Editorial

Editor's perspectives — January 2014

This new year editorial will not take the form of my previous perspectives due to the fact that I am attending the College of Surgeons of East, Central and Southern Africa meeting in Harare, Zimbabwe, and I do not have access to the articles to be published in this edition.

Therefore I am going to take the opportunity of writing about what I have been learning about at the conference with its emphasis on the problems encountered working in third world conditions, and perhaps compare the problems to those faced in the first world.

Of course, some of the problems are the same and the type of surgery performed very much depends on the resources available. Minimal Access Surgery is practised to some extent in the larger centres and in the private sector, but hardly ever in the rural setting or in the poorer countries.

Patients present much later in the third world so that their conditions and the pathology is much more advanced than we usually see. There are a variety of reasons for their late presentation — often the distance to the nearest hospital is enormous; the cost of travelling to the hospital beyond their means; fear of what may be done to them in hospital; treatment, and therefore delay, by non-medically qualified persons; ignorance and the unavailability of treatment.

Some conditions uncommon in the Western world such as volvulus, possibly due to genetic anatomical differences, or a very high fibre diet are much more common. HIV and the place of circumcision was covered extensively. Trauma from road traffic accidents, civil wars and domestic violence is rife and accounts for a large proportion of admission to hospitals. It more often than not affects younger people and is a huge drain on most countries’ financial resources, as well as a loss to the economy by the loss of working days.

Most of the more sophisticated and specialized topics were presented from surgeons working in large centres. Endoscopic surgery featured in many papers from Harare surgeons in Zimbabwe, yet even diagnostic laparoscopy was rare in most countries. Advanced minimal access surgery is rarely performed due to the expense, lack of facilities and/or lack of trainers. One of the lectures I presented was on laparoscopic hernia repair. One of the many questions put to me was “what is the place of these operations where resources are limited or in the rural setting?” My answer was naturally “none” and I described my experiences working for “Operation Hernia” in South America where we repaired most hernias under local anaesthetic using sterilized mosquito net as the mesh.

It was a rare opportunity to see conditions thankfully not, or very very rarely, seen by me now such as advanced breast cancer, Kaposi sarcomas etc., as well as those conditions I am more used to seeing.

I will be visiting some of the hospitals in and around Harare over the next few days and I am sure I will learn much more from their surgeons than they will learn from me. I believe there should be much more cross fertilization especially with trainee and younger surgeons. The experience of working in a third world country is immense, and for their surgeons the ability to be exposed to more modern techniques and research is invaluable.

Another year stretches before us and I wonder whether the divide between the richer and poorer countries will increase or improve. If we can share our knowledge and practices more, hopefully we can decrease this chasm.

Although I am uncertain of the content of this edition I feel certain it will be of our usual high standard and contain helpful articles for all of you.

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Available online 13 December 2013