MAY/JUNE 2010 | VOLUME 16 | NUMBER 3

THE BULLETIN

Official magazine of the Santa Clara County Medical Association and the Monterey County Medical Society

NEW HEALTH REFORM LAW - *WHAT YOU NEED TO KNOW*

No Preexisting Conditions • New Benefits
Guaranteed Basic Benefits • Required Coverages
State-run Insurance Exchanges • Tax Credits
Financially-sound Medicare

DR. ANDRESEN EXAMINES THE CHANGES, PAGE 6

www.sccma-mcms.org

THE VOID THAT FILLS THE HEART

By Michael T. Margolis, MD, FACS, FACOG

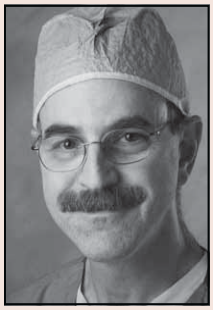
In June of 1992, I had the great fortune to spend a month during my pelvic surgery fellowship repairing vesicovaginal fistulas at a mission hospital in Northern Ghana. Located close to the Gambaga escarpment and hundreds of miles from the next available legitimate hospital, our team of American and Ghanian physicians provided surgical care for locals in the village of Nalerigu. The operating room conditions were primitive, but functional, and the patients were, for the most part, remarkably sick, many with advanced surgical pathology. My wife was in Atlanta, 25 weeks pregnant with our first child. Cell phone technology was not what it is today, so we hadn't been able to speak with each other for a month.

One rather beautiful night around 3:00 AM, a midwife knocked on the door of my guesthouse. Since I'm an OB/GYN, labor and delivery was requesting my help. The midwife informed me they had a patient with a problem. We walked together a hundred yards or so to the hospital, while I inquired about the problem at hand. "A patient has delivered her placenta," she explained to me. "I'm sorry, what's the problem?" I asked. "The patient delivered her placenta," she repeated. Confused, I asked, "Why is it a problem that a patient has delivered her placenta?" "Because the baby won't come out," she said. Shaking the cobwebs out of my head, I remarked, "That's not possible!" "Yes, it is," she said.

Examination of the early teenage patient showed an intact placenta down at her knees. The umbilical cord entered her vagina, and the necrotic fetal caput was jammed against the introitus. I'd never seen or heard of anything like this before. The midwife asked what to do, so I put the patient in extreme McRoberts position, applied suprapubic pressure and asked her to instruct the patient to push! After several hard pushes, a macerated fetus delivered. I estimated that the term baby had been dead 2-3 days. The patient rested a couple hours, then in the morning got up and started walking back to her village, Lord knows how many miles away.

The patient showed little emotion throughout her ordeal. Darwin's theory was good to her that day and she survived. The baby wasn't lucky. There was nothing else to say. She acted as if it was just a matter of fact, and indeed, it was. Unfortunately for the patient, though, what she just experienced was only the beginning of her problems. A brewing postpartum necrotic process was now underway. The problem, unbeknownst to this never-to-be-mother, was that her vaginal and bladder walls had been severely damaged during labor. Anatomy, primitive cultural practices, and limited access to health care would soon combine to produce in her a vesicovaginal fistula.

In short, obstetric injury caused by several days of obstructed labor results in pressure necrosis to the vagina and bladder. In 7-10 days, her genito-urinary tract would slough, resulting in a devastating vesicovaginal fistula. This fistula can loosely be thought of as a "void" of vaginal/bladder wall through which urine continuously leaks per the vagina.



Michael T. Margolis, MD, FACS, FACOG has been an SCCMA member since 1997. He is board certified in gynecology and is currently practicing in the San Jose area.

Soon, her physical, reproductive, and social life will change dramatically for the worse and she will begin to live a life of misery. She will leak urine continuously per her vagina; she will be unable to reproduce; she will be divorced by her husband, ostracized and thrown out of her village because she smells of urine; she will be alone. It will be said by some that she is being punished by God for sins she must have committed.

That was an isolated moment of life in the fistula belt of Sub Saharan Africa in 1992. Bad as it was, the sad fact is, that scenario has been recurring continuously throughout the continent since man evolved in the Great Rift Valley of East Africa 100,000 years ago, and little has changed to this day.

