Overseas Specialist Surgical Association of Australia (OSSAA)

Hospital National Guido Valadares (HNGV)
Dili, Timor Leste

Plastic and Reconstructive Surgery team visit

4 – 11 March 2023

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Plastic and Craniofacial Surgeon

Team Leader, OSSAA

INTRODUCTION

Following the successful return of our OSSAA Plastic and Reconstructive surgical team to HNGV in Dili in November 2022 for the first time post-Covid pandemic, the large number of still untreated cases reinforced the need for a rapid follow-up visit in early 2023.

Negotiating with our long term clinical East Timorese counterparts, there was a clear desire on the part of the HNGV administrative staff to take ownership of the organisation and logistics of the in-country aspects of the teams visit. This transition of responsibility represents another small but important step in the 'decolonisation' of the delivery of specialist surgical services in Timor Leste. For the first time our HNGV counterpart clinicians and hospital executive took full responsibility for advertising of the impending visit, arranging outpatient assessment clinic and in hospital allocation of operating theatre time and staffing, and surgical ward alterations to facilitate the large volume of surgical patients managed throughout the week.

Having determined that the OSSAA team should return early, news a week before our arrival that Dr Joao Ximenes would soon be heading to Cuba on a scholarship aiming to achieve specialist training, added to the importance of this visit. The wonderful news that Joao would at last get some formal recognition of his special surgical skills is tinged with sadness that we will be without him for 2 years. This visit did allow for further support of Dr Quely, who we first worked with in November 2022 and who Dr Joao has anointed as his replacement in his absence. Continuity of the program should thus be maintained.

This visit occurs almost 23 years to the day since our surgeons first signed agreements with what was then Rumah Sakit Umum Dili, now HNGV and is the 50th volunteer surgical team to work in Timor Leste under the OSSAA banner.

TEAM PERSONEL :

The visiting OSSAA team for this visit to HNGV, Dili was as follows:

Dr Mark Moore	Plastic and Craniofacial Surgeon Women's and Children's Hospital and Royal Adelaide Hospital, Adelaide
Dr Matthew Grill	Anaesthetist Women's and Children's Hospital and Private Practice, Adelaide
Sr Vanessa Dittmar	Theatre Nurse Women's and Children's Hospital, Adelaide
Sr Amanda McFall	Anaesthetic/ Recovery Nurse Women's and Children's Hospital, Adelaide

PARTICIPATING LOCAL STAFF AND COUNTERPARTS:

The planning and in-country organisational effort for this visit was orchestrated by the executive and clinical staff of the HNGV. Under the leadership of Dr Marcelino and Dr Alito, the Clinical and Executive Directors of the HNGV all preparations for the team were performed by hospital staff.

In particular arrangements for advertising the visit were facilitated via the medium of social media, led by Mr Mok (Cornelio Mok Freitas) our operating theatre nurse coordinator- Facebook and WhatsApp proving a spectacular success in attracting many patients for assessment. Mr Mok and the team also oversaw the planning of the outpatient clinic, arrangements for the operating theatre availability and staffing, and the planning of inpatient ward arrangements.

Dr Joao Ximenes, our counterpart reconstructive surgeon was again joined by his junior colleague Dr Quely Tolendino in the surgery.

Dr Colom da Silva, head of anaesthesia, was assisted by Dr Nanda and Dr Mena, his colleagues and trainees.

Many familiar faces on the scrub nurse, anaesthetic nurse, recovery nurse and sterilising department side assisted with the successful week.

Special mention should be made of Mr Carlito, the senior nurse in Outpatients who has worked at HNGV for more than 40 years, and who organised and controlled a busy but productive outpatient assessment clinic for more than 8 hours on the first Saturday of our visit.

OVERVIEW :

Pre-visit organisation for our team occurred directly with the HNGV administration and executive, the day to day liaison regarding transport, customs permissions and clearances in the hands of Mr Mok and Dr Joao Ximenes.

Hospital administration held meetings in advance of our arrival and set in place the facilities to have two operating tables in the one theatre working simultaneously. Based on the volume of work expected, minimising the disruption to the other operating theatres as well as allowing for the cross pollination of ideas and assistance/ guidance for both surgical and anaesthetic teams, this seemed and indeed functioned as a very successful logistical solution. The potential infection control issue was noted but did not materialise. Each operating team consistently performed the surgical checklist for each operative case.

