

Doctors News **East Africa**

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Business
The Greatest Habit of All

Opinion
**Quality of Life: A Health
Care Outcome**

Doctor Profile
Meet the Family Doctor
Dr Jacqueline Kitulu

KENYA

UGANDA

TANZANIA

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Welcome to your professional business and lifestyle magazine, *Doctors News EA*. This 15th edition marks yet another milestone for us. It has been three years of interesting interaction and learning since *Doctors News EA* was founded in 2008. To all who have given us encouraging support, we say thank you and as we head into our fourth year, we look forward to partnerships that are even more fruitful.

Part of *Doctors News EA*'s mission is to keep you informed on new developments in the medical sector. In this edition's What's New section, we have a piece on the recent workshop in which experts in Minimal Access Surgery converged at the International Centre for Minimal Access Surgery in Nairobi. The workshop aimed at promoting Minimal Access Surgery, which is starting to take hold in Africa in a big way. Read about it on page 10.

Our Doctor Profile features Dr Jacqueline Kitulu, who shares with us her experience in family medicine. Business columnist Carole Kimutai has written an informative article about what sets successful people apart- effective personal management.

Read about quality of life as a health care outcome in the Opinion column. We also bring you a Disease Pictorial on recurrent ulcerated pleomorphic sarcoma of the anterior neck region. Also in this issue, the Hospital Profile is about what the National Spinal Injury Hospital is doing to give hope to spinal cord injury patients.

Doctors News EA is distributed to 5000 doctors across East Africa. We welcome you to send us your contribution and comments on editor@eadoctorsnews.co.ke or post them to Sterling Media Limited, P.O. Box 2665-00200 Nairobi.

Happy reading!

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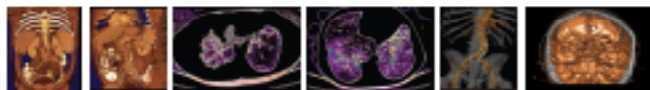
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Integrating Palliative Care in Government Hospitals

In February 2011, the Kenya Hospices and Palliative Care Association (KEHPCA), hosted a group of 40 health care professionals, a multi-disciplinary team that included doctors, nurses, clinical officers, social workers and pharmacists for a six day palliative care course. Those trained will be on the forefront to initiate/coordinate palliative care within the ten level 5 and provincial government hospitals following a circular by the Ministry of Medical Services to integrate palliative care in the services offered by the hospitals.



The National coordinator of KEHPCA, Dr Zipporah Ali (right) facilitating a session during the training

care in Kenya. More patients will have access to palliative care and pain relief through services that are close to them. This initiative is a great measure of KEHPCA's strong advocacy program.

The venue of the training was the Methodist Guest House and Conference Center, Nairobi. Following the training, those trained will undergo clinical placements in the hospices near their working areas.

Some of the topics covered in the training included:

- The principles of palliative care
- Pathophysiology, assessment and management of pain, both in adults and paediatrics
- Symptoms management in palliative care
- Principles of communication and counseling, bereavement, ethical issues among others.

KEHPCA undertook site visits to eight of the ten government hospitals in 2010 after the circular was released and one of the major concerns identified was limited awareness and shortage of trained personnel in palliative care. This course was organized to address this gap in knowledge and assist to start/strengthen palliative care services.

KEHPCA will continue to offer technical support to the government hospitals as they establish palliative care services within the hospitals. This is a great achievement in the history of palliative

Pulse Oximeters for Gertrude's

The Gertrude's Garden Children's Hospital is grateful to The Global Pulse Oximeter Project in partnership with Smile Train International for donating twelve Pulse Oximeters to the Hospital.

Pulse oximeters enable a rapid, non-invasive way of determining how much oxygen there is in arterial blood. The probe has a light source. The haemoglobin absorbs the light and depending on how much is absorbed the processor



Sr Mwaura (R), presenting the equipment to a Jacaranda ward nurse at Gertrude's Childre's Hospital

gives the proportion that is oxygenated. This is dependent on a palpable pulse. Pulse oximeters are used during anesthesia, sedation procedures and recovery phase, in Casualty, ICU, Wards and ambulances.

The device is used to determine when a patient has less oxygen than the body needs before it shows clinically and therefore allows for timely intervention.

Pulse oximetry has greatly advanced patient monitoring over the years. Hopefully, it will be become a routine procedure in Africa.

Improving access to Sexual and Reproductive Health Services

Kenya Red Cross Society (KRCS) has commissioned maternity wards in the North Rift Region, which it constructed in partnership with the European Union (EU), Finnish Red Cross and the Ministry of Public Health and Sanitation.

Beneficiary communities mobilized and participated in the realisation of the goals envisioned in the three-year Sexual and Reproductive Health (SRH) Project. Through the Project, Community Health Workers empowered people with knowledge and skills to increase the demand for reproductive health services offered by the Ministry of Public Health and Sanitation. The Finnish Red Cross source for the Project's funds from the EU.

To address the health inequalities that Kenya suffers, Kenya Red Cross Society is making its contribution in health and development by:

- **Strengthening the individual:** Women in the project site were educated to make health choices, despite the challenges and barriers faced by the poor in changing health behaviour.
- **Strengthening the community** using community development approaches whereby local groups identify their needs and then develop local alliances to address their needs.
- **Partnership with key stakeholders** including the Ministry of Public Health and Sanitation to increase access to sexual and reproductive health services.

However, there is need to address gaps in resource base and to bring in more expertise in reproductive health in Kenya's pastoralist areas. Caring alone without infrastructure and expertise will not solve women's reproductive health problems among the marginalised communities.



