BOTSWANA SURGICAL SOCIETY

Promoting excellence in surgical care

7TH ANNUAL GENERAL MEETING & SCIENTIFIC CONGRESS

8-9 NOVEMBER 2024 | 07h30 - 16h30 DAILY | GRAND ARIA HOTEL, GABORONE

THEME: ACCESS TO SURGICAL CARE, BRIDGING THE GAP

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BOTSWANA SURGICAL SOCIETY
Promoting excellence in surgical care

FOREWORD

Dr Moneimang Makgasa
BSS President

Dear Esteemed Members, Colleagues, and Guests,

It is a great honor and privilege to welcome you to the 7th Annual General Meeting and Scientific Congress of the Botswana Surgical Society. This year, we come together under a theme that resonates deeply with our shared mission: ***"Access to Surgical Care - Bridging the Gap."*** As we gather to address the complexities of access to surgical care, we acknowledge that, like many middle-income countries, Botswana faces unique challenges in ensuring timely and equitable care for all.

Throughout this congress, we will explore the realities of access limitations, the implications of delayed care and diagnosis, and the steps we can take to bridge these gaps. The presentations and discussions ahead promise to shed light on these pressing issues, inspire new approaches, and reinforce our collective commitment to advancing surgical care in Botswana.

This congress also marks an important occasion as we elect a new committee. We look forward to the dedication and vision that our incoming leaders will bring, carrying forward the Society's mission with vigour and determination.

Thank you for your presence and participation. Let us make the most of this gathering, learn from one another, and strengthen our resolve to ensure accessible and quality surgical care for all. Welcome, and may this year's congress be inspiring and fruitful for everyone.

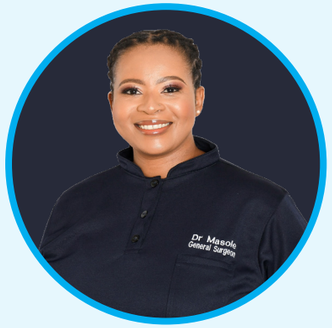
Enjoy the congress.

BOTSWANA SURGICAL SOCIETY
Promoting excellence in surgical care

BSS COMMITTEE

PRESIDENT
Dr Moneimang Makgasa
MB ChB (NUIG), FCS-ECSA, FRCSI
Consultant General Surgeon and Interventional Endoscopist
Based @ Sidilega Private Hospital and SKMTH

VICE PRESIDENT
Dr Mpapho Motsumi
PhD(Surgery), MMed Gen. Surg, FCS (SA), FCS(ECSA), MCS(ECSA), MUDr
Head of Surgery Department & Senior Lecturer in General Surgery
COSECSA Country Rep
Faculty of Medicine, University of Botswana



SECRETARY
Dr Ludo Masole
MBBS(Monash Aus), FCS(SA), Mmed Gen Surg(Wits)
General and Laparoscopic Surgeon
Based @ SKMTH & Sidilega Private Hospital

DEPUTY SECRETARY
Dr Nkhabe Chinyepi
MBBS(UWI), FCS(SA), Mmed Gen Surg (UCT)
Lecturer in General Surgery
Faculty of Medicine, University of Botswana

TREASURER
Dr Raymond T. Ladu
MBBS, MMED(Surg), FICS, FCS(ECSA)
General Surgeon
City Medical Centre, Riverside and Francistown Academic Hospital

SOUTH REPRESENTATIVE
Dr Kefilwe Boineelo Benjamin
MBBS Hons (Monash), Fc Orth SA, Mmed Ortho (Wits)
Hand Fellow: CHBAH Hand Unit
Orthopaedic Hand and Upper Limb Surgeon

NORTH REPRESENTATIVE
Dr Andrew Ojuka
MBChB, MMed Surgery, FCS(ECSA), DMAS
General Surgeon, Riverside Hospital, Francistown

