Sewa Sangh Trust (SSST) is a non-profit voluntary organization, based in Chitrakoot, Satna district, Madhya Pradesh in India and has been providing health care services to the poor of the surrounding districts since 1950. Polio correction, reproductive health, dental health, family planning, leprosy eradication, malaria eradication, tuberculosis treatment, surgery, primary healthcare, alternate medicine; primary, secondary and undergraduate education, computer training, nursing schools and outreach progammes are just some of the progammes the trust is involved in.

The Sadguru Netra Chikitsalaya Hospital Complex

The Sadguru Netra Chikitsalaya Hospital is a partner with Project ORBIS (http://www.orbis.org/bins/content_page.asp?cid=459-462-523&lang=1)

In the year 2000, the trust established an independent 350-bedded eye hospital named the 'Sadguru Netra Chikitsalaya' (SNC) at Chitrakoot. Treating over 100,000 patients every year, the hospital carries out up to 40,000 eye surgical procedures annually, mainly cataract extraction.


High-volume cataract surgery at SNC

At present, it is expanding to provide state-of-the-art pediatric eye care to the rural poor, set up and supported by the charity ORBIS.

My aim was to visit the Sadguru Netra Chikitsalaya for a week in December 2004 in order to carry out specialist Ophthalmic Plastic Surgery in the Eyelid and Orbital region of the face for both adult patients and also on behalf of the Rural Paediatric Ophthalmology Centre at Sadguru Nethra Chikitsalaya, Chitrakoot

This type of adult and paediatric eyelid surgery would be for tumours and eyelid reconstruction, correcting congenital and acquired eyelid disorders, Orbital Surgery, including tumour excision and orbital implants, complex Ocular Surface Reconstruction Surgery for scarring disease of the eyelids and surface of the eye and paediatric lacrimal surgery (for severe watery eyes).

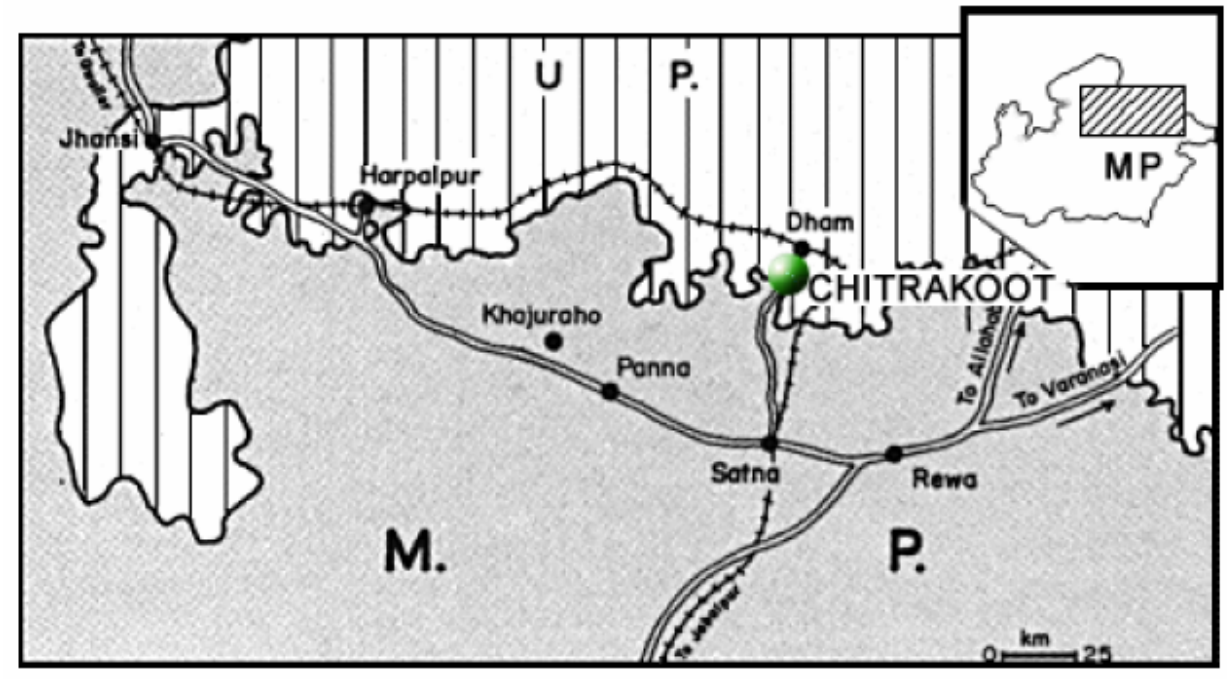
I was also asked to give lectures to resident doctors on Surgical Oculoplastic techniques, and on the Management of common periocular disorders.

