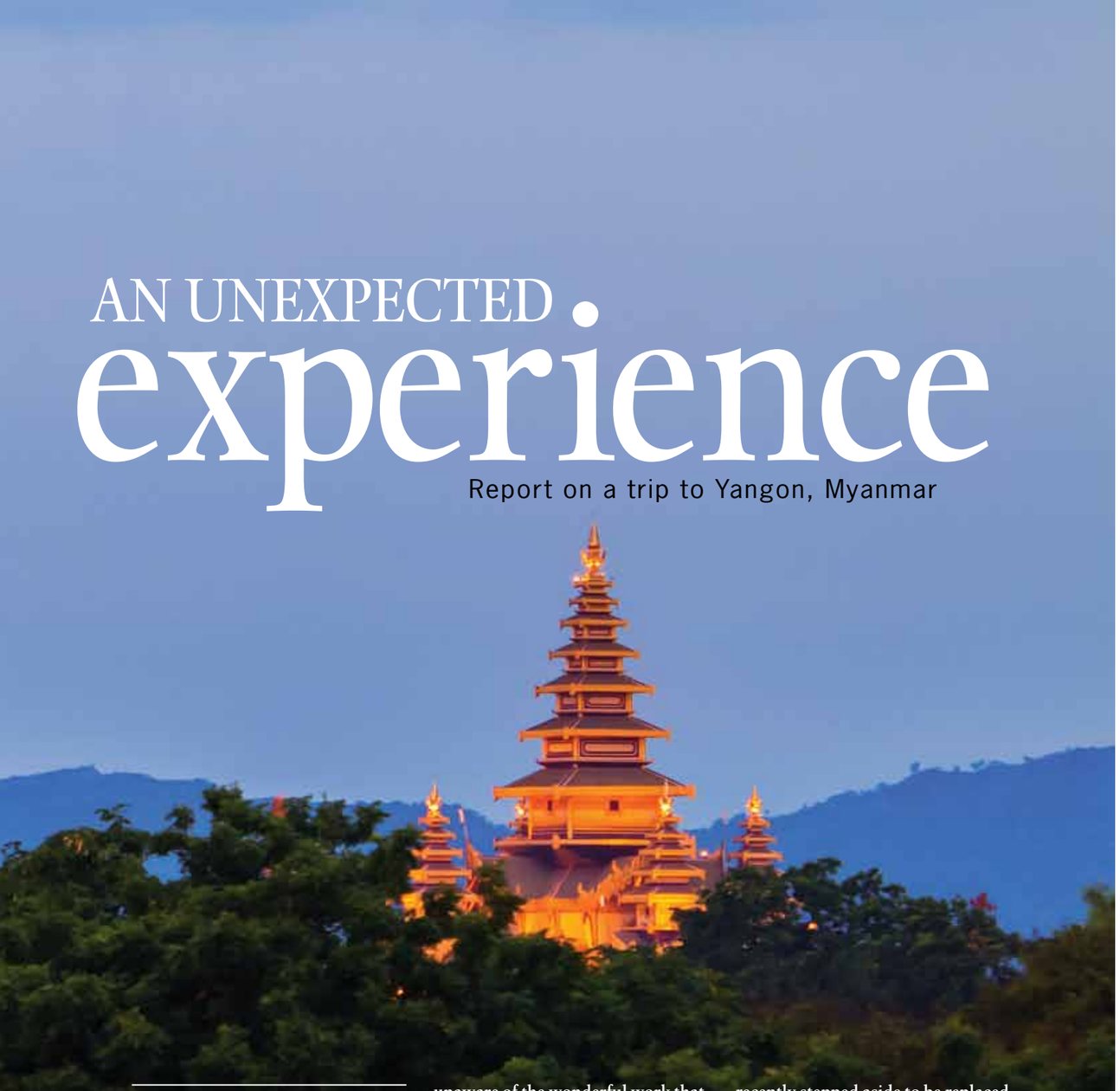
AN UNEXPECTED experience

Report on a trip to Yangon, Myanmar



JOHN MASTERTON
CHAIR, ROWAN NICKS COMMITTEE

Late one evening towards the end of January 2014 I received a most unexpected phone call from Sydney. It was from Bruce French, a member of the Rowan Nicks Committee. He, supported by Alan Gale, asked me if I would like to join a group from the Adventist Hospital in Sydney who were going to Yangon leaving mid-February.