BOTSWANA SURGICAL SOCIETY
Promoting excellence in surgical care

PROGRAM OF EVENTS

BOTSWANA SURGICAL SOCIETY
7TH ANNUAL GENERAL MEETING & SCIENTIFIC CONGRESS

November 8-9, 2024

PROGRAM

DAY 1

BOTSWANA SURGICAL SOCIETY
Promoting excellence in surgical care

FRIDAY 8 NOVEMBER 2024

TIME	SUBJECT	TOPIC	PRESENTER
0730 - 0830	Arrival and Registration	Arrival and Registration	All Participants
0830 - 0840	Welcome	Welcome Remarks	President
0840 - 0900	Foreword	Guest of Honour - Dr Juliet Bataringaya	WHO Botswana Representative
0900 - 0920	BSS Charity Work	Ghanzi Outreach report	Dr Masole
0920 - 0940	Surgical Access in BW	Lessons from BSS outreaches - needs assessment report	Dr Makgasa
0940 - 1000	Primary Health	Primary healthcare revitalization - pathway to improved access to surgery	Dr Ramotsababa
1000 - 1020	Surgical Training	Surgical training progress - the role of society	Dr Motsumi
1020 - 1040	Paediatric Surgery	Botswana paediatric Surgical Services - 5 year comprehensive plan	Dr K. Motlhobogwa
1040 - 1100	Tea Break	Tea Break	Tea Break
1100 - 1115	Sponsor	Diagnofirm Laboratories Botswana	Diagnofirm Laboratories Botswana
1115 - 1140	Global Surgery	Comparison of Robotic vs Conventional Total Knee Arthroplasty- a propensity matched pair analysis	Dr Rajesh Malhotra
1140 - 1150	Sponsor	Apollo Hospitals India	Apollo Hospitals India
1150 - 1220	Global Surgery	Advances in Neuro and Spine Surgery	Dr Sudhir Tyagi
1220 - 1240	Cardiothoracics	Quantum Leap in Cardiothoracic Surgery in Botswana; the Bokamoso Private Hospital Experience	Dr William Manyilirah
1240 - 1300	NSOAP	Factors that determine the decision to delivery interval and its associated poor perinatal outcomes for emergency caesarean births in Princess Marina Hospital	Dr K. L .Ganagagabo
1300 - 1400	Lunch	Lunch	Lunch
1400 - 1420	Plastics	Ascending the Reconstructive ladder - The Journey So Far	Dr Tjinjeka
1420 - 1440	NSOAP	Management and use of Bloods in the Surgical Patient	Dr Namanyane
1440 - 1500	Neurosurgery	Approach to Spine Metastasis	Dr Abiot Kgaodi by Zoom
1500 - 1510	Tea Break	Tea Break	Tea Break
1510 - 1520	AGM	Pre- AGM Nominations	BSS Fellows
1540 - 1600	Cardiothoracics	Pulmonary Echinococcosis presentation at BPH; late presentation and missed diagnosis	Dr William Manyilirah
1600 -	Closure	Closure	Closure
1800 till late	Evening Cocktail	Cocktail Evening - Grand Aria	All Participants

DAY 2 PROGRAM

BOTSWANA SURGICAL SOCIETY
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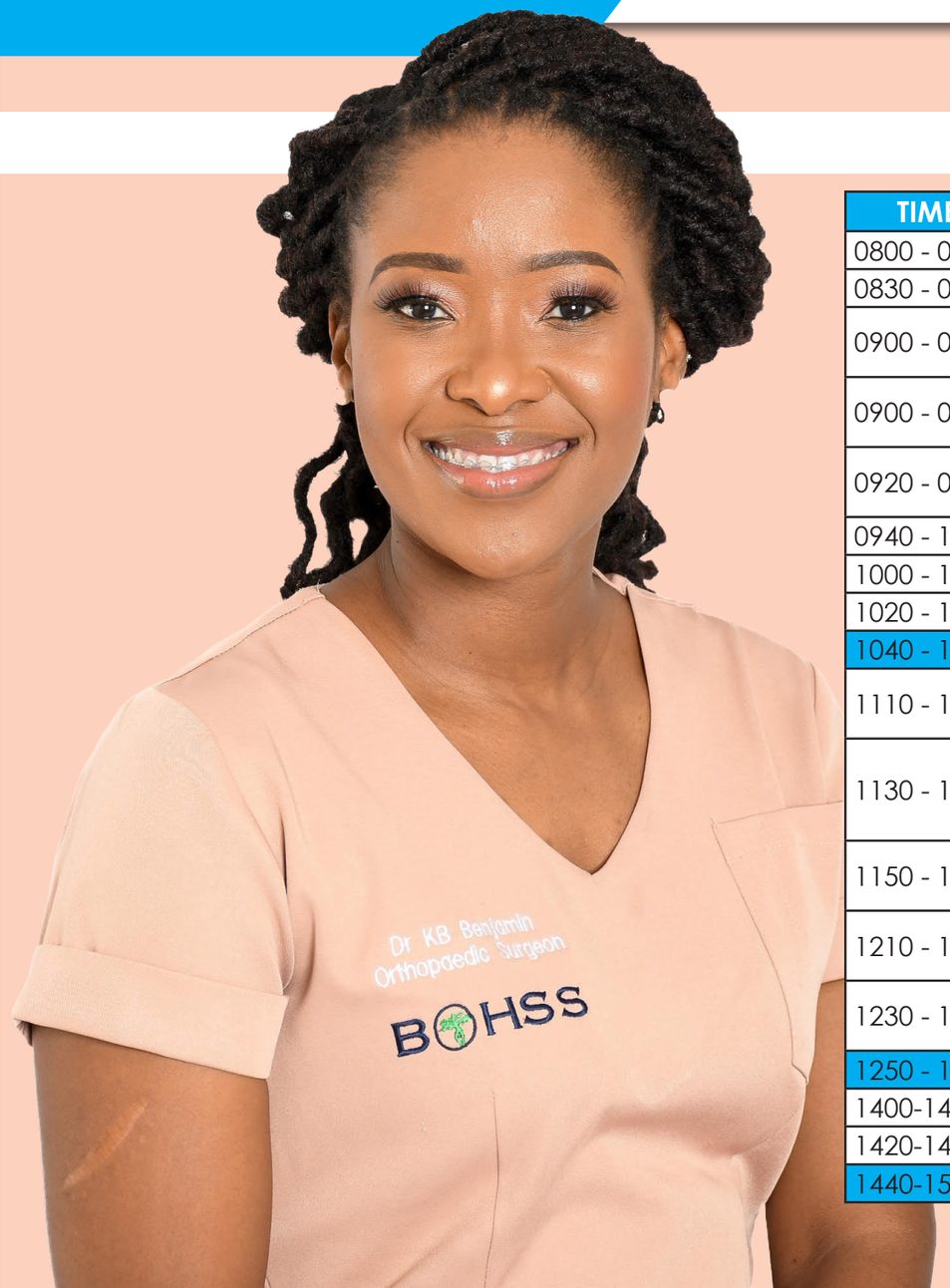