The team arrived on the Friday afternoon flight and was met by Mr Mok, who facilitated an uneventful passage through airport customs. Transfer to the Plaza Hotel followed, with outpatient assessment clinic scheduled for early on Saturday morning at HNGV.

Outpatient screening once again continued from 0830hr through till about 1700hr, with over 130 cases assessed, triaged for surgical lists or waitlisted. After seeing 60-70 cases we had once again filled our operating lists for the following week, meaning the need to construct a waitlist for future visits. The concept of how to construct and maintain a waitlist was discussed with local colleagues so as minimise the disappointment and frustration for cases traveling long distance on more than one occasion without accessing care. They expressed a desire to further explore how this can be managed and applied for future visits. Interestingly on this visit, of the 19 cleft palate procedures performed, 5 patients were seen and waitlisted for palate repair in November 2022, and 4 patients underwent cleft lip repair in November, returning early for palate repair – effectively 9 of the 19 cleft palate repair cases were waitlisted.

Several severe burn contractures in young patients were seen and need to be surgically managed on the next visit. The treatment of burns acutely and of late contractures remains a large unmet need, somewhat compromised by the lack of post-operative physiotherapy and splinting services.

The operating theatre was set up to allow two operating tables to function side by side. Its large size allowed Dr JX to work under the theatre fixed light while Dr Mark used the small mobile light to one side of the room. Most days the starting times for each list were slightly staggered, thus allowing efficient use of space and human resources.

Theatre lists were drawn up for each day, and then allocated to one or other of the operating tables. Dr JX continued to focus on the unilateral lip repair patients, with these cases anaesthetised by Dr Colom, Dr Nanda and the Timorese nurse anaesthetist staff. By weeks end he had performed another 15 primary lip repairs as well as one lip revision procedure. Dr Mark was assisted by Dr Quely throughout the week with a focus on cleft palate and bilateral cleft lip cases. These patients were anaesthetised by Dr Matt assisted by local anaesthetic trainee Dr Mena and other nurse anaesthetists.

Maintenance of rapid surgical case turnover was possible because of the excellent work of the sterilising staff – Mr Calisto and his colleagues ensuring that both operating tables could continue without delays. Some shortage of theatre gowns meant that disposable gowns were used to supplement later in the week.

Be the end of the 5 days operating we had completed 58 elective procedures on 55 patients – several of the cleft cases needing two procedures. Late on Friday one of the general surgeons consulted us about a 1 year old girl with poorly controlled hydrocephalus and an exposed non-functioning ventriculo-peritoneal shunt. We described a solution for management of the soft tissue wounds, and were able to perform surgery as an emergency on Saturday morning before Dr Matt departed home. When seen 4 days later the patient remained free of overt infection, but will sadly not progress well in the long term.

During the week three cases were deferred because of fever/ chest infection, with replacement cases being rapidly located so as to best utilise the available time. One cleft palate patient required a return to theatre from recovery for post operative bleeding, with an uncomplicated course subsequently.

At the completion of the week the OSSAA teams have now almost completed 1200 cleft operations in Timor Leste. Dr JX has continued to perform cleft lip surgery in the interim since our November visit – about 15 case of unilateral cleft lip repair. Of our team's cleft cases operated since the year 2000, 1072 are primary operations, with 77% being cleft lip repairs. This ratio of predominantly cleft lips is distinctly different from what we experience in a high income country like Australia. There remain many factors which continue to limit the number of cleft palate repairs performed including awareness of cleft palate, especially isolated cleft palate, education, feeding issue in palatal clefts and timely access to surgery.

Dr JX imminent departure to Cuba for specialist training leaves a potential deficit in local resources. His interim replacement Dr Quely is junior, but does have the support of Dr Colom and the theatre nursing staff. Our team will also have a role in mentoring her during this new phase.