REACHING THE HOSPITAL

Following a delayed almost 11-hour flight from London to Delhi and an overnight stay in Delhi before boarding a flight to Khajuraho, the flight was aborted at Varanasi (a stop before Khajuraho), due to poor visibility at Khajuraho. I was forced to stay overnight at Varanasi and resume my journey the next morning.

The road to Chitrakoot!

The next day, I left Varanasi for Chitrakoot in a small saloon-car for an 8-hour, 260 km journey on semi-built, pot-hole ridden, occasionally cobblestone rickety roads and finally reached the hospital at 7:30pm that evening. Due to the remote location of this hospital, I did not have a mobile phone signal, which was a strange feeling at first!



I had a warm welcome by the project coordinator, Anand and the Director of the hospital and had dinner with many of the resident doctors and staff who gave me some more history about the place.

This rural village hospital is extremely large and serves a population with a radius of 800 km and 2 States. It is run by a charity Trust and the majority of patients are treated free of charge. In addition to general and paediatric ophthalmic services, the hospital also provides general medical and surgical facilities as well as community care progammes.

The Admission Centre for the hospital. All patients are booked in electronically on a hospital network database. Primary care and dispensing of spectacles is also carried out in the admission room.

Resident doctors traditionally join the organization for a minimum of two years and during this time, work 11-hours a day, up to seven days a week. Most of the doctors are resident in training with a positive attitude towards working at the hospital.

Anand, the project coordinator of the Trust as well as the local project coordinator for ORBIS joined the Trust a year ago and is from south India. He joined because of his interest in setting up community programmes. I was told by one of the staff that he regularly works 14-hour days throughout the week and lives on site. Over the last year he has been extremely successful in developing an infrastructure in order to allow expansion of both the hospital services as well as community programmes. Manoj, a vitreoretinal surgeon has been here for the last year as well. His wife and child lived nine hours away in Lucknow and he points out that working here requires him to be away from his family for up to eight months of the year. Due to the lack of vitreoretinal surgical equipment available, Manoj explained that a significant portion of the patients that he sees with retinal disease often require referral to Delhi, 13 hours away by train and clearly too costly to consider for many patients. His greatest dilemma is in rationalizing who to refer, as the treatment in Delhi will not be for free and will of course

have to be paid for by the patient. His decision for recommending referral is often therefore based both in terms of what the patient can afford and also what likely benefit they are going to gain in terms of quality of life. As the majority of patients seen in the hospital are poor and often of limited education, this is usually one of the greatest challenges he faces on a daily basis.

I was quite interested and excited to hear that in the next few days Dr. Sharad Partani was due to return from the UK. He was appointed at the hospital 4 months ago and secured a 3-month post in the UK as an observer with an oculoplastic surgeon in order to gain some oculoplastic experience before returning to the Trust so that he may provide an oculoplastic service. His timely return would therefore allow me to work alongside him and perhaps help in any difficult areas of surgery before leaving.

I was given a timetable for the week here, which included seeing patients preoperatively from 8 a.m. followed by surgery the rest of the day and lectures in the evening.