SATURDAY 9 NOVEMBER 2024

TIME	SUBJECT	TOPIC	PRESENTER
0800 - 0830	Registration	Registration	All Participants
0830 - 0900	Surgical oncology	Access to Surgical Care: Still an African Dream?	Dr Ngwisanyi-David
0900 - 0920	Cardiothoracic	Complex Aortic Surgery in Botswana; the Bokamoso Private Hospital Experience	Dr William Manyilirah
0900 - 0920	Vascular	Aneurysmal arterial diseasse- dismantling an atomic bomb before explosion	Prof Pavle Kovaceviz
0920 - 0940	Endocrine	Management of Adrenocortical tumours: Experience in Botswana	Dr Tshipayagae
0940 - 1000	Paediatric Surgery	Management challenges in disorders of sexual differentiation	Dr Hanna Getachew
1000 - 1020	AGM	AGM agenda	BSS Fellows
1020 - 1040	AGM	AGM Elections	BSS Fellows
1040 - 1110	Tea Break	Tea Break	Tea Break
1110 - 1130	Vascular	Superior Vena Cava Syndrome in renal patients- serious Pan-African health problem	Prof Pavle Kovaceviz
1130 - 1150	Medical Education	The Knowledge, Attitude, Practice, and Stressors of Medico-legal Issues among Medical Students, Medical Officers, and Residents: the Botswana Experience	Prof Alemayehu
1150 - 1210	Paediatric Surgery	Paediatric stoma services: provision of care and ensure dignity for all	Chabo Lelaka
1210 - 1230	Cardiothoracics	VATS for complex thoracic disease in Botswana; a case of uniportal VATS pneumonectomy and subxiphoid thymectomy	Dr William Manyilirah
1230 - 1250	Urology	Renal Vein Thrombosis associated with retroviral disease in Southern Africa: Case Report	Dr Mangala
1250 - 1400	Lunch	Lunch	Lunch
1400-1420	Sponsor	Sponsor	Sponsor
1420-1440	Council	Introduction of new council	Outgoing President
1440-1500	Closure	Vote of Thanks	New President

ABSTRACTS

SURGICAL TRAINING IN BOTSWANA. THE ROLE OF THE SOCIETY

INTRODUCTION

The Botswana Surgical Society is an indispensable partner in surgical training in Botswana. The University of Botswana, the College of Surgeons, and the Society collaborate on issues of program implementation, quality assurance, resource optimization, and capacitation. It is in this context that we reflect and report on our partnership performance. The following are the milestones we achieved.

QUALITY ASSURANCE

We applied for Princess Marina Hospital's reaccreditation for FCS and MCS training. The reaccreditation process was successfully conducted on August 20th, and the hospital was reaccredited for the next five years. Furthermore, we conducted a pre-accreditation visit to Nyangabgwe Referral Hospital in February this year and deemed the hospital ready for accreditation. The expansion of training sites is essential in improving access to training and increasing capacity.

On trainers' capacity-building, the University of Botswana, the College, and the society successfully trained 12 trainers by providing the Training of Trainers course. This was the second such course aimed at increasing our pool of accredited trainers. The society continues to work together with the UB and the College to improve the quality and access to surgical training.

CAPACITY

Our programme is fully localised thanks to our partnership. We currently have 10 active trainees. The number of applicants for 2025 has quadrupled, probably an indication of growing demand and confidence in the programme. Two of the 10 residents are expected to write their fellowship examination this year and 2 MCS examinations. The 4 trainees have successfully written their part I examination which was hosted at the University of Botswana for the first time.

Dr Mpapho Joseph Motsumi
PhD(Surgery), MMed Gen. Surg, FCS (SA), FCS(ECSA), MCS(ECSA), MUDr
Head of Surgery Department & Senior Lecturer in General Surgery
COSECSA Country Rep
Faculty of Medicine, University of Botswana

CONCLUSION

The surgical training programme has come a long way. Our challenge is to guide its growth. Surgical training should adapt and respond to society's needs to become locally relevant. This can only be achieved through meaningful collaboration.