Examination of Egyptian mummy specimens from 2000 BC have provided the first documented physical evidence of ruptured bladder from pregnancy. Clearly, this problem dates back to the origin of our species and the biologic phenomenon known as vaginal delivery. It is estimated

Old and young fistula patients (age approx. 51 and 13 y/o respectively)

that currently at least two million women live with obstetric fistula in Africa and an additional 50,000 to 100,000 new women are affected each year.

Vesicovaginal fistula in Africa occurs almost exclusively as a result of obstetric injury and it is a widespread plague – if you will – throughout the entire continent. Some sources have the rate of fistula development at 1% of all deliveries. These fistulas are the result of a combination of obstetric, anthropologic, cultural, political, and financial factors that blend to form the "perfect storm" of conditions for female reproductive disaster. Of course, the tragic fact that goes without saying is, women who suffer from fistula are the ones who survived childbirth. You have to live to get the fistula. Furthermore, looking at the bigger picture, obstetric morbidity and mortality pales in comparison to other more ubiquitous disease processes in Africa.

Life expectancy for women in the United States is 81 years of age. Despite what some in the political arena might say, Americans live remarkably long and healthy lives despite the self-imposed poor lifestyle habits that many choose to perpetrate upon themselves. Compare this to Uganda, where the life expectancy for women is approximately 51 years of age, and much of Africa is roughly the same. To add perspective, China's life expectancy is 75, Peru's is 72, and India's is 67.

Maternal mortality in the U.S. is 8 deaths per 100,000. In Uganda, it is 510 per 100,000. Uganda has it easy compared to Eritrea, where the maternal mortality is 1,000 per 100,000. It's even worse in Sierra Leone, where 2,000 out of 100,000 women die every year in childbirth.

Why, then, is the maternal mortality rate in relatively "fortunate" Uganda 6,400% higher than here in the U.S., and what interest is any of this to you and me? The first question can be answered easily. The answer to the second question the reader will, ultimately, have to decide for him or herself.

The physical risk factors for birth trauma in African women start with age. Early marriage with childbirth at a young age, before growth of the pelvis is complete, is the most significant risk factor for injury. In fistula patients, the average age at the time of wedding is 13 years old. Ninety-eight percent of women are under the age of 18 when they marry. The average age at the time of first pregnancy is 16 years old, while 81% are under the age of 18. Young girls have first babies well before the bony pelvis is mature enough to accommodate a full-term fetus. The age of maximum fecundity in human females is roughly 22. That is the age that biologic factors most favor reproduction in our species.

Other physical factors include a relatively high prevalence of the anthropoid and android type pelvis in Africans, neither of which favor easy vaginal

The Void That Fills The Heart, from page 21

delivery. Widespread malnutrition further contributes to the development of a pelvis, that is, when it comes down to it, too small to allow for safe passage of a baby.

The social factors causing this problem are rooted in the traditional custom of early marriage. Ironically, young girls are married off to prevent promiscuity and premarital pregnancy. This counterintuitive custom is so ingrained in the culture that change is not even a consideration. Much press was given to the tragic story of a 12-year-old Yemeni girl forced into marriage who died in labor. This phenomenon has been the way of life for such cultures historically, and it continues today. The press has only recently discovered it.

Add to this the generally held belief that parturition is regarded as a normal process not requiring medical attention until complications are at an advanced stage, and the knowledge that people who go to hospitals in Africa often die (mostly because patients are usually moribund with disease by the time they present to the inadequately equipped hospitals) and we start to see the problem.

Finally, poverty and no access to health care in third world countries is a problem of epic proportions. Poverty begets disease. As Americans, we simply do not know how amazingly fortunate we are to live as well as we do. We have an embarrassingly selfish habit of narcissistic preoccupation with "double decaf mocha lata frappa crappa fricken chinos…." At least, that's what I believe.

So then the question becomes, why is this of interest to anyone? I can only speak for myself. Eighteen years ago, I attended a lecture on vesicovaginal fistulas and at that time I knew I had to learn fistula repair so I could help those in need. I chose to leave my pregnant wife for a month so I could go gallivanting off to Africa, and she still lets me know her feelings about that to this day! On the other hand, the month I spent in Ghana and several subsequent missions in Peru and Uganda have been, without question, the happiest times of my professional career. The few times I've gone are nothing, however, when compared to Bay Area titans of mission service such as Henry Hamilton, MD, in Burlingame; Arthur Basham, MD, in San Jose; and Paul Hensleigh, MD (deceased), of San Jose. There are many others whose names are not mentioned for lack of space. These physicians have set the gold standard of humanitarian work for our profession.