Some of the beneficiaries of the Sexual and Reproductive health project in Turkana

In partnership with the Ministry of Health and other experts, KRCS has trained facility level staff in reproductive health services. Further, the Sexual and Reproductive Health Project made various gains including construction and equipping of four maternity wards in Sigor sub-district Hospital, Sekerr Dispensary, Kanakurdio Dispensary and Kaikor Health Centre.

The Project also supported the renovation of dilapidated buildings at Katilu which were converted to a maternity ward. Two fully equipped ambulances were purchased and donated to the Government facilities, with initial support to staff and running cost being covered by the KRCS. The total funding for SRH Project was in excess of Ksh 170 Million.

The Project was initiated to support the Government in addressing the needs for Safe motherhood including supporting referral for obstetrics emergencies, addressing unmet needs for family planning services, gender based and sexual violence, adolescent reproductive health especially with regard to HIV/AIDS and other sexually transmitted infections.

KNH Appoints Acting CEO

Dr. Charles E. Kabetu has been appointed as the KNH acting Chief Executive Officer (CEO) following the expiry of Dr. Jotham N. Micheni's contract. Dr. Kabetu who has over 27 years work experience, joined KNH in 1983 for internship then Senior House Officer Anesthetist in 1984, rising through the ranks to Chief Medical Specialist in anaesthesia in 2001. He became Deputy Director in charge of Clinical Services in 2007. Dr. Kabetu has provided a leading role in anaesthesia and critical care services at KNH. He has also worked in Mater and Aga Khan Hospitals in Nairobi in addition to professional attachment in Westminster, Brompton and Charing Cross Hospitals, UK and King's Daughters Children Hospital in USA. He has also been involved in the Operation Smile Mission (OPSMILE) activities in Kenya where he has served in various capacities including Medical Director, as well as participating in international conferences on establishing global standards of care for OPSMILE in 2007 and 2010.

On Several occasions, Dr. Kabetu has been involved in evacuation of critically ill patients from Nairobi to London and USA. As an experienced Anaesthetist, Dr. Kabetu has published in various journals among them the East Africa



Dr Charles Kabetu

Medical journal. The one time Chairman of Kenya Society of Anesthesiology, Member of the Advisory Committee Getrude's Garden Children Hospital, Dr. Kabetu has served KNH as Chairman of Employee Excellence award, Scheme of Service and Suitability Assessment Committee for Private Wing staff. In addition, he has been a member of the "Skin Care" Committee as well as Head of the Critical Care and High Dependency Units. He is also a lecturer at the Kenya Medical Training College (KMTC) and University of Nairobi. Dr. Kabetu has vast of training and experience in management and corporate governance and has been involved in preparation of KNH Strategic Plans 2005-2010 and 2008-2012.

Dr. John Odero Ong'ech, Head of Obstetrics and Gynaecology department

Dr. Richard Bwana Ombachi: Head of the Accident and Emergency Department.

Dr. John Muihe Maimba, Head of the dermatology Department.

Dr. Hezra Odondi Opere, Head of Anaesthesia Department.

The Mater Hospital Hosts Arthroscopy Symposium

Three leading Arthroscopy specialists from USA led by Dr. Scott Powell recently carried out Knee and Shoulder Arthroscopy operations at The Mater Hospital from 31st January to 3rd February 2011. Over 15 Kenyan Orthopaedic doctors and nurses from local hospitals converged at The Mater Hospital theatres to observe and learn the arthroscopic techniques.

On 4th February, there was a full day Arthroscopy symposium at the Hospital. The visiting surgeons used models and gave the local surgeons the chance to put in implants and practice arthroscopic techniques in a dry lab. They also gave multiple talks on set up, portals, diagnostic scope,



Dr Scott Powell taking participants through a session during the symposium

subacromial decompression, rotator cuff repair, SLAP repair, Bankart repair, ACL reconstruction and meniscus work.

It was a full day of interactive teaching and discussion with intensive exchange of skills. Over 30 local doctors, nurses and theatre staff attended the symposium. For more information, please visit the website www.materkenya.com

Doctors wishing to book their private patients for the next Arthroscopy mission can get in touch with The Mater Hospital through Mr. Boniface Muli on: bmuli@materkenya.com or 0720-556 815.



Participants in a Health Emergencies in Large Populations (HELP) course training in Nairobi. The course is a product of partnerships between The Kenya Red Cross Society, The Ministry of Medical Services, International Red Cross Committee, World Health Organization and Jomo Kenyatta University of Agriculture and Technology (JKUAT). The second HELP course was scheduled for 14th-25th March 2011



A health worker gives the pneumococcal vaccine to a child at the New Kitengela Health Centre on the first day of the vaccine's roll out. The pneumococcal vaccine was launched by H. E. President Mwai Kibaki on 14th February 2011, at the KICC.



The Aga Khan University Hospital, Nairobi held a free public forum themed "Cancer can be Prevented" to raise awareness on preventive measures and the importance of early diagnosis of different cancers. Dr. Patricia Muthaura (centre) an Obstetrician Gynaecologist who made a presentation on the cancer of the cervix discusses the topic with Gladys Karinge (right) and Nyambura Mburu (left) who attended the forum.



His Excellency Mr. David B. Collins (centre), the Canadian High Commissioner to Kenya cut a ribbon to officially launch the new Ophthalmology Referral Centre at Aga Khan University Hospital, Nairobi (AKUH,N) on 28 January 2011. He was accompanied by Ms. Asmita Gillani (left), the Chief Executive Officer, AKUH, N and Mr. Firoz Rasul, President, Aga Khan University, senior hospital staff and guests. Ophthalmology Referral Centre will focus on specialized tertiary referral eye care services, including eye care research and innovation as well as provide training for health care professionals in ophthalmology. Comprehensive eye clinic services will also be available



Prof. Githu Muigai (L) with The Nairobi Hospital CEO, Dr Cleopa Mailu, EBS, during the Children's Charity Heart Fund Annual Golf Tournament, presentation cocktail. The event was held on 18th February 2011 at the Karen Country Club.