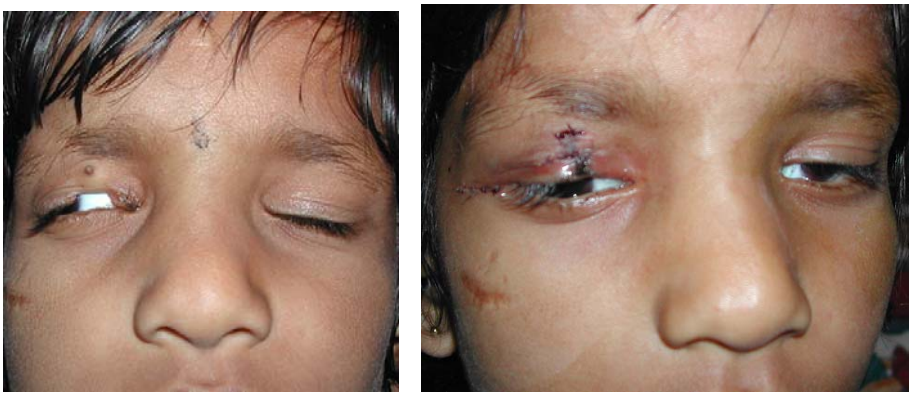
That evening, I also met the driver who was sent by the hospital to collect me from Khajuraho airport the previous day. He was a helper in the hospital who normally helped with odd jobs and transporting patients. The poor fellow had waited at Khajuraho airport until the evening and due to the poor driving conditions was forced to stay near the airport overnight before returning back the next day. This arrival of mine had clearly been a disruption for all parties involved!

The climate and temperature varies throughout the day, ranging form 10 degrees below freezing at night with fog that seems to last throughout the morning, to a pleasant warm afternoon.

On the first morning, I took part in the outpatient clinic and then operated on two cases before lunchtime. One was Samia, a 6-year-old girl with a congenital droopy upper eyelid (ptosis). In a rural culture where traditional arranged marriages are the norm, the presence of any congenital malformation, even something as small as a droopy upper eyelid may raise concern regarding an underlying disorder in the family and would quite easily put an end to any prospect of marriage.

Samia, before and 2 days after surgery to her right upper eyelid

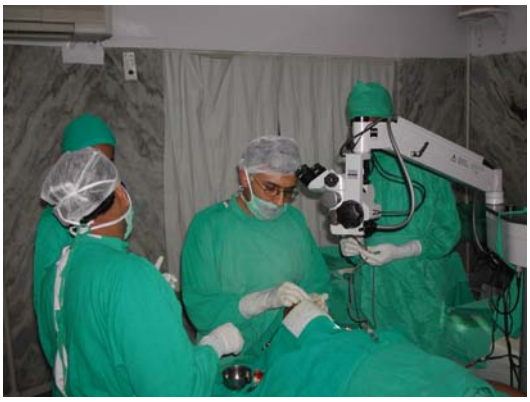
Radha, a 7-year-old girl with Goldenhar's syndrome (a congenital disorder that gives rise to odd development of facial structures) was born with an incomplete right upper eyelid. She was therefore unable to close her right eye properly and in addition to this being cosmetically unsightly, was troubled by constant discomfort in her right eye. I was able to reconstruct her right upper eyelid so that not only could she close it properly but it also looked cosmetically similar to the other side.



Radha, before and 1 day following surgery to reconstruct her right upper eyelid

At the end of operating that day, at 8 o'clock in the evening, I then began my scheduled teaching for the 10 residents in the hospital. In view of the fact that congenital ptosis (droopy upper eyelids) was clearly a common problem here I gave a one-hour lecture on the evaluation and management of ptosis. I had also brought along with videos of surgical techniques on CD-ROM for the doctors to keep and learn from. In addition, the department managed to connect a video camera to their operating microscope. Although most eyelid and orbital surgery does not require the use of a microscope, and in fact a microscope would get in the way whilst operating, I was happy to work

around the microscope so that they were able to record every procedure I carried out during my stay.