The executive of HNGV acknowledges our teams successful visit with a short formal function at the end of the week. Speeches were given outlining the activities and the learning outcomes from both sides. We were able to confirm that the administrative staff of HNGV had indeed facilitated and overseen a very successful, productive week of clinical work and teaching, which should provide a template for ongoing visits. Ongoing refinement and modification of accommodation and transport arrangements may further improve service delivery – possibility of on - site accommodation of the team to better oversee pre and post operative care, and reduce demands on transport.

Several of the team had the opportunity to visit Baucau for a few days after the week in Dili. Dr JX arranged for us to meet Dr Evangelino, the director of the Baucau, and a short tour of the hospital and theatre complex was possible. There was general enthusiasm from Dr Lino and the head of the operating theatre Mr Alcino (who has worked with our team previously at the old Baucau Hospital) for a return visit by our team, thus reducing the travel needs of patients from Viqueque, Los Palos and Baucau.

Among the patients assessed there were two with significant craniofacial deformities whose surgical management can not be performed in Timor Leste. A 4 year old with orbitofacial neurofibromatosis, referred by Dr Joao Pedro, general surgeon will need a combined transcranial

approach to treat her eye socket issue. A young child was born at HNGV on the day our team arrived with bilateral Tessier oro-ocular clefts – seen on day 3 of life, we have commenced the process for sponsoring initial surgical treatment in Adelaide.

In addition a 26 year old woman with a significant midfacial deformity after previous upper jaw resection in Timor Leste, with subsequent free flap reconstruction in Indonesia requires extensive further surgery if she is to achieve any sort of quality of life. Her case will be discussed with colleagues here in Australia to evaluate further reconstructive surgical options.

Timor Leste continues to be a place of amazing coincidences and chance meetings. Whilst operating in Dili discussion turned to a patient with bilateral cleft lip and palate who was treated about 20 years ago . Aged 12 years then, she had both her lip and palate treated simultaneously. Mr Mok noted that she was his senior by 2 years at school which was where we followed her up many years ago, and have not seen her since. Then Dr Quely explained she also knew this patient, and on her phone showed a photo of the patient now married and with a child.

Whilst visiting Baucau hospital we met Mr Alcino, now in charge of theatres, who we worked with back in the old hospital. In his office in pride of place was an old photo of Dr Dave Sainsbury taken with staff more than 10 years ago on one of our previous visits. Two days later at HNGV I bumped into Mr Alcino in the carpark as he attended a management seminar -after not seeing him for 10 years, we meet twice in 3 days. Minutes before that had a chance meeting with Mr Elvis Guterres, who worked for RACS and assisted our team about 10 years ago. We have not seen him since and he described being in Mozambique for 5 years, and is now assisting with the East Timor Eye Project screening programme.

RECOMMENDATIONS :

Ongoing and increased support for plastic and reconstructive surgery services in Timor Leste whilst Dr Joao Ximenes away obtaining specialist qualification in Cuba.

Evolution of the relationship with HNGV administration re trip planning

- Accommodation potentially closer to hospital if Dr Quely needs extra support after hours.
- Transport provided by Mr Mok and hospital vehicle – may refine further.

Proposed visit to Baucau later in the year – perhaps coincident with a Dili team – need for more resources and consumables.

Development of a waitlist for next visit – have list constructed in advance of the visit. Allows better planning of consumables needed and less disappointment for untreated patients.

Two children and one adult patient potentially in need of treatment in Australia with charitable support.

ACKNOWLEDGEMENTS :

Special thanks is due to the whole of the HNGV team which welcomed our OSSAA team for the second time in 4 months, providing a very professional and efficient atmosphere where we could work toward our common goal of treating so many patients. This included the team's in country transport, and meals for the team and theatre staff.

To Mok, whose attention to all the details of making our trip a success was of the highest order and set the standard for future visits.

To Ronnie who drove the team to and from the hospital each day, waiting patiently for our late finishes.

Ethicon/ Johnson and Johnson for their ongoing generous support of suture supplies, that enable the ongoing treatment of so many cleft cases.
The various public and private hospitals in Adelaide which support our team and its various members.

NURSING REPORT

We had an an amazing week undertaking procedures on 56 Surgical patients collaboratively with the efforts of Dr Joao Ximenes and his colleagues at NGV. The days were busy, though not horrendous with most days being finished by 1700 hours.