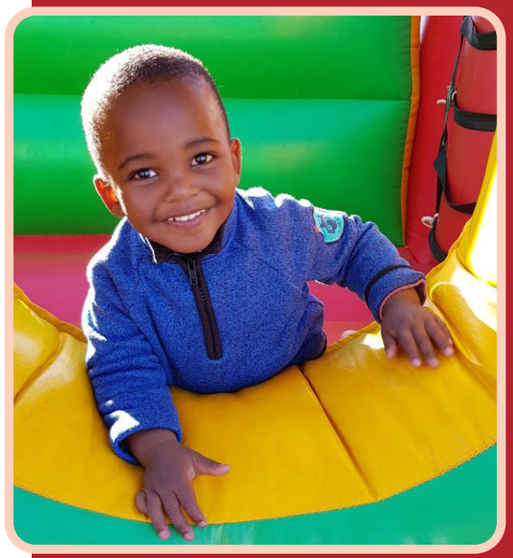
ADVANCES IN NEURO AND SPINE SURGERY

Dr Sudhir Tyagi

As we explore the forefront of these critical fields, the presentation will highlight groundbreaking techniques, innovative technologies, and evidence-based practices that are reshaping patient care.

Recent developments, such as minimally invasive surgical approaches, enhanced imaging modalities, and robotic-assisted techniques, have significantly improved surgical outcomes and reduced recovery times. It will also discuss the integration of personalized medicine and multimodal pain management strategies that are enhancing postoperative recovery and minimizing complications.

The aim is to provide a comprehensive overview of how these advances are transforming surgical practice and improving quality of life for patients.



Dr Kutlo Motlhobogwa
Peadiatric Surgeon

STRENGTHENING CHILDREN'S SURGICAL CARE IN BOTSWANA

Every child in Botswana deserves access to care when they need it.

Children Surgical working group developed a report make recommendations on what needs to be done to ensure the sickest of these children, those who need a surgical intervention, can survive, and thrive.

The report considers how that surgical service can be built on existing successful developments by the Ministry of Health, multiplying that impact as a result.

Creating Centres of Excellence in two main population hubs is the fastest way to bring care to the greatest number of children. More excitingly perhaps, it is also the fastest way to scale up access to care for even the most remote child in Botswana.

A national referral network, upskilling of district hospital teams, surgical camps from the two Centres of Excellence to remote communities, training local people to care for local children.

Dr. Kago Lame Ganagagabo
MBBS (UBSoM) MMed OBGY (UBSoM)

FACTORS THAT DETERMINE THE DECISION-TO-DELIVERY-INTERVAL AND ITS ASSOCIATED POOR PERINATAL OUTCOMES FOR EMERGENCY CESAREAN BIRTHS IN PRINCESS MARINA HOSPITAL

Submitted in partial fulfilment of the requirements for the degree.
Master of Medicine in Obstetrics and Gynaecology
Department of Obstetrics and Gynecology, Faculty of Medicine, University of Botswana
Supervisor: Dr Badani Moreri-Ntshabele Co-Supervisor/s: Prof Justus Hofmeyr

BACKGROUND

Cesarean births are performed for various indications and can be done electively or as an emergency. In the case of the latter, delivery must be done within a certain period of time from decision making to performing a cesarean birth for delivery of the baby. The Decisionto-delivery Interval (DDI) can be affected by multiple factors which can lead to poor perinatal outcomes. Multiple studies show that the recommended 30-minute standard is not achievable in most settings and propose for categorization of emergency cesarean births with different standards for each. This, however, does not contradict the need for optimum DDI to avoid catastrophic outcomes such as fetal and maternal morbidity and mortality which can carry long term physical and psychological sequelae.

AIM

To identify factors that lead to a DDI of more than 30 minutes and associated perinatal outcomes for emergency cesarean births in Princess Marina Hospital (PMH).

OBJECTIVES

- To determine the DDI for emergency cesarean births in PMH.
- To determine factors that affect the DDI for emergency cesarean births in PMH.
- To determine the prevalence of poor perinatal outcomes in relation to DDI more than 30 minutes for emergency cesarean births in PMH.

MAIN OUTCOME MEASURE

The Decision-to-Delivery-Interval for emergency cesarean births in PMH and reasons for delays identified as well as associated poor perinatal outcomes.

METHODS

This study was conducted as a retrospective cross-sectional study within Princess Marina Hospital. It included all women who had an emergency cesarean birth at term during the research period and excluded all patients who had been referred from other facilities for emergency cesarean birth. Data was extracted from patient records and relevant personnel using a data extraction tool as well as oral interviews, and then analysed and presented using EpiInfo and Microsoft Excel.

RESULTS

The study had 246 participants, with majority, 30.5%, being between 26-30 years of age. 61% of the participants were multiparous and 64.2% had no prior cesarean birth. For all cesarean births, only 6 (2.4%) could be done under 30 minutes. The shortest DDI achieved was 14 minutes for a case of fetal distress while the average for category 1 cesarean births was 93.7 minutes and 199.4 minutes for category 2 cesarean births. The study found no statistically significant number of adverse neonatal outcomes for deliveries under or over 30 minutes. The study also found that women had no statistically significant number of adverse maternal outcomes regardless of DDI. The most common reasons for delays to delivery were a lack of theatre space, patient preparation and optimization, and the presence of adhesions during the surgery.