The fistula team with fistula patients, Uganda 3/09

Clearly, vesicovaginal fistulas are not the only pathologic entities causing human suffering, indeed in the grand scheme, they are a drop of water (so to speak) in an ocean of pathology and suffering seen worldwide. Every disease entity known to man, and some unknown, afflicts the unfortunate poor of the world and, for obvious reasons, they cannot all be discussed here. Vesicovaginal fistulas are simply the pathologic process that called me into action.

Physicians work hard and are often unappreciated. We spend countless hours caring for our patients and fighting for fair compensation. We miss out on time with our families and still take grief from various sectors. Still, medicine is and always will be an honorable profession. Furthermore, there is great need amongst our fellow beings for help. There is no written duty to help them, but we can help, therefore, in my opinion, we should. Like with the young woman at the beginning of this dialogue, it's just a matter of fact. No emotion need be appended to this. Just do it. Why not?

The opportunity to help those in need is not, by the way, limited to physicians. Those who have served on medical missions have included nurses whose heroic efforts cannot be overstated, respiratory technicians, businessmen, office workers, college students, and even musicians such as my own pianist brother from New York.

Furthermore, non-medical missions abound. Celebrities are well known to campaign for certain causes. Politicians have served as well, including Jerry Brown and our own

local Tom Campbell. Indeed, Tom and his wife Susanne have served numerous teaching missions to Africa, including volunteer work in Rwanda, Eritrea, and Ghana. They have taught on six different occasions during the summer, over the last ten years. Susanne teaches fundraising (to administrators of African universities that need desperately to supplement their budgets), and Tom teaches microeconomics and public finance. He believes his students include the future leaders of each country and hopes they will be more effective in creating real growth and personal opportunity because they obtained some grounding in basic economics. Such unselfish activity must be recognized as true and good work in the service of people in need. It's wonderful to acknowledge that there are ethical politicians from both sides of the aisle, like Tom and Susanne Campbell, who care enough to help.

But if one is looking for a more subjective reason for volunteering, the following passage from a little known thesis on fistula may help to explain part of the reason that I choose to help:

"Carried by her mother and her grandmother, this 14-year-young girl was brought into the examination room smelling offensively. Cachectic from the enormous effort and trauma it had taken her to deliver over a period of four days, a dead male infant, without professional help in the bush, she was too weak to support herself; also, she had developed bilateral drop feet. The very offensive smell was due to the continuous leaking of urine per vaginam from an extensive urethrovesicovaginal fistula and to the passing of diarrheic stools per vaginam from an extensive rectovaginal fistula with total perineal rupture and sphincter ani rupture; the cervix and uterus could not be identified, most of the paraurethral, deep transverse perineal and levator ani muscles were gone, and the labia minora were (sub) totally lost; in fact, she presented with one big cloaca. She had, as well, deep pressure ulcers over the sacrum and both major trochanters; the wounds over the scapulae had healed off with scar tissue. She did not remember very much, as she had been unconscious or semiconscious most of the time. What a change from the proud girl who had been married three years ago to an elderly man who did not want to have his wife around anymore. The only proud thing about her now were her breasts, unbelievably still young and full, as if nothing had happened, reminding us that this was a young girl whose adolescent and adult life had been wrecked at a time when it should have just started."

Approximately 20 post-op fistula patients with the only nurse caring for them.


Fistula patients, Ghana 1992. Pleasant, elegant (even in sickness), appreciative, and always smiling.

Personal Observations
Kees Waaldijk, MD, PhD
The (surgical) management of bladder fistula in 775 women in Northern Nigeria, 1989

How could one know of such suffering and not choose to do something? I don't know. I think most of us are pretty much the same inside, decent human beings who happen to be physicians. I believe most of us could choose to help at some time or another in our careers, and I encourage everyone who hasn't done so to do it, at least once. If you can't go, please donate equipment, money, or supplies. There are many organizations accepting volunteers and some are based in the Bay Area.

If you help, at least some avoidable human suffering will be alleviated, and the service to humanity that you provide will bless you with happiness and fulfillment words can't describe. Go there – wherever *there* may be for you – with a sense of professionalism, service, and humility and feel for yourself; my guess is it will fill your heart, and you will get as much out of the experience as the patients you help, and perhaps even more.

Safe travels.