A procession of the Cecily McDonnell School of Nursing Graduates during the 2011 graduation ceremony held on 28th February.

“Minimal Access Surgery is the future of surgery”- ICMAS



Participants take a group photo during the workshop

Participants drawn from several medical colleges in Kenya and Uganda recently attended a workshop at the ultramodern International Centre for Minimal Access Surgery (ICMAS) in Nairobi from 26th to 28th January 2011, state of the art facility. The workshop was facilitated by Prof. Ray Garry a world renowned expert in Minimal Access Surgery, from the University of Western Australia, and a leading local expert, Dr. Rafique Parkar. The International Centre for Minimal Access aims to encourage and promote Minimal Access Surgery in Africa, by providing a high quality service delivery, and to conduct regular and sustained training for Surgeons and support staff in the region.

Speaking at the official opening of the workshop, Prof. Robert Armstrong, Dean, Medical College, The Aga Khan University commended the Centre and its ultramodern

facilities and encouraged all medical teaching facilities to promote a mutual relationship in propagating skills in recent surgical technologies so as to benefit patients. At the same function, Prof. Reuben Koigi Kamau, Chairman at the Department of Obstetrics and Gynecology at the University of Nairobi, noted that the facility, which was regarded as one of the best in Africa has already drawn tremendous interest and support, regional, and it was encouraging to see these developments happening in Kenya.

ICMAS is equipped with a high-end, state of the art facility unmatched in the region to perform precision state of the art surgery through these techniques which until recently required large debilitating, ugly and painful incisions on the human body.

Minimal Access Surgery makes it possible for Surgeons to reach various organs in the body cavities through small incisions (Minimal Access).

ICMAS has acquired the complete Access range of endoscopic equipment required for carrying out minimal access surgery. These include: A complete High Definition Tower on boom arms, the Harmonic Scalpel and a wide range of high precision instruments.

Minimal Access Surgery eliminates the need for a large incision, instead Surgeons use an ENDOSCOPE, a thin 10mm telescope-like instrument that provides excellent and magnified interior views of the human body. The endoscope, once inserted in the body, is attached to a tiny camera and light source that allow well-correlated images to be sent through a fibre optic cord to a Medical Grade Monitor. The Surgeon, by watching the monitor can now undertake to perform virtually up to 85 – 90% of the common surgical procedures by using small hand instruments inserted through secondary punctures, which are 5mm in diameter.

Minimal Access Surgery has several advantages over the open methods of Surgery. The overall surgical risk to the patient is significantly reduced, when undergoing this modality of Surgery. The smaller incisions commonly used in this new technique are less traumatic hence patients experience less pain after Surgery. This in turn reduces the need for strong pain medication and even antibiotics. Reduction in Hospital stay invariably makes this method of Surgery much cheaper with less morbidity. Patients recover faster, hence spending less time away from work. Those who undergo Minimal Access Surgery are usually fully recovered and back to work in less than 7 - 10 days, regardless of the complexity of the Surgical procedures performed. This compares favorably to the standard 1 to 6 weeks of postoperative rest and recovery period currently

Minimal Access Surgery makes it possible for Surgeons to reach various organs in the body cavities through small incisions (Minimal Access)

suggested for the “open” Surgical procedures. By allowing patients to return to work sooner, employee sick pay, the need for additional help to care for the children and the need for patient’s relatives to take time off from work are also considerably reduced. Scarring of the stomach wall is also significantly less, which is cosmetically more important, particularly in women in the reproductive age group. Formation of adhesions in the abdomen is less common in Minimal Access Surgery, hence post operative pain and related complications are significantly reduced.

No matter how complex the Surgery is, it is rare for patients undergoing Minimal Access Surgery to require prolonged postoperative hospitalization. This invariably leads to significant economic savings and reduction in patient stress and inconvenience. The economic advantage of Laparoscopic Surgery results in direct, significant and immediate savings to third party payers, employers and insurance firms. This would be one important factor of introducing and embarking on this mode of Surgery. Since operating times are relatively shorter, in trained

hands, the use of expendable supplies are significantly reduced, postoperative hospitalization and morbidity minimized the average cost of the Surgical procedure is comparatively reduced by upto 25 - 30 % of the currently available methods.

All in all it is imperative that these new modalities of surgery are made available to our patients and at the same time they gradually become more aware of the advantages of Minimal Access Surgery.

In any Country, it is the market forces that determine the success of any ventures, and likewise the acquisition of the state of the art health facilities will be entirely dependent on the acceptance and availability of Minimal Access Surgery in Kenya.

The Greatest Habit of All

By Carole Kimutai

“Things which matter most must never be at the mercy of things which matter least.”
- Goeth

I had heard and read many reviews about Dr. Stephen Covey’s book *7 Habits of Highly Effective People*. The book has been on my to-read list for several years now. I have not read the book because of a simple reason – lack of time – an excuse many of us use to explain away important things.

A few months ago, I decided to catch up on my reading by listening to audio books and that is how I finally went through Dr. Covey’s book. The audio version is not a word for word version of the book but a summary so I highly recommend that you get the book and make personal notes while reading. “The Seven Habits of Highly Effective People embody many of the fundamental principles of human effectiveness. These habits are basic; they are primary. They represent the internalization of correct principles upon which enduring happiness and success are based,” he writes.