Dr Joao Ximenes and Mr Cornelio Freitas are to be commended for their efforts working with the hospital to coordinate such a successful visit by our team, taking ownership of the program.

Mok and Theo were the two most consistent nurses who worked with the team. Interest from other staff members was greater at the start of the week, with a number of nursing students present on one of the days also. One of the nursing students was given the opportunity to double scrub with a case for Dr Joao.

In order to successfully achieve the volume and teaching undertaken this week, Mok had organised for two operating tables to be set up in the same large operating theatre. Whilst he had some concerns about infection control practices, there was a clear delineation between the surgical team and scrub nurse for each table with no cross over contaminations. The greatest risk was the volume of cables running along the floor creating trip hazards.

The scavenging from the machines was joined together before it reached the wall outlet. This presented no issues for staff working in this environment.
Staff were observed to remain diligent with their sharps management. The counting process seemed to run out of steam as the week progressed.
Mok maintained his role of charge nurse for the week. The role was delegated back to myself for coordination on the occasion he needed to step out and then Theo took control of the scrub procedures.
Mok took control of the start of day huddle most days, delegating this role to me on day two, I think simply to get a perspective on another person running this. He did extremely well in making a roll of stickers available for all staff each day to write their name and role on in order to facilitate communication between all OSSAA and HNGV theatre staff.

Our operating lists did not necessarily reflect the locations of patients and on the occasion we needed to use staff from outside our team to send for patients, this was sometimes more difficult and perhaps something we need to do better next time.

Printed pages of surgical safety check lists were made available for most patients. We ran out of copies on a few occasions and undertook verbal ones. The copies of the checklists appeared to stay in theatre and were not placed in the patients notes during their intraoperative episode and therefore am unsure whether they are undertaken for perioperative audit purposes or on a larger scale.

Staff engaged in undertaking surgical counts with enthusiasm at the start of the week, however that enthusiasm waned as the week went on and there were a few instances where countable items were observed to be added without being added to their documented count. Their surgical counts were undertaken on the white board for each case and then erased. Opportunity to develop this further and gain further traction would be for Mok to take the lead and document a small table on the back of the surgical safety check list page to ensure

that momentum is followed through as an entire patient safety sheet and permanent record making the sheet a double sided sheet.
Interestingly there was a document on the wall reminding anaesthetic staff about the use of raytec and surgical counts. There were however no packs or gauze with any raytec strips in them for this to be relevant.

Mok found the usual tin sterilised gauze to be quite thick and managed to source some other gauze with less loose threads for surgical procedures, however these had to be opened individually and contained no raytec strip in them. They were what we would describe and use as dressing gauze.
A multitude of linen bundles were placed on a trolley outside our theatre each day. The bundles were shared between patients with clean hands. Disposable gowns were provided on occasion when they were short on linen gowns.
No efforts were made by any of the scrub staff to make their trolleys waterproof. The cover was a double layer of drape not impervious to fluid.

The theatres had not been cleaned when we arrived on Tuesday morning from the day prior which marginally delayed our start time. Bins do not appear to be emptied between cases, instead when they are full or at the end of the day. Scrub staff were observed to wipe their trolleys with aquiem hand gel and a gauze between cases however there were no visible attempts to clean the operating table or any solutions available to facilitate this process. Instead clean bed sheets were made available for each patient. An informal checklist for the wall could be developed as a reminder and prompt for all staff.

The anaesthetic machine used by Dr Grill passed all of its testing prior to use however part way through the Monday list, it was observed that the sevo was leaking onto the bench of the machine. The cannister did not appear to lock onto the machine adequately even when the Isofluorane cannister was removed. Dr Colam removed the Sevofluorane cannister from his machine and indicated he had no problem with this as they rarely used it, having their own local supply issues and therefore primarily used isofluorane.
Many thanks to Mr Calisto in CSD for his assistance in washing and packing trays. The bench top sterilisers again were used for our Plastics trays and Dr Joao's sets. The larger sterilisers were used for the linen and gowns. The trays did occasionally come out wet and needed additional drying time.

Some of the instruments on our trays need to be revised. There is at least one needle holder, a couple of scissors and a few forceps that potentially need replacing.
We need to find a reliable supplier for the CO2 tubing as these are no longer available via our previous access methods. It may mean we need to look at some new portable capnograph units given the age of these machines also.
The globes on the laryngoscope handles are also quite old and would be beneficial to source some quotes on new LED handles however the capgnographs are possibly more urgent.