CONCLUSION

The standard of delivery for emergency cesarean births within 30 minutes was not achieved in Princess Marina Hospital. The DDI was not proven to be statistically significant in its effect on poor feto-maternal outcomes, however, improvement of the DDI is still vital in order to avoid adverse outcomes of clinical significance.

KEYWORDS: Decision-to-Delivery Interval, Poor Perinatal outcomes, Princess Marina Hospital

THE KNOWLEDGE, ATTITUDE, PRACTICE, AND STRESSORS OF MEDICO-LEGAL ISSUES AMONG MEDICAL STUDENTS, MEDICAL OFFICERS, AND RESIDENTS: THE BOTSWANA EXPERIENCE

Alemayehu Ginbo Bedada, MD[1]; Tecle Hagos Bahta, LLM[2]; Detlef Richard Prozesky, MBChB, MCommH, PhD[3]

[1]Department of Surgery, Faculty of Medicine, University of Botswana, Gaborone, Botswana
[2]Department of Law, Faculty of Social Sciences, University of Botswana, Gaborone, Botswana
[3]Department of Medical Education, Faculty of Medicine, University of Botswana, Gaborone, Botswana

BACKGROUND

Patients expect health professionals to be proficient and accountable in their clinical practice including applying medico-legal principles. The knowledge, attitude, practice, and stressors related to medico-legal issues among medical students (MSs), medical officers (MOs), and residents have not been investigated in Botswana.

DESIGN

A cross-sectional quantitative study was conducted. An online questionnaire was used to collect data on demographics, knowledge, attitude, practice and common stressors in medico-legal matters. Data were summarized and analyzed to demonstrate significant differences between study groups.

PARTICIPANTS

All levels of MOs (including Medical Officer interns) and residents, and MSs at the end of their first and third clinical years at the Princess Marina Hospital were invited to participate in this study. The overall response rate was 54.9%

RESULTS

The 191 study participants included: 41.9% MSs, 23.0% MOs, and 35.1% residents. Males contributed 52.9% and females 47.1%. Knowledge of 'dual loyalty' conflicts and agencies who handle medico-legal issues was limited. In most cases, residents reported significantly higher levels of knowledge than MOs and MSs. There were no significant differences between the groups in the attitude items related to the medico-legal practice. Residents and MOs reported more frequent practice than MSs and, in several cases, significantly so; one exception being that residents report their medical errors significantly less often than MOs and MSs. Fear of legal consequences and lack or inadequacy of knowledge of medico-legal matters and policies were reported as the most important stressors, though not significantly different between the groups.

CONCLUSION

The three groups reported reasonable levels of medico-legal knowledge and practice but with significant gaps. Participants expected that responsible authorities should provide more medico-legal training and resources. Fear of legal consequences and lack or inadequacy of knowledge of Botswana's medico-legal policies and laws are the leading causes of stress. Consequently, contextually appropriate and locally relevant medico-legal courses should be developed and taught as core courses.

KEYWORDS

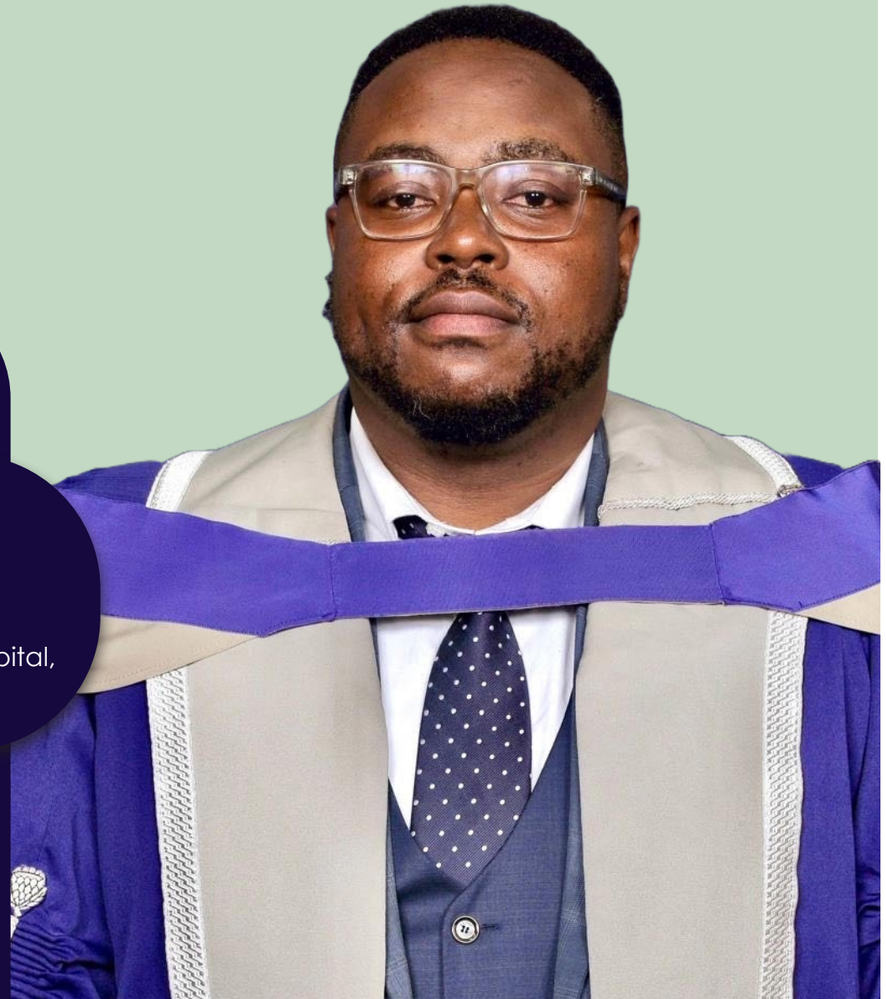
Attitude, Knowledge, Medico-legal issues, Practice, Stressor