Defining a habit

A habit is the intersection of knowledge, skill, and desire. “Knowledge is the theoretical paradigm, the what to do and the why. Skill is the how to do. Desire is the motivation, the want to do. In order to make something a habit in our lives, we have to have all three,” writes Dr. Covey.

Of all the seven habits, Habit 3 stood out for me. Remember at the beginning I said my excuse for not reading Dr. Covey’s book was lack of time; Habit 3 struck me deeply because it is about putting first things first – the principle of personal management. In the essay *The Common Denominator of Success* by E. M. Gray – a scholar who spent his life searching for the one denominator that all successful people share – he

found it was not hard work, good luck, or astute human relations. The one factor that seemed to transcend all the rest embodies the essence of Habit 3: Putting First Things First. “The successful person has the habit of doing the things failures don’t like to do,” he observed. Dr. Covey advises people to organize and execute around priorities; the challenge is not to manage time, but to manage ourselves.

Urgent verses important

Dr. Covey has divided our daily activities into a Time Management Matrix with four quadrants. Quadrant I deals with urgent and important tasks, Quadrant II deals with not urgent, but important tasks, Quadrant III deals with urgent but not important tasks, and Quadrant IV deals with not urgent and not important tasks.

Urgent meaning it requires immediate attention. It’s “Now!” Urgent things act on us. A ringing phone is urgent. Urgent matters are usually visible. They press on us; they insist on action. They are often popular with others; they are usually right in front of us and often they are pleasant, easy, fun to do. But often, they are unimportant.

Important on the other hand, has to do with results. According to Dr. Covey, if something is important, it contributes to your mission, your values, your high priority goals. We react to urgent matters. Important matters that are not urgent require more initiative, more proactivity.

Classifying tasks

Quadrant I - urgent and important - deals with significant results that require immediate attention.



Quadrant I activities are often 'crises' or 'problems.' Many people who operate on Quadrant I people are crisis managers, problem-minded, and deadline-driven producers. Management guru Peter Drucker defines effective people are not problem-minded; they are opportunity-minded. They feed opportunities and starve problems.

According to Dr. Covey, Quadrant II is the heart of effective personal management. It deals with things that are not urgent, but are important. Things like building relationships (with workmates, family and friends), writing a personal mission statement, long-range planning (including financial), exercising, preventive maintenance, preparation - all those things we know we need to do, but somehow seldom get around to doing, because they are not urgent. If we spent most of our time on Quadrant II activities, we would be much happier people.

People who spend a chunk of their time in Quadrant III doing 'urgent, but not important' activities think they are

in Quadrant I. They spend most of their time reacting to things that are urgent while assuming they are also important. However, the urgency of these matters is often based on the priorities and expectations of others. Dr. Covey says people who spend time almost exclusively in Quadrants III and IV lead irresponsible lives.

Dr. Covey says effective people stay out of Quadrants III and IV because, urgent or not, they are not important. They also shrink Quadrant I down to size by spending more time in Quadrant II.

Most people say their main fault is a lack of discipline. However, Dr. Covey believes the basic problem is that their priorities are not deeply planted in their hearts and minds. As you set out today, how have you prioritised your activities? This could be what stands between you and success.

*Caroline Kimutai is the Editor of MANAGEMENT magazine, a publication of the Kenya Institute of Management.
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Quality of Life: A Health Care Outcome

By Dr J A Aluoch FRCP, EBS

“It is quality rather than quantity that matters.”

“Life is the art of drawing sufficient conclusions from insufficient premises.”

Quality of Life is tied to perception of ‘meaning’. The quest for meaning is central to the human condition, and we are brought in touch with a sense of meaning when we reflect on that which we have created, loved, believed in or left as a legacy.

WHAT IS QOL? QOL may be defined as subjective well-being. Recognising the subjectivity of QOL is a key to understanding this construct. QOL reflects the difference, the gap, between the hopes and expectations of a person and their present experience. Human adaptation is such that life expectations are usually adjusted so as to lie within the realm of what the individual perceives to be possible. This enables people who have difficult life circumstances to maintain a reasonable QOL.

Quality of life could also be considered the product of the interplay among social, health, economic and environmental conditions which affect human and social development.

The best way of approaching quality of life measurement is to measure the extent to which people’s happiness

requirements’ are met – ie those requirements which are a necessary (although not sufficient) condition of anyone’s happiness – those ‘without which no member of the human race can be happy.’

Quality of Life is often defined in a very negative way, simply as the absence of health threatening hazards from the environment or as the absence of medical problems

Quality of Life is often defined in a very negative way, simply as the absence of health threatening hazards from the environment or as the absence of medical problems. Quality of life (QoL) has become an important outcome indicator in health care evaluation. A clear distinction has to be made between QoL – focusing on individuals’ subjective satisfaction with life as a whole and different life domains –

and health-related QoL (HRQoL), which refers to the absence of pathology.

Patients’ self-reported outcome (e.g. quality of life) have become an increasingly important source of information in health care. This has been helped by a focus on the empowerment of help-seeking individuals and the prevalence of various chronic illnesses. The limited curing effect of treatment services for chronic diseases

such as diabetes and depression, for example, has created the need for long-term treatment and shift from cure to care, with attention to the patients' perspectives. The best known patients-reported outcome is quality of life (QoL). During the last decades various disciplines have focused on QoL, however, the concept is vague and its use inconsistent. Researchers often consider terms like "health status" and "health-related quality of life" (HRQoL) as synonymous with QoL resulting in the inconsistent use of the concept. HRQoL has its foundations in a definition of health and this contrasts sharply with subjective well-being or subjective QoL. It measures the effects of a disease on individuals' everyday functioning, with special attention given to physical and psychological limitations. HRQoL is frequently used in general medicine to demonstrate the absence of pathology. In social sciences and psychiatry, on the other hand, there is a strong focus on respondents' reported satisfaction with life as a whole, including a multidimensional or holistic approach to the concept of QoL.

