Salamu (greetings) from Tanzania! It has been a busy few weeks here in Arusha, a bustling town at the base of Mt. Meru (an active volcano!) and about 60 miles from Mt. Kilimanjaro, the highest peak in Africa. Arusha is the starting point for many people who travel here to climb Kilimanjaro or go on safari in the Serengeti, so the town is an interesting mix of locals and wazungu (white people) tourists, NGO workers, and others. So far I have been spending most of my time at Selian Hospital, a small, rural complex about a 90 minute, mostly uphill walk from our house. Needless to say, sometimes I take the bus! Selian is a very interesting place, with more resources than some, but still very limited. Patients and their families pay cash, so we are limited not only by what services we have available, but also by how much a patient can afford. Learning how to practice medicine without the tests, imaging, and equipment that I’m used to having has been a very interesting challenge, and my learning curve has been steep! It’s an odd (and frustrating) feeling to have interns and registrars ask your opinion on diagnosis or management as if you’re the expert, but to have no advice to offer because nothing you would do at home is available here. I’ve seen more kids die here in 3 weeks than in my entire residency career (except perhaps the NICU), and of things children almost never die from at home: meningitis, TB, DKA. In some cases we will never know exactly what they died from. Sometimes I think that getting comfortable with not knowing is the hardest part.

On the bright side, I’ve also seen really sick kids make amazing recoveries. Nowhere is this more apparent than in the NICU at ALMC (Arusha Lutheran Medical Center), the other hospital where I spend my time. This hospital is in the center of town, and is a larger, tertiary care center. The NICU there is one of the most modern, well-equipped NICUs in the country. It’s nowhere near a level IV NICU at home (for example, we have no vents, and our CBC machine was broken the entirety of my first 2 weeks), but our survival rate is 90%, which includes 600 gram preemies and kids with severe HIE. It’s pretty amazing how much you can do with just CPAP, kangaroo care, and NG feeds. The Tanzanian doctors we’ve been working with are also really impressive. By necessity, their clinical skills are much broader than ours – by the end of their intern year, all physicians, regardless of specialty, can perform C-sections, repair hernias, resuscitate babies, and respond to any number of emergencies in patients of all ages. In Tanzania, you have to pay to complete residency, so for some physicians, intern year is the extent of their formal training. Good thing they acquire so many skills in that time! On weekends we explore the city, take Swahili lessons, and enjoy the warm weather, while reading about blizzards at home :-)

I am also looking forward to some more travel opportunities in the coming weeks. In the meantime, if you are thinking of coming to Tanzania, karibu muda wowote (you are welcome anytime)!

If you are interested in the Pediatric Global Health Track or have something to add to this newsletter contact Emily Danich at edanich@umn.edu
Dear Friends,

We have a unique opportunity this month. On April 18th at 6 pm we will learn about Native American Child Health from local experts. This month, Pediatrics is leading the Tropical and Travel Medicine Seminar in Ben Pomeroy Student Alumni Center, Room 215 on the St. Paul Campus.

For our Global Health Pediatrics track residents - this is an opportunity you will want to make every effort to attend. Dr. Krish Subrahmanian and colleagues will present and lead the discussion. Dr. Joe Wooley also introduce you to a new elective in Rosebud, South Dakota. A light dinner will be served.

See you there! Cindy

Publications:

Acute bilirubin encephalopathy and its progression to kernicterus: current perspectives

The U.N Set 17 Goals To Make The World A Better Place. How's It Doing?

‘Amazing’ News about the Awful Guinea Worm

Phew! That's the single word that describes how I've felt the last 12 days. I feel like I've been running a marathon since the end of March, and it's only just beginning to slow down. My marathon started with E.K, a 6yo girl with nephrotic syndrome that was brought in with a 2 day history of unconsciousness and several weeks of puffiness. Her GCS was 6 at admission and her sodium was 115. But this last Sunday, EK was at the hospital chapel service with her uncle and I beamed with joy when they said hello! EK's management has not been as challenging as B.F, the 7yo boy that came in on a Saturday evening with inspiratory stridor which rapidly progressed to biphasic stridor and near-complete upper airway obstruction. He had pseudo-membranes all over his tonsils and oro-pharynx. We made a clinical diagnosis of respiratory diphtheria. Dexamethasone and nebulized epinephrine didn't do much for him. He needed to be emergently intubated and I became his primary intensivist, supported from a distance by Dr. Slusher. He was intubated for 2 days before we switched him to a tracheostomy tube, and he still needed mechanical ventilation for another 3 days because he had developed aspiration pneumonia. Both EK and BF are still not completely “out of the woods”, but they are doing much better now, and such patients keep me going.

I feel I've lost as many patients in the last 3 weeks, as the first 3 months. Some may have lived if they were in the U.S. A 4-day old, 32 week preterm male was referred for management of intestinal obstruction. He also had severe neonatal jaundice exceeding cut off for EBT. I started an exchange blood transfusion. We controlled his jaundice, stabilized electrolytes, obtained an abdominal x-ray that showed the classic double-bubble sign of a proximal intestinal obstruction, which confirmed my diagnosis of duodenal versus jejunal atresia. However, that was not all of his pathology! When he was taken to the OR on Easter Sunday, the surgeon found that the rest of his small intestine distal to the atresia was gangrenous all the way to the cecum from malrotation. There's no way to survive without small intestines in this environment, as we do not even have the capacity to provide TPN. My best parenteral concoctions have been made up of amino acids, dextrose and electrolytes. We also cannot send people home with central lines and home nursing. There appears to be no center for intestinal transplants in sub-Saharan Africa, based on my wife's research and email exchanges with a transplant network. Even if he could get a transplant, the lifelong immunosuppression and troubleshooting would be a herculean task for his 19 yo first-time mother and very doting father. So, the parents opted for palliative care and took him home. The little guy probably died after a few days. His story still breaks my heart even as I write.

On a more positive note, I’m trying to work on some quality improvement projects this last three weeks. I was able to take a break with my family this past Saturday morning to attend the wedding ceremony of one of the surgical residents (See picture). I am grateful to have been able to participate in the care of pediatric patients at Mbingo Baptist Hospital since the middle of January. I will miss the people and this beautiful place when we head back to Minnesota at the end of April, but I’m also looking forward to getting some rest. Now I need to get back to writing my email consults as I have some challenging cases for which I need input from specialists.

Chief’s Corner—Note from Dr. Ife Ojo while in Cameroon:

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