One of the highlights of the next morning was to supervise Dr. Kuldeep to do a congenital upper eyelid ptosis repair. Dr. Kuldeep is the resident senior pediatric ophthalmologist for the hospital and therefore he is responsible to the care of all children who pass through the department. He explained to me that although children with congenital droopy eyelids commonly come to the hospital for treatment, as he has not been trained in eyelid surgery, he has traditionally not been able to offer this service. He explained that instead, he has traditionally carried out eyebrow suspension procedures for all these patients, which although may be suitable in a selected type of case, it is clearly not ideal for the vast majority of children with droopy eyelids. I was thrilled to have supervised this case through its entirety in order to allow Dr. Kuldeep to complete the whole procedure.


Teaching Dr Kuldeep ptosis surgery

It was obvious that the benefit to both myself and the resident staff in me coming here was not in carrying out all the surgery and clearing any sort of

backlog (which would be impossible, anyway), but rather to teach the doctors to carry out the surgery themselves. Until now, the hospital has not been able to offer an Oculoplastic service to the 40 million population that it serves. These patients would otherwise therefore not have any access to care elsewhere and by simply imparting basic principles and surgical training in a handful of techniques, this dire situation could be completely transformed.


Post-operative morning ward round

The Trust has also recognised the need for trained resident doctors and therefore sponsored Dr Sharad Partani to spend three months in the UK in training as a fellow in Oculoplastic Surgery. Although one might say that three months may not be sufficient to gain a comprehensive training, to put this into perspective, this particular doctor who was due to return the following day, was sent entirely at the Trust's expense and did not receive any salary in the UK for his three months period-of-training there. The cost that the Trust would have incurred would have been phenomenal based on the cost of living in India. It would have been the equivalent of at least two years salary in India for that particular doctor.

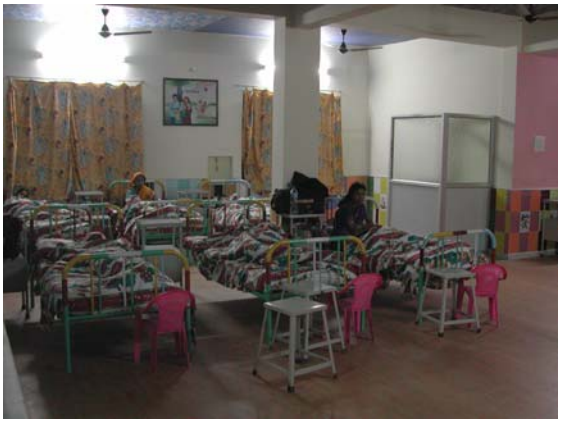
I met Sharad the next day. He is passionate about his subject, keen to discuss non-new concepts and extremely excited about the prospect of developing an oculoplastic service here at the SNC over the next two years. I was even more impressed over the afternoon when I was able to supervise both Sharad and Vivek, another resident doctor in training in the operating theatre. It was extremely gratifying to see two young surgeons see a technique performed for the first time and then be able to perform it so well immediately after, particularly as the procedures they were carrying out were quite challenging.


Teaching Vivek and Sharad eyelid surgery

Interestingly, in the UK under no circumstance would I have considered these cases appropriate for a junior doctor, particularly in view of their level of experience, however, it did not take long to realize that in such an environment as rural India, where facilities and training opportunities are limited, and the workload is phenomenal, that the sooner these doctors learn how to carry out this surgery, the better for all concerned. It was therefore a real pleasure and privilege to have been involved in this small part of their training.