The quality-adjusted life year (QALY) is a measure of disease burden, including both the quality and the quantity of life lived. It is used in assessing the value for money of a medical intervention. The QALY model requires utility independent, risk neutral, and constant proportional tradeoff behavior.

The quality-adjusted life year (QALY) is a measure of disease burden, including both the quality and the quantity of life lived. It is used in assessing the value for money of a medical intervention

The QALY is based on the number of years of life that would be added by the intervention. Each year in perfect health is assigned the value of 1.0 down to a value of 0.0 for death. If the extra years would not be lived in full health, for example if the patient would lose a limb, or be blind or have to use a wheelchair, then the extra life-years are given a value between 0 and 1 to account for this.

The QALY is used in cost-utility analysis to calculate the ratio of cost to QALYs saved for a particular health care intervention. This is then used to allocate healthcare resources, with an intervention with a lower cost to QALY saved ratio being preferred over an intervention with a higher ratio. This method is controversial because it means that some people will not receive treatment as it is calculated that cost of the intervention is not warranted by the benefit to their quality of life. However, its supporters argue that since health care resources are inevitably limited, this method enables them to be allocated in the way that is approximately optimal for society, including most patients.

The meaning and usefulness of the QALY is debated. Perfect health is hard, if not impossible, to define. Some argue that there are health states worse than death, and that therefore there should be negative values possible

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on the health spectrum (indeed, some health economists have incorporated negative values into calculations). Determining the level of health depends on measures that some argue place disproportionate importance on physical pain or disability over mental health. The effects of a patient's health on the quality of life of others (e.g. caregivers or family) do not figure into these calculations.

Outcomes from treatments and other health-influencing activities have two basic components – the quantity and quality of life. Life expectancy is a traditional measure with few problems comparison – people are either alive or not.

Attempts to measure and value quality of life is more recent innovation, with a number of approaches being used. Particular effort has gone into researching ways in which an overall health index might be constructed to locate a specific health state on a continuum between, for example, 0 (= death) and 1 (= perfect health). Obviously the portrayal of health like this is far from ideal, since, for example, the definition of perfect health is highly subjective and it has been argued that some health states are worse than death.

Construction of such measures has number of uses – to identify public health trends for strategies to be developed, to assess the effectiveness and efficiency of health care interventions, or to determine the state of health in communities.

QALY calculation

The Quality Adjusted Life Year (QALY) has been to combine the quantity and quality of life. The basic idea

of a QALY is straightforward. It takes one year of perfect health-life expectancy to be worth 1, but regards one year of less than perfect life expectancy as less than 1. Thus an intervention which results in a patient living for an additional four years rather than dying within one year, but where quality of life fell from 1 to 0.6 on the continuum will generate:-

1. 4 years extra life @ 0.6 quality of life values 2.4
2. Less 1 year @ reduced quality (1 – 0.6) 0.4
3. QALYs generated by the intervention 2.0

QALYs can therefore provide an indication of the benefits gained from a variety of medical procedures in terms of quality and life and survival for the patient.

Traditionally, outcome in medicine and health care have largely been determined by the objective medical evaluation (e.g. measurable changes in health parameters, disease status, cost of care). Increasingly, it has become clear that the perspective of the patient is also a critical variable. As a result, emphasis has shifted gradually toward including evaluations of medical/health-related outcomes from the patient's perspective.

Such assessments potentially are of use to clinicians, researchers, administrators, and policy makers since that offer a profile of the current state of an individual who is experiencing a particular illness or chronic disease. This provides additional information beyond that offered by traditional medical and clinical measures, and thus is valuable in helping to understand the wide variability in individual responses to similar conditions. For example, some individuals with severe arthritis active in their

work and social relationships, while others with the same or lesser degree of arthritis become virtually housebound and isolated. HRQL effectiveness of treatments.

Many terms are used interchangeably (e.g, quality of life, health status, health-related quality of life) to discuss the effect of diseases, such as arthritis, on functioning and sense of well-being. At the broadest level, quality of life refers not only to health status, but also to environmental and economic factors (e.g, income, educational attainment) that can substantially influence well being. Thus, different conceptual frameworks guide how quality of life is defined and measured.

For example, investigators who are interested in the evaluation of the quality of medical care outcomes tends to place greater emphasis on the development of measures that focus on overall well-being. In contrast, those operating from a medical ethics perspective tend to develop measures assessing the importance that an individual places upon his/her quality of life. As a result, there are hundreds of tests purporting to measure different aspects of quality of life. However, when the focus is on the impact of disease or medical condition on functional health status and well-being as perceived and reported by the patient, health-related quality of life (HRQL) generally is considered the most appropriate aspect of quality of life for investigation. HRQL encompasses emotional, physical social and subjective feelings of well that reflect an individual's subjective evaluation and reaction to his/her illness. Burden of disease and cost-effectiveness analyses are especially useful for quantifying the impact of particular modifiable risk factors, analyzing disparities in QALYs both at the

national and local (community) levels and for small sociodemographic subgroups, and examining changes over time. To integrate quality of life into economic analyses, the effectiveness of the health interventions in question is measured using a metric known as "utility", which is anchored at values of 0 (dead) and (perfect health). Results from cost-utility analyses are reported as cost per quality-adjusted life years (QALYs) gained, which are derived by incorporating the utilities as weights in the life expectancy calculation. The weights are derived from the health-related quality of life (HRQOL) associated with relevant health state. Cost per QALY gained is a unique and preferred measure of the economic value of different interventions because it permits comparison across disease groups.