A significant number of Cleft palate repairs remain on the waitlist and were restricted based on our availability of equipment. These patients on a list developed by Dr Joao should be offered priority on the next surgical mission, and at least one extra gag with an appropriate complement of tongue blades for that gag.
The resources for the next trip need to factor in the waitlist and what was achieved on this trip with a small margin on top of that. Given Dr Joao will not be in country next visit, two surgeons could potentially be considered.

Had we recognised the volume of work to be undertaken and taken more equipment, more procedures possibly could have been performed on this visit. We ran out of dental needles Thursday afternoon and both Palate sutures and Marks gloves early Friday morning. We came extremely close to running out of Local Anaesthetic by the end of the trip also.

We need to work on the fact that staff do not disappear to the tea room between cases and do in fact stay and get ready early. There were a couple of occasions where the surgeons were scrubbing and we had to go and find staff.

Mok is an extremely valuable member and resource to OSSAA however we need to engage with his management and other staff more also.
Mok made himself very available to us however it was evident that he was stretching himself thin to do so. He has a large commitment to this team and project however there also needs to be more engagement from other staff beyond just him to sustain this ongoing.

A big congratulations to Dr Joao for being able to receive a formal scholarship in CUBA. This will place extra demand on Mok in the future and we need to be mindful that he has a wife studying overseas and is looking after two children with family support. He also intends to Study abroad himself which he should be commended for his ambition and determination which is why there needs to be greater involvement from more HNGV theatre staff.

For small children weight considerations need to be added to the surgical safety check list to ensure safe doses of lignospan are administered.

HNGV management and Mok could be provided with RAH and WCH policies on mobile phones, in addition to RAH, WCH and Acorn Cleaning schedules to help guide and develop their own governance schedules. They could also be provided with Surgical count sheets from RAH and WCH to help them provide a framework to develop their own to further enhance patient safety.

All of the HNGV staff should be commended on their efforts for making this such a successful trip

Vanessa Dittmar

SUMMARY OF CLINICAL ACTIVITIES :

Total Patient Consultations **> 140**

Cleft lip/ palate **> 100**

Total Surgical Procedures **59**

56 patients operated, 3 had two procedures

Cleft lip – Unilateral	**24**
- **Bilateral**	**5**
Cleft palate	**19**
Alveolar bone graft	**1**
Cleft lip revision	**3**
Cleft palate revision	**1**
Lip pit excision	**1**
Burn surgery	**2**
Flap revision	**1**
Neurofibromatosis exc	**1**
Scalp wound /flap	**1**

Gender :

Male	**35**
Female	**21**

Age range :

< 1 year	**13**
1-2 year	**10**
2-5 years	**18**
5-10 years	**5**
>10 years	**10**

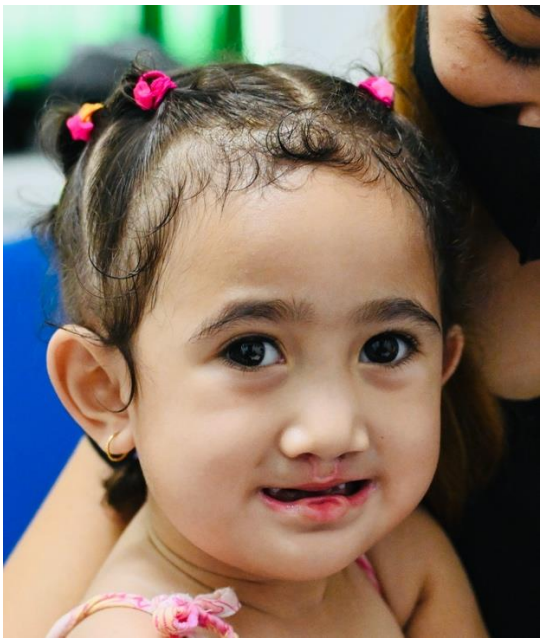
Primary Cleft Surgery :