That evening, we sat down for another hour of lectures. This time, I carried out a patient-centered problem-based style of presentation based on the cases that I seen over the last few days. I had brought my digital camera and had taken photos of virtually every patient I had see so far. By showing them pictures of these patients and encouraging discussion around various aspects of their care, we recovered almost every topic in oculoplastic surgery over 90 minutes. What amazed me was that these doctors see a huge number of patients with advanced disease in their day-to-day practice yet ironically, due to their extremely heavy workload, they are either too tired at the end of the day or do not consider many of these topics unique enough to warrant such discussion anymore.

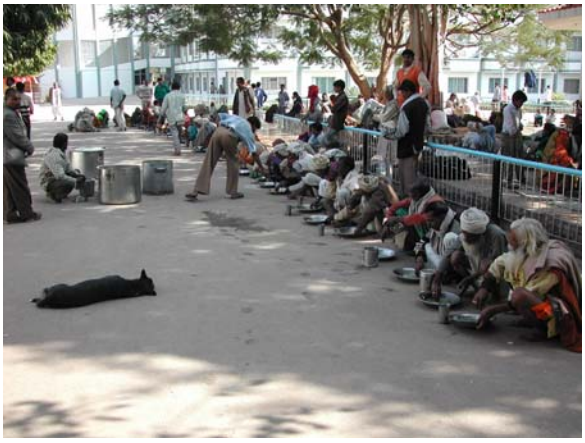
I was also privileged to witness the opening of the new paediatric ward that day. This ward was part of the new paediatric building and Centre, funded by the US charity, ORBIS. In comparison to the poor hut that sits on a field and houses the patients who come from far free treatment, this new paediatric ward looked stunning. It looked in many ways similar to any hospital ward in a developed country and stood out like a mirage in context of the setting.



The new paediatric building and ward

The adult ward for fee-paying patients

A field tent acting as a ward for non-fee paying patients, by far the largest group

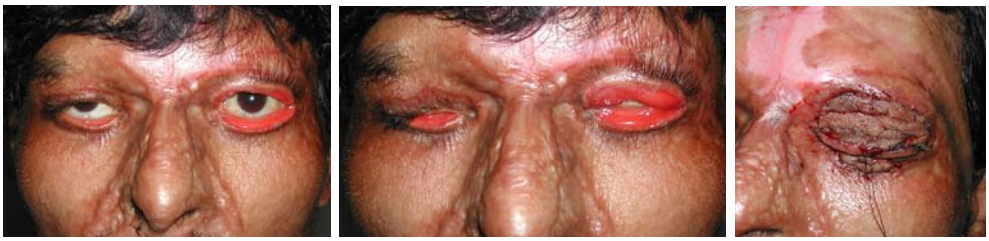


Patients and visitors being served lunch

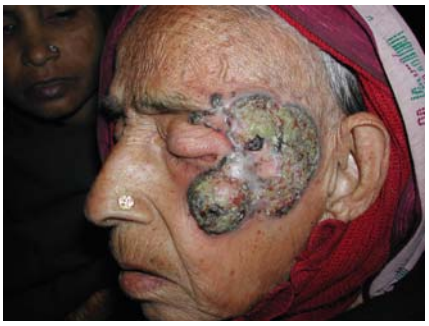
In a fit of madness I agreed to join Anand each morning at 5:30am for a 90 minute yoga meditation session. I grew to really enjoy this, particularly as I knew it was only for a week!

During my stay the project development coordinator for ORBIS UK came to visit along with the Chairman of the Trust for an inaugural ceremony to mark both the setting up of a regional Vision Centre and also the pediatric eye care center in the hospital. Vision Centres are a new initiative by the World Health Organization whereby each district in India is to be serviced by a Vision Centre, consisting of two rooms run by ophthalmic assistants who are able to carry out simple primary ophthalmic care and fitting and prescribing of glasses. I was unexpectedly requested to give a speech. I summed up my feelings by simply saying that visiting Chitrakoot and the SNC was an extremely humbling experience and I now realised more than ever how lucky I really was. I tried to explain to many of the non-medical