Is life worth living? Why? Assume science makes you immortal, what will you then do for eternity? Such questions help us to put into perspective just what is satisfying about life and what we would rather discard. But it also highlights that we would not wish to just repeat the same things over and over again-production line style. Even we love becomes boring if we are forced to do nothing else, humans need variety in our lives.

Our definition of quality of life is: The degree to which a person enjoys the important possibilities of his/her life. Possibilities result from the opportunities and limitations each person has in his/her life and reflect the interaction of personal and environmental factors. Enjoyment has two components: the experience of satisfaction and the possession or achievement of some characteristics, as illustrated by the expression: "She enjoys good health." Three major life domains are identified: Being, Belonging, and Becoming.

Recurrent Ulcerated Pleomorphic Sarcoma of the Anterior Neck Region

By Dr Bernard M Ndung'u



Fig 1

A 45 year old Somali lady presented with a rapidly growing mass of the anterior triangle of the neck for a duration of one year. It had ulcerated three months prior to presentation and had a foul smelling discharge from the deep ulcer.

She has had two previous surgeries for a similar but smaller swelling in 2001 and 2005. The histology reports of the previous specimens were not available. Examination showed a middle-aged pale lady with a large hard, non-tender mass in the anterior triangle about 12 × 7 cm with a central ulcer whose floor was covered with a foul smelling suppurative fluid. The edges were inverted and the base was firm (Fig 1).

CT scan showed a freshly large thyroid mass with gross distortion of local anatomy and retrosternal extension. FNAC was reported as mesodermal/mesenchymal tumour and open biopsy was recommended. An incisional biopsy was reported as pleomorphic sarcoma. She was euthyroid.

The patient was prepared for wide excision surgery (Fig 2a and b). Intra-operatively, the tumour was found to have grown into the right internal jugular vein (Fig 3a and b) and encroaching on the phrenic and vagus nerves.

Debulking was accomplished with no residual macroscopic tumour (Fig 4a and b) and the patient referred for a course of radiotherapy (Fig 5).



Fig 2a

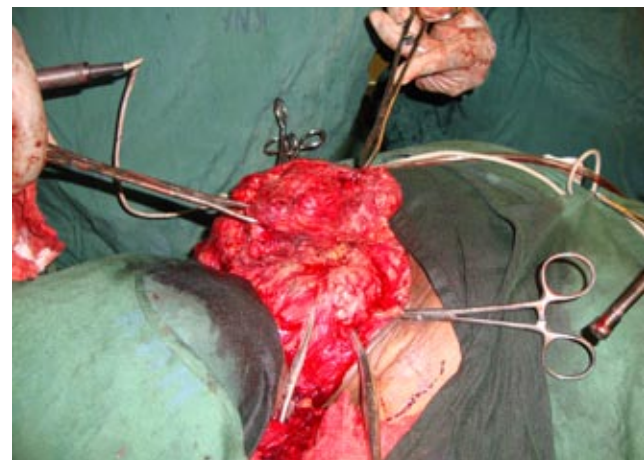


Fig 2b



Fig 3a



Fig 3b

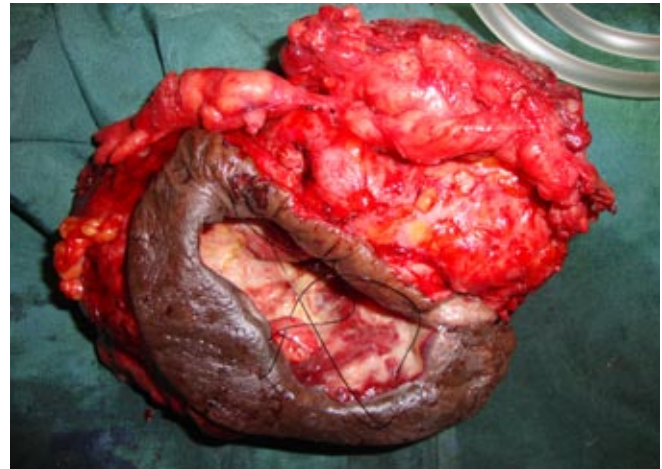


Fig 4a



Fig 4b



Fig 5: Post irradiation

Sarcomas of the anterior neck region occur very infrequently. Riedel's Thyroiditis may be confused on clinical grounds alone with malignant transformations because of its invasive features, but sarcomatoid carcinoma is the main entity to be discarded in this regard. This is accomplished through histological examination by the finding of carcinomatous areas and/or reactivity with epithelial markers. These features set apart sarcomatoid carcinoma from true sarcomas.

This pictorial report concerns a patient with recurrent anterior neck tumour. Although the previous histology reports were not available for correlation and epithelial cell

markers were not performed, the intra-operative finding of invasion of adjacent neck structures and involvement of vascular structures coupled with histological confirmation of two independent pathologists demonstrates it to be a pleomorphic sarcoma.

Sarcomas of the thyroid are aggressive tumours that most likely arise from stromal or vascular tissue within the gland. The mainstay of treatment is wide excision. Radiation therapy may be used in an adjunct setting. They are unresponsive to chemotherapy and recurrence is quite common accounting for the overall poor prognosis.

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Meet the family doctor

By Patricia Muigai

For Dr Jacqueline Kitulu, fulfilment comes from having a job that affords her the opportunity to forge meaningful relationships. As a general practitioner, she gets to interact with a lot of people on a daily basis. “Initially as I was studying in medical school I wanted to specialize in anaesthesia, but I later on realized that I wanted to do something different. I worked at the Nairobi Hospital’s casualty for four years and that was when I realized that I actually enjoy talking to patients as opposed to anaesthesia where there’s not much interaction,” she begins.