Alemayehu G. Bedada, MD, FACS, FCS (ECSA)
Asso. professor of Surgery, Assi. Program Director
Department of Surgery, Faculty of Medicine, UB
Sir Ketumile Masire Teaching Hospital, F2073
LL: +267 355 5614, Cell: +267 73184160

APPROACH TO SPINE METASTASIS

Dr Bakang Abiot Kgaodi

Affiliation: Spinal Surgery Unit;
Groote Schuur Hospital and
Red Cross War Memorial Children's Hospital,
Cape Town, South Africa



INTRODUCTION

Metastasis to the Spine is the most common form of malignancy to the spine, approximately 20x the prevalence of primary Spine tumours. Highest incidence in the 4th and 6th decade of life. The occur in approximately 20% of all patients with cancer. Up to 10% of all spine metastasis require surgical management.

CASE SUMMARIES

Presented is a practical and feasible approach to this very common problem with the help of 2 cases that presented to our unit.

The main case is of a 35-year-old female who presented to casualty with acute onset weakness, myelopathy and back pain. This case illustrates the approach, rationale and evidence for clinical decision making as well as the type and timing of surgery in these instances from an environment easily reproducible in Botswana.

The second case is of a young HIV infected female with a presentation similar to spine metastasis but with an alternative diagnosis. It highlights the importance and nuances in working through the differential diagnosis and highlights the immediate (closed reduction) and definite surgical principles in care.

CONCLUSION

Metastasis to the spine are very common and as such a practical and evidence based approach in the care of these patients in a setting easily reproducible in Botswana is of utmost importance. These cases illustrate how to approach this management from a spectrum of a casualty officer to spine surgeon and thus bridges an existing gap in our care in Botswana.

RENAL VEIN THROMBOSIS ASSOCIATED WITH RETROVIRAL DISEASE IN SOUTHERN AFRICA: CASE REPORT

BY: AM MANGALA, M MODIMAKWANE, WG MABUZA.

Affiliations: Department of Urology, Mafikeng Provincial Hospital, Mafikeng, North west, South Africa.

Renal vein thrombosis(RVT)is a rare but potentially life threatening condition that can occur secondary to several underlying disorders, including nephrotic syndrome and malignancies. This case report describes a 38-year-old HIV-positive woman who presented with a one-day history of right hemi-abdominal pain and right flank tenderness. Upon further investigation, she was diagnosed with acute RVT.The patient's HIV status, coupled with her history of non-adherence to antiretroviral therapy, likely contributed to a hypercoagulable state, increasing her risk of RVT.

The case highlights the growing burden of thromboembolic events in HIV-positive patients in regions such as sub Saharan and Eastern Africa, where HIV remains highly prevalent. The clinical course of RVT in HIV patients can be complicated by HIV-associated nephropathy, immunosuppression, and vascular endothelial injury, all of which contribute to an increased risk of thrombus formation. Diagnostic imaging, particularly computed tomography(CT) and Doppler ultrasound, played a key role in confirming the diagnosis. Treatment involved anticoagulation therapy with low-molecular-weight heparin, followed by a transition to warfarin.

This case underscores the importance of early recognition and management of RVT in HIVpositive individuals, especially those with poorly controlled HIV, to prevent renal dysfunction and other serious complicatons. Further research is needed to explore optimal management strategies for RVT in this high-risk population.

INEQUITABLE ACCESS TO SURGICAL CARE IN BOTSWANA. BREAST DISEASES. EXPERIENCE AT SCOTTISH LIVINGSTONE HOSPITAL BOTSWANA.

Dr Sara Hernández Aranguren.

Specialist in General Surgery.
Master in Medical-Surgical Emergencies and Clinical Oncology, Diploma in Oncological Surgery.
Hospital Julio Trigo López Habana Cuba.