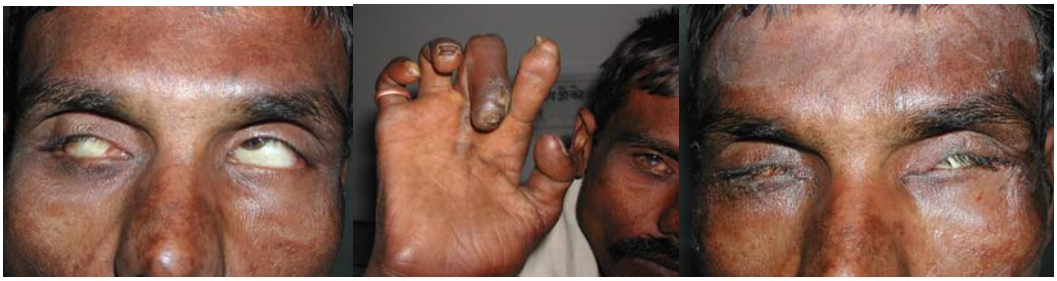
audience (who probably didn't even know what the term "oculoplastics" meant!) that although this Centre has already achieved so much in terms of being able to carry out 40,000 eye procedures a year, 35,000 approximately of which are cataracts, there is clearly an un-met need for oculoplastic surgery, which has such a direct impact on the preservation of sight in terms of the role of the eyelids. I explained that within the first two days here, I had performed surgery for a wide range of conditions including burn's victim with eyelids that were so damaged that that the upper eyelids were stuck to their eyebrows and lower eyelids to the cheeks, victims who had lost their eyelids and had remained in severe discomfort as a result for many years due to the lack of any facility for eyelid surgery, people with blinding disease due to eyelid scarring malposition as a result of Trachoma, children who had been born with incomplete eyelids and those who had been born with droopy eyelids that obscured vision…and so on and so forth… The Chairman of the Trust presented me with a beautiful gift, a Shawl and a small ornament. I was certainly not expecting this and was extremely touched by their kind gesture and gift.



An unfortunate victim of a severe burn injury that resulted in scarring and contraction of his eyelids. He required skin grafts to all 4 eyelids



An advanced large basal cell carcinoma around the left eye

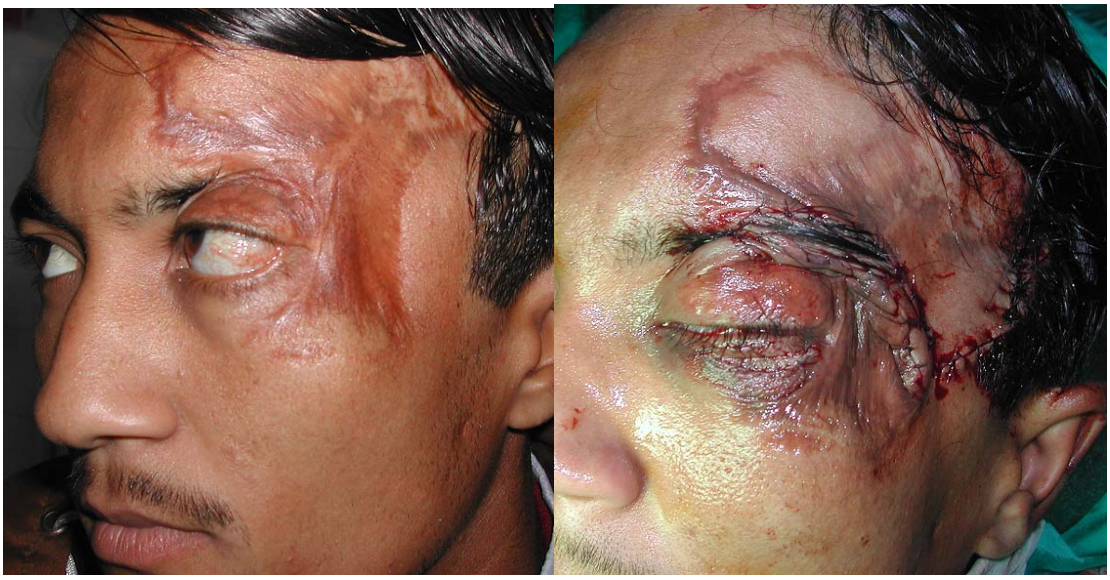


A young man with leprosy who is unable to completely close his eyes due to weakness of the eyelid muscles (facial palsy) on both side. The picture on the right shows the improvement in eye closure 1 day following eyelid surgery.