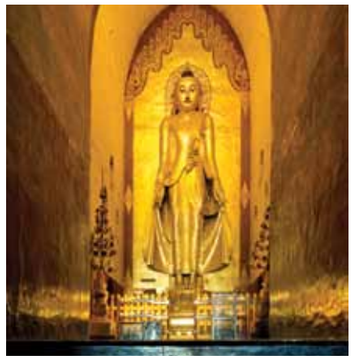
I was completely taken aback. First I had barely heard of the Adventist Hospital affectionately known as the San and secondly I was quite unaware of the wonderful work that had been done by the group over many years in the area of overseas aid in the field of cardiac surgery particularly in Myanmar.

The driving force behind this splendid work was Alan Gale, a cardiac surgeon with prodigious energy particularly in overseas aid. Some 10 years ago Alan started going regularly to Myanmar with a cardiac team from the San to teach and advise. The objective was very much in line with the philosophy of Rowan Nicks – to transfer knowledge and skill.

From early beginnings the team concept grew in scale. Alan has recently stepped aside to be replaced by Bruce French. But this is by no means an individual effort. The team to which I was invited consisted of nearly 45 volunteers all self-funded, which was a matter of some amazement to me.

It consisted of a very dedicated coordinator, Chris Waite, who is an intensive care nurse, three cardiac surgeons, anaesthetists and a very comprehensive group of cardiologists, nurses etc. Many of the participants had been to Yangon many times. I think the record was 16 times by Dr Paul Wajon, cardiac anaesthetist and perfusionist from Sydney.

Alan Gale (left) and Brigadier-General Tin, General Superintendent, Defence Services General Hospital, Yangon, Myanmar and Chief of Cardiac Surgical Services with John Masterton (right).



Rowan Nicks Scholar Win Win Kyaw with John Masterton.

When Bruce French first asked me, I was somewhat hesitant because I wondered where I would fit in. However, with significant encouragement from my colleagues in the Rowan Nicks Committee I accepted the invitation with alacrity. I am so glad I did. I knew that I would meet two former Rowan Nicks scholars in Yangon and a prospective scholar all of whom were cardiac surgeons. This was an added incentive.

The journey to Myanmar via Singapore was made that much more pleasant as I had as a companion a very charming paediatric intensive care nurse, Kiraka Nakazawa, who is based in Melbourne. Not all the team were from the Adventist Hospital. There were representatives from Adelaide, Brisbane and even an American Nurse who was based in Ulan Bator in Mongolia.

Coordinator Chris Waite set off for Myanmar on February 12 in order to get things organised. There was a considerable amount of equipment to be supervised bearing in mind that the team would be deployed in three hospitals. These were the Defence Services General Hospital and the Yangon General Hospital, which were the original hospitals to which Alan Gale had gone 10 years ago.

In recent times the Yangon General Hospital has been visited several times by our immediate past-President Michael Hollands. It is here that Professor Khin Maung Lwin our first Myanmar Rowan Nicks scholar is head of cardiac surgery. The third hospital where the team was to be working is a combined children's and adult hospital where our other scholar Prof. Win Win Kyaw is based. A small group was also to be deployed to Mandalay for a few days. I did not go there.

The whole party were put up in the Traders Hotel which is good as it is centrally located. Alan Gale, Kiraka and I arrived on the same flight from Singapore at close to midnight on Saturday, February 15.

It was characteristic of Myanmar hospitality that we were met at the airport by Win Win Kyaw, Aung Zaw Myo our next scholar who is going to St. Vincent's Hospital in Melbourne with Mr Yii the cardiac surgeon and Sandar Ko, a charming and incredibly helpful lady from the Defence Forces General Hospital. As it transpired, she looked after the needs of us all throughout the week ahead. We finally made it to the hotel about 1am on Sunday morning.