Dr Kitulu says that more people are now recognizing the role of a GP. “Many of the younger doctors have specialized in something, and that is okay, because some specialties are seriously understaffed, but that one person who has the entire history of the patient, and knows them in totality is a very important link. You have the patient’s family history and can coordinate treatment—referring and then doing the follow up where necessary. In countries where they have a strong General Practice system, everybody starts with a GP. The GP filters out the cases and identifies what needs to be done to move forward, refers and even follows up, so that if for example the patient is due to return for a checkup, they are reminded about it and so on.”

Born and raised in Nairobi, Dr Kitulu comes from a relatively big family—she is the first-born in a family of six. She decided from early on that she was going to be a doctor. “In my family, there were two doctors that I looked



up to. I admired what they did and decided I would do the same. Being a doctor takes up plenty of my time, but I enjoy it.” She attended Precious Blood Riruta, a Catholic high school where rules had to be followed strictly and everything was streamlined. This prepared her well for her future career, because it shaped her into an extremely organized person.

After high school, Dr Kitulu went to the University of Nairobi, School of Medicine. “Those were six long, tough years,” she says, adding that it is encouraging to see how things have changed since then. “I remember we were ten female students in a class of 100. Now they are almost equal in number, so there will be lots more female doctors in future. This is a big step.”

In 1999, Dr Kitulu joined Avenue Healthcare, and then moved to the Nairobi Hospital about two years later. Here

she worked at the hospital’s busy Accident and Emergency department, where she gained a lot of experience. “Casualty is a good place to start because it exposes you to just about everything and you get to interact with the senior consultants. Interacting with the various consultants also opens your mind to the specialties you may want to do. I established good working relationships with many of them, some of which have lasted to date,” she says. With such a good foundation, it was not difficult for her to get admitting rights to the Nairobi Hospital when she left to do her general practice.

At the Nairobi Hospital, Dr Kitulu also got a lot of training especially on emergencies. There was advanced cardiac life support, pediatric advanced life support and that is how she became a trainer in pediatric advanced life support.

She is a Resuscitation Council of UK (RCUK) certified instructor. “I run training courses at Getrude’s and Aga Khan Hospitals. We go out and train doctors, nurses and other staff on how to manage emergencies. Together with several other emergency trainers, we have formed the National Resuscitation Council of Kenya, in which I am the vice chair. Our aim is to streamline emergency training in Kenya and have our own Kenyan guidelines. This would be in terms of whom trains, the standards they use and if these standards are acceptable and so on.”

Moving to private practice

In 2004, a couple of factors led Dr Kitulu to her current practice. “A relative of mine who was a doctor and a good friend passed on. This was her practice actually. Her husband suggested I take it up. I thought about it and accepted.” Besides encouragement from people such as Dr Musoke and Dr Judy Shaw, the Kenya Association of Family Physicians was getting people interested in general practice and Dr Kitulu was invited to their meetings where her interest in general practice grew. “At the same time they were starting a family medicine program at Moi University. They were looking to design the curriculum and I was in the initial committee. Now here I am seven years later in general practice and enjoying it.”

Coming from casualty where patients constantly streamed in, the pace was at first slow for Dr Kitulu. “Suddenly I was on my own. It was different in terms of, I had been seeing patients purely, and then suddenly here I was in charge of an establishment. I had to familiarize myself with things like accounts, HR, administration, marketing and so on. However, I took it in stride and moved on with it. With time, the practice grew, and I eventually partnered with other doctors at the Karen surgery,” she says. Karen Surgery is a family Medical Practice in Karen, Nairobi.

The Kenya Medical Women’s Association

Dr Kitulu is the current chair of the Kenya Medical Women’s Association. Started in 1983 by Prof Miriam Were, KMWA is an association for female medical doctors and dentists. It is a sister organization to Kenya Medical Association and has about 400 members. “Our strategic plan looks to work towards achieving some of the Millennium Development Goals especially those focusing on women and children’s health. We have partnered with like-minded people on the same.”

In 2008, Dr Kitulu was appointed to the National Economic and Social Council. This is an advisory body to the Government, which encompasses people from different sectors. Its primary mandate is to advise Government on

coordinated policies aimed at promoting economic growth, social equity and employment creation, and at reducing poverty and inequality. “From the medical fraternity there is myself from KMWA and Dr Gakombe of the Kenya Hospitals Association. One of the things we try to do is to get the issue of health financing addressed. This is still a difficult area.”

With all these responsibilities, balancing between work and life is a bit of a challenge for Dr Kitulu. “I have a family—a husband and two children, my practice and all those other responsibilities. One is stretched trying to do the best everywhere. Sometime in 2010, I reached a point where I decided to plan on what I want to continue doing and what I have to drop, because one cannot do everything, other people can do them as well,” she says.

For someone who is already in a private practice, building a career in terms of going back for studies is almost impossible, because the practice will suffer. “I intend to pursue Member of the Royal College of General Practitioners (MRCGP) and a Masters degree in leadership management in the near future,” says Dr Kitulu.

Like in other businesses, obtaining financing for growing a private practice is sometimes a challenge. “Some of the ways around that is having a group practice. Another way is to have proper accounting and auditing. Many times in medicine, we focus on treating patients and forget that we are running an enterprise as well. We as medical practitioners need to work on this area. One can do several trainings on basics of managing a business, things relevant to what one is doing. And I think that should actually be in the curriculum in medical school, so that we are taught how to run a business,” she adds.