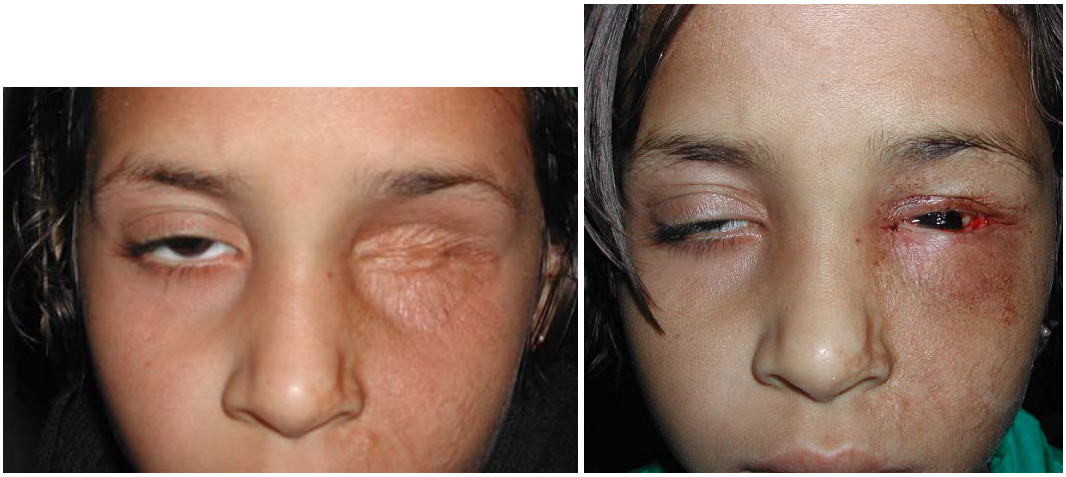
Teaching Vivek and Sharad eyelid surgery was an extremely gratifying experience. By the second day, these two doctors were not only assisting me but also be carrying out surgery themselves and by the third day I was supervising parallel operating lists and was thrilled to see them performing quite complex surgery based on their experience so far.

The days were exhausting. I would usually wake up at 5:15am, join the early morning yoga meditation session which finished at 7am. After breakfast and a morning ward-round I would spend the rest of the day in the operating theatre until approximately 6:30pm.

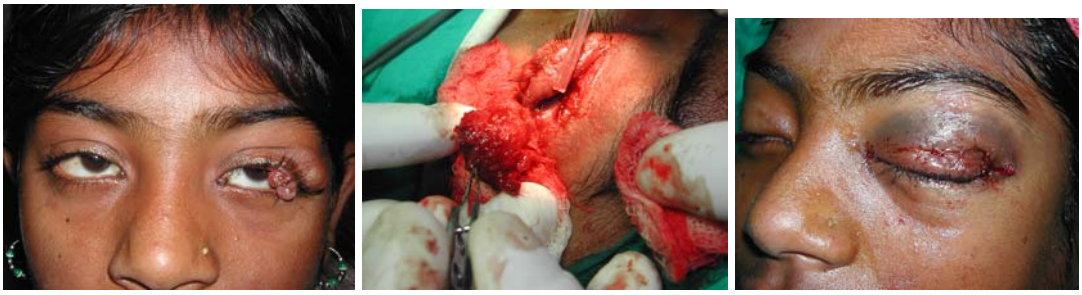
Some interesting cases that I operated upon included restoring eyebrows to the young man who had sustained significant facial deformities and burns following an injury many years ago.