Cleft Lip		**29**
	<1 year	**9**
	1-2 years	**9**
	2-5 years	**9**
	5-10 years	**1**
	>10 years	**1**
Cleft Palate		**19**
	<1 year	**3**
	1-2 years	**1**
	2-5 years	**9**
	5-10 years	**4**
	>10 years	**2**

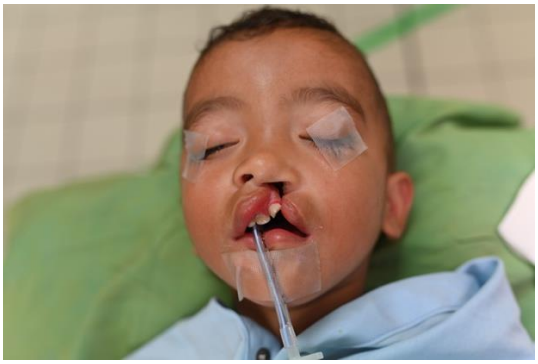
HNGV entrance with banner welcoming OSSAA team

Outpatient clinic with more than 100 patients registered and being triaged

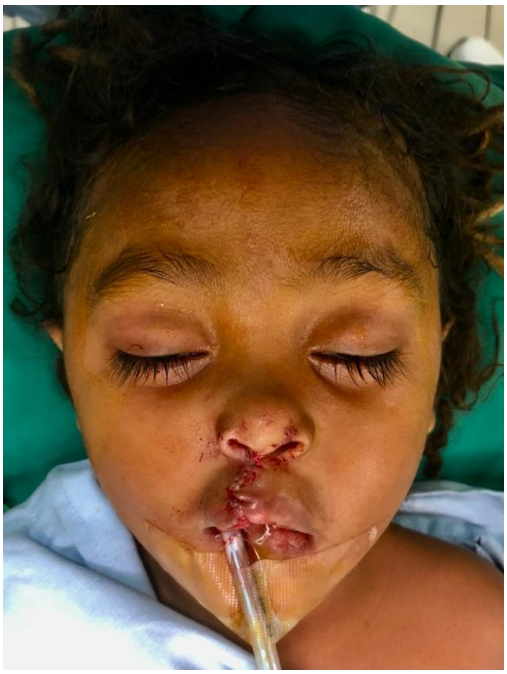
Two operating tables in the one theatre space (above), and Dr JX operating on cleft lip patient with Dr Colom overseeing the anaesthetic (below)



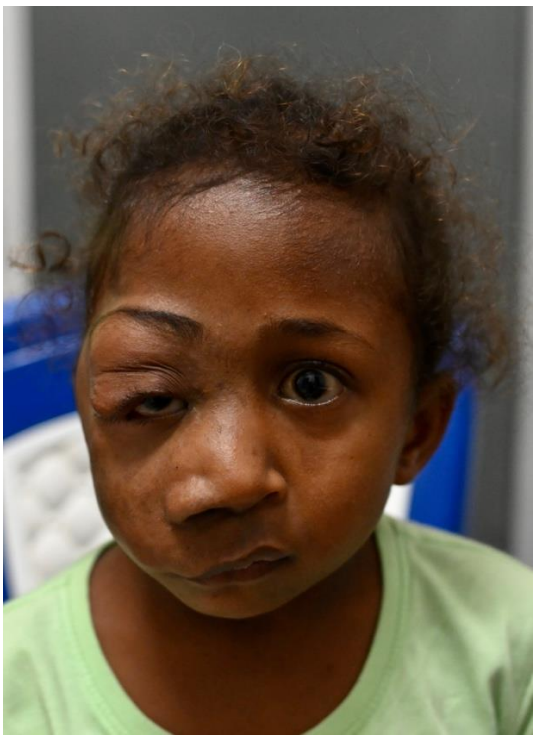
Two patients with bilateral cleft lip and palate who underwent lip repair in November 2022, returned this visit for palate repair. The lower patient with Van der Woude syndrome also underwent excision of lower lip pits.



Left complete cleft lip, pre- and post-operative views



Right complete cleft lip, pre- and post-operative views



Right orbitocranial neurofibromatosis

Rare oro-ocular (Tessier) clefts

Mok with OSSAA team members

Dr Joao Ximenes with Dr Mark Moore