In spite of our late arrival Alan and I, after the usual American style sumptuous breakfast on the Sunday morning, fronted up at a case conference at Win Win's hospital at about 10.30am headed by Bruce French and Win Win who started off with presenting an extremely rare case of an infant with an abdominal aortic aneurysm which was given as a paper at the Annual Scientific Congress in Singapore.

Then a series of fascinating cases were presented and discussed with the aim to decide whether to operate during the week ahead. Other than Bruce French, there was Bruce Bastian, interventional cardiologist from Newcastle and a veteran of many visits, Rob Hislop, Intensivist from Royal Prince Alfred Hospital and a number of other members of the team. The interchange of ideas was very good. I looked on while Alan Gale participated in the discussion. ▶

Alan and I moved off after lunch to meet Prof. Khin Maung Lwin at the General Hospital with Aung Zaw Myo who is in the cardiac unit there. Once more there was a case conference where some very challenging problems were presented. Homayoun Jalali was the team's cardiac surgeon who was assigned to be at the General Hospital throughout the week. One patient who presented was in significant heart failure and was rejected as a candidate for surgery. That took us to the end of the day.

Monday was to be the beginning of the full working week for all the team with theatre sessions in all three hospitals under the team's remit. Alan was my guide. First we visited the Defence Services General Hospital, which is not purely for the military and deals with both adults and children. I was not able to ascertain how the general population gets access to this hospital, which is seemingly well funded and under the overall charge of Brigadier General Tin Maung Aye, a long time friend of Alan Gale.

We first visited the recently refurbished Intensive Care Unit where the staff had set up a display celebrating Alan's 10 years of involvement with the unit. This was quite impressive with acknowledgement of the Australian commitment (Open Heart International). The intensive care unit was spacious, well-equipped and on a par with similar facilities in Australia.

Next we went into the operating suite where two theatres were in full swing. In the first an open heart operation was just being concluded. The facilities in this and the neighbouring theatre were first class. For example the cameras recording the operations were very sophisticated and the heart lung machines were very adequate as observed by someone not himself an expert.

In the second theatre I witnessed the closure of an atrial septal defect being done under the supervision of Graham Nunn, from Sydney. Overall my impression was that the Military Hospital was well run and adequately financed. At the conclusion of our visit Col. Tin gave us a general review of the running of his facility.

The Military Hospital is quite far out of town and from there Alan and I called into the General Hospital briefly before returning to the Traders Hotel and the usual group meal in the evening.

Bruce French (left) with patients and staff and Rowan Nicks Scholar Win Win Kyaw (right).

"The team to which I was invited consisted of nearly 45 volunteers all self-funded, which was a matter of some amazement to me"

Tuesday saw us driving out to the Military Hospital again where Alan was due to give a talk which did not eventuate and there was a publicity photo shoot for the two of us. We then proceeded to the General Hospital where there was much discussion by the team's anaesthetist as to the wisdom of him anaesthetising a small child for a difficult open heart procedure. He felt uneasy about this as his expertise was in the adult field. Consequently, the case was cancelled.

On Wednesday we visited Win Win again. She was in the midst of inserting two prosthetic valves in a patient. Again bearing in mind my very superficial knowledge of these matters, I reckoned she did it very well. Alan thankfully agreed.

During the week I had the privilege of visiting cardiac catheter labs in the General and Military Hospitals. These were new experiences for me with a background of General Surgery and Burn Care. In both instances the facilities had been generously supported by overseas donors. Consequently they were not the very latest, but they seemed very adequate. The Open Heart International operatives seemed comfortable with them too.

The final night in Yangon was wonderful. We had a gala dinner in the Traders Hotel for all the team and our hosts who were generous in their thanks and generosity in presenting us with gifts. I at no time had felt on the outer. This was confirmed by many spontaneous remarks.

For my part I had a thoroughly rewarding time and met many people whom I will remember as friends. The Open Heart International was really a great group of people who deserve to be recognised much more for their contribution to the wellbeing of a people who are so much in need of support.

In conclusion, I have no doubt that this trip has helped me understand even more the vision of Rowan Nicks and the benefit of dialogue with those who need the help of our College.