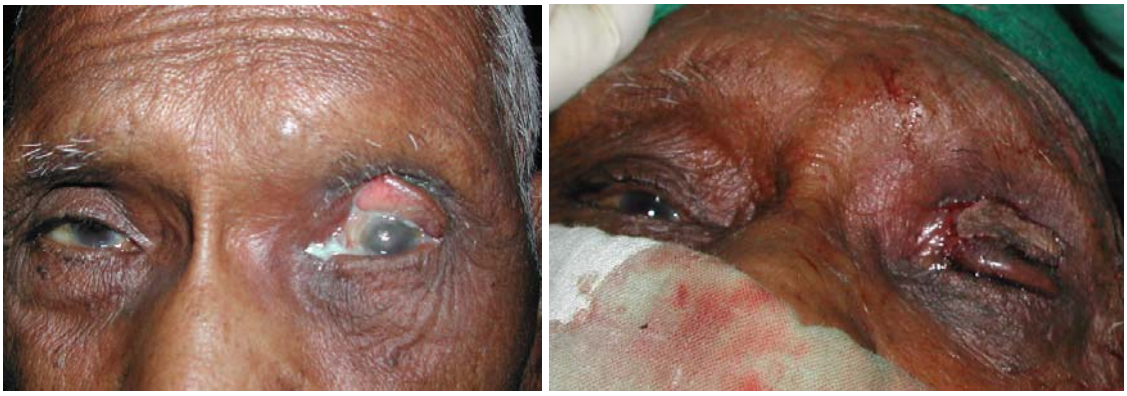


Another interesting case was of a 7-year old girl who had burned the left side of her face four years ago as a result of a hot-oil injury. This had resulted in her eye being permanently scarred and shrunken and eyelids fused together. I was able to open up her eyelids and reconstruct a lining behind in order to allow for an artificial eye to be fitted. The next day she looked totally different. Her artificial eye looked great and she felt extremely comfortable with it.



There were days when I didn't finish operating until 8pm. One particularly hard day comprised of a whole list of difficult cases, including a child with a large growth behind her eyelid, in her orbit.





Elderly gentleman who had sustained an injury many years ago that tore his left upper eyelid, causing it to contract up into his eyebrow and preventing him from closing his eye. This was released and the eyelid reconstructed with the aid of a skin graft (right).

On my last day I left the hospital at 6am in order to drive for 5 hours to Khajuraho Airport. The sunrise was stunning at 6 o'clock, with a lingering mist that stayed until lunchtime. Rural, India is truly a beautiful place to be in.

As I suspected, the flight to Delhi had been cancelled due to poor visibility in Delhi. The nearest train station was 4 hours away in order to catch a 7-hour train ride to Delhi. However, the train was already running at least 4 hours late! I therefore decided to drive from Khajuraho to Delhi. I ended up in a four-wheel drive with an Italian Professor, an ex-patriot from Kenya and two drivers. This 12-hour car journey turned into a 17-hour nightmare once we hit fog 50 km from Delhi. With visibility of 2 metres we crawled along in dense traffic on a road full of trucks for the next 5 hours. After a 26-hour car journey of 1000 km on rough roads, I had finally reached Delhi airport at 8am to catch my 9am connecting flight!

CONCLUSION

I am glad to have had the opportunity to visit the The Sadguru Netra Chikitsalaya Hospital in Chitrakoot. It was an extremely rewarding experience for me and one which I would hope to repeat in the future. Visits such as this, and collaboration will always have a beneficial impact, perhaps often long-term and indirect, on their ability to deliver and maintain a high standard of care for a wide range of services. Training and teaching is an ideal example of how such a large volume of patients may be helped in the long-term with the aid of limited resources. The direction of resources to this purpose must only be encouraged.