Recently, Dr Kitulu was nominated for the Organization of Women in International Trade (OWIT)- Nairobi Chapter, Woman of the Year Award. Every year, OWIT presents this award to an outstanding woman leader who has demonstrated outstanding contributions to the status of women within the international business and trade community.

Typically Dr Kitulu’s workday begins from 5 am and ends at 5.30 pm. “I go for my work out at the gym at five in the morning about four times a week. To unwind, I read obsessively and widely— fiction, biographies etc. I also like volunteering when I can find the time.” She is an External Medical Escort for the International Organization for Migration (IOM) and evacuates medically unstable refugees to new homes in various countries including Australia, Canada and the USA.

Restoring Broken Lives



The National Spinal Injury Hospital is transforming itself into a modern facility as it plays a bigger role in meeting the needs of patients, writes Patricia Muigai

When spinal cord injury occurs, it is life changing, and depending on its severity, may have far-reaching implications; one moment you are freely going about your business and the next; you are confined to a wheelchair for life. Coming to terms with such a situation is not only difficult, but victims often face many other challenges. The National Spinal Injury Hospital (NSIH) is a specialized unit that was set up in 1944 to take care of such patients.

Located in Kilimani area, off Lenana Road in Nairobi, the hospital was initially called the Amani Chesire Hospital, and was privately run. Its mission then was to rehabilitate and resettle soldiers with spinal injuries sustained during the Second World War.

After Kenya attained independence in 1963, the Government of Kenya took over running the hospital and renamed it to the National Spinal Injury Hospital. From a 20-bed capacity unit, the hospital now has a bed capacity of 40, and aims to increase this in future.

The hospital is mainly funded through the Ministry of Medical Services. Owing to the fact that the needs of spinal injury patients are numerous, and being one of the only three such facilities in Africa, the hospital is often overwhelmed by the huge number of patients on its waiting list. Insufficient funds, lack of proper infrastructure, outdated and inadequate equipment and lack of personnel are some of the challenges the hospital has had to contend with over the years.



A Pharmacist dispenses medicine at the hospital's pharmacy

However, the government of Kenya in partnership with various corporations, individuals and organizations are already working together towards transforming the hospital. Dr Dennis Otwor, a doctor at the NSIH said the money the hospital was receiving from the government was hardly enough to develop the hospital. "The average hospital stay for our patients is about three months and most of them are usually the breadwinners in their homes. Therefore, as they stay here the hospital gets very little money from them. Because of that, the hospital can barely survive without additional financial assistance."

The renovations that are currently going on, and which aim to change the face of the hospital have been made possible by donors under the umbrella of the Friends



An ultra modern laboratory

of the National Spinal Injury Hospital. Some of the departments are already complete.

"Before, the infrastructure was generally dilapidated. We are now able to increase our capacity and improve our services because of the donors. We aim to transform this hospital into a model with the capacity to deal with illnesses of the spine beside injury, such as spina bifida, cancer of the spine and others," said Dr Otwor.

Expansion and improved services will also mean reduced waiting time for patients. "The hospital is always 100% occupied. At the same time, it has a waiting list of 150 patients. These are patients in other hospitals and those discharged from hospital waiting at home to come here. Of course, we also have other patients from the East and Central African region."



On going renovations in the wards



Theatre

The long waiting period, Dr Otworì said, has always posed a challenge to the hospital. "As patients wait out there, they are not getting the help they need, and that is a big challenge for us because they may get complications such as recurrent urinary tract infections, which may eventually lead to kidney failure. Some come here emaciated or with severe bedsores. Therefore, the first few months we treat the complications before we can start treating the spinal injury," he said.

Other Services

Even though the NSIH's core mission is to take care of patients with spinal injuries, they have opened their doors to the public for other services. These include a general outpatient department, a specialized orthopedic clinic, specialized general surgical clinic, breast clinic as well as a thyroid clinic. The hospital will soon set up a diabetic clinic.

An operating theatre for both general and orthopedic surgery, assessment of disability in disabled people, an X-ray department, laboratory, physiotherapy and occupational therapy are also available.

Rehabilitating patients who are unable to use some or all of their limbs involves physical therapy. This involves teaching them how to live without having to depend on other people. Apart from that, the hospital takes the burden of resettling these patients.

"We also engage services of counselors. Until the injury, patients have been engaging in normal activity without a problem then suddenly they are paralysed, sometimes for the rest of their life. They also face other problems such as neglect and lack of a social life. Psychotherapy helps them to come to terms with the situation and live positively. We have counselors from the ministry of medical services and volunteers," added Dr Otworì.



Physical therapy in progress at the hospital's gym

The Future

Normally, the NSIH does not admit patients directly, but it is a referral facility. When a person sustains spinal injury, he is taken to the nearest district hospital. After the diagnosis is made, the patient is referred to a provincial hospital then to Kenyatta. Finally, the patient is taken to the NSIH.

The NSIH hopes to be able to admit patients directly and make the admission process more efficient in future. For better prognosis, a patient should be admitted here within six hours of the injury. Such patients have a higher chance of full recovery if the injuries are dealt with within this time. Part of the hospital's expansion plan is the proposed Acute Wing. This would be a 30-bed facility



An Indoor pool

with casualty, an Intensive Care Unit, a High Dependency Unit and a well-equipped operating theatre.

Most of the spinal injuries are because of road traffic accidents, and more than half of these injuries are not complete. However, untrained people handling the injured patients tend to complicate the injuries when trying to assist them after accidents occur. The NSIH aims to collaborate with various stakeholders, such as the Kenya Roads Board and insurance companies in educating the public on road safety, how to manage spinal cord injury and handling accident victims. The hospital further aims to follow up on its patients' treatment after discharging them. They will do this following a proposal they are working on called Outreach Services.