Neuropsychological Evaluation for Cognitive impairment

DR BB G-LOVED

Last month I introduced you to Mr Burt Enderleng, a surgeon in his 70s with an arthritic hip and impaired mobility, who has recently had cases that have suffered complications. He consulted Dr BB G-loved asking, "Should I still be operating?"

Having assessed his physical capability, I must say I was in doubt that he had the stamina for a difficult procedure. Perhaps a hip replacement would restore his mobility and reduce his dependence on analgesics, but it was also my responsibility to assess his cognitive ability.

I gave him a standardised mini-mental examination (SMMSE). This is a commonly used screening test that involves 12 questions that most doctors can knock off in a couple of minutes. Burt Enderleng managed time, date and place (Q1-3), but did struggle on Q4 spelling WORLD backwards; he mixed up the O and the R, but corrected himself (DLORW to DLROW).

On the three words to remember, he got only two (Q5), and then, perhaps frustrated, was somewhat irritated by having to recognise a wristwatch (Q6), a pencil (Q7) and repeating the phrase "No ifs, ands or buts" (Q8). He could follow instructions and closed his eyes on the second prompting (Q9). His complete written sentence was, "I am not sure this is a valid test!" (Q10). His pentagons did overlap on the second attempt, though without the interlocking four-sided figure.

He could easily fold a paper with both hands and put the paper down on the floor, though this provoked a wince on account of his arthritic hip (Q12). In the end, he scored 26 out of 30 (probably abnormal in a high achiever, though in the normal range of 24+). One problem with the mini-mental is that it is only a screening test, and doctors being intelligent, may suffer considerable cognitive impairment before a mini-mental will detect it (ceiling effect).

I was concerned that he may have some mild cognitive impairment, but that is often only detected by co-workers becoming aware of declining work performance. This was why I hoped he would have the insight to undertake the College Competence and Performance Multisource Feedback Assessment.

I told him that I wanted an independent and more objective opinion and that I would arrange for neuropsychological evaluation (NPE) which involves three to four hours of intensive tests. The incidence of cognitive impairment and dementia rises with age, and to continue in operative practice, a high level performance was required, and thus he must be assessed using techniques that will detect subtle changes in his cognitive, motor, behavioural, linguistic or executive functioning.

Possible conditions causing cognitive impairment range from Alzheimer's disease to other types of dementia (vascular or Lewy body), Frontal lobe syndromes and dementia and Parkinson's disease.

There is a vast choice of neuropsychological tests targeting the different domains of higher function – intellectual functioning (Weschler Adult Intelligence Scales –WAIS), academic achievement (WIAT), language processing (Boston Naming Test), visual-spatial processing (Judgment of Line Orientation), attention/concentration (Vanderbilt Assessment Scale), verbal or visual learning and memory, executive functions (WAIS subsets), motor speed and strength, motivation, speed of processing and personality assessment.

NPE is a specialised area, but the tests provide quantifiable data about reasoning and problem solving ability, language, short and long-term memory, working memory and attention, processing speed, visual spatial organisation, visual motor coordination, planning, synthesising and organising abilities. The results are adjusted for estimated premorbid IQ, culture and age, and are less prone to ceiling effects.

NPE needs to be correlated with imaging, preferably a CT and/or MRI; sometimes a PET scan. These tests will differentiate between dementia and psuedodementia, and between deficiency related to disease (including dementia) as opposed to indifference.

In addition to standard lab tests, one should screen for chronic renal impairment, liver disease, hypercalcaemia, hypomagnesaemia, hypothyroidism, B12 deficiency (<250pmol/l is bad for your nervous system) and Vitamin D deficiency (<70nmol/l). It is also hard to draw conclusions about cognitive impairment in patients who are depressed.

Mr Burt Enderleng seemed to be genuinely concerned. He agreed to undertake performance assessment by peers, and to undergo neuropsychological evaluation. I hope he has the patience for the latter. I have to be vigilant when there is a risk of impairment in a medical practitioner, be it from ageing or from illness. His age places him in a higher risk group and the tools do exist that will answer his original question, "Should I still be operating?"

If he is cognitively impaired and does not retire from clinical practice, I will have to inform the Medical Board. My responsibilities are to protect the public as well as my patient, Mr Burt Enderleng. I hope his only problem is his hip.