This year 2024, the Society of Surgeons of Botswana wanted to dedicate its Annual General Meeting to demonstrate that there is inequitable access to surgical care in Botswana. As a general surgeon who worked for 5 years in this country, I can show some experience on this topic.

The retrospective review of the 5 years of work done by us at the Scottish Livingstone Hospital in the Molepolole District in Botswana, from 2016 t0 2021 found that 50% of minor surgeries was done to detect and prevent breast cancer.

We also perform surgical treatment as part of the oncological plan for some of the patients who were treated in the specialized breast clinic of reference hospital.

Observing the importance of district hospital as a bridge between the community and tertiary hospitals where medical care exchange is carried out in both directions.

Points became visible that needed to be improved such as the need to carry out systematic controls of statistics of morbidity and mortality studies.

We conclude that there is accessibility to medical services in Botswana, although it still needs to be improved, so we propose feasibility studies should be carried out for the creation of Diagnostic Clinics specialized in Breast cancer based on district hospitals.

GHANZI OUTREACH INITIATIVE

The Botswana Surgical Society fervently champions accessible healthcare and surgical outreach initiatives. In remote communities, accessing healthcare services, particularly surgical interventions, remains an enduring challenge. The vastness of our country presents a challenge as patients are quite a distance of the city.

The BSS team undertook a surgical outreach program to Ghanzi. The aim being to bring surgical services to the Ghanzi district health management team (DHMT) catchment area. This initiative aligns seamlessly with Botswana's commitment to Sustainable Development Goal 3 (SDG3) - Ensuring healthy lives and promoting well-being for all.

The total compliment of surgeons was seven (7) and one anaesthesiologist. There were three general surgeons, one HPB surgeon, one orthopaedic hand surgeon, one paediatric surgeon, and one plastics and reconstructive surgeon. Two radiologists were part of the team and reported on the mammograms remotely. The urologist was available via tele-conferencing.

SUMMARY

The team travelled by road to Ghanzi from Gaborone to reach Ghanzi at 6pm. There was a big community turn out. Ghanzi DHMT staff were on hand during the entire exercise. Age range was from age 4 months to 82 years. The case mix included general surgery, general orthopaedics, orthopaedic spine, paediatric surgery, urology, hand pathology, breast, hepatic and GTI pathology.

Outpatient clinic reviews were done, as well as surgical reviews for inpatients. This ran concurrently with theatre cases. A total of eighteen (18) theatre cases were done.

Three (3) cases were classified as emergency cases:

1. Tendon repair of traumatic hand injury (Inpatient awaiting referral to PMH)
2. Knee arthrotomy and drainage of septic arthritis (inpatient awaiting referral to PMH)
3. Inguinal hernia repair – irreducible and incarcerated

Screening mammography was conducted, with the assistance of the Medlane mammogram mobile unit. A total of 77 women were screen, and remotely reported by two volunteer radiologists. Direct referrals were made for patients requiring urology follow up, orthopaedic spine and arthroplasty surgery, paediatric surgery, breast surgery as well as general surgery, thus expediting management. All specimens collected were delivered to Diagnofirm pathology services for processing.

The day concluded at 2130hrs. The travelled safely back to Gaborone on Sunday morning.

SPONSORS

1. Lenmed Bokamoso
2. Diagnofirm Laboratories
3. Living waters pharmacy Francistown
4. Topnaic enterprises - Maverick medical supplies
5. Medlane health care
6. AfMED Botswana
7. Dr Tshipayagae

BSS LESSONS LEARNED

LESSONS FROM THE BOTSDWANA SURGICAL SOCIETY OUTREACHES

SUMMARY

The Botswana Surgical Society (BSS) has been conducting surgical outreach programs aimed at bridging the gap between primary healthcare, specialized surgical services, and the community.

Our outreach mission is focused on improving access to surgical care, increasing awareness of cancer symptoms, promoting early presentation, and facilitating the path of care for patients with specific symptoms.

Our initial outreach involved volunteer surgeons from BSS, who conducted patient consultations and performed minor surgeries in collaboration with local health facilities. A mammogram truck was utilized for breast cancer screening, while Diagnofirm sponsored pathology testing, enhancing diagnostic capabilities.

Through these efforts, we educated the public on various surgical conditions, including breast cancer, inguinal hernia, and melanoma. The outreach allowed us to assess community knowledge and identify barriers to timely care, enabling us to address these challenges effectively.

We were able to deliver one session of continuous medical education and several health education topics for patients. There was health screening for other non-communicable disease by one of our partners. Around 104 screening mammograms were done and reported.

A total of 266 patients received consultations and 62 minor and intermediate procedures were performed including three emergency cases. Key outcomes included expedited care for urgent cases, such as a 12-year-old with kyphoscoliosis, stab neck and timely referrals for complex cases.

Despite these achievements, we face ongoing challenges, including the need for sustained support from community healthcare personnel and stronger partnership with the Ministry of Health to ensure continuity of care. These lessons underline the importance of collaboration and resource mobilization in achieving equitable access to surgical care in Botswana. An organized surgical outreach to the rural areas can augment the formal healthcare system resulting in improving access to specialized services.

Dr Moneimang Makgasa

MALPRACTICE

Our experience from Scottish Livingstone Hospital

Dr. Sara Hernández Aranguren

INTRODUCTION

Medical malpractice is a scourge for most medical centers around the world, producing a very high personal and social cost. One in ten patients suffers an adverse effect as a result of the medical care received. 48.2% of adverse events are related to medication, the rest are associated with factors such as procedures, care, diagnosis and communication.

The most frequently reported types of medical malpractice:

1. Delayed medical diagnosis
2. Medication errors
3. Anaesthesia errors
4. Surgical errors
5. Institution errors

OBJECTIVES

1. We retrospectively reviewed the 5 years of work carried out by us at the Scottish Livingstone Hospital in the Molepolole District in Botswana during the period from 2016 to 2021, addressing the topic of medical negligence.
2. Identify sources of medical malpractice that may have occurred in the surgery department of Hospital SL.
3. Observe what was the control measures in place to regulate these probabilities of medical malpractice.
4. Describe ways to prevent negligence.

MATERIAL AND METHODS

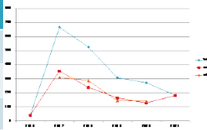
The records of operated cases in the surgical unit were reviewed, as well as the mortality and morbidity reports from the surgery department in the indicated period.

The statistics of all the cases operated in the period of five years were reviewed, extracting those diagnoses that could be related to medical negligence, quantifying and tabulating the data obtained.

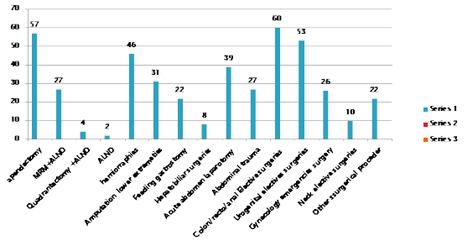
RESULTS

Total of surgeries .SLH 2016-2021

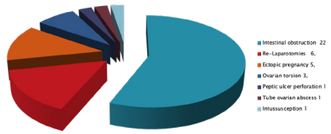
	2016	2017	2018	2019	2020	2021	total
Minor surgeries		312	287	143	143	64	949
Major surgeries	42	356	239	165	129	118	1049
Total of surgeries	42	668	526	308	272	182	1998



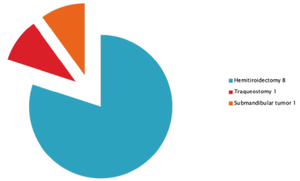
Main diagnoses of patients in minor theatre (20219, 2020, 2021)



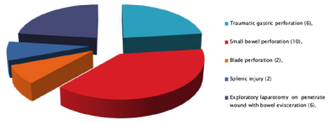
Laparotomies due to acute abmen:2019-2021



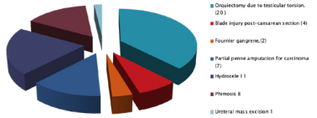
Neck surgeries SLH 2019 - 2021



Abdominal trauma, the main cause of laparotomy:2019-2021



Urological diagnoses in operating room: 2019-21



Gynaecology cause of operation. SLH 2019-21.

DISCUSSION

A total of 762 cases viewed as possible sources of medical malpractice, we were able to detect the following diagnoses:

1. 4 cases of bladder injuries in the course of caesarean sections (0.52% of total cases).
2. Hysterectomies due to uterine rupture and post-caesarean bleeding were 5 (0.65%)
3. Orchiectomy due to testicular torsions with late diagnosis and late treatment, 20 adolescents (2.6%)
4. We did not have any case of surgical negligence as a result of incorrect operations or performed on the wrong patient or on the wrong part of the patient.
5. We observed a low rate of reinterventions, given that only 6 (0.78%) were performed in a period of 3 years.
6. Minor surgeries contributed(44.29%), almost half of the cases, mostly these were excisional biopsies.
7. The biggest challenge here was the massive delay in getting back histology results leading to late diagnoses of breast cancer, penile, as well as melanomas and other skin tumours.
8. Late diagnoses can also be considered as a source of negligence but in this case it was institutional.
9. Morbidity and mortality reports were the only feedback method use to maintain service quality.
10. Other evaluations routines, like deceased evaluation committees, require the presence of other surgical colleagues while in the district hospital there is only one surgeon.
11. The need for interaction with surgeons from other hospitals in the same district and the reference hospital was evident.

CONCLUSIONS

Health institutions can reduce medical negligence with preventive measures obtained from the evaluations of their statistics and the creation of action protocols, measures that can be increased and further standardized in the district hospital of Molepolole SLH.

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Event Manager: **Ms Candy Kelosiwang**
Cell: +267 75004136 / 71785849
Email: kelentsek@gmail.com

Graphic Designer: **Pat Munimonga Mwezi**
Cell: +267 75310586
Email: vamillsmoon@gmail.com

BOTSWANA SURGICAL SOCIETY

Promoting excellence in surgical care

email: botswanasurgicalsociety@gmail.com